DAILY NEWS BULLETIN

LEADING HEALTH, POPULATION AND FAMILY WELFARE STORIES OF THE Day

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India emerges as global hub for Philips' AI healthcare solutions

Anuja Jaiswal
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Amsterdam: India has emerged as the global development hub for more than 85% of Philips' artificial intelligence (AI) solutions for healthcare, underscoring the country's growing role in shaping next-generation medical technologies even as the company bets on AI-enabled diagnostics to help address India's shortage of advanced imaging services and trained specialists.

The company said its Bengaluru innovation campus has evolved into Philips' largest innovation hub globally and serves as a software powerhouse where thousands of engineers develop AI-enabled healthcare technologies for both Indian and international markets. According to Özlem Fidanci, chief of international region at Philips, India's talent pool, digital capabilities and innovation ecosystem have made it central to the company's global AI strategy.

Despite significant improvements in healthcare access, India continues to face gaps in the availability of MRI, CT and other advanced diagnostic services, particularly outside major cities. Fidanci said the challenge is not a single bottleneck such as cost or manpower but a combination of infrastructure, financing, skilled professionals and technology.

"The biggest opportunity lies in combining data, AI, intelligent software and hardware into integrated solutions that improve productivity across the healthcare system. AI should always work with human supervision, supporting clinicians rather than replacing them," she told **TOI**.

She said AI-enabled MRI systems being deployed in Indian hospitals can reduce scan times by up to three times, while improving image resolution by as much as 65%, allowing hospitals to examine more patients using the same infrastructure.

(The writer was in Amsterdam at Philips' invitation

NEW PRESCRIPTIONS

Once-a-week insulin shots arrive in India; but not for all: Docs

TIMES NEWS NETWORK

Mumbai: Almost 104 years after daily insulin shots were first introduced, Indian patients with diabetes now have access to a once-a-week alternative.

Danish drugmaker Novo Nordisk on Thursday introduced Awiqli (insulin icodec), the country's first weekly basal insulin for adults with Type 1 and Type 2 diabetes. India is among the dozen countries where the product was launched.

For doctors, however, the arrival of the drug is less about replacing daily insulin than expanding treatment options. India has an estimated 101 million people living with diabetes and another 136 million with prediabetes, making it one of the world's largest diabetes populations.

In patients with diabetes, insulin — the hormone that allows cells to use glucose for energy — either isn't produced at all or the body's cells fail to use it properly. While everyone with Type 1 diabetes requires insulin, Type 2 diabetes patients need it only when oral medicines can no longer control their sugar levels, either once or twice a day.

Awiqli reduces injections from 365 days a year to 52 days. Novo Nordisk said it could help overcome one of the biggest barriers to insulin therapy in India — fear of daily injections — which often delays insulin initiation by seven to nine years. The company said clinical trials of more than 4,000 adults, including Indian participants, showed better HbA1c reduction than daily basal insulin.

Delhi-based endocrinologist Dr Anoop Misra said the biggest advantage was fewer injections. "There has been little innovation in basal insulin for nearly two decades. Fewer needle pricks may encourage patients to start insulin when they need it," he said.

iStock

DIABETES BREAKTHROUGH

Doctors cautioned, however, that the weekly insulin is unlikely to replace daily injections for everyone. Endocrinologist Dr Shashank Joshi of Lilavati Hospital said patients would still require regular blood sugar monitoring. "It is a useful addition to our treatment options but would be best suited for patients willing to use technology to manage their diabetes," he said.

KEM Hospital endocrinologist Dr Tushar Bandgar, who led one of the Indian trial centres, said the treatment is best suited for patients who still produce some insulin naturally and require only basal insulin replacement. "Those needing multiple insulin injections every day may not benefit as much," he said.

Dr Bandgar added that newer weight-loss drugs and GLP-1 receptor agonists are already reducing insulin requirements in many patients. "While once-weekly insulin is an important advance, the number of patients needing basal insulin may gradually shrink," he said.

eepanshu, a resident of Dastampur village.

his friends Suraj Singh, Tarun Ku-

report is awaited.

Embryos swapped? Couple seeks clarity

TOI

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New Delhi: Nearly five months after a Gurgaon couple alleged that a Delhi private fertility clinic swapped embryos, they are still awaiting answers, although the Centre has sought clarifications from Delhi's Assisted Reproductive Technology (ART) authorities about the case.

The Union health ministry's ART and surrogacy division sent repeated reminders to the state programme officer (ART & surrogacy) in Delhi govt's directorate of health services, seeking an action-taken report. It also asked about the authenticity of records submitted by the IVF centre.

However, in an order dated July 3, the UT Appropriate Authority under the ART and Surrogacy Act decided to keep its proceedings in abeyance, citing pending judicial decisions and an ongoing criminal investigation.

Rahul Rathore and his wife, Meenu Rathore, filed a complaint against SCIIVF Hospital in Greater Kailash, alleging that during the IVF process, the embryos were swapped leading to the birth of twins who, they claim, are not biologically theirs. The couple has been seeking regulatory action against the clinic since Feb.

In its communication dated June 15, the health ministry said "considerable time" had elapsed since the complaint was first referred to the Delhi authorities. It noted that despite repeated reminders, no inquiry report or action-taken report had been submitted.

The ministry sought detailed verification of whether documents submitted by the hospital — such as consent forms, affidavits, donor records, insurance documents, embryo transfer records, admission and discharge summaries, and other statutory records — were genuine and legally valid.

Union health ministry's ART and surrogacy division sent repeated reminders to the state programme officer in Delhi govt's directorate of health services, seeking an action-taken report

It also asked whether the clinic had complied with the provisions of the Assisted Reproductive Technology (Regulation) Act, 2021, and the ART Rules, 2022, including mandatory documentation, record keeping and donor traceability requirements.

Further, the ministry sought to know whether any records had been forged, manipulated, fabricated or backdated after the dispute surfaced. It asked the Delhi authority to furnish a comprehensive report with supporting evidence on priority.

Days later, however, the Delhi ART authority told the ministry that it would not proceed with the matter.

"Accordingly, the present proceedings are kept in abeyance till judicial determination of the matter. No directions shall be issued at this stage. The matter may be revived after judicial adjudication or if any other exigency requires intervention," the authority said in its July 3 order.

The couple has questioned the decision, alleging that the regulator was delaying the inquiry.

"We have also received a copy of the ART authority's order. As far as we understand, there is no separate judicial inquiry that prevents them from examining the documents or carrying out their own statutory responsibilities. We feel the proceedings have simply been put on hold by using technical language to delay the investigation," Rahul Rathore told **TOI**.

"If everything was done according to the law, then the records sought by the Union health ministry should have been produced by now. We have been waiting for months for answers," Rathore said, adding that while they "feel blessed to have the children they are now raising, they want to know the whereabouts of their biological child".

Novo Nordisk's weekly insulin injection to cost Rs 261 in India

Express News Service
New Delhi, July 9

"I WILL die but not start taking insulin shots," complain diabetics at Dr SK Wangnoo's clinic at Indraprastha Apollo hospital. Others tell him that they are frequent travellers or work long hours at a corporate job and cannot take insulin shots every day, sometimes multiple times a day. Pharmaceutical giant Novo Nordisk's once-weekly insulin injection, icodec, may be the answer.

The drug will be sold under the brand name Awiqli, costing Rs 261 per week, cheaper than insulin already available in the market. With a once-weekly shot, this drug is likely to make a headway in switching patients over to insulin, who don't opt for it in the fear of regular pricks.

"Those living with diabetes for eight to ten years, with pills being unable to control the blood glucose levels, need to take insulin injections to prevent further complications.

> **"By introducing better diabetes management products, we want to bring down the HbA1c level (a measure of average blood glucose levels over the last three months) from 8 to 7 in India."**
>
> **VIKRAN SHROTRIYA**
> MANAGING DIRECTOR OF NOVO NORDISK

Yet, most of them are unwilling to switch to the shots. Around 93% of people wish for diabetes control without the use of insulin and there is a need to change this mindset. Initiating insulin early can prevent damage to the organs, nerve endings, and the eye," said Dr SK Wangnoo.

Vikrant Shrotriya, managing director of Novo Nordisk India, added: "Currently, there are six million people on insulin in India, but this number should at least be double. Insulin is a drug that is never abused and is very effective for the treatment of diabetes, yet people stay away from it. We are hoping that the convenience of using this drug would mean more and more people who are recommended insulin start using it."

Shrotriya said: "The Rs 261 per week cost is cheaper than the current price of other insulin analogues, which can cost anywhere between Rs 345 to 453 a week. This drug will essentially cost around Rs 50 a day."

The medicine will be available in two different doses of pre-filled pens — a 700 unit/ml costing Rs 2,611 and a 2,100 unit/ml costing Rs 7,883. A patient usually needs around 70 units per week, which may need to be scaled up depending on their requirement.

Shrotriya adds: "By introducing better diabetes management products, we want to bring down the HbA1c level (a measure of average blood glucose levels over the last three months) from 8 to 7 in India."

The most common side effect of the medicine is hypoglycemia — a condition where the blood glucose levels fall too much — that can affect one in ten persons. Dr Wangnoo, however, assures that this is the same level as seen with other daily insulin shots.

In type-1 diabetics — those who have diabetes because their body does not produce insulin — hypoglycemic events are more common with this drug than the daily insulin. "This usually happens because of a mismatch in the insulin dose that the type-1 diabetics take before a meal and the calories in the meal," said Dr Wangnoo.

Type-1 diabetics have to continue taking their pre-meal fast-acting insulin shots, but they can replace their daily long-acting insulin shot with this, resulting in fewer pricks.

economic zones and high seas.

vent further complications.

ing director of Novo Nordisk

ducing better diabetes man-

One in ten Indians faces risk of cancer before 75: Here is what WHO data reveals

Anuradha Mascarenhas
New Delhi, July 9

CANCER IS steadily becoming one of India's defining health challenges. According to the latest GLOBOCAN estimates, nearly one in ten Indians is at risk of developing cancer before the age of 75, while about seven in every hundred face the risk of dying from the disease before reaching that age.

India recorded 1.41 million new cancer cases and 916,827 deaths in 2022, while more than 3.25 million people were living with a cancer diagnosis made within the previous five years.

The burden is already increasing. According to estimates presented in the WHO Global Status Report on Cancer 2026, India had approximately 1.6 million new cancer cases in 2024, with around 900,000 deaths. Experts now project that annual new cases could climb to 2.8 million by 2050, driven by population growth, ageing and changing lifestyles.

India and China together account for more than half of the global cancer burden, making Asia the epicentre of the disease. Without stronger prevention and early detection, experts warn the region will shoulder an even larger share of the global burden in the coming decades.

India's growing cancer burden is due to multiple forces acting together. One is the increase of life expectance- as it rises so does the number of people vulnerable to cancer.

Equally important are lifestyle changes accompanying rapid urbanisation. Rising obesity, unhealthy diets, reduced physical activity, excessive alcohol consumption and prolonged exposure to air pollution are contributing to increasing rates of several cancers. Smoking continues to drive lung cancer, while smokeless tobacco products — including gutkha, khaini and betel quid — remain a major reason India has one of the world's highest burdens of oral cancer. Improved diagnostic facilities have also resulted in more cancers being detected than in previous decades; experts stress that this does not fully explain the rising incidence.

Dr Isabelle Soerjomataram, Deputy Head of the Cancer Surveillance Unit at the International Agency for Research on Cancer (IARC) said, prevention has become important in India because lung, oral cavity, cervical, breast and colorectal cancers account for a substantial proportion of the country's disease burden. She points to stark differences in access to healthcare between metropolitan centres and nearby rural districts, where delayed diagnosis is common. India's cancer pattern differs significantly from that seen in many Western countries.

Breast cancer emerged as the country's most common cancer, accounting for 192,020 new cases in 2022, followed by lip and oral cavity cancer (143,759 cases), cervical cancer (127,526), lung cancer (81,748) and oesophageal cancer (70,637).

Among women, breast cancer accounts for more than one in four new diagnoses, while cervical cancer remains the second leading cancer despite being largely preventable through HPV vaccination and regular screening.

ILLUSTRATION: C R SASIKUMAR

Cities provide more opportunities for women to work. Why can so few women access them?

Not till cities reduce time, safety, care costs

KANIKA MAHAJAN

THE LATEST PLFS city estimates from the National Statistics Office seem to offer a hopeful story: India's largest cities provide women with better jobs. In the 46 million-plus cities, 65.1 per cent of employed women are in regular salaried work, compared with 50.9 per cent in urban India overall. Yet female labour force participation in these cities is only 25.5 per cent, lower than the urban average of 27.7 per cent. Big cities produce better jobs, but the real question is why so few women can access them.

It should not surprise us that big cities have a higher share of salaried jobs. This is the equilibrium outcome of thicker labour markets. Large cities concentrate firms and utilities such as schools, hospitals and business services, along with more educated workers. Among women, 29.4 per cent in these cities have college-and-above education against 25 per cent in non-metro urban India. Once firms and skilled workers cluster together, more salaried work follows.

Nor is it surprising that employed women in big cities are concentrated in salaried jobs. Women place high value on non-wage attributes such as predictable hours, formal contracts, paid leave, safety, childcare and transport. Research shows that women's participation rises with the expansion of white-collar work, which offers higher returns and social acceptability. Our research similarly finds that larger firms employ more women, likely because they offer amenities like maternity benefits, transport and paid leave.

The salaried-work statistic must therefore be read carefully, since it is conditional on being employed. It tells us only that among the minority of urban women who make it into paid work, many select into better jobs. It does not mean the city has solved women's employment problems. A city where three-fourths of women remain outside the labour force cannot declare success because the one-fourth who work are more likely to be salaried.

The same caution is needed in reading the earnings numbers. On average, women earn 22.7 per cent less than men, an important disparity, but monthly earnings do not account for hours worked. The PLFS data show that women employed in salaried work work almost 12.6 per cent fewer hours per week than men. In bigger urban cities, this hour gap is slightly larger, at around 14 per cent. A simple accounting exercise shows that fewer hours explain almost 20 per cent of the earnings gap. Adding age, education and occupation raises the explained share to just 30 per cent. The larger point remains that a sizeable earnings penalty for women persists irrespective of city size, pointing to a more general problem of gender discrimination.

The harder question is why female participation is lower in the largest cities than in urban India as a whole. One answer lies in the geography of work, since women's employment is not just a wage decision. Evidence from job-search behaviour shows that women search closer to home and are willing to trade off wages for shorter commutes. Indian evidence on urban mobility points the same way. Women are far less likely than men to step out of the home on a given day, reflecting safety, household responsibility, social norms and weak transport systems. Fewer hours worked reflect similar constraints of care, commuting and safety.

This helps explain why rural India has historically shown higher female work participation. Much rural work is low-paid and informal, but agriculture and allied work is often closer to home and easier to combine with domestic responsibilities. As work moves from farms to firms, non-agricultural growth can exclude women in the absence of safe transport, affordable childcare and quality jobs.

The unemployment data also tell the same story. Female unemployment (ages 15-59) is higher than male unemployment everywhere, but the gender gap is larger in the 46 big cities, at 9.81 per cent for women against 6.49 per cent for men, versus 9.07 and 6.36 per cent elsewhere. Big cities are not merely places where women opt out. They are also places where women looking for work face a harder matching problem.

India's urban agenda cannot treat women's employment as an automatic by-product of growth. Cities need frequent and safe public transport, last-mile connectivity, street lighting, mixed-use neighbourhoods, childcare and regulations that make amenities easier for employers to provide. The real lesson from the new data is that even our best labour markets do not work for women. Until cities reduce the time, safety and care costs of taking a job, they will continue to produce better jobs without producing enough women workers.

The writer is associate professor of Economics at Ashoka University and Co-Lead for Employment at the Isaac Centre for Public Policy

Beyond childcare, four other barriers

ROOPA KUDVA

THERE ARE two things worth cheering about in the latest report of the National Statistics Office on India's million-plus cities. First, female labour force participation has climbed from 19.8 per cent in 2017-18 to 27.2 per cent in 2025, showing the sharpest gain of any group. The second is entrepreneurship — in 32 of the 46 million-plus cities, more than 20 per cent of unincorporated establishments are now run by women. Cities have become India's biggest centres of opportunity for women — and increasingly, it isn't only the big metros. In Surat, Vadodara and Pune, 40 per cent of unincorporated establishments are run by women.

Both numbers deserve celebration, but they come with a catch. Female LFPR, even after this gain, is still barely a third of the male rate of 75.9 per cent. Startlingly, despite the shift in aspirations, nearly 70 per cent of women outside the labour force still cite childcare and home commitments as the reason, proof that this is far from a solved problem.

For the rest, however, four gaps explain why the LFPR gap is not closing faster. Every system that touches a woman's working life — how she gets to work, whether she can occupy public space with the same ease as men, whether she rises once she's in an organisation, whether a bank or an investor will fund her — is designed around a male default.

Mobility: For men, the labour market begins at the workplace. For many women, it begins much earlier — on the street, at the bus stop, at the train station. ORF's Women on the Move study found that over half of women reported experiencing harassment on public transport, and a similar share perceive it as unsafe. Women also rarely have linear commutes — their journeys are "chained", dropping children to school, managing errands, on the way to or back from work — while our transport systems are still built around a simple home-to-office trip. If transport isn't reliable, safe or built for how women actually move through a city, labour supply shrinks before an employer even sees the candidate.

Public spaces: The deeper problem is beyond the commute. Look at our public spaces — you rarely see women simply sitting in a park alone, lingering in a café, or spending time on a street without a clear purpose. Women feel they must be doing something legitimate to justify their presence in public space. That's a very different problem from safety alone, and it's one policing can't fix. The answer is designing cities that assume women are full participants in public life — not those who need a reason to be there.

Career progression: Even women who clear the first two hurdles run into a third: They don't rise at the rate they enter. Only 5 per cent of NSE-500 companies are women-led. For years, the explanation has been maternity breaks and caregiving. That narrative is tired and incomplete — it explains some exits, but not why so many women who stay still don't progress into leadership.

A large part of the answer is unconscious bias. Successful women are often less liked than successful men, because traits like assertiveness and driving accountability conflict with longstanding expectations that women be accommodating and nurturing. A firm view from a man reads as conviction; from a woman, as sharp. Women are asked to deliver outcomes while continuously managing tone and perception — and that shapes self-belief and choices, sometimes unconsciously. That is why, as one report showed, men apply for roles when they meet 60 per cent of the qualifications, while women wait until they meet nearly all of them.

This is where the conversation usually runs into a familiar objection — that supporting women somehow means compromising merit. Far from it. Promoting women isn't anti-merit; it's how you actually give yourself the chance to uncover more of it. Organisations that effectively exclude half the workforce aren't protecting standards. They're narrowing them.

Funding: The fourth gap is capital. Women-led MSMEs in India face a credit gap of around 35 per cent, held back by inadequate collateral, lower property ownership and financial literacy. Further up the ladder: Less than 5 per cent of India's VC funding goes to start-ups with a woman founder. Part of the reason is pitch-room dynamics. Studies have shown that investors ask women founders more "prevention" questions — about risk, safety, what could go wrong — while men are asked "promotion" questions, about growth and scale.

Cities have opened a door for women that didn't exist a decade ago. But walking through it still means clearing a commute, a public square, a boardroom and a bank. Until all four are rebuilt for her, closing the gap with men will take far longer than it needs to.

The writer headed Crisil and ONI

YASHEE

Spend on your child's future, draw a line

SBI HAS a new ad. I have multiple questions. The ad says, "Your child will study mechanical engineering and then start a yoga studio. Get ready for life's surprises with long-term SIPs." I duly sat down and thought about long-term SIPs.

The more I thought, the more it left me confused. Am I being asked to plan for my retirement years because the yoga-instructing child won't be able to provide for me? Am I supposed to save so I can fund her yoga studio? Would the mechanical engineer automatically have been the provider type? Turning to the internet for an answer, I searched "SBI mechanical engineer yoga ad". Turns out, other insurance firms have similar offerings, and there is quite a conversation on the subject on social media. From these, some common threads emerged. There is the earnest "dignity and independence in your silver years" framing. There is the rather aggressive "spend on yourself, don't leave a penny for these ingrates" framing. There is the sappy "be the wind beneath your children's wings forever" framing.

Where will you draw the line on spending money on your child, assuming money is neither unlimited nor so limited as to make such thought experiments unnecessary? Millennial parents are a conflicted lot. We are overflowing with good intentions, but not quite sure where to direct them.

The answer, I realise, is learnt early in parenthood. The same struggles you had about time when your kid was a baby will be repeated with money when they are older. Whatever worked for you then will work in the future.

I tried being the martyr mom when my daughter was born. Every waking moment (and most moments were waking moments) was to be spent in her service, every recommendation of what is "best" for her to be followed, irrespective of the cost to me. Did not work out great. I was tired, yes. But more than that, I was resentful and bitter.

Thankfully, I soon realised what my kid needed most of all was a happy mother. A mom who could summon genuine enthusiasm for playing with her, not just a sweaty sense of duty. However, I do know friends who can put up with all sorts of hardships as long as they are meeting the standard of "responsible and dutiful" they have set for themselves or inherited from their parents.

The same approach works for money.

Spend on your children till it doesn't make you resentful. Spend on them till the point you can do so without expecting returns. Spend out of duty if it makes you happy, but remember, they have no obligation to feel the same sense of duty. Stop the day you start reminding them of how much you have spent. Instead, tell them that you need to look after yourself too, and this is all the money you had for them. If that makes them resentful, that is for them to figure out. And you have to make peace with their resentment. Better to deal with someone else's resentment in reasonable comfort than simmer yourself while also worrying about money.

Our job is to educate them, equip them for the world, teach them how to make choices, and then stand back and watch them make those choices. If the choices go wrong, we can shelter them till they feel brave enough to make new ones. Our job is not to fund the choices and then weigh them down with our expectations. I would much rather enrol in my kid's yoga studio than fund an expensive mechanical engineering Master's and expect her to pay for my medical expenses later.

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Fatty liver disease is India's silent epidemic

N is not yet 60. She is a professor and advocate of healthy living, who walked into her doctor's clinic for a routine blood test expecting reassurance. Instead, her report showed elevated liver enzymes. She was incredulous, saying she had never touched alcohol, was a vegetarian and had always followed a healthy lifestyle. But, she also had hypertension and diabetes, both of which ran in her family. That was the clue.

The likely explanation was metabolic dysfunction-associated steatotic liver disease (MASLD). Most people still know it as fatty liver. Until recently, doctors called it non-alcoholic fatty liver disease. In 2023, liver experts renamed it because the old name was misleading because alcohol is not the central issue, metabolic dysfunction is. That distinction matters enormously for India, because there is a silent crisis happening. MASLD happens when fat builds up in the liver in people with excess weight, or with diabetes, high blood pressure, or high cholesterol. You can be a lifelong teetotaler, a vegetarian and a disciplined person and still have it. In India, pooled estimates suggest fatty liver disease may affect around 38% of adults, that is over 100 million people. An important driver is India's diabetes epidemic. The International Diabetes Federation estimated that about 90 million Indian adults were living with diabetes in 2024. Many more have pre-diabetes or do not know they are diabetic. And, where diabetes goes, fatty liver follows.

Milind Javle

The frightening part is that most with MASLD have no pain, symptoms or warning. A routine blood test may be normal or only mildly abnormal and a person can look and feel healthy while fat, inflammation and scarring quietly build inside the liver.

Over decades, some will progress to MASH, the more aggressive inflammatory form. Some will develop fibrosis, cirrhosis, liver failure or liver cancer. The consequences of today's epidemic may not be seen for 20-30 years, when Indians now in early middle-age begin presenting with advanced disease.

This is why liver health can no longer be an afterthought. The problem is that ordinary tests often miss the disease or underestimate its seriousness. A standard ultrasound can detect obvious fatty liver, but it can miss earlier disease and cannot reliably measure scarring. Better tools exist, such as FibroScan, which is quick, painless and estimates liver stiffness and fat. MRI-based techniques are among the most accurate non-invasive ways to measure scarring and fat.

The good news is that fatty liver is often reversible, not with miracle cures, but with the boring things that actually work: weight control, diabetes control, blood pressure control, cholesterol control and regular physical activity. Losing 7-10% of body weight can reduce liver fat and inflammation. Losing 10% or more can begin to reverse scarring in some patients.

This is the most powerful medicine.

The case for starting early is even stronger. The seeds of liver disease in later life are often planted in childhood, college and early adulthood. Until recently, lifestyle change was almost all doctors could offer, and that has changed. The US FDA has approved resmetirom, sold as Rezdiffra, for MASH with moderate to advanced fibrosis, and semaglutide, sold as Wegovy, for MASH. Semaglutide is already available in India, and resmetirom is being introduced through Indian trials and manufacturing plans. These drugs do not replace lifestyle change, they make early diagnosis more important.

Cancer surveillance remains complicated. And for people with cirrhosis or advanced scarring, experts recommend regular monitoring. For the much larger group with simple fatty liver, the right screening strategy is still being worked out. But uncertainty is not an excuse for inaction.

India needs to treat MASLD as a public health threat. The Lancet Commission on liver cancer projects that new liver cancers worldwide could nearly double, from about 870,000 in 2022 to roughly 1.5 million by 2050 if current trends continue. The response should be simple and national: First, prevent obesity early through better food, more activity and honest public education. Second, fold liver checks into routine care for every Indian with diabetes, hypertension, obesity or high cholesterol. Third, make FibroScan and other non-invasive tests widely available. Fourth, closely monitor those with advanced scarring. And fifth, treat early, before damage becomes irreversible.

N's abnormal blood test was a critical and timely warning. Caught early, her fatty liver can likely be reversed. India has the same chance, but not forever. This is not just about the liver; it is about diabetes, diet, schools, food systems and hospitals. If India waits to act, the silent epidemic in our livers will soon become impossible to ignore.

Milind Javle is Herbert L and Olive Stringer professor and clinical medical director — GI Service Line, GI Medical Oncology, UT MD Anderson Cancer Center, and chair, NCI Task Force Hepatobiliary Cancers. The views expressed are personal

situations. West Asia is a ready testing ground.

Checking the spread of cancer in India

One in five people will possibly be diagnosed with cancer in our lifetime. What determines whether that diagnosis is survivable, per the World Health Organization (WHO)'s new *Global Status Report on Cancer* released this week, is geography and income. Five-year survival exceeds 85% in high-income countries and falls below 30% in low-income ones. The clearest evidence of the divide comes from new WHO estimates for breast and childhood cancer survival. For breast cancer, five-year survival is 87% in wealthy nations against 42% in poor ones — a difference not of tumours but of systems.

This is not a knowledge problem. WHO all but admits it: The science exists, the plans exist; the money and the delivery mechanism do not. National cancer control plans exist in 82% of countries, up from half in 2010. But fewer than four in 10 include cancer care in universal health coverage, and only 12 are on track to meet WHO's 2030 mortality-reduction target; 48 are moving backwards. Essential cancer medicines are stocked in 9% to 54% of low- and lower-middle-income hospitals, against 68% to 94% in wealthy ones. HPV vaccination — the strongest protection against cervical cancer — has been folded into 85% of national immunisation programmes; only 31% of girls have actually received it. In India, a national cancer control programme has been running since 1975 and survival has slowly improved, but the programme is yet to get basics in order. According to the last national health survey, fewer than 2% of women aged 30-49 had ever been screened for cervical cancer, fewer than 1% for breast. What failures such as these translate to is this: At least 45% of patients face financial hardship from a diagnosis; treatment abandonment reaches 90% in some settings. This is not because modern medicine has failed, but because a diagnosis in most of the world still means a choice between treatment and solvency.

Cancer cases are projected to nearly double by 2050. Whether that surge is met or merely counted depends entirely on whether commitment turns into capability. The choice, as WHO frames it, is ours to make.

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AIDS prevention society launches drive to improve HIV diagnosis in Karnataka

Afshan Yasmeen
BENGALURU

More than 56,000 people in Karnataka are estimated to be living with HIV without knowing their status, the highest such number among States in the country. This is posing a major challenge to the State's HIV control programme despite free testing and treatment services being widely available, with the changing nature of sexual networks adding to the complexity.

As per estimates from the Karnataka State AIDS Prevention Society (KSAPS), 56,406 people are unaware of their HIV-positive status, making early diagnosis and linkage to treatment a key public health priority. While over two lakh people are already receiving treatment, officials said, the focus is now on identifying those who remain outside the healthcare system.

Over 56,000 in Karnataka are estimated to be unaware of their HIV status.

KSAPS Project Director Padma Basavanthappa told *The Hindu* that one of the biggest hurdles is the changing nature of sexual networks, with increasing numbers of people meeting partners through dating apps.

No voluntary testing

Ms. Basavanthappa said the problem was compounded by the reluctance of people to voluntarily undergo HIV testing. "People still do not walk into testing centres on their own. Many believe they are not at risk, while others avoid testing because they fear stigma and discrimination," she said, pointing out that awareness about HIV transmission also remained inadequate.

To address the gap, KSAPS has launched the Mobilisation for AIDS Suraksha campaign. As part of the campaign, initiated by the National AIDS Control Organisation (NACO), KSAPS has introduced a BreakFree QR code that links users to a confidential self-risk assessment, nearby HIV testing centres and counsellors.

The self-assessment tool asks users a series of questions to determine whether they may be at risk and guides them to appropriate services while protecting their identity.

Gone girls

The death of 14 girls from the Juang community, a Particularly Vulnerable Tribal Group from Odisha at a seafood processing plant in Tamil Nadu's Tiruvallur has brought to the fore the socio-economic realities of marginalised tribal populations despite decades of targeted interventions. Satyasundar Barik visits the Juang villagers who lost their daughters to understand what went wrong in the development journey

When the MGR Chennai Central-Bhubaneswar Superfast Express pulled into the Bhubaneswar railway station on the morning of June 27, Sari Juang, along with her two younger sisters, had just cheated death by a mile. The over 1,800-km journey back to their home State followed a deadly ammonia gas leak at their workplace – a seafood processing plant in Tamil Nadu's Tiruvallur – on June 21.

Sari and her sisters Sasmita and Sumi were witness to the death and destruction caused by the gas leak that tore through the seafood plant, killing their co-workers, mostly women and minor girls from Odisha. Of the 17 migrant workers who died, 14 were from Odisha – all in their teens and from the Juang community – two from Assam, and one from Jharkhand. Some of the workers are still undergoing treatment in hospitals in Tamil Nadu.

According to survivor accounts, the gas leak occurred outside the workers' residential quarters during night, exposing them to toxic fumes while they were asleep. Following initial investigations, officials said labour contractors specifically hired women and even minor girls from the Juang tribal community – a Particularly Vulnerable Tribal Group (PVTG) from Odisha – after luring them with the hope of steady income and advance payments to their families.

By the time Sari reached her village, Kodipasa in Banspal block of Keonjhar district, two of her closest friends had already been cremated.

The Juang community lives in scattered hamlets across the hill districts of Keonjhar, Angul and Dhenkanal, and survive on shifting cultivation and forest produce. The women and girls of Kodipasa leaving their home and travelling the length of the country wasn't usual until recently. "Because of low literacy and non-exposure to the outside world, Juangs are not familiar with migration," said an official of the Tribal Welfare Department. And yet at least 20 girls – three more girls from the village are on ventilator support in Tamil Nadu hospitals – from one village made the journey to the Southern State drawn by the promise of a good income, ₹15,000 per month, for each worker.

'No other option'

"What choice did we have?" Sari retorted. "We are four sisters and two brothers. Our father died years ago. Whatever little our mother earns is not enough to feed all of us. Beyond subsidised rice [provided under the public distribution system], we have nothing," she said. The sisters, aged 18 and below, had set out to Tamil Nadu to earn enough money to build a liveable house in Kodipasa.

Keonjhar is also the home district of Odisha Chief Minister Mohan Majhi, whose government has announced an ex gratia of ₹10 lakh for the families of the deceased. A little away from Sari's home, Basang Juang, 50, pointed to a newly laid tin roof funded by ₹8,000 sent home by her daughter, Phulamani, 18, who was among the first five Juang girls who died in the gas-leak incident.

"My daughter used to travel 10 km every day to Keonjhar town to work as a construction labourer. Even that work was irregular. So, she chose to travel to Tamil Nadu," said Basang.

Two huts away lived Sujani Juanga, in her mid-teens. Her family includes an alcoholic brother, an intellectually challenged sister, and another sister who returned home after marriage. Their mother runs a living working odd jobs. Before she succumbed to the ammonia leak, Sujani had managed to send home ₹4,000 in two instalments.

The poverty and distinct cultural practices of the Juangs led to their identification as a PVTG. To address their development needs, the Juang Development Agency (JDA) was established at Gonasika in Keonjhar in 1978, with a mandate to serve 8,490 people across 35 habitations. Sari's village, Kodipasa, is one of these hamlets.

Nearly five decades on, the presence of a dedicated agency, however, seems to have brought little change to the lives of the people. While infrastructure has improved with blacktopped roads reaching Kodipasa over the past decade, the socio-economic conditions of the villagers remain largely unchanged.

> "My daughter used to travel 10 km every day to Keonjhar town to work as a construction labourer. Even that work was irregular. So, she chose to travel to Tamil Nadu"
>
> **BASANG JUANG**, mother of a victim

The Odisha SC and ST Development Department highlights the establishment of the Kodipasa Ashram School, a residential institution, as early as 1988. Decades later, its impact appears limited. Most boys and girls leave the village soon after appearing for their Class 10 examinations, migrating to other States in search of work.

"The primary source of livelihood for all Juang families in Kodipasa is daily wage labour," said Saibati Juanga, a village elder. "Only one boy had enrolled in college, only to drop out later. We have no alternative means of livelihood except construction work. It is physically demanding, wages are low and irregular, and migration to other States remains the most practical option for our children," said Saibati.

According to the latest report of the Comptroller and Auditor General (CAG) of India on 'Functioning of Micro Project Agencies for development of Particularly Vulnerable Tribal Groups in the State', the literacy rate among villages covered under JDA was 30.18%, decades after focused intervention efforts began.

Fifteen kilometres away, in Rimuligbar hamlet of Banspal block in the district, grief hangs heavy at Sadhar Juang's home. The ammonia leak claimed the life of his 19-year-old daughter Champabati, the first earning member of her family to travel beyond Odisha. Their one-room mud house shelters six members. Champabati had migrated with the hope of improving her family's condition and completing the half-constructed concrete house sanctioned under the Pradhan Mantri Awas Yojana (Rural). Her story echoes that of many Juang girls who died, and those who returned.

Jula Juang, 21, a friend of Champabati, said, "There are 25 Juang families in Rimuligbar, and their financial and social conditions have been worsening. Once we cross 10, we are expected to take care of ourselves. Where will the money come from for clothes, shoes, or even basic necessities? Families are unable to bear the cost. Leaving home is the only option for us even if the workplaces are unsafe."

Champabati's parents said they want to work under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), which has now been replaced with a new scheme. But there isn't any work, they said, adding that this is why their daughter was forced to go to Tamil Nadu.

Odisha is home to 64 different tribes, constituting 22% of the State's population and 9.17% of the country's tribal population. In terms of the number of both Scheduled Tribe communities and PVTGs, Odisha has the highest number of ethnic groups among all States, said A.B. Ota, former Director of the State-run Scheduled Castes and Scheduled Tribes Research and Training Institute (SCSTRTI).

Some hard facts

During the 5th Five Year Plan (1974-79), the Centre decided to focus on development of vulnerable tribal groups and identified 75 such groups in India. Out of the 75 PVTGs identified in the country, 13 groups belong to Odisha with a population of 2.54 lakh. As many as 20 micro-project agencies or State-level tribal welfare bodies, including three new ones, have been functioning since 1976-77 across 14 districts of the State.

The PVTGs receive grants under Special Central Assistance to Tribal Sub-Scheme under Article 275 (1) of the Constitution and Conservation-cum-Development Plan (development of infrastructure, education and health). Besides, regular welfare development programmes of State and Centre are also implemented for the PVTGs.

The Odisha PVTG Empowerment and Livelihood Improvement Programme (OPELIP), an externally aided project with the objective to achieve enhanced living conditions and reduced poverty of PVTGs, was implemented between 2018 and 2024 with an outlay of ₹711.21 crore. Of this, ₹228.29 crore was a loan from the International Fund for Agricultural Development (IFAD).

Apart from this, the Central government came up with the PM-JANMAN Mission with an allocation of ₹24,104 crore for holistic development of PVTGs between 2023-24 and 2025-26. Odisha, with 13 PVTGs, has been a major beneficiary.

Additionally, the ST and SC Development Department has proposed to implement OPELIP-II with an estimated ₹2,422.11 crore from IFAD that includes a loan of ₹1,733.88 crore. The proposal has, however, not received a final go-ahead from the Finance Department.

According to CAG, during 2019-2024, the 17 micro-project agencies received ₹187.55 crore under different schemes and spent ₹424.62 crore from the available funds of ₹461.44 crore, including an opening balance of ₹60.75 crore and interest of ₹13.25 crore.

"Perhaps, Sari did not have any idea about the massive funds being spent on her and the villagers. Otherwise, she would have demanded her share of the funds and settled down in her village peacefully," said Pravakar Juang, secretary of Juang Suraj Sangh, Keonjhar.

The CAG observation points out that of the 84,314 households in 1,679 villages under 17 micro-project agencies in PVTG areas, there were no data about ownership of land land records of 25,000 households (as of March 2024). Of the 84,209 households for which data existed, 40,829 (75%) had ownership over homestead or agricultural land and the remaining 13,260 (25%) did not have any ownership.

PVTGs have lagged in almost all development indicators. During 2015, their literacy rate was below 30% in four micro-project areas. In Tumba development agency, the literacy rate among women was less than 10%.

The audit agency points out that 8,490 projects with an estimated cost of ₹267.79 crore were approved by respective districts for execution by 13 micro-project agencies under MCMKDD during 2019-2024. Out of the sanctioned works, these agencies had taken up 5,223 works (61%) and incurred expenditure of ₹90.64 crore (35%) as of March 2024.

The unutilised amount of ₹174.15 crore included ₹111.52 crore towards the labour component, which could potentially have created income sources through wages for the benefit of the marginalised communities.

Juangs not alone

While the death of 14 Juang girls has drawn attention to the conditions of the community, the situation is no better among other PVTGs.

In Andrahal village of Malkangiri district, Nanda Sisa, a young member of the Bonda community, describes how migration has become the new normal for his community youth.

"COVID-19 was a major disruption in the lives of young Bondas who aspired to pursue higher education. Now, once they cross 18 years of age or complete matriculation, Bondas begin looking for places where they can earn quick money," said Nanda.

While girls board buses to work in prawn processing plants in Visakhapatnam, Andhra Pradesh, boys take up jobs such as security guards or in the apparel sector. "The impact of the regular migration is visible. At least 30 Bonda girls from Andrahal have married outside the community in other districts. Traditionally, Bondas have lived within the Bonda Hills, maintaining a close-knit community," he said.

An 'Evaluation of Bonda Development Agency', conducted by the SCSTRTI, attributes the rise in migration to the lack of livelihood opportunities. "Many have not received the Record of Rights for land ownership. There has been little monitoring by the Bonda Development Agency officials and recommend handholding support in the villages[?]," the report noted. According to the study, 22 Bondas migrated from seven sample villages during 2019-20. Dambaru Sisa, a former MLA from the Chitrakonda Assembly constituency and a member of the Bonda community, said migration has risen in recent years.

"Bondas have broken barriers in education, with some even becoming doctors and engineers. However, their numbers are miniscule. The majority of Bonda children drop out of school and migrate to other States for work," said Dambaru.

Similar accounts of migration reverberate in Niyamgiri Hills, spread across Rayagada and Kalahandi districts, where Dongria Kandh, a PVTG, resides.

Umi Daniel, an expert on migration, said, "Migration is not bad. However, girls aged below 18 working in hazardous sites and unsafe environments is certainly a cause for concern. The Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979, which mandates registration of workers, is hardly implemented in the State."

In the aftermath of the Tiruvallur tragedy, Odisha's Labour Department has filed complaints with eight police stations across Keonjhar seeking a thorough probe into circumstances under which the 14 girls died and demanded action against labour agents, who mediated to take girls and boys to other States. In the police complaints, the department said it has facilitated the safe return of 58 migrant workers. Of the 24 migrant workers from Telkoi block of Keonjhar working at the seafood facility, 11 were minors. According to the FIRs lodged in the case, the minor girls had been hired in the names of adult women whose identification documents were used without their knowledge.

As Sari tries to make sense of the changed circumstances, she is unable to decide whether she will travel to Tamil Nadu for work again. For now, she is in her village. Life, as she knew, has changed but the reasons to leave home have not.

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Homes left behind: Parents of Champabati Juang, (right) Basang Juang pointing towards the new tin roof of her home laid with the help of ₹8,000 sent by her daughter, Phulamani. Both Champabati and Phulamani died in the gas leak incident in Tamil Nadu.

Why is the Centre revising the NFSA?

Why has the Centre proposed changing AAY foodgrain entitlements? How will the proposed amendment affect households? Why are Tamil Nadu and Kerala opposing? Could the amendment widen regional disparities in foodgrain allocation?

EXPLAINER

T. Ramakrishnan

The story so far:

On July 6, Tamil Nadu Chief Minister C. Joseph Vijay urged the Centre to retain the present provision of 35 kg of foodgrains per household per month under the Antyodaya Anna Yojana (AAY) meant for the poorest of the poor, and not to make it a per capita system. The next day, the CPI(M) Polit Bureau voiced its concern and demanded that the proposed amendment to the entitlement criteria be dropped. About 10 days ago, immediately after the Union government made public its plan to amend the National Food Security Act (NFSA), Kerala's Food Minister Anoop Jacob expressed reservations over the move.

What is the amendment mooted?

On June 24, the Union Food and Public Distribution (F&PD) Department, while publishing a draft amendment Bill to the NFSA, said every person belonging to AAY households would be entitled to seven kg of foodgrains per month, subject to a maximum of 35 kg per household per month. At present, the entitlement is for the entire household with a ceiling of 35 kg per month. The proposed amendment covers the first proviso to sub-section (1) of Section 3 (Right to receive foodgrains at subsidised prices by persons belonging to eligible households) of the Act. The public can comment on the amendments till July 13 and send their views by email to suneel.sachdeva@nic.in and saurabhkumar.edu@gov.in.

Why is the change being proposed?

The existing household-based entitlement, though intended as a protective measure for the most vulnerable families, results in significant inequities depending upon the size of the household, according to the F&PD Department. Smaller households receive a higher per-capita entitlement, whereas larger households receive a lower per-capita entitlement, which may fall below the entitlement available to priority households.

The aim and purpose are to remove intra-category inequities, provide for more rational foodgrain allocation, and better align entitlements with nutritional requirements, a note prepared by the department said.

However, the proposed amendment does not seek to address the inclusion of ineligible persons as beneficiaries, a problem that persists at the State level.

What is the story behind the two southern States' opposition?

It is not for the first time that the two States are articulating their opposition to matters concerning the food policy, as their contemporary political history has an important ingredient – the politics of food. Kerala, which has a long history of the public distribution system (PDS) dating back to the now abolished princely State of Travancore, introduced informal food distribution mechanisms to mitigate the food shortage of the poor and vulnerable, and was perhaps the first to launch a formal PDS in 1962, three years before the establishment of the Food Corporation of India (FCI). At least on two occasions – 1952 and 1967 – Tamil Nadu saw political upsets, the incumbent regime getting reduced to a minority in 1952 and being shown the door (in 1967). The reason was that the governments of the periods in question were not being swift in handling the rice shortage. Since 1967, successive Chief Ministers of the State have been cautious in taking decisions with regard to the subject of rice.

It was no wonder that the two States were vociferous in their stand in the run-up to the formulation of the NFSA. Though the Congress-led United Democratic Front (UDF) took charge in 2011 in Kerala, the government did not agree to the implementation of the 2013 law – an Act of Parliament – despite the Congress-led United Progressive Alliance regime at the Centre pushing the legislation. The main reservation it had was that the NFSA would lead to the removal of a "large number of poor families" from the list of beneficiaries and put an "enormous financial burden" on the State. However, the then Chief Minister, Oommen Chandy, at one point in time, committed himself to the enforcement of the law in his State, though it was left to his successor, Pinarayi Vijayan, to take the formal decision.

In Tamil Nadu, Jayalalithaa, as Chief Minister, stridently opposed the law because immediately after she came to power in May 2011, her government started the distribution of rice, free to all the ration cardholders, regardless of their economic status. She had criticised the government for stating that those who would be left out of the NFSA would not be eligible to receive free rice. Eventually, she extracted a major concession from the Union government that the existing allocations, as they stood in 2013, for all the States would be legally safeguarded.

Hence, it was no surprise that the two southern neighbours joined the rest of the country in November 2016 in implementing the law.

'The existing household-based entitlement, though intended as a protective measure for the most vulnerable families, results in significant inequities depending upon the size of the household'

Why are Tamil Nadu and Kerala opposing the amendment to NFSA?

Explaining how Kerala would be affected by the latest move, Mr. Jacob has pointed out that States such as his, characterised by nuclear families, will be at a disadvantage as there will be a reduction in the quantity of free foodgrains for families with fewer than five members. He has recalled that even in 2013, when the law took effect, his State took the stand that the AAY cardholders deserved "special consideration," a position that it continues. "As a consumption State, any cut in Kerala's allocation is a matter of concern," Mr. Jacob stated.

Mr. Vijay, who referred in his letter to Mr. Modi about how the amendment would cause a fall in the monthly allocation of foodgrains from 65,261 tonnes to 42,040 tonnes, stated that the number of AAY cardholders below the family size of five members is 15.75 lakh (out of a total of 18.64 lakhs), covering 58.51 lakh beneficiaries (total: 69.27 lakhs). "Rice provided to the AAY cardholders is a staple ingredient of all three meals of the day and cannot be substituted with any other commodity from the open market, resulting in substantial out of pocket expenses," he said.

Besides, Anuradha Talwar, a functionary of the Right to Food Campaign, said that the amendment would bring a "North-South divide" in foodgrain allocation, as families in northern States would get higher allocations as their average family size was bigger than that of the southern States.

What is the way forward?

Ideally, such a change should have been subjected to greater public scrutiny to arrive at a consensus. However, T. Sadagopan, president, Tamil Nadu Progressive Consumer Centre and veteran activist who served on the State government's panels on food, suggests that the Centre chalk out a middle path by making the allocation of 30 kg per family, irrespective of family members. This would help the Union government to cut down its subsidy bill.

Grains of debate

The Centre's proposed amendment to the National Food Security Act has triggered concerns that foodgrain allocations under the Antyodaya Anna Yojana could fall for many households in the southern States

Fine balance: The aim and purpose of the amendment are to remove intra-category inequities, provide for more rational foodgrain allocation, and better align entitlements with nutritional requirements. [illegible]

Table 1: AAY coverage, beneficiaries and foodgrain allocation

State	Ceiling of AAY households (lakhs)	AAY coverage: No. of AAY households (in lakhs)	AAY coverage: No. of persons (in lakhs)	Allocation of foodgrains** for 2026-27 (in tonnes)
Andhra Pradesh	9.09	8.46	22.48	3,81,557
Karnataka	12	10.8	42.72	4,60,740
Kerala	5.95	5.93	20.51	2,50,128
Tamil Nadu	18.65	18.57	62.21	7,83,771
Telangana	6.43	5.64	15.88	2,38,074
Puducherry* (U.T.)	0.32	0.24	0.77	0*
Share of the South	52.51	49.16	162.77	21,21,278
All India	250	217.81	777.41	88,10,842

Source: Foodgrain bulletin for May 2026, Department of Food and Public Distribution, Government of India

*As Puducherry follows the concept of direct benefit transfer, no allocation has been made

** foodgrains - rice, wheat and coarse grains

Table 2: Off take and distribution in the Southern States

How the South fared during the current financial year up to the month of May 2026 (tonnes)

State	Allocation	Off take (Overall)	Distributed
Andhra Pradesh	63,183	63,993	57,837
Karnataka	79,790	37,318	35,803
Kerala	41,790	39,612	33,458
Tamil Nadu	1,80,463	1,90,135	1,21,709
Telangana	89,879	59,530	38,893
Share of the South	3,82,230	4,40,375	1,73,986
All India	18,56,508	17,34,588	13,75,421

THE GIST

- The Centre has proposed amending the NFSA to change AAY foodgrain entitlements from a household-based system to a per capita allocation of 7 kg per person, subject to a maximum of 35 kg per household, to address inequities in the existing system
- Tamil Nadu and Kerala have opposed the proposal, arguing that it will reduce foodgrain allocations for households with fewer than five members and increase the burden on poor families, particularly in States with predominantly nuclear families.
- While the Centre says the amendment will make foodgrain distribution more equitable, critics warn it could widen regional disparities, and some have suggested a middle path of a fixed 30 kg allocation per household

NEW PRESCRIPTIONS

Once-a-week insulin shots arrive in India; but not for all: Docs

TIMES NEWS NETWORK

Mumbai: Almost 104 years after daily insulin shots were first introduced, Indian patients with diabetes now have access to a once-a-week alternative.

Danish drugmaker Novo Nordisk on Thursday introduced Awiqli (insulin icodec), the country's first weekly basal insulin for adults with Type 1 and Type 2 diabetes. India is among the dozen countries where the product was launched.

For doctors, however, the arrival of the drug is less about replacing daily insulin than expanding treatment options. India has an estimated 101 million people living with diabetes and another 136 million with prediabetes, making it one of the world's largest diabetes populations.

In patients with diabetes, insulin — the hormone that allows cells to use glucose for energy — either isn't produced at all or the body's cells fail to use it properly. While everyone with Type 1 diabetes requires insulin, Type 2 diabetes patients need it only when oral medicines can no longer control their sugar levels, either once or twice a day.

Awiqli reduces injections from 365 days a year to 52 days. Novo Nordisk said it could help overcome one of the biggest barriers to insulin therapy in India — fear of daily injections — which often delays insulin initiation by seven to nine years. The company said clinical trials of more than 4,000 adults, including Indian participants, showed better HbA1c reduction than daily basal insulin.

Delhi-based endocrinologist Dr Anoop Misra said the biggest advantage was fewer injections. "There has been little innovation in basal insulin for nearly two decades. Fewer needle pricks may encourage patients to start insulin when they need it," he said.

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DIABETES BREAKTHROUGH

Doctors cautioned, however, that the weekly insulin is unlikely to replace daily injections for everyone. Endocrinologist Dr Shashank Joshi of Lilavati Hospital said patients would still require regular blood sugar monitoring. "It is a useful addition to our treatment options but would be best suited for patients willing to use technology to manage their diabetes," he said.

KEM Hospital endocrinologist Dr Tushar Bandgar, who led one of the Indian trial centres, said the treatment is best suited for patients who still produce some insulin naturally and require only basal insulin replacement. "Those needing multiple insulin injections every day may not benefit as much," he said.

Dr Bandgar added that newer weight-loss drugs and GLP-1 receptor agonists are already reducing insulin requirements in many patients. "While once-weekly insulin is an important advance, the number of patients needing basal insulin may gradually shrink," he said.

दबदलने को केवल महिला श्रद्धालु ही खींचेंगी। संवाद

बनाने में महत्वपूर्ण योगदान देगा। ब्यूरो

सहित कई अतिथि व सामाजिक कार्यकर्ता मौजूद रहे।

शोध : एचआईवी वैक्सीन के लिए संक्रमण रोकने वाले एंटीबॉडी खोजे

हिमांशु अरविंद मिश्र

वैज्ञानिकों को सामान्य इम्यून सिस्टम वाले बंदरों में ऐसे एंटीबॉडी विकसित करने में मिली सफलता

नई दिल्ली। एचआईवी वैक्सीन की खोज में वैज्ञानिकों को महत्वपूर्ण सफलता मिली है। प्रतिष्ठित जर्नल नेचर में प्रकाशित एक अध्ययन में पहली बार वैज्ञानिकों ने सामान्य इम्यून सिस्टम वाले बंदरों में ऐसे एंटीबॉडी विकसित करने में सफलता हासिल की है, जो एचआईवी वायरस को निष्क्रिय करने की क्षमता रखते हैं। हालांकि यह सफलता अभी सीमित है और इसे एचआईवी वैक्सीन का अंतिम समाधान नहीं माना जा रहा। हालांकि विशेषज्ञ इसे पिछले कई दशकों में हुई सबसे महत्वपूर्ण प्रगति में से एक बता रहे हैं।

अध्ययन में शामिल बंदरों में से केवल एक में एंटीबॉडी का स्तर उस सीमा तक पहुंचा, जिसे संक्रमण से सुरक्षा देने वाला माना जाता है। वहीं 44% बंदरों में ही रक्त में एचआईवी को निष्क्रिय करने वाले एंटीबॉडी विकसित हुए। वैज्ञानिकों का कहना है कि शोध की असली उपलब्धि परिणाम नहीं, बल्कि वह नई तकनीक है जिसके जरिये यह हासिल किया गया। एचआईवी दुनिया के सबसे जटिल वायरसों में से एक है। इसके तीन बड़े कारण हैं।

पहला यह कि वायरस अपने ऊपर शर्करा (ग्लाइकेन) की एक परत चढ़ा लेता है, जिससे शरीर की प्रतिरक्षा प्रणाली उसे आसानी से पहचान नहीं पाती। दूसरा यह बहुत तेजी से म्यूटेट (रूप बदलता) करता है और तीसरा यह कि शरीर में प्रवेश करने के बाद इसकी संरचना लगातार बदलती रहती है। इन्हीं वजहों से पिछले 40 वर्षों में एचआईवी वैक्सीन के लगभग सभी बड़े प्रयास विफल रहे हैं। 2009 में थाईलैंड में परीक्षण की गई आरवी144 वैक्सीन संक्रमण के जोखिम को केवल 31 फीसदी तक कम कर सकी थी। इसके बाद मर्क की स्टेप, वैक्सीन, दक्षिण अफ्रीका की एचवीटीएन-702 व इंबोकोडो व मोसिको जैसी परियोजनाएं प्रभावी साबित नहीं हो सकीं।

तीन चरणों में तैयार : *वैज्ञानिकों ने इस वैक्सीन को तीन चरणों में विकसित किया। इसमें प्राइमिंग, बूस्टिंग व पॉलिशिंग शामिल है। मतलब सबसे पहले शरीर में मौजूद बेहद दुर्लभ बी-कोशिकाओं की पहचान की गई, जिनमें एचआईवी से लड़ने वाले एंटीबॉडी बनने की क्षमता थी। इसके बाद कई चरणों में ऐसे इंजेक्शन दिए गए, जिनमें एचआईवी की संरचना के अधिक वास्तविक रूप दिखाए गए। इससे बी-कोशिकाएं धीरे-धीरे वायरस को पहचानने में बेहतर होती गईं। अंतिम चरण में एंटीबॉडी को इस स्तर तक विकसित करने की कोशिश की गई कि वे एचआईवी के कई अलग-अलग प्रकारों को निष्क्रिय कर सकें।*

नतीजे कितने सफल हैं? : अध्ययन में दो तरह के परिणाम सामने आए। आधे से ज्यादा बंदरों में प्रतिरक्षा कोशिकाएं सही दिशा में विकसित हुईं। 44 फीसदी बंदरों में रक्त में एचआईवी को निष्क्रिय करने वाले एंटीबॉडी पाए गए। केवल एक बंदर में एंटीबॉडी का स्तर उस सीमा तक पहुंचा।

भारत में बेसल इंसुलिन लॉन्च..रोज नहीं, साल में सिर्फ 52 इंजेक्शन

डायबिटीज मरीजों को हफ्ते में एक ही बार लेना होगा इंसुलिन

नई दिल्ली। डायबिटीज मरीजों के लिए राहत की खबर है। डेनमार्क की दवा कंपनी नोवो नॉर्डिस्क ने भारत में पहली बेसल इंसुलिन अविक्ली (इंसुलिन आइकोडेक) लॉन्च की है। उसका दावा है कि इसे हफ्ते में एक बार ही लगाना होगा। यह टाइप-1 व टाइप-2 के वयस्क मरीजों के लिए है। इससे रोज इंसुलिन इंजेक्शन लगाने से मुक्ति मिल सकेगी।

कंपनी का दावा है कि अविक्ली ऐसा बेसल (लंबे समय तक असर करने वाला) इंसुलिन है, जिसे क्लिनिकल इस्तेमाल के लिए मंजूरी मिली है। इससे साल भर में लगने वाले इंजेक्शनों की संख्या 365 से घटकर सिर्फ 52 रह जाएगी। ब्यूरो

2611 रुपये में 700 यूनिट

नोवो नॉर्डिस्क इंडिया के एमडी विक्रांत श्रोत्रिय ने बताया, अविक्ली की 70 इंसुलिन यूनिट वाली साप्ताहिक डोज की कीमत 261 रुपये (2.74 डॉलर) है। यह दो वैरिएंट में है। पहला एक एमएल (700 यूनिट) वाला पेन जिसकी कीमत 2,611 रुपये है। दूसरा 3 एमएल (2,100-यूनिट) वाले पेन की कीमत 7,833 रुपये है। यानी यह 3.73 रुपये/यूनिट पड़ेगी, जो रोजाना बेसल इंसुलिन की तुलना में 30 से 40% तक सस्ती है। अविक्ली को अगले सप्ताह भारतीय बाजार में उतारा जाएगा।

चिंताजनक

गरीब मुल्कों में जरूरी कैंसर की दवाएं पहुंच से दूर, हर साल एक करोड़ लोग कैंसर से गंवाते हैं जान

92 फीसदी लोग कभी न कभी कैंसर से होंगे प्रभावित : डब्ल्यूएचओ

• नई दिल्ली। विश्व स्वास्थ्य संगठन (डब्ल्यूएचओ) की नई रिपोर्ट में कहा गया कि दुनिया के 92 प्रतिशत लोग अपने जीवन में कम से कम एक बार कैंसर के असर का सामना करेंगे। इनमें से हर पांच में एक व्यक्ति को कैंसर हो सकता है। रिपोर्ट के अनुसार, कैंसर से जुड़ा अनुभव सभी लोगों के लिए समान नहीं है। गरीब और अमीर देशों के बीच इलाज, जांच व दवाओं की उपलब्धता में बड़ा अंतर है।

डब्ल्यूएचओ और उससे जुड़ी संस्था इंटरनेशनल एजेंसी फॉर रिसर्च ऑन कैंसर (आईएआरसी) की संयुक्त रिपोर्ट के मुताबिक, हर दिन दुनिया में 26 हजार से ज्यादा लोगों की मौत कैंसर से होती है। हर साल करीब 2.06 करोड़ नए मरीज सामने आते हैं, जबकि लगभग एक करोड़ लोगों की मौत इस बीमारी से हो जाती है। हृदय रोगों के बाद कैंसर दुनिया में मौत का दूसरा सबसे बड़ा कारण है। रिपोर्ट में कहा गया कि उच्च आय वाले देशों में स्तन कैंसर से पीड़ित 87 प्रतिशत महिलाएं पांच साल तक जीवित रहती हैं, जबकि कम आय वाले देशों में यह आंकड़ा सिर्फ 42 प्रतिशत है। इसके अलावा, दुनिया के तीन में से केवल एक देश ने ही कैंसर के इलाज को अपनी सार्वभौमिक स्वास्थ्य सेवा (यूनिवर्सल हेल्थ कवरेज) का हिस्सा बनाया है। एजेंसी

डब्ल्यूएचओ की रिपोर्ट में कहा गया कि कैंसर की रोकथाम के लिए तंबाकू नियंत्रण और टीकाकरण जैसे कार्यक्रमों में कुछ प्रगति हुई है। वैश्विक स्तर पर तंबाकू के इस्तेमाल में 27 प्रतिशत की कमी आई है और 82 प्रतिशत देशों ने राष्ट्रीय कैंसर नियंत्रण योजना बनाई है। इसके बावजूद इन प्रयासों का असर लोगों की जान बचाने के स्तर तक नहीं पहुंच पाया है।

27% कमी तंबाकू के इस्तेमाल में

गरीब व अमीर देशों में बड़ा अंतर

रिपोर्ट में यह भी सामने आया कि गरीब देशों में जरूरी कैंसर की दवाएं लोगों की पहुंच से बाहर हैं। कम और निम्न-मध्यम आय वाले देशों में कैंसर की 20 प्रमुख दवाओं की उपलब्धता सिर्फ 9 से 54 प्रतिशत तक है, जबकि उच्च आय वाले देशों में यह 68 से 94 प्रतिशत के बीच है।

कैंसर को केंद्र में रखकर बनें नीतियां

डब्ल्यूएचओ ने कहा कि कैंसर का आर्थिक, सामाजिक और मानसिक बोझ लगातार बढ़ रहा है। ऐसे में दुनिया के सभी देशों, अंतरराष्ट्रीय संगठनों, शोध संस्थानों, निजी क्षेत्र और सामाजिक संगठनों को मिलकर काम करना होगा। रिपोर्ट में कैंसर के इलाज को सार्वभौमिक स्वास्थ्य सेवा से जोड़ने, मरीजों और उनके परिवारों को केंद्र में रखकर नीतियां बनाने पर जोर दिया गया है।

नई शुरुआत... कंपनी का कहना है कि यह अगले हफ्ते से भारतीय बाज़ार में उपलब्ध होगी

रोज़ नहीं, हफ्ते में एक बार इंसुलिन, एक्सपर्ट बोले- सलाह लेना ज़रूरी

■ NBT रिपोर्ट, नई दिल्ली

AI Image

डायबिटीज के मरीजों के लिए एक ऐसी दवा लॉन्च की गई है, जिसे रोज नहीं, बल्कि हफ्ते में एक बार लेकर शुगर को कंट्रोल किया जा सकेगा। इसको लेकर कंपनी का दावा है कि हफ्ते में एक बार लगने वाली बेसल इंसुलिन दुनिया की पहली ऐसी दवा है, जिसे वयस्कों में टाइप-1 और टाइप-2 डायबिटीज के इलाज के लिए मंजूरी मिली है। वहीं, विशेषज्ञों का कहना है कि यह दवा एक नया विकल्प है, लेकिन इसे सिर्फ डॉक्टर की सलाह पर ही शुरू करना चाहिए। हर मरीज के लिए यह इंसुलिन उपयुक्त हो, ऐसा जरूरी नहीं है। डेनमार्क की दवा कंपनी नोवो नॉर्डिस्क ने भारत में अवीक्ली नाम की इस नई इंसुलिन को लॉन्च कर कहा, यह अगले हफ्ते से बाजार में उपलब्ध होगी। ▶▶ पेज 9

365 नहीं, साल में सिर्फ 52 इंजेक्शन

अब तक बेसल इंसुलिन लेने वाले मरीजो को हर दिन इंजेक्शन लगाना पड़ता था। नई इंसुलिन आने के बाद उन्हें सालभर में 365 की जगह सिर्फ 52 इंजेक्शन लगाने होंगे। इससे इलाज को नियमित रखना आसान हो सकता है। कंपनी के मुताबिक रोज इंजेक्शन लगाने का डर, दर्द और खर्च की वजह से कई मरीज इंसुलिन शुरू करने में 7 से 9 साल की देरी कर देते है।

RML से खराब ऑक्सिटोसिन इंजेक्शन ज़ब्त

ड्रग कंट्रोल डिपार्टमेंट का छापा, 2675 इंजेक्शन सीज

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■ नई दिल्ली : डॉ. राम मनोहर लोहिया (RML) अस्पताल में सप्लाई किए गए घटिया क्वॉलिटी के ऑक्सिटोसिन इंजेक्शन का मामला सामने आया है। सूचना मिलने के बाद ड्रग कंट्रोल डिपार्टमेंट ने अस्पताल में छापेमारी की, जहां घटिया क्वॉलिटी के ऑक्सिटोसिन इंजेक्शन पाए गए। अधिकारियों ने अस्पताल में रखे 2675 इंजेक्शन जब्त कर मामले की जांच शुरू कर दी है। सूत्रों का कहना है कि इसी कंपनी के ऑक्सिटोसिन इंजेक्शन की सप्लाई राजस्थान के कोटा स्थित एक सरकारी अस्पताल में हुई थी, जहां पांच महिलाओं की मौत का मामला सामने आया है।

दिल्ली सरकार के ड्रग्स कंट्रोल विभाग को 4 जून को एक ई-मेल मिला, जिसमें ऑक्सिटोसिन इंजेक्शन आईपी 5 आईयू/एमएल (1 एमएल), बैच नंबर 1-7681 (निर्माण तिथि: नवंबर 2025, एक्सपायरी: अक्टूबर 2027) पर संदेह जताया गया था। यह इंजेक्शन पंजाब के अमृतसर स्थित एक कंपनी द्वारा बनाया गया था। रिपोर्ट के अनुसार, जांच में यह दवा 'नॉट ऑफ स्टैंडर्ड क्वॉलिटी' यानी निर्धारित गुणवत्ता मानकों पर खरी नहीं मिली। क्योंकि इसमें सक्रिय तत्व ऑक्सिटोसिन (सिंथेटिक) बिल्कुल नहीं मिला। रिपोर्ट के अनुसार, इसी बैच के 1 एमएल क्षमता वाले 3000 एम्प्यूल्स की सप्लाई आरएमएल अस्पताल को 22 अप्रैल को हुई थी, जो संबंधित कंपनी की ओर से भेजे गए थे।

सूचना मिलने के बाद 17 जून को ड्रग्स कंट्रोल विभाग की टीम ने आरएमएल अस्पताल के इंजेक्शन ड्रग्स यूनिट का निरीक्षण किया। जांच के दौरान संबंधित बैच के 2875 इंजेक्शन स्टॉक में मिले। इनमें से जांच के लिए नमूने लेने के बाद बचे हुए 2675 इंजेक्शन को जब्त कर सील कर दिया गया।

ड्रग कंट्रोल डिपार्टमेंट के अधिकारियों का कहना है कि प्रारंभिक जांच में इस इंजेक्शन की क्वॉलिटी खराब पाई गई है। हालांकि, इंजेक्शन के कुछ सैंपल लेकर जांच के लिए भेज दिए गए हैं। जांच रिपोर्ट आने के बाद स्थिति और स्पष्ट हो सकेगी।

5

डिलिवरी के बाद ब्लीडिंग रोकने के लिए यह इंजेक्शन लगाया जाता है

कब और किसे दिया जाता है ये इंजेक्शन?

कस्तूरबा अस्पताल की सीनियर गायनेकोलॉजिस्ट डॉ. मालती सिंह बताती हैं कि ऑक्सिटोसिन इंजेक्शन का इस्तेमाल दो तरीके से किया जाता है। एक डिलिवरी से पहले अगर गर्भवती को दर्द देने के लिए होता है। कई मामले ऐसे भी होते हैं, जिसमें 9 महीने पूरे होने के बाद भी महिला को दर्द नहीं होता है। दूसरा, डिलिवरी के बाद होने वाली ब्लीडिंग को रोकने के लिए यह दिया जाता है। अगर ऑक्सिटोसिन इंजेक्शन की क्वॉलिटी ठीक न हो तो यह महिला की जान के लिए खतरा बन सकता है।

2-8 डिग्री की जगह गोदाम में रूम टेंपरेचर पर रखे गए थे इंजेक्शन

■ NBT रिपोर्ट, नई दिल्ली

ऑक्सिटोसिन इंजेक्शन के घटिया क्वॉलिटी की सप्लाई को लेकर दिल्ली ड्रग कंट्रोल डिपार्टमेंट अलर्ट मोड पर है। डिपार्टमेंट की टीम ने एक दवा कारोबारी के पटपड़गंज इंडस्ट्रियल एरिया में स्थित एक फार्मास्यूटिकल फर्म के गोदाम में शुक्रवार को निरीक्षण के दौरान रूम टेंपरेचर पर रखे 31700 ऑक्सिटोसिन इंजेक्शन जब्त किए हैं, जबकि मानक के अनुसार इन्हें 2 से 8 डिग्री टेंपरेचर पर रखा जाता है। ऐसे में विभाग को आशंका है कि गलत तरीके से लंबे समय तक रखे जाने के कारण दवा की प्रभावशीलता कम हो सकती है, जिससे मरीजों की जान को खतरा पैदा हो सकता था। यह कार्रवाई हेल्थ मिनिस्टर डॉ. पंकज सिंह के निर्देश पर की गई है।

निरीक्षण के दौरान ड्रग कंट्रोल डिपार्टमेंट ने पाया कि ऑक्सिटोसिन इंजेक्शन IP 5 IU/ml (जो प्रसव के बाद इस्तेमाल होता है) के एक बैच को प्रोडक्ट लेबल पर साफ तौर पर लिखी गई जरूरी स्टोरेज शर्तों 2 डिग्री सेल्सियस से 8 डिग्री सेल्सियस के बजाय कमरे के सामान्य तापमान पर रखा गया था। यह स्टॉक मई 2026 में खरीदे जाने के बाद से कथित रूप से इसी स्थिति में रखा हुआ था। वहीं, परिसर में एक चालू रेफ्रिजरेटर मौजूद था, लेकिन उसमें कोल्ड स्टोरेज में रखी जाने वाली कोई भी दवा नहीं रखी गई थी।

31700
इंजेक्शन जब्त किए गए, हेल्थ मिनिस्टर के निर्देश पर की गई कार्रवाई

वहीं, स्वास्थ्य मंत्री डॉ. पंकज कुमार सिंह ने कहा कि सीएम रेखा गुप्ता के नेतृत्व में दिल्ली सरकार यह सुनिश्चित करने के लिए पूरी तरह प्रतिबद्ध है कि लोगों को मिलने वाली हर दवा की क्वॉलिटी, सुरक्षा और असर के सर्वोच्च मानकों पर खरी उतरे। मरीजों की सुरक्षा से समझौता करने वाली किसी भी लापरवाही, खासकर जीवनरक्षक और गंभीर बीमारियों की दवाओं के मामले में किसी भी तरह पर स्वीकार नहीं की जाएगी और दोषियों के खिलाफ सख्त कानूनी कार्रवाई की जाएगी। उन्होंने कहा कि ड्रग कंट्रोल डिपार्टमेंट को सख्त निर्देश दिया गया है कि वे राजधानी दिल्ली में निरीक्षण अभियान को और तेज करें। दवाइयों को रखने और उनकी क्वॉलिटी से जुड़े नियमों का उल्लंघन करने वाले किसी भी व्यक्ति या संस्था के खिलाफ सख्त कार्रवाई सुनिश्चित की जाए।

ड्रग कंट्रोल डिपार्टमेंट अलर्ट

■ ड्रग कंट्रोल विभाग ने पटपड़गंज इंडस्ट्रियल एरिया में एक फर्म के गोदाम पर की कार्रवाई

इंसुलिन हफ्ते में एक बार लेने से इलाज हुआ आसान, पर निगरानी रखें: एक्सपर्ट

भारत में पहली बार हफ्ते में एक बार दी जाने वाली इंसुलिन लॉन्च

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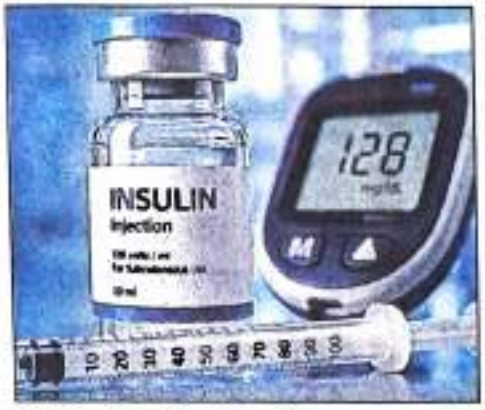

नई दिल्ली: डेनमार्क की दवा कंपनी नोवो नॉर्डिस्क ने भारत में अवीक्ली नाम की नई इंसुलिन लॉन्च की है। कंपनी का दावा है कि यह हफ्ते में एक बार दिए जाने वाला बेसल इंसुलिन है, जो टाइप-1 और टाइप-2 डायबिटीज के वयस्क मरीजों के लिए है। भारत में 10 करोड़ से ज्यादा लोग डायबिटीज से पीड़ित हैं, जबकि 13.6 करोड़ लोगों को प्री-डायबिटीज है। फिलहाल देश में करीब 60 लाख लोग इंसुलिन थेरेपी ले रहे हैं।

एम्स के मेडिसिन डिपार्टमेंट के प्रफेसर नीरज निश्चल ने कहा कि हफ्ते में एक बार लगने वाली लॉन्ग-एक्टिंग इंसुलिन दुनिया के कुछ देशों में पहले से इस्तेमाल हो रही है। नई साप्ताहिक लॉन्ग-एक्टिंग इंसुलिन आने से रोज लगने वाले बेसल इंसुलिन के इंजेक्शन की जरूरत कम हो जाएगी। हालांकि, भोजन के बाद लगने वाली शॉर्ट-एक्टिंग इंसुलिन की जरूरत कई मरीजों में पहले की तरह बनी रह सकती है।

प्रो. निश्चल ने कहा कि इस तरह की नई इंसुलिन की शुरुआत के दौरान सही डोज तय करने में कुछ समय लग सकता है। इस दौरान हाइपोग्लाइसीमिया (ब्लड शुगर बहुत कम होने) का खतरा भी रह सकता है।

'अपने डॉक्टर की सलाह जरूर लें'

एम्स दिल्ली के प्रोफेसर नवल विक्रम ने कहा कि हफ्ते में एक बार लगने वाली बेसल इंसुलिन पर कई देशों में अध्ययन हुए हैं और उनमें इसके अच्छे परिणाम देखने को मिले हैं। हालांकि, हर ब्रांड की इंसुलिन की प्रभावशीलता और उसके क्लीनिकल परिणाम अलग-अलग हो सकते हैं। इसलिए किसी भी नई साप्ताहिक इंसुलिन पर जाने का फैसला मरीज को अपने डॉक्टर की सलाह पर ही करना चाहिए। रोज लगने वाली इंसुलिन से साप्ताहिक इंसुलिन पर शिफ्ट करते समय डोज का सही निर्धारण और समय-समय पर उसका एडजस्टमेंट करना पड़ता है।

अब रोज नहीं, हफ्ते में एक बार लगेगा इंसुलिन इंजेक्शन

- डेनमार्क की दवा कंपनी नोवो नोर्डिस्क ने भारत में पहली बार लांच किया 'अवीकली'
- सालभर में केवल 52 इंजेक्शन लगाने होंगे, खर्च मात्र पौने चार रुपये प्रति डोज

जागरण न्यूज नेटवर्क, नई दिल्ली: डायबिटीज के मरीजों के लिए राहत भरी खबर है। डेनमार्क की दवा कंपनी नोवो नोर्डिस्क ने भारत में टाइप-1 व टाइप-2 डायबिटीज से पीड़ित वयस्कों के लिए सप्ताह में एक बार लगने वाला इंसुलिन इंजेक्शन 'अवीकली' लांच किया है। कंपनी का दावा है कि यह दुनिया का पहला बेसल इंसुलिन है, जिसे रोजाना की बजाय सप्ताह में केवल एक बार लेना होता है।

इस नई थेरेपी से मरीजों को सालभर में 365 की बजाय केवल 52 इंजेक्शन लगाने पड़ेंगे। कंपनी के अनुसार, वैश्विक आनवड्र्स-1 क्लीनिकल ट्रायल में अवीकली ने रोजाना दिए जाने वाले इंसुलिन ग्लारजीन-यू100 की तुलना में ब्लड शुगर (एचबीए1सी) को बेहतर ढंग से नियंत्रित करने और ग्लूकोज को सुरक्षित स्तर पर अधिक समय तक बनाए रखने में अच्छे नतीजे दिए। साथ ही, अधिक मरीज बिना गंभीर हाइपोग्लाइसीमिया (ब्लड शुगर का बहुत कम हो जाना) के लक्ष्य हासिल कर सके।

एएनआइ के अनुसार, नोवो नोर्डिस्क इंडिया के प्रबंध निदेशक विक्रांत श्रोत्रिय ने कहा कि सप्ताह में एक बार इंसुलिन लेने की सुविधा मरीजों में इंजेक्शन का डर, इलाज की जटिलता और नियमित दवा लेने से जुड़ी मानसिक बाधाओं को कम कर सकती है। कंपनी ने इसके 700 यूनिट पैक की कीमत 2611 रुपये तय की है, यानी प्रति यूनिट लागत लगभग 3.73 रुपये होगी, जो कई मौजूदा रोजाना इंसुलिन विकल्पों से 30 से 40 प्रतिशत तक कम बताई जा रही है।

इंद्रप्रस्थ अपोलो हास्पिटल के वरिष्ठ एंडोक्रिनोलाजिस्ट डा. एस.के. वांगनू ने कहा कि रोजाना इंजेक्शन की वजह से कई मरीज इंसुलिन थेरेपी शुरू करने में देरी करते हैं। ऐसे में सप्ताह में एक बार लगने वाला इंजेक्शन समय पर इलाज शुरू करने और बेहतर शुगर नियंत्रण में मददगार हो सकता है।

मीडिया रिपोर्ट के अनुसार, भारत में 10 करोड़ से अधिक लोग डायबिटीज से पीड़ित हैं, जबकि करीब 13.6 करोड़ लोग प्री-डायबिटीज की श्रेणी में हैं। विशेषज्ञों के अनुसार, देश में मरीज औसतन सात से नौ वर्ष की देरी से इंसुलिन थेरेपी शुरू करते हैं। ऐसे में आसान उपचार विकल्प इस देरी को कम करने में अहम हो सकता है।

क्या करता है इंसुलिन

इंसुलिन वह हार्मोन है जो ग्लूकोज को खून से शरीर की कोशिकाओं तक पहुंचाने में मदद करता है। टाइप-1 और एडवांस्ड टाइप-2 डायबिटीज के मरीजों को ब्लड शुगर नियंत्रित रखने के लिए इंसुलिन की जरूरत पड़ती है। अब तक अधिकांश मरीजों को इसे रोजाना लेना पड़ता था, लेकिन नई साप्ताहिक थेरेपी इस प्रक्रिया को काफी आसान बना सकती है।

कोई अदालती रिकार्ड नहीं मिला।

जा सकता।

बेघर ब्लड कैंसर मरीज को इलाज के लिए सरकार दे तीन लाख : कोर्ट

जागरण संवाददाता, नई दिल्ली: दिल्ली हाई कोर्ट ने एम्स में ब्लड कैंसर का इलाज करा रहे बेघर मरीज को बड़ी राहत दी है। कोर्ट ने दिल्ली सरकार को एक सप्ताह के अंदर तीन लाख रुपये की वित्तीय सहायता एम्स को जारी करने का निर्देश दिया है। अदालत ने स्पष्ट किया कि मरीज के पास उपलब्ध नहीं होने वाले दस्तावेज की मांग कर सहायता देने में देरी नहीं की जा सकती।

न्यायमूर्ति स्वर्ण कांता शर्मा ने यह आदेश विक्रांत तिवारी की याचिका पर दिया। याचिकाकर्ता के अधिवक्ता अशोक अग्रवाल ने दलील दी कि विक्रांत के पास इलाज का खर्च उठाने के लिए कोई आर्थिक संसाधन नहीं है। विक्रांत वर्ष 2024 से डिफ्यूज लार्ज बी-सेल लिम्फोमा (ब्लड़ कैंसर) से पीड़ित हैं। इसके अलावा वह टीबी और एचआइवी से भी संक्रमित हैं।

रेखा गुप्ता ने कहा कि दिल्ली में मेट्रो नेटवर्क का विस्तार स्वच्छ पर्यावरण

ऑक्सीटोसिन के इंजेक्शन जब्त

नई दिल्ली, प्रसं। दिल्ली सरकार के ड्रग कंट्रोल विभाग ने विशेष निरीक्षण अभियान चलाकर पटपड़गंज औद्योगिक क्षेत्र के फार्मास्युटिकल प्रतिष्ठान से 31700 ऑक्सीटोसिन के इंजेक्शन जब्त किए गए।

इनकी गुणवत्ता सुनिश्चित करने के लिए आवश्यक तापमान पर सुरक्षित नहीं रखा गया था। बल्कि अनिवार्य कोल्ड चेन स्टोरेज के मानकों का उल्लंघन कर कमरे के तापमान पर रखा गया था। इस वजह से इंजेक्शन की गुणवत्ता खराब थी। दिल्ली के स्वास्थ्य मंत्री डॉ. पंकज कुमार सिंह के निर्देश पर यह कार्रवाई की गई। यह इंजेक्शन से 2 से डिग्री पर रखना होता है।

फॉर्मूला आधारित पढ़ाई से शिक्षा में बढ़ीं समस्याएं

अनुराग बेहर | सीईओ, अजीम प्रेमजी फाउंडेशन

पिछले हफ्ते एक स्कूल में गया था, जहां एक शिक्षक करीब 20 छात्रों से 'भिन्न' का सवाल हल करा रहे थे। बच्चों ने कागज को आधे और चौथाई हिस्सों में मोड़ रखा था। वहां हलचल, रंग और चहल-पहल थी। कक्षा समाप्त होने पर जब कुछ बच्चों से पूछा कि भिन्न क्या होता है, तो वे अवाक रह गए। उन्होंने अपने हाथों में मुड़े हुए कागज को देखा और फिर मुझे देखा। उनके पास कहने के लिए कुछ नहीं था। शिक्षक ने कक्षा में अभ्यास तो करा दिया, लेकिन कोई बच्चा सीख नहीं पाया था। इसमें शिक्षक की कोई गलती नहीं थी। वह पूरी ईमानदारी से वही करा रहे थे, जिसे अच्छी पढ़ाई मानी जाती है। गलती एक ऐसी बौद्धिक चूक में थी, जिसने दो दशकों से स्कूली शिक्षा का बेड़ा गर्क कर रखा है। हम अभी भी इसके नतीजे भुगत रहे हैं।

यह गलती 'रचनावाद' (कंस्ट्रक्टिविज्म) से जुड़ी है। इंसान को सीखने के लिए आंशिक रूप से 'रचनावाद' महत्वपूर्ण है। यह कहता है कि किसी निष्क्रिय दिमाग में ज्ञान डाला नहीं जा सकता। इसके लिए सीखने वाला स्वयं सक्रिय रूप से समझ बनाता है और नई चीजों को उन चीजों से जोड़ता है, जिनको वह पहले से जानता है। साल 2005 के 'नेशनल करिकुलम फ्रेमवर्क', यानी राष्ट्रीय पाठ्यचर्या रूपरेखा में इस सिद्धांत को शिक्षा की सोच के केंद्र में रखा गया और रटंत विद्या, पाठ्य-पुस्तकों के दबदबे और बच्चे को खाली बर्तन समझने जैसी मूल समस्याओं को हल करने के लिए कुछ नहीं किया गया।

सबसे अहम सबक यह है कि फॉर्मूला आधारित शिक्षा विवेक का शत्रु है। इसलिए, यहां मूल बात यह देखना है कि बच्चा सीख रहा है या नहीं।

सीखना निर्माण की एक सक्रिय व सतत प्रक्रिया है, लेकिन इस विचार को हमने छोड़ दिया और इसकी जगह 'पढ़ाने में निर्देश कम से कम होने चाहिए' को अपना लिया। इसमें 'शिक्षक को समझाने की जहमत नहीं उठानी है, निर्देश देना तानाशाही है, बच्चों को गतिविधि के जरिये खुद विचार खोजने चाहिए, अभ्यास व याद करना समझ के दुश्मन हैं' जैसी बातें होने लगीं। रचनावाद सोचने-समझने का एक फॉर्मूला न रहकर, पालन करने वाला एक सिद्धांत बन गया। प्रशिक्षण कार्यक्रम में इन्हें नारों की तरह सिखाया गया, जैसे 'गतिविधियां अच्छी हैं, लेकिन समझाना बुरा है; खोज अच्छी है, बताना बुरा है; समझना अच्छा है, याद रखना बुरा है।' पाठ्य-पुस्तक में अध्यायों की शुरुआत ऐसी गतिविधियों से की जाती हैं, जिनको कराने के लिए शिक्षक के पास न तो समय होता है और न तैयारी। कक्षा की निगरानी करते वक्त यह देखा जाता है कि कितनी गतिविधियां हुईं, न कि यह कि किसने क्या सीखा?

इंसानी मामलों में यह एक पुराना पैटर्न है, जो सिर्फ शिक्षा तक सीमित नहीं है। अल्फ्रेड नॉर्थ व्हाइटहेड ने इसे 'फैलेसी ऑफ मिसप्लेस्ड कंक्रिटनेस' कहा था, यानी किसी अमूर्त विचार को ही वास्तविकता मान लेना। प्रत्येक अमूर्त अवधारणा कुछ चीजों को छोड़कर किसी न किसी मुख्य बात को उजागर करती है। रचनावाद कक्षा, बच्चों की संपूर्णता, विषय, शिक्षक, संसाधन आदि को छोड़ देता है। जब इस अमूर्त विचार को ही सर्वोपरि मान लिया जाता है, तो बाकी चीजों के साथ ऐसा व्यवहार किया जाता है, जैसे वे हैं ही नहीं। इस गलती में ही क्रूरता निहित है। इसके असर हरेक पर समान रूप से नहीं होते हैं। इसमें शिक्षित माता-पिता के बच्चे घर में मिलने वाली शिक्षा के कारण शिक्षा संबंधी कमियों से बच जाते हैं, लेकिन ऐसे परिवारों के छात्रों को कोई सहारा नहीं मिलता, जिनके परिवार की पहली पीढ़ी शिक्षा के क्षेत्र में जा रही होती है।

बच्चे की गरिमा और ज्ञान को जीवन से जोड़ना आज भी महत्वपूर्ण विचार हैं। अच्छा शिक्षण कर्म किसी फॉर्मूले का पिछलग्गू नहीं हो सकता। यह पूरी तरह से विवेक का मामला है। शिक्षक के लिए यह जानना जरूरी है कि कब समझाना है और कब बच्चों को संघर्ष करने देना है, कब कोई गतिविधि समझ को गहरा करती है या केवल समय बिताने का साधन भर है और किन चीजों को अभ्यास के माध्यम से आत्मसात कराना है, ताकि मन सोचने के लिए स्वतंत्र रहे। कुल मिलाकर, सबसे अहम सबक यह है कि फॉर्मूला आधारित शिक्षा विवेक का शत्रु है। इसलिए, मूल बात यह देखना है कि बच्चा सीखता है या नहीं?

(ये लेखक के अपने विचार हैं)

पालथी लगाते समय रखें यह ध्यान

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बारिश में बुखार वायरल या डेंगू?

मानसून में वायरल और डेंगू का खतरा बढ़ जाता है। इन दोनों बुखार में क्या है अंतर, आइए जानें...

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जरूरी जांच

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उपचार

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बचाव

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रोजनामचा