General Knowledge Today

GS-II: 16: Current Policy and Issues in Public Health

Integrated IAS General Studies:2016-17

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Contents

Model Questions

1. Examine India's performance in achieving the Millennium Development Goals (MDGs) related to public health. What lessons can be learnt to achieve related Sustainable Development Goals? Discuss.
2. What are the challenges or providing Universal Healthcare in India? Do you agree with the view that tax-financed model of UHC is more suitable to India in comparison to insurance model? Discuss.
3. Explore various provisions in the constitution of India that helped Supreme Court to establish Right to Health as an implied fundamental right under Article 21.
4. Is Right to Health on lines of Right to Education feasible in India? Discuss keeping in view the call made by draft National Health Policy, 2015.
5. What are the key proposals of National Medical Commission Bill, 2016? To what extent, this bill addresses the present shortcomings of Medical Council of India? Discuss critically.
6. What are Neglected Tropical Diseases (NTDs)? Discuss their implications in public health for India.
7. Critically analyze the provisions of Mental Healthcare Bill, 2016 keeping in focus Section 309 of IPC.
8. To what extent, the mis-use of provisions of NDPS Act are responsible for its being one of the harshest laws in India?
9. Compare the functions of ASHA, ANM and Anganwadi Workers. Why the National Health Policy 2015 has made a call to develop a cadre of Urban ASHAs? Discuss keeping in focus the role they have played Public Health delivery.
10. What are the major challenges in eliminating Malaria? To what extent, the National Framework for Malaria Elimination addresses these challenges. Discuss.
11. Differentiate between Rational and Irrational Fixed Dose Combination Drugs (FDCs). What has been the recent government policy towards them? Explain.
12. What is the benefit of putting drugs into various schedules such as Schedule H, Schedule X and Schedule H1? Discuss while making a differentiation between them.
13. Discuss various steps taken by the government to eradicate TB in India? What are the challenges and to what extent, the new vaccine VPM1002 seeks to address those challenges?
14. Provision of primary healthcare system has been a big challenge in Indian healthcare system. In this context, the concept of Mohalla clinics in Delhi seems to be well designed than earlier healthcare interventions. Discuss how they work, and what the reasons for their success are.

Do you think this model can be successfully be replicated in rural areas of India?

Topic 1. Institutional Framework around Public Health in India

In the constitution of India, items such as public health, hospitals and sanitation fall in the State list. However, the items having wider ramifications at the national level like population control & family welfare, medical education, prevention of food adulteration, quality control in manufacture of drugs etc. have been included in the Concurrent list. Thus, both state and union governments are able to make laws on these subjects.

Ministry of Health and Family Welfare

The Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health and Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. Apart from these, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

In addition to the 100 per cent centrally sponsored family welfare programme, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, Leprosy, Tuberculosis and Blindness in designated areas. Besides, State Health Systems Development Projects with World Bank assistance are under implementation in various states.

The Ministry of Health and Family Welfare comprises the following departments as follows:

Department of Health and Family Welfare

The Department of Health and Family Welfare is responsible for implementation of national level programmes for control of communicable and non- communicable diseases, hospitals and dispensaries and medical education.

Department of AYUSH

The department of AYUSH takes care of promotion of indigenous systems of medicine such as Ayurveda, Homeopathy, Unani, Siddha and ongoing research in indigenous medicine.

Department of Health Research

The Department of Health Research is mainly concerned with research in medical and health activities.

National AIDS Control Organization

National AIDS Control Organisation (NACO) is responsible for planning and implementation of programmes for prevention and control of AIDS. Earlier, it was a department under the Ministry. The Modi Government has now merged it with National Health Mission (NHM).

Directorate General of Health Service (DGHS)

Directorate General of Health Services (DGHS) is an attached office of the Department of Health and

Family Welfare and has subordinate offices spread all over the country. The DGHS renders technical advice on all medical and public health matters and is involved in the implementation of various health schemes.

Public Health System in India

The public health system in India comprises a set of state-owned health care facilities funded and controlled by the government of India. Some of these are controlled by agencies of the central government while some are controlled by the governments of the states of India.

- All India Institutes of Medical Sciencesowned and controlled by the central government. These are referral hospitals with super speciality facilities. Currently, AIIMS are located in Bhopal, Bhubneshwar, Jodhpur, New Delhi, Patna, Raipur and Rishikesh.
- Regional Cancer Centresare cancer care hospitals and research institutes controlled jointly by the central and the respective state governments.
- Government Medical Collegesowned and controlled by the respective state governments. These are referral hospitals.
- District Hospitals or General Hospitals: Controlled by the respective state governments and serving the respective districts (administrative divisions in India).
- Taluk hospitals: Taluk level hospitals controlled by the respective state governments and serving the respective taluks (administrative divisions in India, and smaller than districts).
- Primary Health Centres: The most basic units with the most basic facilities, and especially serving rural India.

Various Bodies in Public Healthcare

Medical council of India

MCI is a statutory body established and governed by Indian Medical Council Act 1956. We have discussed MCI and issues related to its working in past; and this document also has discussed it again.

Central Health Education Bureau

CHEB is an apex institution under DGHS for the health education and health promotion in the country. The Bureau is located in New Delhi. Its functions include imparting long-term and short-term training programmes to different levels of health and non – health professionals.

Pharmacy Council of India

The Pharmacy Council of India is a statutory body constituted under the Pharmacy Act, 1948. It is responsible for the regulation of pharmacy education and practice of profession in the country for registration as a pharmacist. At present, there are around 500 approved institutions.

Dental Council of India

Dental Council of India is a statutory body established under the Dentists Act, 1948 with the prime objective of regulating dental education, profession and its ethics in the country.

Indian Nursing Council

The Indian Nursing Council is a statutory body constituted under the Indian Nursing Council Act, 1947. The Council is responsible for regulation and maintenance of uniform standards of training for nurses, midwives, ANMs and Lady Health Visitors in India. The Council prescribes the syllabi and regulations for various Nursing courses.

National Eligibility and Entrance Test (NEET)

NEET is a national level common medical entrance examination to allow class XII students or XII passed students to sit in a single entrance examination to get admission to almost all medical colleges in India, including private medical colleges. We have already discussed NEET in education related document of our programme.

Topic 2. Public Health: MDG Achievements and Way Forward for SDGs

The deadline to achieve the millennium development goals (MDGs) expired in 2015. Out of the total 10 health targets, India was able to achieve or get close to achieve *only four* targets. As per WHO's annual World Health Statistics for 2015, these four targets are as follows:

- *Target 4-A: Reduce under-five mortality rate by two thirds.* India was able to achieve 58% reduction in under-five mortality rate between 1990 and 2013.
- *Target 5-A: Reduce maternal mortality rate by three quarters.* India was able to achieve 66% reduction in maternal mortality between 1990 and 2013.
- *Target 6-A: halt and reverse the spread of HIV/AIDS.* India was able to achieve 57% reduction in HIV incidence between 2001 and 2013.
- *Target 6*-C: Halt and reverse incidence of malaria and other major diseases: India was able to achieve 50% reduction in mortality rate of tuberculosis between 1990-2013.

India either made no substantial progress or made little progress in Target 5-B (achieve universal access to reproductive health); Target 7-A (halve proportion of population without substantial access to safe drinking water and basic sanitation). In summary, India was able to reach near the MDG with respect to maternal and child survival.

Shortcomings of MDGs

Year 2016 marks the end of MDG era and paves way for Sustainable Development Goals (SDGs) that the world would strive to achieve in next 15 years. The lessons learnt through MDGs are as follows: *Firstly*, the MDGs received high level political commitment nationally and globally. Needless to say, similar kind of commitment should be there for SDGs. *Secondly,* while MDGs helped to improve overall health of the countries, focus was on aggregate targets ignoring the inequalities between the

countries. *Thirdly,* MDGs did not capture the economic benefits of good health and direct consequences of ill-health. When people fall sick, there is high out of pocket expenditure on healthcare which has direct consequences for national economy. *Fourthly,* MDGs did not capture the prevention, early detection and response to NCDs (Non-communicable Diseases) as well as epidemics such as SARS, Ebola, Zika, MERS etc.

Public Health: MDGs versus SDGs

Unlike MDGs which had three dedicated health goals, SDG agenda has only one health goal {SDG-3} which aims to "ensure healthy lives and promote well-being for all in all ages". Under this goal, there are 13 broad targets that not only take unfinished agenda of MDGs but also take into consideration the current epidemiological incidences. It counts in NCDs, ill-effects of environmental hazards and epidemics. Further, this target is also linked to several other SDGs such as poverty, gender equality, education, food security, water sanitation etc.

What should be done to achieve SDG-3?

The single SDG-3 goal envisions that no one is left. It provides scope to bring health at centre of economic growth agenda. It can also serve as an anchor to implement the Universal health Coverage (UHC) in the country. Further, following are the key policy suggestions to achieve SGD-5:

Firstly, since both the national and state governments should put health on top priority and as a cornerstone of economic agenda. The proposal of draft National Health Policy, 2015 to raise public expenditure on public health from current 1% to 2.5% of GDP needs strong political commitments and efforts. *Secondly,* The country should fight with more vigour to eliminate / reduce neglected tropical diseases (NTDs), Malaria, Tuberculosis, NCDs etc. The programmes and interventions need to be taken on a wide scale but at grassroots level. *Thirdly,* the government should make all efforts to implement the universal health coverage. It will help to prevent people from slipping into poverty due to out of pocket expenditure on illness. *Fourthly,* the state and central governments need to build robust rural health system. India's public health infrastructure in rural areas is in tatters not only due to fund shortages but also due to wide scale corruption in rural public health. Thus, there is a need to develop strong system for monitoring, evaluation and accountability.

Topic 3. National Health Mission [Background]

In May 2013, the UPA government had launched National Urban Health Mission, which was later integrated into National Rural Health Mission and a new National Health Mission was created from 2014-15. Both NUHM and NRHM are now two of six components of NHM. The six components of National Health Mission as follows:

1. National Rural Health Mission (now called NRHM-RCH Flexipool

2. National Urban Health Mission Flexipool for population above 50000
3. Flexible pool for Communicable disease
4. Flexible pool for Non communicable disease including Injury and Trauma
5. Infrastructure Maintenance
6. Family Welfare Central Sector component.

National Rural Health Mission

The major functions under this sub-mission is to provide ***Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A) Services*** to the rural deprived people through its network of **ASHA, ANMs and AWWs**. NRHM, also called NRHM-RCH Flexipool is one of the components of NHM and is for all towns and villages below population of 50,000.

Under this mission, government seeks to provide accessible, affordable and quality healthcare to rural population. Thrust of this mission is to provide a fully functional, community owned, decentralised health delivery system in rural areas.

National Urban Health Mission

National Urban Health Mission (NUHM) seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary healthcare. NUHM covers all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner.

Flexible Pool for Control of Communicable Diseases

Under National Health Mission, the Flexible Pool for Control of Communicable Diseases has been created to combine and integrate all the ongoing schemes related to communicable diseases. These include

- National Vector Borne Diseases Control Programme (NVBDCP): Covers Malaria, Filaria, Kala-azar, Japanese Encephalitis (JE), Dengue and Chikungunya.
- Revised National Tuberculosis Control Programme (RNTCP)
- National Leprosy Control Programme (NLEP)
- Integrated Disease Surveillance Programme (IDSP)

Flexible Pool for control of Non Communicable Diseases (NCD)

The Flexible Pool for Control of Non-communicable Diseases has been created to combine and integrate all the ongoing schemes related to non communicable diseases. These include:

- National Programme for Prevention and Control of Cancer, Diabetes,
- Cardiovascular Diseases and Stroke (NPCDCS)
- National Programme for the Control of Blindness (NPCB)
- National Mental Health Programme (NMHP)

- National Programme for the Healthcare of the Elderly (NPHCE)
- National programme for the Prevention and Control of Deafness (NPPCD)
- National Tobacco Control Programme (NTCP)
- National Oral Health Programme (NOHP)
- National Programme for Palliative Care (NPPC)
- National Programme for the Prevention and Management of Burn Injuries (NPPMBI)
- National Programme for Prevention and Control of Fluorosis (NPPCF)

Broad Objectives of National Health Mission

National Health Mission is basically a conglomerate of all existing health schemes of the country. The broad measurable objectives of this mission in totality are as follows:

- Reducing MMR to 1/1000 live births
- Reducing IMR to 25/1000 live births
- Reducing TFR (Total Fertility Rate) to 2.1
- Prevention of anaemia in women aged 15-49 years
- Prevent and reduce mortality & morbidity from communicable, non-communicable
- Injuries and emerging diseases

- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- Less than 1 per cent microfilaria prevalence in all districts
- Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Various Initiatives under National Health Mission

Accredited Social Health Activists (ASHA)

At present, there are around 8.96 lakh Accredited Social Health Activists in India to serve as facilitators, mobilizers and providers of community level care. An ASHA is the *first port of call in the community especially for marginalized sections of the population*, with a focus on women and children.

Rogi Kalyan Samiti

A Rogi Kalyan Samiti is a registered society whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the patients in the hospital. The Government provides financial assistance to these committees. Currently, there are more than 30,000 Rogi Kalyan Samitis (RKS) in India.

Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) was launched with objective of reducing maternal and neo-natal

mortality by promoting institutional delivery among the poor pregnant women. This scheme is currently being implemented in all states. Under the scheme, *cash assistance is provided to eligible pregnant women for giving institutional birth in a Government health facility*. Since the inception of NRHM, 7.33 crore women have been benefited under this scheme.

Janani Shishu Suraksha Karyakram (JSSK)

This scheme was launched in 2011 and entitles all pregnant women delivering in public health institutions to *absolutely free and no expense delivery, including caesarean section.* This scheme marks entitlement based approach in health schemes includes free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges. Similar entitlements are available for all sick infants (upto 1 year of age) accessing public health institutions. All states and union territories are implementing this scheme.

National Ambulance Services

This initiative includes ambulance services by dialling 108 or 102 telephone numbers. Dial 108 is a emergency response system to attend to patients of critical care, trauma and accident victims etc. Dial 102 services are for basic patient transport aimed to cater the needs of pregnant women and children though other categories are also taking benefit and are not excluded.

India Newborn Action Plan

The current NDA Government had launched *India Newborn Action Plan (INAP)* in September 2014 as a response to the *Global Every Newborn Action Plan (ENAP),* which was launched in June 2014 at 67th World Health Assembly.

This action plan focuses on *preventable newborn deaths and stillbirths*. The objective is to achieve Single Digit NMR by 2030 and Single Digit SBR by 2030. Implementation has to be done under RMNCH+A framework. {Details}

Rashtriya Bal Swasthya Karyakram (RBSK)

This initiative was launched in February, 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of the four Ds i.e *Defects at birth, Diseases, Deficiencies, Development delays including disability*.

Rashtriya Kishore Swasthya Karyakram

This initiative was launched in January, 2014 to reach out to 253 million adolescents with focus on the adolescent health programme beyond reproductive and sexual health and brings in focus on life skills, nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

Child Death Review

Child Death Review (CDR) is a strategy to understand the geographical variation in causes of child deaths and thereby initiating specific child health interventions. Analysis of child deaths provides information about the medical causes of death, helps to identify the gaps in health service delivery and social factors that contribute to child deaths. This information can be used to adopt corrective measures and fill the gaps in community and facility level service delivery. With uniform CDR process and formats across the states, information can be compared over a period of time and common factors identified and addressed through the national programme. This contributes to overall improvement in quality of care and reducing child mortality.

Topic 4. Draft National Health Policy 2015: Salient Features

India's third {draft} National Health Policy was released in 2015. Prior to this, two National Health policies (1983 and 2002) had served in guiding the approach for the health sector in the Five-Year Plans and for different schemes. Since 2002 when the last Health policy was formulated, things have changed and therefore it called for a new Health policy in order to address the concerns of the day today.

Key proposals of the policy

The goal of the new health policy is attainment of the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

Increasing Public Health Expenditure to 2.5% of GDP

Draft NHP-2015 envisages increasing the public expenditure to health from present 1% to 2.5% of GDP. However, the draft neither gives a timeline to achieve this nor explains how funds will be mobilized except increasing taxes on alcohol and tobacco, gains from medical tourism and possibility of creating a health cess on the lines of education cess. The proposed cess will come from industries that are unhealthy and toxic: "*Extractive industries and development projects that result in displacement or those that have negative impacts on natural habitats or the resource base can be considered for special taxation extractive*"

National Health Rights Act

The policy calls for making health as justifiable right and envisages enactment of *National Health Rights Act* in order to make *health a fundamental right*.

Private Participation

The policy envisages private participation in delivering the health services through a well networked public health delivery system. Further, it calls for ensuring universal access to free drugs and

diagnostics in government hospitals.

Non-communicable Diseases

For the first time, Non-communicable Diseases (NCDs) have been included in the national health policy. In recent decades, the NCDs have emerged as major cause of mortality in India.

National Urban Health Mission (NUHM).

There is a special focus on the urban poor and the policy underlines the need to set up a National Urban Health Mission (NUHM).

Urban ASHAs

The policy calls for developing a cadre of urban accredited social health activists (ASHA). The policy also calls for greater synergy and cooperation between ASHAs and auxiliary nurse midwives (ANMs).

Health Research

The policy underlines the importance of health research in the country and makes a case for a *Department of Health Research* though not much detail about its function has been given. Policy also talks about need for India to contribute to global health research, and develop its own policy in international health and health diplomacy. It says that India should be an equal partner rather than mere recipient of technical assistance in field of health.

Conclusion

India suffers from gaps in public health policy and implementations; and therefore National Health Policy seeks to address the urgent need to improve the performance of health systems. The changes which led to the formulation of the new health policy include-*Firstly*, Health Priorities are changing. The *second* important change in context is the emergence of a robust health care industry growing at 15% compound annual growth rate (CAGR). *Thirdly,* incidence of catastrophic expenditure due to health care costs is growing and is now being estimated to be one of the major contributors to poverty. *Fourthly,* economic growth has increased the fiscal capacity available. Therefore, the country needs a new health policy that is responsive to these contextual changes.

Topic 5. Universal Health Coverage

Universal Health Coverage (UHC) is free access to healthcare to all, enabled and guaranteed by the government and provided by public as well as private sector. UHC is now widely adopted by many other countries both as a developmental imperative and the moral obligation of a civilized society.

Challenges to Universal Healthcare in India

The Constitution via DPSP mandates every state with "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". However,

insufficient funding of public facilities, combined with faulty planning and inefficient management over the years, has resulted in a dysfunctional health system that has been yielding poor health outcomes. India's public spending on health — just around 1 per cent of GDP — is among the lowest in the world.

Further, India's public and private health sectors operate on two contrasting planes. The public sector means largely for the poor. It is underfunded, understaffed, overcrowded and inefficiently managed. The private sector on the other hand, caters chiefly to those who can afford it. The private sector is flourishing, rapidly modernizing and striving to offer world-class facilities with an eye on capitalizing on medical tourism. Thus, a contrast in public and private healthcare sector is the biggest challenge in providing UHC in India. The other challenges are as follows:

- Overly bureaucratic legal and regulatory framework around public health delivery infrastructure.
- Still not enough availability of generic drugs through the public system.

Suitable Model for India

Globally, there are *two models* of achieving UHC objective and these models vary from country to country. First is **tax-financed model**, while second is **insurance model.** Some countries deliver care through salaried public providers; others have adopted capitation as the preferred model for payment for out-patient care, and fee-for-service for in-patient care. For example, while in Canada, UHC is financed through Federal and Provincial tax revenue, in Germany, there is a sickness fund. In New Zealand, the National Health Service is publicly financed through general tax revenue.

Which model is more suitable for India – has been a subject of debate. Various committees (including Planning Commission's High Level Expert Group) had recommended for a tax funded and cashless at delivery model of UHC. The reason is that the health insurance schemes may exclude the majority of people and leave the poor behind. Such schemes also prioritize advantaged groups in the formal sector and drive up inequality. Thus, instead of collecting contributions from people who are too poor to pay, the countries making most progress towards UHC *have prioritized spending on health from general taxation* – either on its own or pooled with formal sector payroll taxes and international aid.

Apart from these two, there was a suggestion of a "Managed Care" Model also. In a managed care system, large networks (in the Indian situation these are mostly controlled by corporate hospitals) would be invited to compete for public funds and provide different sets of services. Patients will need to buy these services, which would be provided in separate packages, thereby fragmenting the health system and compromising quality and continuity of health care. The foremost example of managed

care today is the United States, which has among the highest per capita expenditures on health, yet the worst health indicators among Organisation for Economic Co-operation and Development (OECD) countries. Naturally, for India, such a model can be problematic.

Current Status

The problem with India's UHC plan is that it is looming between "sound economics" and "social good". UHC project, which was declared a priority for the 12th Plan period (2012-17), has been shelved due to fiscal constraints during the NDA Government.

Topic 6. Right to Health: Current Provisions

Right to Health is not included as an explicit fundamental right in the Indian Constitution. Most provisions related to health are in Part-IV {Directive Principles}. These are:

- Article 38 says that the state will secure a social order for the promotion of welfare of the people. Providing affordable healthcare is one of the ways to promote welfare.
- Article 39(e) calls the state to make sure that *health and strength of workers, men and women, and the tender age of children are not abused.*
- Article 41 imposes duty on state to provide public assistance in cases of unemployment, old age, sickness and disablement etc.
- Article 42 makes provision to protect the health of infant and mother by maternity benefit.
- Article 47 make it duty of the state to improve public health, securing of justice, human condition of works, extension of sickness, old age, disablement and maternity benefits and also contemplated. Further, State's duty includes prohibition of consumption of intoxicating drinking and drugs are injurious to health.
- Article 48A ensures that State shall Endeavour to protect and impose the pollution free environment for good health.

Apart from DPSP, some other provisions related to health fall in 11th schedule and 12th schedule as subjects of Panchayats and Municipalities respectively. These include drinking water, health and sanitation, family welfare, women and child development, social welfare etc.

The above description makes it clear that most provisions related to health fall in DPSP in the constitution. They are non-justifiable and no person can claim for non-fulfilling of these directives. However, Judiciary has widely interpreted the scope of Right to Health under Article 21 (right to life) and has thus established right to health as an implied fundamental right. Not only article 21 but also other articles under Part-III have been linked to Right to Health. For example, Article 23(1) prohibits traffic in human beings. Since trafficking of women leads to prostitution, which in turn is to major factor in spread of AIDS, this article has been linked to Right to Health. Similarly, Article 24

says that No child below the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment. It is directly related to Child health.

Further, in relation to the serious medical cases, the supreme court has provided certain directions such as:

- Provision of adequate health facilities at public health centers.
- Upgradation of sub-divisional level hospitals to make them capable of treating serious patients.
- To ensure availability of bed in any emergency at State level hospitals, there should be a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment, which is required.
- Proper arrangement of ambulances adequately provided with necessary equipments and personnel.

Further, the Supreme Court in *Paramanand Katara v Union of India* case gave a landmark judgement that a every doctor at government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life of a patient.

Topic 7. Inclusion of Health as a Fundamental Right

There has always been a lingering question so as to make Right to Health as a fundamental right similar to right to education. The draft national health policy, 2015 proposes the following formulation- "*the Center shall enact, after due discussion and on the request of three or more States a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable.*"

Issues

In the previous topic, we have studied that Supreme Court has widely interpreted the scope of Right to Health under Article 21 (right to life) and has thus established right to health as an implied fundamental right. Making this right justifiable in nature would help to enforce strict compliance to deliver better health services. However, there are several questions:

- Has India reached to a level of economic development to make it justifiable? When we make a law justifiable, its denial becomes an offense.
- Since health is a state subject, is Union capable of making a central law/ amending the constitution and impose such legislation on states? If not, then how a justifiable act can be voluntarily implemented by states.
- If there is a central law, what should it focus? The state list items (public health standards on water, sanitation, food safety, air pollution etc) or health rights (access to health care and

quality of health care).

Is Right to Health on lines of Right to Education feasible?

Right to education, which was declared a fundamental right in 2009 has several parallels with healthcare: the quality of education in government schools and the quality of services in public hospitals and primary health centres; the insistence, as a result, of even poor parents on their children attending private schools, however badly run; the beeline to private hospitals even by poor patients; and the small and large glitches in the implementation of the law. The lesson is obvious: what looks excellent on paper becomes a different proposition when it has to be put into practice.

In summary, a Central Law may not be feasible. The National Health Policy suggests that states should be voluntarily opt to adopt such a law by a resolution of their Legislative Assembly. It further says that the state which have per capita public health expenditure rate of over Rs 3800 per capita (at current prices) should be in a position to deliver on this- and though many States are some distance away- there are states which are approaching or have even reached this target.

Topic 8. Issues Around Medical Council of India

In first week of April 2016, a Parliamentary Standing Committee had come up with its 92nd report on "Functioning of the Medical Council of India". In this backgrounder, we look into various issues of functioning of the MCI.

About Medical Council of India

MCI is a statutory body established in 1934 in British India via the Indian Medical Council Act, 1933 on the lines of General Medical Council (GMC) of UK with twin mandate to regulate medical practice and medical education in the country. To upkeep with the changed environment, this act was repealed in 1956 and was replaced with a new act. The new act also broadened the mandate of MCI and established it as an apex body with responsibility of establishing and maintaining high standards of medical education and recognition of medical qualifications in India. This act was further modified in 1964, 1993 and 2001. Thus, today, the various functions of MCI can be broadly kept in two categories viz. medical education and ethics. These are as follows:

- MCI maintains uniform standards of UG as well as PG medical Courses in India.
- It recognizes / derecognizes medical degrees of India / foreign countries for India; and maintains register of doctors in the country.
- Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.
- Upholding the ethics in medical education and profession in India.

What went wrong with MCI?

For last few decades, MCI has been subject to severe criticism. In 2010, its president Ketan Desai {who was also President Elect of World Medical Association then} was arrested on charges of accepting huge bribe for recognizing one of the private medical colleges. He was later released and reinstated. Apart from the corruption, the following are some of the major issues {also highlighted in the Parliamentary Committee Report} regarding functioning of the MCI.

- It has failed to create a curriculum that produces doctors suitable for Indian context, especially in rural / poor urban areas.
- It has failed to maintain uniform standards of medical education.
- There has been devaluation of merit in admission, particularly in the private medical colleges, due to prevalence of capitation fees in these colleges.
- There has been excessive focus on the infrastructure and human staff but without substantial evaluation of quality of teaching, training and imparting skills in medical institutions.
- MCI has failed to raise the abysmally low doctor-population ratio.
- It has failed to rationalize the setting up of Medical Colleges in the country as per regional needs and this has led to geographical misdistribution of the medical education resulting in concentration of institutes in some states while absence in others.
- In words of parliamentary committee, MCI had failed to "*produce a competent basic doctor.*"
- MCI has put excessive focus on medical educationat the cost of another mandate of *upholding the ethical practice*. Thus, the commmittee recommended that MCI should be split in two parts – one dealing with education while other dealing with ethics.

Recommendations of the Parliamentary Standing Committee

The following are the important recommendations of the panel, if implemented are likely to have far reaching consequences for the health sector:

- It has suggested to replace the existing architecture of the MCI with four independent boards dealing with:
    - Curriculum development, teacher training, and standard setting for undergraduate and post-graduate education,
    - Accreditation and assessment processes of colleges and courses for ensuring uniformity in standards,
    - Registration of doctors and licensing, and
    - Overseeing adherence to ethical standards.
- It has favored a new architecture which is in tune with the current needs and aspirations of the country.

- It favors replacing the principle of election with nomination.

Expected outcomes of the proposed reforms

The proposed reforms are likely to plan the required human resources essential for primary care by promoting family medicine and general physicians along with specialists. It will also make medical education affordable by rationalizing the standards. It would pave way for the uniform national entry and exit examination. However, this recommendation was overruled by the Supreme Court and has been pending appeal.

Main shortcomings of the report

The report is silent on policy of corporatizing public assets in the name of establishing medical colleges to provide quality care. The Ministry of Health and Family Welfare has recently sanctioned funds to upgrade 58 district hospitals to medical colleges. The idea behind such upgradation of district hospitals to medical colleges was proposed to cut down on the costs of establishing a separate 300-bed hospital for a new college as well as utilizing the available specialists for teaching. It is argued that it will pave way for the rural population to access the specialist services at an affordable cost. For instance, Bhuj district hospital was leased to the Adani Group for 99-years and in 2015 the 300-bed Chittoor district hospital in Andhra Pradesh was leased to Apollo Group for five years for establishing a medical college. In the past, the experience of handing over district hospitals to private entrepreneurs had invited controversies on the ground that poor will be denied access to free health care. Though the committee has strongly condemned commercialization of the health sector it has not come up with any clear directions on this subject.

It has not recommended a rigorous assessment of all the 400-plus existing medical colleges by a high level committee. Such measures are needed to usher in the credibility to the system and prohibit the production of poorly trained doctors. This type of exercise was carried out in the U.S. in 1910 which found that only 16 out of 155 medical schools were functioning as per the expected norms.

Lastly, the committee has given the power of deciding the fee structure to the Health Ministry. It would have been prudent if that power of evolving and regulating fee structure is awarded to the new system within its mandate.

Way forward

The parliamentary committee has fairly done its job by indicting the MCI. Now it is time for the government to take action on the report. The MCI may be set aside with immediate effect. Instead a team of eminent people needs to be appointed as a transition team to work out the new architecture. The help of the Law Commission may be sought to draft a new law to safeguard the interests of the new body and prevent it from becoming overly centralized.

Elitism should not be allowed to rule over the medical education. As in U.K. and many other

European countries, medical education should fall under the purview of the government.

National Commission for Human Resources for Health

The *National Commission for Human Resources for Health Bill, 2011* was introduced in the Rajya Sabha on December 22, 2011. The bill seeks to establish the following with a mandate to prescribe minimum standards for health education:

- National Commission for Human Resources for Health (NCHRH),
- National Board for Health Education (NBHE), and
- National Evaluation and Assessment Council (NEAC).

The Bill seeks to repeal the following acts:

- Indian Nursing Council Act, 1947.
- Pharmacy Act, 1948.
- Dentists Act, 1948.
- Indian Medical Council Act, 1956.

NCHRH is proposed to be established under the Ministry of Health & Family Welfare as an overarching regulatory body for medical education and allied health sciences. The main objective is to reform the current regulatory framework and enhance the supply of skilled manpower in the health sector. The proposed NCHRH would subsume:

- Medical Council of India,
- Dental Council of India,
- Nursing Council of India and
- Pharmacy Council of India.

The NCHRH shall have the following functions:

- Determine and maintain the minimum standard of human resources in health education by adopting the following measures:
    - Conducting studies to assess the needs of human resources in states,
    - Conducting elections in national councils
    - Providing necessary grants to the NBHE, NEAC and councils
    - Regulating the entry of foreign institutions in consultation with NBHE.

The NBHE is proposed to facilitate academic studies and research in emerging areas of health education and shall conduct a screening test for medical practitioners to enroll in a professional council.

The Bill proposes to constitute the *National Commission for Human Resources for Health Fund* to meet the expenses of the various bodies.

The Bill also proposes to impose penalties for various offences such as running institution without permission, practicing without enroling, and enroling without a screening test.

Topic 9. National Medical Commission Bill, 2016

The NITI Ayog has introduced the National Medical Commission Bill, 2016 which would be extending to the whole country recently in order to create world class educational system. The bill seeks *to repeal Indian Medical Council Act 1956* and be replaced by a body called National Medical Commission.

Salient Provisions

- The bill seeks to address the following:
- Ensure adequate supply of high quality medical professionals at both undergraduate and postgraduate levels.
- Encourage medical professionals to incorporate the latest medical research in their work and to contribute to such research.
- Provide for objective periodic assessments of medical institutions.
- Facilitate the maintenance of a medical register for India and enforce high ethical standards in all aspects of medical services.
- Ensure that the medical institutes are flexible enough to adapt to the changing needs of a transforming nation.

Medical Advisory Council

The bill seeks to constitute a Medical Advisory Council which will undertake the following functions:

- The Council shall serve as the primary platform through which the states would put forward their views and concerns before the National Medical Commission (NMC) and shall help shape the overall agenda in the field of medical education & training.
- The Council shall advise the National Medical Commission (NMC) on the measures to determine, maintain and coordinate the minimum standards in the discipline of medical education, training and research.
- The Council shall advise the National Medical Commission (NMC) on measures to enhance equitable access to medical education.

Criticism of the bill

It is argued that via attempting to restructure the Medical Council of India (MCI) in order to overhaul medical education in India, the Central government is actually taking away its autonomy. Under the existing Indian Medical Council Act 1956, the states and the Centre nominate and elect

members to the MCI, which is India's apex body for regulating medical education and registering doctors, but a new proposal gives all authority to one committee constituted by the government.

The doctors argue that draft bill should actually check growing commercialisation of medical education; rather the policy seeks to further accelerate privatisation and commercialisation of medical education.

There is definite need for overhaul of the MCI because medical education and sciences have evolved rapidly over the past few decades. But the need of the hour is to ensure checks and balances so that the MCI doesn't lose its autonomy and democratic structure.

Topic 10. Privatisation of Health Sector

There are three main elements of health care: prevention, treatment and rehabilitation. However, the state infrastructure is unable to meet these three elements productively. This calls for dire engagement of the private players in the healthcare sector.

What makes entry of private players in the health sector important?

It is an accepted fact that the government is unable to cope with demand of the healthcare services. The government is unable to provide comprehensive quality healthcare. Infrastructural bottlenecks in public system have made the State and Central Governments to invite private players to deliver critical healthcare. There is a big opportunity for private healthcare to fill up this gap.

The private sectors have the potential to contribute to the health industry as they can get the financial aid from bankers, venture capitalists, pharmaceuticals, business houses, etc.

Healthcare no longer is restricted to providing just health service but it has evolved into a competitive, performance –driven industry, which demands the best management skills related to manpower, technology and finance. To provide this qualitative healthcare, it becomes important for the entry of private players which are blessed with funds.

Tatas, Apollo, Wockhardt, Escorts, Max India, Fortis, Piramal, Ispat, Duncan, Escorts etc. have been the major contributors in India in athe arena of private healthcare.

It is to be observed that with the advent of Managed Care Systems in the form of Preferred Provider Organization (PPO), which will transform into Health Maintenance Organization (HMO) in long run, the private health care industry is now poised to undergo a drastic change. This will encourage private health care entrepreneurs to promote India as a Regional Health Care Hub.

What has the private sector got to offer?

The private health care sector has its own pros and cons. On the pros side it has Individualised care and better nursing and allied services. However, there is also the flip side to it. Some of them are listed below:

- Privatisation leads to steep hike in health expenditures, attributable to the increased costs of medical consultations, drugs and devices, medical tests and hospitalisation.
- Also, because of the pressure to make a profit, many private doctors, hospitals and diagnostic centres promote uncalled-for investigations and treatment in order to recover their initial investment.
- Privatisation has also encouraged unhealthy competition among the groups involved, since the objective is not only to earn, but to earn more than others.
- Privatisation leads to the relative neglect of problems from which there is little to earn.

Way forward

In order to live up to the vision to provide universal health coverage i.e. ensure universal access to quality healthcare, there is a pertinent need for engagement of private players in this sector. There is definitely the need of the hour for stronger partnership between the public and private sector to achieve the Sustainable Development Goals (SDGs) in order to ensure healthy lives and promote wellbeing for all by 2030.

Privatisation has undoubtedly improved the quality of health care, and widened its scope and availability. Private sector will continue to flourish, since they provide curative and rehabilitative services that the state does not provide. However, privatisation has resulted in a number of problems which are alien to Indian society. Promoting health care merely as a consumer service and product is both unhealthy and risky. Therefore, the ball lies in the court of the government of the day to take remedial steps to curb the ill effects of private sector.

Topic 11. Growing Concerns about Hysterectomies

Since last year there is a growing concern over Hysterectomy being performed over women mostly poor women in India. Hysterectomies are elective surgeries that are sometimes recommended for women 35 years and older to treat symptoms like uterine fibroids and post-menopausal bleeding.

Background

- Hysterectomies have been reported largely from rural pockets of Gujarat, Rajasthan, Bihar, Chhattisgarh, Karnataka, Maharashtra, especially in the last six years.
- Chittorgarh based Narendra Gupta of Prayas had moved a PIL in the Supreme Court in 2012. He had stated that the total number of hysterectomies in India is lower than in the West. But it is alarming that 30-32 is the average age group of women undergoing the procedure here, while in the West post-menopausal hysterectomy is common. This makes the situation to be taken under control.

- Private hospitals are considered to be hand in glove with diagnostic centres that would do a sonography, give the report in an hour, and conclude that the uterus is about to become cancerous.

Hysterectomy is rampant amongst poor

Poverty coupled with illiteracy is the main reason behind rural poor women to undergo hysterectomy. The doctors are able to play with the psyche of the individual and convince the poor ladies to even undergo hysterectomy for simple white discharge, irregular menstrual cycles and even abdominal pain.

The doctors create a fear psychosis in their minds that if not operated, there would be chances of cancer.

Lastly, loss of daily wages during menstruation also makes the prospect of undergoing hysterectomy more appealing to poor rural ladies.

Problems associated with Hysterectomy

Hysterectomy might be considered a boon for many, but it is coupled with many side effects which even doctors would be hiding from patients:

- It disturbs hormonal balance of body, especially removal of ovaries. Increases risk of bloating and water retention by body.
- It increases the risk of heart attack and other diseases as female hormone oestrogen protects women from it. Ovaries should preferably be retained by every woman at least till 65 years of age.
- It increases chances of breast cancer

Hysterectomy and Medical Tourism

India is becoming a hub for foreign patients coming for various medical treatments and surgeries including the Hysterectomy Surgery. The reason behind this is that the hospitals and medical centers in India are hygienic, and maintain the highest quality of medical services and amenities making the country most preferred destination in the world. Besides this, the cost at which hysterectomy can be done is another reason which attracts patients from abroad to choose India as destination.

Conclusion

This practice is definitely a sign of "human rights violation". Health activists are of the opinion that it is high time that the government takes strong action. Hysterectomies cause physical and emotional damage to women. There is a definite need for a regulation like in the case of the PCPNDT (Pre-Conception and Pre-Natal Diagnostic Techniques Act) that doesn't allow an ultrasound without proper documentation.

It is a welcome move wherein The National Family Health Survey-4 included a question on

hysterectomies. This fact sheet will be the first comprehensive data on the worrying trend.

Finally, it would be advisable to take the suggestion put forward by The OXFAM report, which stated that India should end its public-private partnership programmes, that allows poor women with government insurance plan to undergo a hysterectomy in private hospitals uncles and until better regulation is in place.

Topic 12. Neglected Tropical Diseases

Neglected tropical diseases or NTDs are a group of chronic disabling infections affecting more than 1 billion people worldwide, mainly in Africa and mostly those living in remote rural areas, urban slums or conflict zones. Beyond their negative impact on health, NTDs contribute to an ongoing cycle of poverty and stigma that leaves people unable to work, go to school or participate in family and community life.

The 17 NTDs covered by WTO are as follows:

1. Buruli Ulcer
2. Chagas disease(American trypanosomiasis)
3. Cysticercosis
4. Dengue/Severe dengue
5. Dracunculiasis (guinea-worm disease)
6. Echinococcosis
7. Fascioliasis
8. Human African trypanosomiasis
9. Leishmaniasis
10. Leprosy
11. Lymphatic filariasis
12. Onchocerciasis
13. Rabies
14. Schistosomiasis
15. Soil transmitted helminthiasis
16. Trachoma
17. Yaws

Some of these 17 neglected tropical diseases (NTDs) affect millions of Indians also. The WTO has released a document on January 26 and this document says that over $2 billion is needed to prevent and treat all people at risk of contracting a common NTD by 2015. Out of these diseases, two culprits' viz. **dengue and cysticercosis** – are costing India about $45 million every year. Globally,

NTDs affect one in six persons, many of them among the world's poorest. The coordinated efforts include categories of research and development, drug supply and resources for implementation. The programme aims to improve the lives of over 1.4 billion people worldwide and help them achieve self-sufficiency. Around one billion of the poor across the world suffer from NTDs, mostly in urban slums. As per WTO, NTDs kill an estimated 534,000 people each year.

Topic 13. The Mental Healthcare Bill, 2016

The Mental Healthcare Bill, 2016 was recently passed by Rajya Sabha. The Bill would be repealing the existing Mental Health Act, 1987.

Background

- There are around 6-7% of the country's population suffering from some kind of mental illness, while 1-2% suffer from acute mental diseases.
- Currently, to address mental illness, The mental Health Act, 1987 is in existence. However, it is being criticised for its inadequate provisions to protect the mentally ill persons.
- The Indian government in 2007 had ratified the United Nations Convention on the Rights of Persons with Disabilities, which required the laws of the country to align with the convention. To that effect, the Mental Health Care Bill, 2013, was first introduced in the Rajya Sabha to repeal the existing Mental Health Act, 1987.

Key Features

- The Bill provides, every person has right to access mental health care and treatment from services run or funded by the government.
- Under it, these also have right to equality of treatment, protection from inhuman and degrading treatment, access to their medical records free legal services etc.
- It also has a provision to protect, promote and fulfill the rights of such persons during delivery of mental health care and services.
- The Bill focuses on community based treatment and special provisions for women and health have also been provided.
- In case of person who attempts to commit suicide shall be presumedto be suffering from mental illness at the time of attempting suicide unless proved otherwise.
- Such person shall not be liable to punishment under section 309 (attempt to commit suicide) of Indian Penal Code (IPC).
- It also provides for establishment of Central and State Mental Health Authority. It also establishes Mental Health Review Commission and Board (MHRCB) as a quasi-judicial body.

Important Provisions of the Mental Healthcare Bill, 2016

Mental Healthcare Bill seeks to decriminalise the Attempt to Commit Suicide

Besides decriminalising suicide, the bill seeks to impose duty on the government to rehabilitate such person to ensure that there is no recurrence of attempt to suicide.

Seeks to fulfil India's international obligation pursuant to the Convention on Rights of Persons with Disabilities and its Optional Protocol

India signed and ratified the Convention on 1st October 2007. The Bill adopts a more nuanced understanding of "mental illness" than the Act of 1987. The Act of 1987 is narrow in its approach.

Seeks to adopt a rights-based approach, which is a first in the mental health law of India

Chapter V of the Bill operates as a charter of rights for persons with mental illness consolidating and safeguarding the basic human rights of these individuals. The Bill guarantees every person the right to access mental health care and treatment from mental health services run or funded by government. The Bill also recognises the right to community living; right to live with dignity; protection from cruel, inhuman or degrading treatment; treatment equal to persons with physical illness; right to relevant information concerning treatment other rights and recourses; right to confidentiality; right to access their basic medical records; right to personal contacts and communication; right to legal aid; recourse against deficiencies in provision of care, treatment and services.

Provisions for registration of institutions and regulation of the sector

The Bill provides for the creation of Central and State Mental Health Authorities in order to ensure registration and supervision of mental health establishments; to develop quality and service norms for these establishments; to ensure registration of psychologists, mental health nurses, psychiatric social workers; to train law enforcement officials and mental health professionals about implementation of the Bill; and to advise government on mental health related issues. Registration of mental health establishments is made mandatory by providing for stringent penalty for violation.

The Bill allows only restricted use of Electro-convulsive therapy

The Bill would completely prohibit Electro-compulsive therapy ("ECT") as a measure of emergency treatment. It also prohibits ECT without muscle relaxants and anaesthesia. ECT is completely prohibited for minors except with informed consent of the guardian and prior permission of the concerned Board.

The Bill seeks to tackle stigma attached to mental illness

By addressing mental illness from a holistic perspective and by empowering mentally ill persons, the Bill seeks to remove the stigma attached to mental illness. It is a serious effort to usher in equality for the mentally retard individuals.

Questions & Answers

This bill should be analyzed in the light of the below questions:

- *Mental Healthcare Bill will be bypassing Section 309 of IPC?*
- *Still, the Mental Healthcare bill is a concern for mentally ill patients with respect to property.*

Mental Healthcare Bill will be bypassing Section 309 of IPC?

The Section 309 of the IPC makes any attempt to commit suicide a punishable offence for which imprisonment could extend up to a year.

There have been debates since long such as the 42nd report of the Law Commission in 1971 which called for decriminalizing attempt to suicide. Subsequently, the Indian Penal Code (Amendment) Bill, 1978 was passed by the Rajya Sabha omitting Section 309 of IPC. However, the proposed law could not be passed as the Lok Sabha was dissolved before the Bill could be passed.

Again in 1997, The Law Commission altered it position in the 156th report, where it recommended retaining the provision. This was in reaction to the famous Gian Kaur versus State of Punjab case of 1996 which upheld the constitutional validity of Section 309.

Finally, in 2008, the Law Commission, again in its 210th report, called for decriminalizing and humanization of attempt to suicide. It was here that the attempt to suicide was suggested to be regarded as a manifestation of a diseased condition of mind deserving treatment and care rather than an offence to be visited with punishment.

The final shape to decriminalising suicide would therefore be given by the Mental Healthcare Bill, 2016 if it is passed by the Lok Sabha and it becomes an Act.

The Mental Healthcare bill is a concern for mentally ill patients with respect to property.

The Act of 1987, had provisions for property of the mentally ill patients. However, the Mental Healthcare Bill, 2016 pays no heed to this issue. This is appearing as a serious cause of concern because the mentally ill persons could easily be exploited and their property could be taken away from them, leaving such individuals in a perpetual state of dependency.

Therefore, keeping this issue in mind, where the bill is providing so many rights and immunities to the mentally ill persons, no provision for the property management is a matter of concern.

The Standing Committee on the bill has therefore recommended that the central government implement necessary transitory schemes so that the persons do not fall in the trap of dependency.

Way Forward

The Bill under consideration mandates the central and state governments to ensure access to mental health services in every district. However, what is lacking in the bill is the financial aspect which has made no estimates of the expenditure required to meet the obligations and nor does the bill provide

details of the sharing of expenses between the central and state governments.

For the bill to work in actuality, allocation of adequate funds is utmost needed.

Public Health being a state subject and also keeping in mind of the financial constraints faced by the states, it would become important on the part of the central government to step in to ensure funds for successful implementation of the law.

Topic 14. Growing Concerns of Dementia

Dementia is a syndrome which is usually chronic and characterized by a progressive, global deterioration in intellect including memory, learning, orientation, language, comprehension and judgement due to disease of the brain.

It is said to mainly affect older people. Only about 2% of cases start before the age of 65 years. Dementia is considered to be one of the major causes of disability in late-life.

Background

The Dementia Report 2010 has stated the following:

- In 2010, there were 3.7 million Indians with dementia and the total societal cost is about 14,700 crores.
- The numbers are expected to double by 2030 cost would increase three times.

Also, The World Alzheimer Report 2015 led by King's College London has stated that out of 47 million people living with dementia, 4.1 million live in India.

Government initiatives for older persons

With respect to Dementia, India does not yet have a National Dementia Policy. However, there are three main initiatives in India, which are aimed at elder care/ support and health and include some specific dementia-related initiatives in them. These are:

Scheme of Integrated Programme for Older Persons (IPOP)

This is a central sector scheme in order to improve the quality of life of the Older Personsunder this, financial assistance is provided to State Governments/ Panchayati Raj Institutions/ Urban Local Bodies and Non Governmental Organisations for running and maintenance of projects related to elders, such as setting up old age homes, day care centres, mobile units, helplines and counselling centres, etc. Day care, helpline, counseling, and old age homes for persons with dementia fall under the purview of this scheme.

National Programme for the Health Care for the Elderly (NPHCE)

This scheme is under the Ministry of Health and Family Welfare. It includes multiple ways to improve healthcare for the elderly, through better education in geriatric medicine, setting up community-based primary centres and better district centres, as well as dedicated facilities and

special beds for the elderly. Initiatives to train healthcare professionals for dementia, setting aside beds for persons with dementia, and other such areas, shall fall in the purview of this national programme.

Indira Gandhi National Old Age Pension Scheme (IGNOAPS) and other such schemes

These are part of the National Social Assistance Programme(NSAP) (under Ministry of Rural Development). These do not have any direct, additional support for persons with dementia, but are still important because any special support for persons with dementia based on poverty or pension schemes may fall in this purview.

Way forward

Some efforts in the following way can be undertaken to address the issue of Dementia progressively:

- The recent Mental Healthcare Bill can have a large impact on the persons facing dementia. It would mean as to the way mental illness is defined and which sections of this act may be including/ excluding persons with various types of dementia, and how dementia may be seen as affecting mental capacity and other such aspects.
- Also disabilities which falls under the Ministry of Social Welfare and Empowerment may include persons with mental illness, and mental illness may be defined to include dementia.

- A legislation related to Maintenance and Welfare of Parents and Senior Citizens under the Ministry of Social Justice and Empowerment can spell out the role of families coping with dementia.
- Efforts such as Dementia Awareness Month which is been held in Australia having a theme 'you are not alone' must be replicated even by India in order to address the growing concern of Dementia.

Topic 15. Generic Medicines and Public Health

A generic drug is identical or bioequivalent to a branded drug in its dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. The only difference between a branded drug and generic drug is that the branded drugs are sold at substantial discounts from the branded price.

Novartis Issue

Novartis had filed an application for a patent for Glivec, the blood cancer drug to be sold in India. However, The Indian Supreme Court had refused to allow the world's leading pharmaceutical company to patent a new version of a cancer drug.

This decision was considered to be major step forward in enabling poor people to access medicines in the developing world.

This ruling holds importance because there are many generic companies in India who manufacture and sell cheap copies of the drug in the developing world and has implications for HIV and other modern drugs too.

Analysis: Generic Medicines are life-savers for many but are bitter as well

With all the benefits of quality and affordability generic medicines have to offer, there have been dissenting voices regarding the generics as well.

There are concerns about that not all drugs that are available in their generic form have the active ingredient which is present in the original drug to take care of a particular ailment. Therefore, in critical life-saving situations, one cannot experiment with generic drugs.

"Generic drugs may be cost-effective, but branded drugs are always better because they come into the market after rigorous research and development. Although the efficacy of generic drugs would have been tested, yet there are chances of reactions," said another doctor.

The other concern shown by the activists is the issue of pricing of generic drugs. It so happens that the dealer would have bought the generic medicine from the manufacturer at a cheaper price but sold it to the customer at MRP. The customer would be in the perception that he has benefitted with the lesser price, but in reality the dealer makes profits.

There is also the concern of spurious drugs been sold by the dealers. As generic drugs are manufactured by all pharmaceutical companies, spurious drugs can be dispensed by the dealers to customers. People need to be careful and check for the company's name on the pack.

Pradhan Mantri Jan Aushadhi Scheme

The Jan Aushadhi Scheme (Public Medicine Scheme) is a direct market intervention scheme of the Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers. Its aim is to make available quality generic medicines to all at affordable prices through Jan Aushadhi Store (JAS) opened in each district of the states. It was first launched in 2008 to provide quality medicines at affordable prices to the economically weaker sections of the society. The first JAS was opened at Amritsar Civil Hospital in 2008.

However, the scheme faces certain constraints such as:

- Over dependence on support from State Government.
- Poor Supply Chain management.
- Non-prescription of Generic Medicines by the doctors.
- State Governments launching free supply of drugs.
- Lack of awareness among the public.

Way Forward

In order to meet the goal of Universal Health Coverage, generic medicines are need of the hour.

However, a serious regulation on the quality of the drugs is needed.

The Lancet journal has stated that out-of-pocket spending comprises 58 per cent of the total out of which two-thirds is on drugs. The poor people are impoverished and adding to the agony when it comes to health is drug costs. Therefore, it is vital, that governments act on multiple fronts — making listed essential medicines available free or nearly free to all in hospitals through higher public spending, widening access to generics through Jan Aushadhi outlets, and closely monitoring professional practice to eliminate prescription of irrational, non-essential drugs that have no curative effect.

Topic 16. Issues Around Narcotic Drugs and Psychotropic Substances Act (NDPS)

As per the NDPS Act, narcotic drugs include coca leaf, cannabis (hemp), opium and poppy straw. Psychotropic substance means any natural or synthetic material or any salt or preparation covered under the 1971 convention on Psychotropic substances.

Conventions for control of narcotic drugs

The following conventions various forms of control to limit the use of narcotic drugs and psychotropic substances:

- The UN Single Convention on Narcotics Drugs 1961.
- The Convention on Psychotropic Substances, 1971
- The Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988

India is a signatory to all these three.

Narcotic Drugs and Psychotropic Substances Act, 1985

To give effect to the above international conventions and treaties, NDPS Act was enacted and came into force in 1985. The law was enacted hastily without much debate. Since then act was amended thrice (1988, 2001 and 2014).

NDPS Act has made stringent provisions for the control and regulation of operations relating to narcotic drugs and psychotropic substances. NDPS Act forbids production, manufacturing, cultivation, selling, possession, purchase, transport and consumption of any narcotic and psychotropic substance.

Why the provisions of the NDPS Act are considered harsh?

NDPS is considered as one of the harshest laws in the country.

As per the NDPS Act, the minimum sentence for dealing with drugs is 10 years rigorous imprisonment coupled with a fine of Rs. 1 lakh. On the other hand, the punishment for heinous crimes like rape and human trafficking is only 7 years imprisonment.

No bail is granted for those persons booked under this act. In addition, no relief can be obtained by the drug convicts through suspension, remission and commutation of sentences passed.

Even worse, NDPS Act prescribes capital punishment for repeat offenders of drug trafficking even though the offence cannot be called as a heinous crime. It is felt that death penalty is too harsh for the crimes of this nature. However, government defends death penalty by saying that even International Narcotics Control Board (INCB) has never objected to the death penalty offered to the drug convicts.

Amendments To NPDS Act

1989 amendment

It introduced very harsh provisions in to the act to act tough on drug convicts and drug use. It introduced mandatory minimum sentence of 10 years' imprisonment, bar on suspension and commutation of sentences passed, restrictions on bail and mandatory death sentence for repeat offenders.

Consequence

People arrested for possessing few milligrams of contraband intended for personal use/medical use was made to languish in jail for over 10 years.

2001 amendment

It introduced grading of punishment on the basis of the quantity of drugs involved into small, commercial or intermediate. This classification was made on the criticism that the act offered disproportionate sentencing structure.

2014 amendment

It introduced the following provisions:

- It created a new category called "essential narcotic drugs" which will be regulated and specified by the central government.
- The objective of the law was expanded to include promotion of scientific and medical use of narcotic drugs.
- It made awarding death penalty for repeat offences discretionary. Instead, the courts can alternately impose 30 years imprisonment.

How the provisions of NDPS Act are misused? What are the consequences?

Even though the courts have clarified that drug convicts involving small quantities of drugs can avail a right to get bail, neither the convicts nor the police seems to be aware of the law. In many cases indiscriminate raids are conducted to book offenders' especially street users.

Courts have clarified that people charged with offences involving small quantities of drugs have a right to get bail. Yet, neither police nor people who use drugs seem to be aware of the law, indiscriminate raids and arrests, especially of street users are not uncommon. For instance, after the

Shakti Mills Incident, Mumbai police arrested 12,275 persons under the NDPS Act in 9 months compared to approximately 4000 arrests the police had made in the previous year.

Even though the law permits the use of narcotic and psychotropic substances for medical purposes, police seems to be unaware of this provision. A substance named buprenorphine was used to treat opiate dependence. But once Punjab police raided a clinic and charged the psychiatrist under the NDPS Act, the treatment was stopped in all the other clinics and now the patients have no other option than to cure themselves and are forced to use illegal and riskier drugs.

Due to lack of awareness, those manufacturers who manufacture the drugs legally are also sometimes not sparred by the enforcement authorities.

What are the difficulties drug convicts faces in jails?

Due to the absence of medical staff in jail, unending news of death inmates continue to be reported form the jails. These deaths are accused due to health problems and alleged negligence by jail authorities. It is found that drug users desperately need help but government facilities are limited and inadequate.

Treatment for Drug Dependence

National Fund for the control of Drug Abuse

This fund was created in May 1989 and the rules were notified in 2006. The fund receives contributions from central government, individual donors and proceeds from the sale of property forfeited from drug trafficking. NGOs and governmental departments can request grants from this fund for drug control activities, treatment, preventive education and for spreading awareness.

De-addiction centres

As per the provisions of the NDPS Act, De-addiction centres can be set up central government, state governments and voluntary organizations. The following centres provide treatment for drug dependence:

- Government hospitals
- NGOs: They receive grants from Ministry of Social Justice and Empowerment (MOSJE) to run integrated rehabilitation centres to treat drug addicts and make them gainfully employed.
- Privately owned de-addiction centres which are licensed by the *Mental Health Act, 1987*.

What is the way forward?

- Drug addicts need more medical and not jails. Putting them behind the bars without any treatment aggravates their condition and in many cases result in suicide of the inmates. A drug addict has to be given treatment, rehabilitation and social reintegration more than punishments.
- Law Commission which is presently reviewing criminal justice and sentencing should make

note of the excesses and harsh punishments that NDPS Act provides and make appropriate recommendations to abolish disproportionate penalties like capital punishment.

- Enforcement agencies need to be sensitized and people who use drugs to access evidence-based treatment services should not be slapped with imprisonment and criminal prosecution.
- The use of narcotic and psychotropic medicines should be widened if its effectiveness is scientifically proven along with safeguards against illicit diversion.
- Government should consult psychiatrists, civil society organizations, academics and patients while issuing drug policy formulations.
- India is a country with long history cannabis and opium use. Instead of trying to create a drug free society, government should apply harm reduction principles to drug policy formulation.
- National Human Rights Commission and State Human Rights Commission should take suo-motu cognizance of the excesses committed by the enforcement agencies under NDPS Act.
- India can also emulate European and Latin American countries as and when applicable. These countries have decriminalised personal use and possession of drugs in varying degrees. They have found that decriminalisation has not led to any adverse consequences. Instead, non-punitive measures were found to have improved health and well being of drug addicts. For instance, in Portugal, overdose and drug related HIV infections got reduced after the decriminalisation of drug use. US is also reforming its laws.

Conclusion

Government should strive to frame laws in which the civil liberties, health and justice are not ignored. NDPS Act which was passed in haste needs to be reviewed hastily.

Topic 17. Quercetin and Public Health

Recently, a team from the Indian Institute of Science, Bengaluru, had found that Quercetin helps to prevent multiplication of cancerous cells by blocking the process of cell division. This makes the application of Quercetin in the Health sector very important. Quercetin belongs to a group of plant pigments known as flavonoids that gives many fruits, flowers, and vegetables their colors. Its sources include Tomatoes, broccoli, raw asparagus, raw red onion, red and black grapes, apple, apricot, cherry and coriander.

Economic Significance of Quarcetine

Quarcetine is typically found in veggies and fruits. Therefore, it has economic significance in two ways- firstly, it will help boost the horticulture sector wherein production would increase and secondly it stands out to be economical for the common man as it is naturally found ingredient and the medicine containing quarcetine would be cheaper for an individual. Therefore, an economic

benefit directly links with a social cause.

Applicability of Quarcetine

The application part of quarcetine is wide. Quarcetine being antioxidants can help to neutralize free radicals.

- Quercetin may help protect against heart disease and cancer. Quercetin can also help stabilize the cells that release histamine in the body and thereby have an anti-inflammatory and antihistamine effect.
- It also helps to reduce symptoms of allergies, including runny nose, watery eyes, hives, and swelling of the face and lips.
- Quercetin also helpsto preventhigh cholesterol as people who eat diets high in flavonoids have lower cholesterol.
- Quercetin supplementation helps to reduce blood pressure in people who have hypertension.

Besides the above stated benefits, quarcetin helps to prevent bladder pain and prostatitis.

Quarcetine's role in prevention of Cancer

The Indian Council of Medical Research (ICMR) noted that in 2016 the total number of new cancer cases is expected to be around 14.5 lakh and the figure would likely reach to nearly 17.3 lakh new cases by 2020.

The number of cancer cases looks huge and in this situation quercetin can help reduce the number to a great extent. Quarcetine possesses a variety of potent anti-cancer attributes and can even be combined with chemo drugs to treat cancer.

The intelligence in every cell of our body is called NF-kappaB. This gene signal figures out how the cell will deal with stress, and comes up with new solutions if it has not previously seen the problem. When NF-kappaB is forced to work overtime due to an unresolved problem its gene activity runs "hot" and is typically associated with excessive inflammation. Cancer literally hijacks NF-kappaB and uses its intelligence to further the survival of cancer cells.

Quercetin directly helps to turn down NF-kappa B activity, thereby interfering with the hijacking process. Furthermore, quercetin directly turned on a different set of gene signals that induced cell death to the cancer cells.

This brings out the importance of nutrition and especially quarcetine which can help prevent a dangerous disease known as cancer.

Topic 18. Health Technology Assessment and MTAB {CGS Article}

The UPA Government had decided to establish a Medical Technology Assessment Board

(MTAB) under the Department of Health Research (DHR) in Ministry of Health & Family Welfare in 2012. This body was established with key objectives such as:

- To encourage and standardize the cost effective health interventions to reduce cost and variance in patient care.
- To reduce overall out of pocket expenditure in medical treatment.
- To streamline the medical reimbursement procedures
- To be a part of overall regulatory, promotional structure being established in the DHR to accelerate indigenous production of health products, instruments or medical devices that are vital for providing cost effective healthcare.

However, the body remained a non-starter till December 2015. In December 2015, the NDA Government appointed an advisory group under Dr. V M Katoch {former secretary DHR} to bring MTAB in life. Currently, this board is yet to be fully established. India also does not have a formal Health Technology Assessment (HTA) programme as of now.

Why MTAB was in news?

It was in news as the Department of Health Research (DHR) had recently signed a MoU with *National Institute of Care and Excellence* (NICE) of the United Kingdom for help and capacity-building in Universal Health Care (UHC). The government is also in process of joining the online network of *Thailand's Health Intervention and Technology Assessment Programme* (HITAP) which was established to offer health coverage to all Thai people through careful selection of interventions and packages.

What is Health Technology Assessment (HTA)?

HTA is basically a multidisciplinary policy approach which uses clinical effectiveness, cost-effectiveness, policy and ethical perspectives to provide insights and evidence upon which rational policy decisions on the usage of health technology can be made. HTA can be applied for either a single technology (such as a drug or device) or complex interventions (such as rehabilitation). It can be used for individual patient care or public health.

How Health Technology Assessment Works?

HTA is used as a tool to enable the assessment and comparison of health technologies using same metric of cost-effectiveness. Its outcome results in benefit of the patient as well as technology producers because only those technologies which are cost effective are promoted for widespread use.

What is status of Health Technology Assessments in India?

In India, policy decision making process in healthcare is complex due to multiplicity of organizations with overlapping mandates. Generally, the decision making is neither evidence based nor tries to bridge the gap between evidence and policy. While HTA is frequently used in other countries including some of the poor countries, India is yet to launch a formal HTA programme. As there is an

incremental growth in healthcare products and services, there is a need for innovation in affordable medical devices and interventions also. Thus, any move toward, universal healthcare would need a proper HTA system in place which focuses on evidence-based decision making in healthcare policy.

What should be the framework of establishing HTA in India?

The Government needs to establish HTA as an independent process free of technology producers and medical service providers. The HTA needs to be properly linked with the Policy-making to ensure that the population gets better access to cost effective healthcare.

What is HITAP and What India can learn from it?

Health Intervention and Technology Assessment Program (HITAP) was established in 2007 in Thailand as a Non-Profit organization. Its responsibility is to appraise various health technologies and programs as a social health policy. It is also a part of International Health Policy Program (IHPP), Thailand.

The HITAP International Unit (HIU) has also supported other countries for capacity building and Health Technology Assessment (HTA). It can help India in setting up a proper and formal HTA process in the country as a milestone towards Universal Healthcare. The recent MoU is a right step in that direction.

Further Reference

- Health technology assessment in India: The potential for improved healthcare decision-making {link}
- NITI Aayog: Shift Towards Evidence Based Policy Making {Link}

Topic 19. Comparison of ASHA, ANM and Anganwadi Workers {CGS Article}

One of the key components of the National Rural Health Mission / NHM is to provide every village in the country with a trained female community health activist called ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as an interface between the community and the public health system. Notable points about ASHA are as follows:

- ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
- She should be a literate womanwith formal education up to class eight. This may be relaxed only if no suitable person with this qualification is available.

Functions of ASHA

- To work as fountainhead of public health programmes in her village
- Work as first port of call for health related demands of deprived sections of society

- Promote institutional delivery, universal immunization and other public health initiatives
- Referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets
- Provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
- Counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
- Mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
- Work as deport holder for Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
- There will be one ASHA per 1000 population.

Since 2013, when the National Urban Health Mission was launched, ASHA are being selected in urban areas as well. Several evaluations and successive Common Review Missions show that the ASHA has been a key figure in contributing to the positive outcomes of increases in institutional delivery, immunization, active role in disease control programmes (malaria, kala-azar and lymphatic filariasis, in particular) and improved breastfeeding and nutrition practices. The majority of states have placed an active training and support system for the ASHA to ensure continuing training, on site field mentoring and performance monitoring.

A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification of ASHAs would be done by National Institute of Open Schooling (NIOS). The following components of the programme, namely, the Training curriculum, State Training Sites/District Training Sites, Trainers and ASHAs and ASHA Facilitators would be taken up for accreditation/certification. The Certification of ASHAs and accreditation of associated agencies involved in ASHA Training is intended to enhance competency and professional credibility of ASHAs, improve the quality of training and ensure desired programme outcomes, provide an assurance to the community on the quality of services being provided by the ASHA, besides promoting a sense of self recognition and worth for ASHAs.

Auxiliary Nurse Midwife and Anganwadi Worker (ANM)

Auxiliary Nurse Midwife (ANM) is a resource person for ASHA. They hold weekly/fortnightly meeting with ASHA, and provide on-job raining by discussing the activities undertaken during the week/fortnight and provide guidance in case ASHA encounters any problem. ANM also ensures that ASHA gets the compensation for performance and also TA/DA for attending the training schedule.

Anganwadi Worker (AWW)

Anganwadi Worker (AWW) guides ASHA in performing activities such as organising Health Day once/twice a month at Anganwadi Centre and orientating women on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of immunisation etc. Anganwadi worker is a depot holder for drug kits and will be issuing it to ASHA.

Topic 20. National Framework for Malaria Elimination (NFME) 2016-2030 {CGS Article}

In February 2016, the Government has launched National framework for Malaria Elimination, which outlines the strategies for eradication of the disease by *2030*. The framework defines *goals, objectives, strategies, targets and timelines* which are developed to serve as a road map to eliminate malaria and improve health and quality of life of the people.

Key strategic approaches defined by NFME

States/UTs are classified into categories depending upon their Annual Parasite Incidence (API) or malaria endemicity. API number gives the number of cases affected by malaria per 1000 population per annum.

- *Category 0*: prevention of reintroduction phase.
- *Category 1*: Elimination phase. States falling under this category have the API equal to 1 at both state and district levels. 15 states/UTs fall under this category: Haryana, Goa, Kerala, Himachal Pradesh, Jammu and Kashmir, Manipur, Punjab, Rajasthan, Sikkim, Uttarakhand, Chandigarh, Daman & Diu, Delhi, Lakshadweep and Puducherry.
- *Category 2*: Pre-elimination phase. States falling under this category has the overall API less than 1 but has greater than one in some districts. 11 states fall under this category: Nagaland, Gujarat, Andhra Pradesh, Assam, Bihar, Karnataka, Maharashtra, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal.
- *Category 3:* Intensified control phase. States which has API>1 at both state and district levels falls under this category. These states are Madhya Pradesh, Chhatisgarh, Arunachal Pradesh, Meghalaya, Mizoram, Odhisha, Tripura, Andaman and Nicobar Islands, and Dadra and Nagar Haveli.

The districts are considered as the unit of planning and implementation and the high endemic areas are specially focused. Special strategy has also been designed for the elimination of *P.vivax*. The accredited social health activists will be provided special kits for immediate diagnosis of the disease. In addition, distribution of mosquito nets will also be increased.

Objectives of NFME

According to NFME, the following are identified as the objectives:

- Elimination of malaria by 2022 from all low (Category 1) and moderate (Category 2) endemic states/UTs (26);
- Reduction in the incidence of malaria to less than 1 case per 1000 population in all States/UTs and the districts and elimination of malaria in 31 states/UTs by 2024;
- Interruption in the indigenous transmission of malaria by 2027 in all States/ UTs (Category 3);
- Prevention of re-establishment of local transmission of malaria in areas where it has been completely eliminated and by 2030 maintaining the malaria-free status of the country.

Short term milestones

- Under the 12th Five Year Plan, the target has been set to achieve API<1 at both the state and district levels by 2017.
- All states/UTs are expected to include malaria elimination in their broader health policies by the end of 2016.
- 15 states/UTs falling under category 1 (elimination phase) are expected to interrupt transmission of malaria and achieve zero indigenous cases and deaths due to malaria by the end of 2020.

Primary advantages in eliminating malaria

It is estimated that annually in India alone more than 1 million cases are reported to have been affected by malaria and it has emerged as one of the worst public health crises that India has ever faced. The disease endangers the life of 1 in every 6 Indians and the economy loses $2bn in lost productivity each year. In India, the tribal areas are particularly the most affected from malaria, which pulls the children out of school, burdens the family by pushing them in to debts and further leads to the death of many people.

Eradication of malaria will result in reduction in the expenditure on diseases control programme and will also reduce the out of pocket expenditure which needs to be made currently by the poor people. The elimination will help to fight other mosquito-borne diseases as well. According to the experts, investment made on malaria control and prevention activities will ultimately result in almost 20 times gains in reducing expenditure on healthcare along with bringing down the burden of diseases.

When it will be deemed that malaria has been completely eradicated?

The area will be considered malaria free if it records no indigenous transmission of *Plasmodium vivax* and *Plasmodium falciparum*, which are responsible for causing the disease. Once all the districts achieve this, then the country will be declared as malaria-free.

Constraints in implementing

Neglect of malaria and unreliable data:

Though, malaria is viewed as a public health crisis, eradication was assigned a low priority for decades. This has made the current effort ineffective and confusing to implement. In addition to this, there is no reliable data to know how many people suffer from this disease annually as estimates do not take into account the 60-80% patients in the urban area who gets treatment from private hospitals. Although malaria is made as a notifiable disease, penalities are not imposed on doctors and hospitals if they are not notifying.

Efforts taken by India to control malaria are less than most of the Asia and African countries. According to the WHO data, India spends the least on each individual living in a highly malaria prone area than any other country in the region including Bangladesh and Bhutan.

Other inadequacies:

The anti-malarial programme suffers from mismanagement of funds as a result of poor governance by the implementing agencies. Insufficient mosquito nets and pesticide sprays have undermined their efficacies.

Steps that need to be taken to address the constraints

With the availability of medicines and diagnostic kits, the delivery mechanism has to be streamlined to enable access to them. Overburdened staffs tend to underperform. So, more community health workers and supporting staffs need to be appointed and trained to function effectively. Budgetary allocation for the programme in specific and overall health care in general has to be increased. Also, steps have to be taken to create awareness among the people so as to ensure their active participation. Lastly, there is a need for community mobilization and sustenance of efforts to make this program successful.

Endnotes

With successful eradication of diseases like Polio and Maternal and Neonatal Tetanus, proper efforts with effective implementation may help in malaria eradication by 2030 as aimed by NMFE.

Topic 21. Jan Aushadhi Scheme {CGS Article}

The *Jan Aushadhi Scheme* (Public Medicine Scheme) is a direct market intervention scheme of the *Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers* {not health ministry}. Its aim is to make available quality generic medicines to *all* at affordable prices through *Jan Aushadhi Store*

(JAS) opened in each district of the states. It was first launched in 2008 to provide quality medicines at affordable prices to the economically weaker sections of the society. The first JAS was opened at Amritsar Civil Hospital in 2008.

Objectives

- To make available low priced quality medicines for all – thereby reducing the unit cost of treatment per person, more specifically for persons suffering from chronic ailments.
- To create demand for generic medicine and encourage doctors especially in the government hospitals to prescribe generic medicines to their patients.
- To create awareness among people about the efficacy of the generic drugs.

About generic medicines

Generic medicines are unbranded medicines which are identical or bioequivalent to the branded ones and have the same efficacy in terms of therapeutic value to its branded equivalent. These medicines are available at a much cheaper price than the branded medicines.

Implementing agency

Bureau of Pharma PSUs of India (BPPI) is the implementing agency. It was established in 2008 and comes under the Department of Pharmaceuticals with the support of all the Pharma CPSUs such as:

- Indian Drugs and Pharmaceuticals Limited (IDPL),
- Rajasthan Drugs and Pharmaceuticals Limited (RDPL)
- Karnataka Antibiotics and Pharmaceuticals Limited (KAPL)
- Bengal Chemicals and Pharmaceuticals Limited (BCPL)

BPPI got registered as an independent society in 2010 under the Societies Registration Act, 1860

BPPI primarily focuses on coordinating marketing of the generic drugs through the Jan Aushadhi stores and sourcing of medicines from Pharma CPSUs and Private Sector. It also manages the supply chain and ensures proper running of the Jan Aushadhi stores.

Who can open Jan Aushadhi stores?

Non-governmental organizations, charitable institutions, private hospitals, reputed professional organizations and self help groups can open new Jan Aushadhi stores. Around 182 Jan Aushadhi stores have been opened and out of which 111 are oprerational as of july 2015 in 16 states/UTs like Punjab, Haryana, Odisha, Andhra Pradesh, Delhi, Rajasthan, Uttarakhand, West Bengal, Jammu and Kashmir, Himachal Pradesh and Jharkhand.

One-time assistance of Rs.2 lakh for establishment and one time start up cost of Rs. 50,000 is paid to the operating agency of each outlet as government assistance.

How many medicines are covered under this scheme?

At present 361 medicines are covered by this scheme and the government proposes to increase it to

500. These medicines are packed in special Jan Aushadhi packs with bilingual labels stating clearly the generic name of the drug.

Major constraints faced by this scheme

The public sector undertakings in the pharmaceutical sector are unable to cover all of the 361 medicines identified in this scheme. They are able to cover only 130 medicines. A study made by the *Public Health Foundation of India* has identified the following factors to be the major constraints in making the scheme unsuccessful:

- Over dependence on support from State Government.
- Poor Supply Chain management.
- Non-prescription of Generic Medicines by the doctors.
- State Governments launching free supply of drugs.
- Lack of awareness among the public

What have been stated regarding the scheme in the budget 2016?

The government has planned to open 3000 Jan Aushadhi stores in 2016-17. Rs.35 crore has been allotted for Jan Aushadhi stores in this budget. Recently, the government has stated that the scheme will be relaunched soon with private participation and will be renamed as the **Prime Minister's Jan Aushadhi Yojana.**

Topic 22. Debate on injectable contraceptives for women in India {CGS Article}

In December 2015, the Indian government has announced to introduce injectable contraceptives for women in the public health system and family welfare programme. The first phase will be implemented in medical colleges and district hospitals with family planning counsellors. But few health groups and women's organisations are expressing concerns about safety of women with the use of injectable contraceptive drug called **Depot Medroxyprogesterone Acetate** (DPMA).

Why there is a need for injectable contraceptives in India?

Indian women are scored very low in health parameters with high incidence of mortality and morbidity in the reproductive years. Most of these health problems of Indian women are related to high fertility rates due to unmet need for family planning. As per the District Level Household and Facility Survey-3, unmet contraception in India is about 21.3 per cent. This unfulfilled need is responsible for unintended pregnancies, unsafe abortions, deaths and life-long morbidity.

One of the main reasons for the high unmet need is the limited number of contraceptives available. In India only five contraceptive methods are available whereas in many developing countries seven

methods are available including injectables and implants. Out of the available methods, female sterilisation is the mainstay of the national family planning programme. Female sterilisation accounts for 74.4 % of overall contraceptive use in India. According to health surveys, the unmet need for spacing methods among the young married women was 25.1% and 14.9% in the age group 15-19 and 20-24, respectively. It is necessary to introduce injectable contraceptives for expanding the basket of available choices for women with a focus on spacing methods.

What is DMPA and what are the concerns about its use?

DMPA is progestin-only, injectable contraceptive method. It is injected either to arms or the buttocks. The DMPA shot is to be given every three months and fertility returns after four months of its discontinuation. It is one of the cheapest methods available for contraception. Norethisterone Enanthate (NET-EN) is another injectable contraceptive that is to be given for every two months.

But the use of DMPA and NET-EN are reported that it leads to many health problems in women including menstrual irregularity, demineralisation of bones, abdominal bloating and discomfort, mood changes, decreased sex drive, etc.

Few health groups and women's organisations have arguing that in 1995, the Drugs Technical Advisory Board (DTAB), the highest decision-making body on technical matters in the Ministry of Health &Family Welfare, held that Depo-Provera (a well-known brand name for medroxyprogesterone) is not recommended for inclusion in the family planning programme.

There are also concerns expressed about using injectable contraceptives as a tool to target the growth of Muslim population in the country.

Are the concerns valid?

Injectables as a contraceptive method is widely in many countries as part of family planning programme. It is in use for over two decades. They were first made available to women in Asia in 1970s. Since 1990s, they have been available in the private sector in India. A study on DMPA pilot programs in Rajasthan and Uttar Pradesh showed that women had the positive opinion about the method. The WHO also recommended that, women of age group 18-45 can use DMPA without any restriction. For adolescents and women above 45 years age, its usage outweighs the safety concerns about fracture risk. Studies found that women lose bone mineral density (BMD) during DMPA use, but are recovered after its discontinuation.

Now there is availability of enough scientific evidence to deal with safety concerns, counselling and follow-up, which encourage the launch of injectable contraceptives as part of national family planning programme. There are legitimate concerns about their use but these concerns are equally applicable to other available contraceptive methods. However, the side-effects are out-weighed by

the benefits with use of contraceptives in preventing unsafe abortions and unintended pregnancies. Hence the concerns should not hinder the introduction of new methods of contraceptives.

What is the way forward?

Indian women cannot be denied their right to choose the globally acceptable injectable contraceptives. A healthy debate with sufficient scientific evidence is necessary for changing negative opinion about injectable contraceptives.

Topic 23. Fixed Dose Combination Drugs {CGS Article}

Fixed-drug combinations (FDCs) refer to the combinations of two or more active drugs {called APIs or Active Pharmaceutical Ingredients} in a single dosage form. Such combination of drugs is used for treatment of wide range of ailments including HIV/AIDS, Malaria, Tuberculosis etc.

Advantages and Disadvantages

The single-most advantage of FDCs is that it gives a *simple dose schedule* which results in reduced "pill burden" and increased patient compliance. Such simple schedule is much better for elderly people or patients suffering from multiple disorders. Further, in multiple drugs, the doctors as well as patients might confuse on exact composition or dose of each APIs. Thus, the logic behind development of FDCs is to simplify the treatment regime.

However, there are several disadvantages. For example, if the doctors wish to alter the dosage of one drug in the combination, it would be impossible. The patient may not need one or few of the drugs in the FDCs but cannot be removed from dose schedule. Similarly, the cock-tail of drugs usually results in more adverse side-effects than individual drugs. Further, if one drug causes allergy or any other side-effect, the whole FDC cannot be prescribed for the patient.

Rational and Irrational FDCs

The general acceptance is that most drugs should be formulated as single compounds. However, as we discussed above, there are certain circumstances when FDCs are logical to be used. On the basis of few criteria, the WHO defines the FDCs as rational or irrational. A rational Fix ratio combination of drugs is when:

- The combination of ingredients *meets the requirements of a defined population group*
- Such combo has proved to be *definitely advantageous over single compounds.*
- The drug in the combination *should act by different mechanisms* and their mix *should not result in supra-additive toxicity.*

Some of the examples of rational FDCs include sulfamethoxazole + trimethoprim; rifampicin + isoniazid, isoniazid + ethambutol etc. (used in TB); levodopa + carbidopa (used in Parkinson's disease) etc.

However, when the above given criteria are not met, the FDCs would be termed *irrational.*

One example of irrational FDCs is nimesulide + paracetamol formulations for children. Both Nimesulide and paracetamol reduce fever and are anti-inflammatory; and Nimesulide is in fact more effective than paracetamol. This irrational combination puts the children on risk and provides no additional benefits. Thus, it is the mushrooming of irrational FDCs which creates a problem. There are numerous examples which we come across every day of FDCs such as Ibuprofen+paracetamol, cefixime and azithromycin etc.

FDCs in India

FDCs are highly popular in the Indian pharmaceutical market and have been particularly flourishing in the last few years. Rampant introduction of irrational FDCs not only exposes the patients to unnecessary risk of adverse drug reactions but also creates health problem in larger groups of people. Most of these FDCs are available in India as over-the-counter products.

Despite of the fact that it is mandatory for the FDCs to get an approval from Central Drugs Standard Control Organisaton (CDSCO), there is a huge fraction of unapproved FDCs sold OTC in India.

Recent Ban on FDCs

On March 15, 2016, the Health Ministry banned 344 FDCs and that closed the immediate sale of some of the most popular OTC medicines. The ban was on the ground of risk to humans and that safer alternatives are available in the market. Immediately after this ban, many drug companies moved to court to get relief. The court admitted the case and issued a notice to health ministry to file a status report.

Topic 24. Schedule H, Schedule X and Schedule H1 Drugs

In January 2015, the Pharmacy Council of India has published the new Pharmacy Practice Regulations 2015 to regulate pharmacy practice in India.

Important provisions are:

1. Drugs can be dispensed only by a qualified registered pharmacist.
2. Registered pharmacists shall not give his registration certificate at more than one pharmacy and should not allow the owner of the pharmacy to use his registration certificate without attending the pharmacy.
3. Registered pharmacist shall also comply with a dress code by wearing white coat and apron with a badge displaying the name and registration number.
4. Every registered pharmacist shall dispense only those medicines as prescribed by the Registered Medical Practitioner and shall not substitute the prescription.
5. Every registered pharmacist shall maintain the medical or prescription records pertaining to

the patients for a period of 5 years from the date of commencement of the treatment as per regulations.

6. Pharmacists should promote the rational use of drugs.
7. Other guidelines regarding ethical conduct of pharmacists.

Community pharmacy

The present role of pharmacists in India is just confined to collection of prescription and dispensation the drugs. In Western countries, the role of the pharmacists is patient-centric. The broader role of pharmacists and better wages in Western countries played a major role in attracting talented pharmacists away from India. Though there are more than six lakh drug stores in India but there is no culture of community pharmacy. Under community pharmacy, pharmacists are given with wider responsibility.

The newly formed Pharmacy Practice Regulations-2015 seeks to widen the role of pharmacists by bringing uniform ethics code and also broadening their roles and responsibilities towards patients. These new regulations could boost the concept of community pharmacy in India. The new regulations could allow the pharmacist to review the patient's medical history and doctor's prescriptions. They can advise the patient in use of medicine and can take part in clinical decision making. The community pharmacy under the new regulations would also enable the pharmacists to take part in R&D, health awareness and promotional activities.

Various schedules under the Drugs and Cosmetics Rules, 1945

The Drugs and Cosmetics Rules, 1945 has provisions for classification of drugs into different schedules and also guidelines for storage, sale, display and prescription of drugs under each schedule. Major schedules are:

Schedule H

The drugs under this schedule can be sold only based on the prescription of a registered medical practitioner and only the amount specified in the prescription should be sold. It can be supplied only to licenced parties. These drugs should be labelled with the symbol 'Rx' and conspicuously displayed on the left top corner of the label.

Schedule X

Same rules are applied as per schedule H drugs. Here the drug retailer has to preserve the copy of prescription for two years and the drugs should be labelled with the symbol 'XRx' and conspicuously displayed on the left top corner of the label. Schedule X includes narcotic and psychotropic substances-based drugs.

Schedule H1

This schedule was included in 2013 to check the indiscriminate use of antibiotics, anti-TB and some

other drugs in the country. These drugs cannot be sold without a valid prescription. The package of the drugs will have a mandatory warning printed in a box with red colour border. The chemist should maintain the list of the customer names and details of the doctor who prescribed it. The list should be maintained with 3 years of data.

Topic 25. Various Issues Around E-Pharmacies {CGS Article}

Organised e-pharmacies

Under this a licenced pharmacy company will provide service from its own online platform or it will partner with a technology firm to provide the service. Under this model, without a valid prescription the medicines are not provided. This can prevent the self-medication and drug abuse. Using an advanced technology, all the orders are digitally recorded.

Non- organised e-pharmacies

Here medicines are ordered without a valid prescription. And also there is no record keeping mechanism.

Illegal international trade via e-pharmacies

Under this model medicines are exported illegally without any valid prescription and sanction of concerned authorities. Mainly low cost generic medicines are exported to developed countries.

Benefits from organised e-pharmacies

- Customers are able to get the medicines by ordering from digital devices. This will be very helpful to the customers if they are not able to go out.
- Online platforms can aggregate the supplies and help the consumers by doing away with enquiries in the market for a particular medicine.
- Online pharmacies can provide the required necessary information such as drug iterations, side effects, reminders about medicine taking time etc.
- All the purchased medicines history is digitally recorded and this can prevent the problem of drug-abuse and self-medication.
- This will make the pharmacy market more transparent by keeping track of supplier information. This will helpful to find the counterfeit medicines origin.
- The data analysis of the stored information can be used to form public health policies.
- The e-pharmacy model will reduce the working capital requirements and a network of pharmacies can integrate in to a single platform to enlarge their customer base and consolidate the inventory available.
- The record of transactions can help the revenue authorities to arrive at the tax to be paid.

What does Indian Law say about E-pharmacies

In India, sale of scheduled drugs is controlled by rules framed under the Drugs and Cosmetics Act,

1940, Drugs and Cosmetics Rules, 1945, and Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954. Under the Drugs and Cosmetics Act, the 'scheduled' drugs should be sold only by licensed pharmacies on the basis of a prescription by a doctor that mentions the name of the drug and the dosage. *The act does not have any guidelines to regulate online sale of 'scheduled' medicines.* Because of non-existence of rules, online sale of medicines is considered as illegal. We should note that non-prescription products like dietary supplements, nutraceuticals or herbal preparations are allowed be sold online.

Implications of E-pharmacies without regulations

- There is a danger that scheduled medicines are re-ordered by consumers and there will be misuse of the drugs.
- Sale of drugs without a valid prescription encourages the concept of self-medication and it could lead to dangerous problems for the patient. The indiscriminate use of antibiotics could lead to antibiotic resistance.
- Presently no mechanism exists for the e-pharmacies to check whether the prescribing doctor is really a registered medical practitioner or not.
- There are also apprehensions about the storage of drugs in appropriate condition during transit through couriers to consumers. It may lead to loss of potency of drugs.
- The E-pharmacies may impact the availability of the drugs during emergency situations.
- E-pharmacies will impact the small retailers and distributors of pharmacies. The online shops offer huge discounts and it may affect their business. While it benefits customers through cheap rates, it will be a livelihood problem for offline sellers.

Present Status of E-pharmacies in India

In May 2015, Maharashtra's Food and Drug Administration (FDA) has filed an FIR against e-commerce major Snapdeal's chief executive Kunal Bahl and the company's directors for violation of the Drugs and Cosmetics Act, 1940, and the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954.

In July 2015, the health ministry has constituted a sub-committee to examine the issue of E-pharmacies. The committee is formed under the chairmanship of Maharashtra Food and Drug Administration (FDA) Commissioner Harshadeep Kamble. The sub-committee was asked to examine the online sale practices followed by developed countries and their impact on public health. The committee has invited comments from various stakeholders including public companies and trade bodies. The sub-committee is yet to submit the report.

On 29 th October 2015, the Bombay High Court has declared the online sale of medicines as illegal and asked the Maharashtra government to take necessary steps to prevent unauthorised sale of drugs

online. The court was hearing a Public Interest Litigation (PIL) seeking a ban on the sale of Schedule 'H' drugs online without prescription drugs or cash memos.

In October 2015, the online pharmacy retailers in the country have formed an association, the Indian Internet Pharmacy Association (IIPA), to promote the use of e-commerce in pharmacy.

Conclusion

The government and regulatory authorities must welcome the inclusion of technology but we must keep in mind the interests of chemists and the safety of patients. The aim should be integration of the e-pharmacies into the existing system. The new upcoming rules must clearly define the roles, responsibilities and liabilities of e-pharmacies in the healthcare system.

Topic 26. Control of Tuberculosis {CGS Article}

Tuberculosis is an *infectious disease* caused by the bacterium *Mycobacterium tuberculosis*. Tuberculosis infection can be of two kinds-*latent and active*. Latent tuberculosis is not contagious and do not show any symptoms since the bacterium remains inactive in the body. Latent tuberculosis can become active tuberculosis in those people who have weak immune system especially in those with HIV and in those who smoke. Active TB gets *transmitted through air* when people with active TB cough, sneeze, spit and speak. Tuberculosis affects mainly the lungs of a person, but it can also affect other parts of the body.

What is VPM1002?

VPM1002 is the newly developed TB vaccine which is based on the BCG vaccine which is in use as of today. It is a recombinant *BCG (bacillus Calmette-Guérin)* vaccine and contains genetically modified *mycobacterium bovis bacteria*. In this vaccine, a gene in the existing BCG vaccine has been exchanged to increase its immunogenicity. This built-in gene makes the vaccine to get easy recognition from the cells of the immune system and protects the organism against the actual infectious tuberculosis pathogens.

VPM1002 was developed at the Max Planck Institute for Infection Biology, Berlin. This vaccine has been sub-licensed to the Pune-based Serum Institute of India Limited.

Why is a new TB vaccine needed?

Search for an improved TB vaccine is more than 90 years old. *Bacillus Calmette-Guerin (BCG)* is the only available licensed vaccine to fight against TB, which was developed in the early 20th century. BCG was first used in 1921and has become the most widely administered vaccine in the history of the world. Though BCG is inexpensive and effective, it loses its efficacy in young people and adults and is incapable of reducing the global incidence of TB. Also, the increase in the cases of multi drug-resistant TB (MDR-TB) highlights the need for a new effective vaccine.

At what stage is the vaccine?

VPM1002 has been undergoing clinical trials since 2008. It has proved its efficacy in animal and small scale human trials. According to the scientists, the vaccine when administered reduced the bacteria 100 fold in all animals. Phase I human clinical trials was already conducted in Germany (2009) and in south Africa (2012). Phase '2a' trials conducted on infants in South Africa (2013) have confirmed safety and increased immunogenicity to fight against TB. The 'Phase 2b' trial has been started in South Africa and will be studying 416 babies (newborns) from HIV-positive and negative mothers. This phase of trial is expected to be completed by mid-2017.

Phase III trial in infants will begin in India once the phase '2b' trial ends. Apart from this trial an independent phase III trial involving 2500 adult TB patients who have been infected and cured have been planned to be conducted in India. This independent trial aims to gauge the capacity of the vaccine to protect against the recurrence rate of TB in India. The trial in India is expected to last for 2 to 4 years.

What is the advantage of this vaccine over the existing one?

VPM1002 is expected to replace the current BCG vaccine to protect the children against TB. Unlike the present vaccine, it can also guard against the *drug-sensitive and drug-resistant* TB. Adults may also get benefitted from this vaccine. It will also be able to protect against *pulmonary and extra-pulmonary* TB in all age groups. In contrast, BCG vaccine can only protect against severe forms of the disease among children and is ineffective in preventing pulmonary TB in all age groups including children. VPM1002 is superior over BCG in terms of efficiency and safety.

What is situation of TB in India?

- TB is the top most infectious disease in India and has transformed into a major public health challenge. It is estimated that TB kills 2 people in every 3 minutes and roughly 750 every day. As of 2014, nearly 2.5 million people with active TB are living in India. Out of these cases, 70,000 cases are related to MDR-TB.
- TB recurrence (reinfection and relapse) rate is also higher with atleast 2 lakh to 2.5 lakh people who have been successfully treated getting infected again annually.
- WHO's 20th edition of Global TB Report of 2015 has placed India at top among the 22 high burden countries.
- With increasing population, diagnosing and treating the patients before it gets transmitted to others is quite a challenge.

What are the steps taken by the government to eradicate TB in India?

TB was made as a *notifiable disease* in 2012. This means all the private doctors, caregivers and clinics has to report every case of TB they encounter to the government.

History of TB control

The first effort to control TB began in 1962 with the *National TB Programme (NTP)*. In order to overcome the limitations in NTP, the government launched the *Revised National TB Control Programme (RNTCP) in 1993*. It adopted the internationally recommended *Directly Observed Treatment Short-course (DOTS)* strategy for TB control in India. RNTCP was able to effectively decentralized supervision of TB via the sub-district TB Units.

RNTCP II

RNTCP II was developed to address TB/HIV, MDR-TB and extend RNTCP to private sector. It was revamped with the lessons learnt while implementing RNTCP (1993-2005).

National Strategic Plan for Tuberculosis Control, 2012–2017

In order to fulfill the vision of a "TB-free India", the government has launched National Strategic Plan for Tuberculosis Control, 2012–2017 with defined objectives:

- To ensure early and improved diagnosis of all TB patients including drug resistant and HIV-associated TB,
- To provide access to high-quality treatment for all diagnosed cases of TB,
- To scale-up access to effective treatment for drug-resistant TB,
- To decrease the morbidity and mortality of HIV-associated TB,
- To extend RNTCP services to patients diagnosed and treated in the private sector.

Nikshay

The RNTCP has come up with an innovative and visionary electronic recording and reporting system called Nikshay. It is a new web based system for effective monitoring TB patients across the country.

Topic 27: Mohalla Clinics of Delhi {CGS Article}

Provision of primary healthcare system has been a big challenge in Indian healthcare system. The need for a functioning primary healthcare system, which can be accessible within a reasonable geographical distance, has been recognised long back in 1970s. The Alma Ata declaration (1978) and India's National Health Policy of 1983 and 2002 had accepted the importance of a functioning primary healthcare system.

Absence of a functioning primary healthcare system leads to large proportion of patients with common illness turning to secondary and tertiary care institutions for treatment. This results in overcrowding, long hours of wait, poor quality of service delivery, etc. Finally these patients end up in consulting non-qualified doctors or private doctors with out-of-pocket expenditure. The tertiary healthcare systems neither have time nor resources to handle every common illness.

Mohalla Clinics in Delhi

The Delhi government has come up with an innovative concept called Mohalla clinics. The concept was announced in the state budget for 2015-16, and the aim was to set up 500 such clinics in the first year. The Delhi government had allocated Rs. 209 crore for setting up of 500 such clinics. Each Mohalla clinic has about 50-60 sq meter built up area, in a plot of about 100-150 sq. meter, in a semi-permanent structure built with modern technology and latest design in an economical way.Each clinic will have a doctor, a nurse, a pharmacist, and a laboratory technician.At a later stage, the clinics would be provided with specialist doctors.

The clinic will take care of primary healthcare needs of people living within a kilometre of it.The services provided by them include outpatient consultations, immunisation, free medicines and diagnostics, family planning, referral and counselling services. The clinics timing will be 8 AM to 2 PM and some may operate in evening timings also. Each Mohalla clinic is linked to polyclinics (multi-speciality clinics) for logistical support and also for referral of patients who needs specialist care. The first such clinic was set up in July 2015 in Peeragarhi area of North-west Delhi. The cost to establish the clinic was Rs.20 lakh.

Advantages from Mohalla clinics

The concept of Mohalla clinic has a number of advantages.

- These clinics would increase the geographical access to healthcare services and reduces the travelling time and waiting time at the health facilities.
- Majority of patients feels uneasy in approaching big health facilities until they become seriously ill. The easy access provided by the Mohalla clinics would encourage patients to approach the clinics during early stage of the illness.
- Patients spend around 70% of the health expenditure on medicines and diagnostics. The provision of free medicines and 50 diagnostic services at free of cost would considerably reduce the healthcare expenditure for poor people. The easy access would also reduce the transportation cost and waiting time (opportunity cost of missing work).
- The rising burden of non-communicable diseases among poor would require lot of preventive care. The patients with hypertension and diabetes would require free medicines and also counselling services. The counselling services provided at Mohalla clinics would attract the patients to access those services. An effective referral service from these clinics would help the patients.
- The cost for setting up of such clinics would be much less than the cost for setting up of a secondary hospital.

Delhi has a number of reasons for success of such clinics. There is enough budgetary support from

Delhi government. There is no difficulty in allocation of additional resources. Delhi has a big network of secondary and tertiary healthcare facilities to absolve the referral cases from Mohalla clinics. Delhi also has enough human resources in terms of availability of doctors, paramedical staff, and lab technicians. The high population density regions in Delhi would make such clinics viable and become popular.

Challenges

The one disadvantage with the concept of Mohalla clinics is they may not work in rural areas, which are low population density areas. The potential challenges in running of Mohalla clinics would be monitoring the working of 500 such clinics. There is a chance of abuse of drugs as they are easily accessible. Maintaining of medicine stocks at so many locations would be a challenge.

However, use of technologies like CCTV's, IT solutions for inventory management, providing necessary skills to staff, use of biometric IDs to track patients, tie up with local NGos, etc. can help in facing the challenges.

The mohalla clinic concept is well designed than earlier healthcare interventions. The other state governments can study the concept of neighbourhood clinics and take up the pilot projects in Metros and other big urban areas.

General Knowledge Today

GS-II- 17: Current Topics in Education and Human Resources

Integrated IAS General Studies:2016-17

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Contents

Model Questions

1. What were the major implications of moving "Education" from state list to concurrent list in the seventh schedule of the constitution? Discuss keeping in view the past National Education Policies of India.
2. Discuss the salient features of draft National Education Policy, 2016. To what extent, this policy addresses the problems of the elementary, middle and higher education in the country? Discuss.
3. Examine the current infrastructure in *Professional Military Education (PME)* in India. Do you agree with the criticism that the proposed Indian National Defence University (INDU) is an unwanted superimposition on current system? Discuss critically.
4. Some express the concern that the Indian National Defence University (INDU) may become yet another dysfunctional bureaucratic monolith. While keeping the draft INDU Bill in focus, critically examine the design and framework around this proposed university.
5. What is the rationale behind proposed Higher Education Financing Agency (HEFA)? While discussing its functions and funding, examine its financial viability prospects.
6. While enumerating the parameters of ranking in National Institutional Ranking Framework (NIRF) adopted by the Ministry of Human Resource Development (MHRD), critically examine importance of such rankings.
7. What are the various issues around Teachers Training in India? Discuss in the light of various initiatives under National Education Mission towards the same.
8. To what extent, the GIAN initiative has been able to achieve its stated objective? Discuss.
9. Despite the fact that the constitution of India has not prescribed any educational qualifications to contest for the Parliament and the State Assemblies; various states in India have prescribed minimum qualifications for Panchayat elections. How it affects our grassroot democracy? Discuss while putting Supreme Court observations in light.
10. Can expansion of MOOCs solve the fundamental inadequacies of Indian Higher Education? What are the challenges? Discuss.
11. "*Instead of increasing the private participation in education sector, focus should be on making public schools as good as private ones.*" Discuss critically while analyzing the pros and cons of private sector participation in the education sector.
12. "There is high level of inequality in learning outcomes wherein only a small proportion of students are able to acquire good learning." While focussing on reasons, suggest ways to improve learning outcomes in the country.

13. Despites of its advantages, NEET has been in centre of severe criticism, particularly of its not being pragmatic in character. Discuss critically.
14. Analyze the major challenges to skilling in India. Do you think that creation of a separate ministry has helped to impart formal skill certification to more people in the country? Discuss.
15. What do you understand by Choice Based Credit System (CBCS)? What are its advantages and criticisms? Discuss.
16. Examine the link between techno-centered development approach and Higher education in India? What are the challenges to it? Also suggest reforms to enhance the quality of higher education.
17. What are the major proposals of draft National Education Policy, 2016 towards Right to Education? Do you think that these proposals conflict with the intent of the RTE act? Examine Critically.
18. While elucidating major barriers which stand in the way of girls education, discuss the efforts being made in this direction, along with your suggestions.
19. Discuss with examples the advantages of Community Schooling in the country. To what extent, community schooling can fill the gap in elementary education in the country? Analyze.
20. The no-detention policy has been successful in preventing drop-outs as there is remarkable increase in enrolments in schools. However, the policy has backfired due to several loopholes. Discuss.
21. Successive governments have failed to achieve a 6% of GDP expenditure target for education sector. While keeping in view the limited resources at disposal of the central government, give suggestions to achieve this target.

Topic 1. Draft National Education Policy 2016: Salient Features

The draft of National Education Policy (NEP) 2016 was released recently by the MHRD and suggestions were invited on the same from the public domain. The focus of the policy is to address gender discrimination, the creation of educational tribunals, and a common curriculum for science, mathematics and English.

Motto, Vision and Mission

The motto of the new policy is "*Educate Encourage Enlighten*". Vision is to create a credible education system capable of ensuring inclusive quality education and lifelong learning opportunities for all.

Among others, the missions include: Ensuring equitable, inclusive and quality education for all; foster quality education with strong focus on education reforms; promote acquisition by all learners of relevant skills, including technical and vocational skills, for work and entrepreneurship.

Salient Features

Pre-school Education

Government schools don't provide any pre-primary education and due to this, pre-school education has not received desired attention. The new policy envisages:

- Implementation of Pre-school education for age group 4-5 years. Steps would be taken to frame curricula and develop learning materials for pre-school education in Anganwadis.
- The states will develop a cadre of pre-primary education.
- Government will design appropriate regulatory and monitoring regime for private schools.

Curriculum Renewal and Examination Reforms

- Government / NCERT will carry out curriculum reforms to meet emerging aspirations.
- A national curriculum will be designed for science, math and English.
- To prevent high rates of failure at class X level, the class X exams in Mathematics, Science and English will be at two levels: Part-A at a higher level and Part-B at a lower level.
- Procedural reforms will be undertaken for *migration of students from one institution to other*.

Learning outcomes in School Education

- Norms for learning outcomes will be developed and applied uniformly to both private and government schools.
- Within the parameters prescribed by the RTE Act, States will have the flexibility to design and plan for the infrastructure keeping in view the local conditions.
- The present provisions of *no-detention policy will be amended*, as it has seriously affected the academic performance of students. The no detention policy will be *limited up to class V and the system of detention will be restored at the upper primary stage*.
- Effective steps will be taken to improve teaching standards in schools

School Education

- Each State will undertake a detailed exercise of school mapping to identify schools with low enrolment and inadequate infrastructure.
- Minimum standards for provision of facilities and student outcomes across all levels in school education will be laid down.
- Kendriya Vidyalayas (KVs) and Jawahar Navodaya Vidyalayas (JNVs) will be expanded and Kasturba Gandhi Balika Vidyalayas (KGBVs) will be expanded and upgraded

Protection of Rights of the Child & Adolescent Education

- Framework and guidelines for ensuring school safety and security of children will be

developed.

- Every Principal and teacher will be made aware of the provisions of the relevant Acts, Rules, Regulations, etc.
- The *Adolescent Education Programme* and *National Population Education Programme* will be integrated into the curriculum of schools in a phased manner.
- Adolescent Education will be included in pre- and in-service training programmes of secondary school teachers.
- Self-learning online programmes on child rights will be developed for the benefit of students, teachers and parents.
- Schools will engage trained counsellors to confidentially advise parents and teachers on adolescence problems faced by growing boys and girls.

Inclusive Education and Student Support

- Curriculum will cover the issues of social justice and harmony and legal measures in order to avoid social discrimination.
- With the objective of encouraging merit and promoting equity, a National Fellowship Fund, primarily designed to support the tuition fees, learning materials and living expenses for about 10 lakh students will be created.
- A zero tolerance approach on gender discrimination and violence will be adopted.
- There will be dedicated funds for R&D to strengthen disability studies in higher education.

Literacy and Lifelong Learning

- Existing initiatives will be strengthened and curricula revamped with multi-pronged strategies involving Self Help Groups, NGOs, Government etc.
- The Government will set up an apex body of experts to look into remodelling and strengthening of AE programmes and develop scientific criteria for assessing the learning outcomes of adults in literacy, skill development, prior learning and equivalency for certification which may also facilitate entry into the formal education system.
- Adult literacy programme will incorporate skill development and digital, financial and legal literacy.

Skills in Education and Employability

- Skill development programmes in school and higher education system will be reoriented
- A detailed plan for the creation of skill schools for improving employment opportunities for secondary school students in special focus districts will be prepared.
- Joint certificates by the Sector Skill Council and the School/College authorities to help students take up wage-employment or start their own enterprise.

Use of ICT in Education

- A concerted effort will be made to make ICT an integral part of education across all levels and domains of learning.
- Online maintenance of all records of a child from the time of admission till the time of leaving the school will be made mandatory.
- IT reporting systems will be a powerful tool to better school management and performance.

Teacher Development and Management

- A transparent and merit based norms and guidelines for recruitment of teachers will be formulated in consultation with the state governments.
- All vacancies in teacher education institutions and all positions of head teachers and principals will be filled up.
- At the National level, a Teacher Education University will be set up covering various aspects of teacher education and faculty development.
- A separate cadre for teacher educators will be established in every state.

Language and Culture in Education

- All states and UTs, if they so desire, may provide education in schools, upto Class V, in mother tongue, local or regional language as the medium of instruction.
- Indian culture, local and traditional knowledge will be given adequate space in the school education.
- Educational institutions will instill among students civic sense, discipline, punctuality, cleanliness, good conduct, empathy towards elderly.
- Keeping in view special importance of Sanskrit to the growth and development of Indian languages and its unique contribution to the cultural unity of the country, facilities for teaching Sanskrit at the school and university stages will be offered on a more liberal scale.

Self -Development through Comprehensive Education

- Physical education, yoga, games and sports, NCC, NSS, art education, Bal Sansad, covering local art, craft, literature and skills, and other co- scholastic activities will be made an integral part of the curriculum and daily routine in schools for the holistic development of children. Facilities for the above will be a pre-requisite to the recognition of schools.
- Funds will be earmarked by the government/ school management for all co-scholastic activities in schools.

School Assessment and Governance

- The framework of school standards with various parameters and indicators to measure school quality, professional competence of teachers, school leadership and the school management,

as well as, self-appraisal and performance assessment will be used throughout the country

- A mechanism will be put in place for accreditation of school boards.
- Principals/head teachers will be held accountable for the academic performance of the schools and its improvement.

Regulation in Higher Education

- An independent mechanism for administering the National Higher Education Fellowship Programme will be put in place.
- A Central Educational Statistics Agency (CESA) will be established as the central data collection, compilation and consolidation agency with high quality statistical expertise and management information system which will be used for predictive analysis, manpower planning and future course corrections.

Quality Assurance in Higher Education

- An expert committee will be constituted to study the systems of accreditation in place internationally. It will draw from the experiences of some of the best practices followed by countries having well performing systems and will suggest restructuring of NAAC and NAB as well as redefining methodologies, parameters and criteria. .
- Evaluation/ Accreditation details of each institution will be available to the general public through a dedicated website, to enable students and other stakeholders to make informed choices.

Open and Distance Learning & MOOCs

- The National Institute of Open Schooling (NIOS), in collaboration with Ministry of Skill Development & Entrepreneurship, will redefine itself to address the large potential demand for vocational education. The issues of management, monitoring and oversight of NIOS will be addressed appropriately.
- A quality assurance mechanism for accreditation of all universities/institutions offering ODL / MOOCs will be put in place to ensure quality, promote, innovation and reshape and modernise the ODL / MOOCs courses and programmes.

Internationalisation of Education

- Selected foreign universities, from the top 200 in the world, will be encouraged to establish their presence in India through collaboration with Indian universities.
- In order to increase acceptability of Indian students abroad and to attract international students, Indian HEIs will be encouraged to work towards internationalization of curricula aligned with international levels so as to make it globally compatible with best ranked institutions of the world.

- Internationalisation will be included as one of the components for allocating additional financial resources to government-funded HEIs.

Faculty Development in Higher Education

- A task force of experts will be set up to study the recruitment, promotion and retention procedures, followed by internationally renowned universities and institutions and suggest measures to promote intellectual and academic excellence in HEIs.
- A national campaign will be launched to attract young talent into the teaching profession. In order to attract young talent into teaching profession, a career growth of research students, such as M.Phil&Ph.D scholars, will be created.
- A mechanism of assessment of academic performance of faculty including peer review will be put in place so as to ensure academic accountability of public-funded institutions.

Research, Innovation and New Knowledge

- A clear reorientation of research agenda of National University of Educational Planning and Administration (NUEPA) will be undertaken to reflect actual issues on the ground.
- Steps will be taken to promote generation of new knowledge and their applications and introduction of these new domains into the curricula of higher education to consolidate and strengthen India's position as a soft power.

- In order to promote innovation, creativity and entrepreneurship, 100 more incubation centres will be established in HEIs over a period of next 5 years.
- International collaborations and networks will be promoted for developing human resources required to sustain new knowledge with special focus on inter-disciplinary research and studies.

Financing Education

- The government will take steps for reaching the long pending goal of raising the investment in education sector to at least 6% of GDP as a priority.
- Instead of setting up new institutions, which require huge investments, priority of the Government will be to expand the capacity of existing institutions.
- In order to encourage excellence and efficiency, performance-linked funding of higher education institutions will be implemented.

Topic 2. National Education Policy: Past Policies

So far, two National Education Policies have been in force in India. Third one is the recent draft.

National Education Policy, 1968

First such policy had *come in 1968* under Indira Gandhi government. Prior to this policy, a resolution in Lok Sabha was moved in 1964 by Congress MP Siddheshwar Prasad, who criticized the

government for not paying enough attention to education and centre lacked a uniform vision and definite philosophy for education. The government of the day agreed that there should be a national and coordinated policy towards education. The government then set up a 17 member Education Commission under UGC chairperson DS Kothari {**Kothari Commission**}. On the basis of recommendations of Kothari Commission, the first National Education Policy was released in 1968. This policy had called for a *National School System*, which meant that all students, irrespective of caste, creed and sex would have access to education of a comparable quality up to a given level. Further, it envisaged a common educational structure {10+2+3} which was accepted across the country and most of us have studied under that system. It also advocated use of mother tongue as medium of teaching in early school years. Another major call was strengthening the research in the universities.

Performance of NEP-1968

The 1968 policy or NEP-I was not very successful. There were several reasons for this. *Firstly*, at that time, a proper programme of action was not brought out. *Secondly,* there was a shortage of funds, India's economy was in tatters. *Thirdly,* at that time, Education was in state list, so role of centre was little on how the states would implement this scheme. Despite this, the key legacies of this policy include our current 10+2+3 system of education; and three language formula, which is followed by most schools. Science and Math were now getting more priority.

National Education Policy, 1986

The 1986 policy was issued during tenure of Rajiv Gandhi as Prime Minister and it was updated in 1992 when PV Narsimha Rao was prime minister. This policy focussed on modernization and role of IT in education. More attention was paid on restructuring the teacher education, early childhood care, women's empowerment and adult literacy. It also accepted autonomy of universities and colleges, something which was resisted in past.

Performance of NEP-1986

In comparison to the 1968 policy, the 1986 policy performed better. There were several reasons to this. *Firstly*, this policy came after 42nd amendment in 1976. In this amendment, five subjects were transferred from State to Concurrent List including Education, Forests, Weights & Measures, Protection of Wild Animals and Birds; and Administration of Justice. *Secondly,* now centre was able to accept wider responsibility and introduced a number of programmes in line with this policy. Most of our classic government schemes such as Sarva Shiksha Abhiyan, Mid Day Meal Scheme, Navodaya Vidyalayas (NVS schools), Kendriya Vidyalayas (KV schools) and use of IT in education were started under the NEP of 1986.

Topic 3. National Education Policy: T.S.R. Subramanian Committee

In 2015, Narendra Modi Government had set up a committee under former Cabinet Secretary TSR Subramanian to chalk out a new education policy. This committee had submitted its report in May, 2016.

Key Recommendations

The committee had presented its report in two volumes with around 90 suggestions. For unknown reasons, the report was not made public for many days by then HRD minister Smriti Irani. Baffled TSR Subramanian himself released some of the highlights. The key recommendations are as follows:

- Government should establish *Indian Education Service (IES)* as an all Indian service with officers on permanent settlement with state governments, but cadre controlling authority vested in HRD Ministry.
- *Education has been given comparatively low priority by both the Central and State governments, judged by the budgetary support provided thus far.* This must change if anything of significant value is to be achieved. Without further wait, the outlay on education should be raised to at least 6% of the GDP.

- There should be a minimum eligibility condition {50% marks at graduation level} for entry to B.Ed courses. Teacher Entrance Test (TET) should be made compulsory for recruitment of all teachers. The centre and states should jointly lay down norms and standards for TET.
- Government should made compulsory licensing or certification mandatory for teachers in government and private schools, with a provision for renewal every 10 years based on independent external testing.
- Pre-school education for children in the age group of 4-5 years should be declared as right {by amendment into RTE} and a programme for it should be implemented immediately.
- The no-detention policy should be continued till class V. At the upper primary level, the system of detention must be restored subject to provision of remedial coaching and at least two extra chances being offered to student to prove his / her capability to move to a higher class.
- The Government should introduce On-demand board exams for flexibility and reducing the stress of students and parents.
- Since malnutrition and anaemia continue to be high among adolescents, the government should extend the mid-day meal (MDM) programme to secondary schools.
- UGC must be made thinner and leaner and UGC Act must be allowed to repeal. A separate

law for management of higher education should be created.

- Government should allow top 200 foreign universities to open campuses across India and give the same degree which is acceptable in the home country of the said university.
- Minority schools should be made to reserve 25% seats for candidates of economically weaker sections (EWS).
- There should be restrictions on Campus politics.

The committee also criticized the governments for too much interference in important appointments, particularly in case of Vice-Chancellors.

Important Past Committees in Education

Radhakrishnan commission (1948-49): The commission dealt with higher education and the report of the commission focused on the expansion and improvement of higher education.

Mudaliyar commission (1952): The commission dealt with secondary education.

Kothari commission (1964-66): The definitive action on education policy was taken only after this commission's report as after the previous two commissions no comprehensive policy was formulated by the government. Based on the report of the commission, Education Policy of 1968 was formulated. The commission's mandate was to advise the government for the development of education at all stage and in all aspects.

Conclusion

The committee has been bold in identifying the crisis in education and bringing to the fore a host of issues. It virtually touched all the weak points of moribund education sector such as low financial allocation, over-centralization, low investment in teacher's education and development etc. The report has made drastic reform recommendations in current bodies related to education including UGC, AICTE, NUEPA, NCTE, NCERT etc.

Topic 4. Draft Indian National Defence University (INDU) Bill, 2015

In August 2016, a *Draft Indian National Defence University (INDU) Bill, 2015* was put online and suggestions were invited from public for the proposed university.

Background

The idea of having a National level Defense University is not new. In 1967, a proposal for National Defence University (NDU) was put forward by Chiefs of Staff Committee. However, for many decades no action was taken. In the aftermath of Kargil war in 1999, the proposal was taken seriously

and the Vajpayee Government set up a Committee on the National Defence University (CONDU) headed by the late K. Subrahmanyam. In 2002, this committee presented its report and advocate the establishment of a National Defence University. The Union Cabinet gave in principle approval for setting up such university at Binola, near Gurugram in Haryana. After this, a PSU EdCIL (India) Limited was given the task for preparing a Detailed Project Report. The final DPR was submitted in 2013. In the same year, the then PM Manmohan Singh had laid the foundation stone for the university at Binola with an objective to create a world class institution in India for higher "defence studies". The recently drafted bill provides statutory backing to establishment of such university to impart *Professional Military Education.*

Objectives of INDU

The main objectives of the proposed University, according to the bill, are as follows:

- To develop and promote higher education and research in *National Security Studies, Defence Management, Defence Technology* and allied areas.
- To promote avenues for higher education for defence personnel through distance and open learning.
- To promote policy oriented research related to national security, both internal and external, including inter-agency responses for hybrid threats, defence and cooperation and to serve as think tank contributing to policy formulation.
- To prepare the personnel of the national security establishments and the academic community from within India and from friendly foreign countries for high-level leadership, staff and policy responsibilities.
- To encourage strategic thinking on defence, and security issues and to initiate debate on such issues both nationally and globally.
- To instil a spirit of jointness amongst various elements of the national security system.
- To develop competence relating to national security issues.
- To network with other national, regional and international institutions or individuals of eminence engaged in the fields of education, research and industry.
- To encourage international and corporate fellowship programmes in the field of strategic studies.

Questions and Answers

Discuss the importance of Professional Military Education for India.

There has always been fear of threats across our porous borders. This makes it very important for our military leaders to think critically, demonstrate professional acumen and lead the rank and file in dangerous and difficult situations. Therefore, it becomes increasingly important to invest in

professional military education(PME) in order to groom officers capable of meeting the rigours of complex politico-military crises and conflicts of the future. The INDU proposal is therefore a step in the right direction.

What is the existing infrastructure for Professional Military Education (PME)?

The current infrastructure is as follows. India has tri-services institutions for Professional Military Education (PME) such as *National Defence College (New Delhi)*, *College of Defence Management (Secunderabad)* and *Staff College* (Wellington, Nilgiris District of Tamil Nadu). Each of them is meant for a particular office profile. The NDC, Delhi is for Brigadiers (and equivalents); CDM, Secunderabad is for Colonels (and equivalents); while Staff College for Majors (and equivalents). Further, several universities offer master's and research programmes in defence and strategic affairs currently.

Is INDU a superimposition over existing infrastructure?

The proposed INDU is *not exactly a superimposition*. Intention is to result in augmentation of the PME capacities and also provide basis for jointness among the three services. *Firstly,* despite of existing institutions, there is an academic vacuum in the country as far as strategic studies are concerned. This university would fill that vacuum. *Secondly,* the university is proposed to be a teaching and affiliating university and existing institutions are supposed to be affiliated to it, thus bringing *oneness in the PME framework in India*. *Thirdly,* it would expand the PME as *four new schools would set up under it* viz. a school of national security, a school of defence technology, a school of defence management and a centre for distance and open learning. It is also expected to set up academic centres abroad as well.

Is the design of INDU conducive for augmentation of PME?

It appears to be yet, there are few criticisms. *Firstly*, it is being criticised because draft bill gives greater control to centre {included defense ministry and defense establishment} than any other central university. The Defence Minister will be chancellor of INDU and head its council, which would be responsible for major policy decisions. Further, chairman of the chiefs of staff committee will be its pro-chancellor and preside over the university's board of governors. This is in contrast with other central universities where eminent people from outside the government have greater say; and HRD minister does not serve as its chancellor. This criticism may be exaggeration because other civilian universities and a defense education establishment have inherent differences and such an establishment has direct to do with the nation's security; and thus needs greater command of army.

Secondly, there is confusion if INDU would follow the UGC set norms, on appointments of faculty. If not, then, basically it would be obviating its aim of being an academic institution.

What is the way ahead?

There are chances that such a university, though founded on a novel objective, becomes another dysfunctional bureaucratic monolith. Some of the suggested ways forward are as follows. *Firstly*, to keep its academic nature intact, there has to be a broader academic council with eminent people from outside government. *Secondly,* appointments must be on the basis of competence and integrity and not seniority and sycophancy. *Thirdly,* more focus should be on research. *Fourthly,* under professional military education, following areas would be focussed and imparted to the officers-

1. Leadership
2. The organization and management of military forces
3. Strategy, tactics, and logistics including Geo-Economics
4. Military history and Geo-Politics
5. National security policy
6. The relationship of armed forces and society; and individual analytical and communication skills
7. Incorporating Basic Physical Sciences and Technology and the application of such disciplines as Earth Sciences especially Geology, Bio Technology, Computer Science, Engineering Sciences, and Metallurgical Sciences.

Conclusion

If India wants to produce officers who are capable of operating in a complex security environment, it definitely requires PME wherein the officers can gauge the emerging strategic environment more closely and understand every aspect from terrain to geography or topology of the battlefield.

Topic 5. Higher Education Financing Agency (HEFA)

Higher Education Financing Agency (HEFA) is a proposed not-for-profit agency with initial capital base of Rs. 1000 Crore. It was announced in Union Budget 2016-17.

Organization

- The HEFA will be set up with *joint participation by the government and philanthropic donors.*
- It would be set up under Companies Act and will be registered with RBI has Non-banking Finance Company (NBFC).
- It will be headed by a banker and will have a board with five donors and five institutions selected on rotation basis.
- All centrally funded higher educational institutions will automatically be added as members.

Objective and Proposed Functions

- The major objective of the HEFA is to leverage funds from the market and supplement them

with donations and CSR funds.

- These funds will be used to finance *improvement in infrastructure in top educational institutions*. The monies of the fund will be used to finance capital expenditure for building quality infrastructure in IITs, NITs, IIITs and IISERs and central universities. It will also be used to fund state-of-the-art research labs and other infrastructure.

Funding and Finances

Total corpse of the body is Rs. 2,000 crore. Out of this, the initial government contribution will be Rs. 1,000 crore. Remaining Rs. 1000 Crore would be collected from 5 other corporate donors {Rs. 200 Crore Each} of which the sponsoring bank would be one. Further, the body will be allowed to raise debt funding of up to Rs. 10,000 crore from the financial markets, including pension and insurance funds. Thus, there is a 1:5 ratio of own funds to debt ratio for HEFA. The debts would be returned back {debt service} from the money received

Infl ows would be from market borrowings, CSR funds from PSUs and other through the escrowed student fee accounts and the donations received from the CSR funds and others.

Meaning for a High Education Institute

An institute will be eligible for a credit limit of 5 times the annual inflow of the student fee from the institution. The institute can then draw *interest-free funds* against an approved capital or research project and repay the amount over 5-10 years through the escrowed student fee. Each institute will have to prepare a detailed master plan on infrastructure gaps that will be assessed by an independent group before releasing amount sought. HEFA will monitor implementation, fund utilisation & review outcome, thus necessitating greater financial discipline across institutes.

Analysis: Can HEFA be financially viable?

The above discussion makes it clear that HEFA is a non-profit organization; it will leverage funds from the market and supplement them with donations and corporate social responsibility (CSR) funds. Thus, its operative and regulatory mechanisms would be crucial to ensure its stability. As far as financial viability are concerned, to become self-sustaining, HEFA needs to manage investment of Rs. 25,000 crore over next five years and manage an inflow of Rs. 2000 crore from the fee escrow accounts, assuming that the institutions will fully pay loan amount. Since institutions would get funds without any interest liability and market borrowings would come at around 12%, there might be a need of robust donations as well as viability gap funding from the government.

Topic 6. National Institutional Ranking Framework (NIRF)

National Institutional Ranking Framework (NIRF) is a methodology adopted by the Ministry of Human Resource Development (MHRD) in order to rank all institutions of higher education in

India. The Framework was approved by the MHRD and launched by Minister of Human Resource Development on 29 September 2015.

Key Facts

- NIRF ranks the institutions broadly on five clusters of parameters viz. (1) Teaching, Learning and Resources (2) Research and Professional Practices (3) Graduation Outcomes (4) Outreach and Inclusivity (5) Perception. These clusters have been assigned certain weightage and weightage is a function of type of institution.
- Ranking methods have been worked out for 6 categories of institutions viz. Engineering, Management, Pharmacy, Architecture, Universities and Colleges
- There are *separate rankings for different types of institutions depending on their areas of operation.*
- The ranking, which will be an annual exercise, was done by an independent and autonomous body National Board of Accreditation (NBA).
- The first ranking was released by MHRD on 4 April 2016.

Questions for Analysis

- *What is the importance of such rankings in India?*
- *What are the grounds of criticism of the same?*
- *What can be suggested taking in account the criticisms?*

What is the importance of such rankings in India?

First in the list is its timing. With the 'admissions season' round the corner, students looking to study in reputed institutions will not have much time to make up their minds. They can make their choice of the institution they wish to take admission into on the basis of the ranking of the institute.

Secondly, prior to this initiative, Indian students have had to rely on the Shanghai or the QS World Rankings which do not take into account the peculiarities of our subcontinent. In many countries, this exercise has been outsourced to third parties, so the move by the Indian government is praiseworthy.

What are the grounds of criticism of the same?

The grounds of criticism for the same are as follows:

- There has been no cross-verification of data before announcing the ranking. The data used for evaluation was submitted by the institutions themselves (Self-verification criteria) and the responsibility for accuracy and authenticity of the data lies with the respective institutions.
- The stated intent of the government was to prepare India-centric ranking parameters that were sensitive to metrics such as access to higher education and social inclusion. Interestingly, the weightage given to India-specific parameters is not pronounced.
- The IITs have chosen to participate in the rankings under the "engineering" category. They

should have competed under the category of "universities".

- Institutions devoted to specific disciplines like Institute of Chemical Technology is ranked along with multidisciplinary universities like JNU/BHU.
- Some top institutions could not have figured in the ranking because they did not participate in the process and submit the data for judging them over various parameters.
- Disciplines like literature, commerce and social work appear to have been left out.
- The country is also being well served by many autonomous institutions that have their own expertise and excellence. Have they been taken into consideration is a question mark.

What can be suggested taking in account the criticisms?

The self-verification criteria are advisable to be cross-checked with an independent agency. The methodology needs to be improved. Ways and means should also be found to reassure students about the authenticity of the data. The categories should include the arts and sciences. The rankings should include 'IPs/ patents by the institute', 'student satisfaction', etc. Outreach and inclusivity are useful data to help students get a feel of the composition and outlook of the university. The NIRF should be transparent about the criteria adopted by it to rank Indian universities.

Topic 7. National Education Mission

All schemes related to literacy / education improvement have been put under the umbrella of National Education Mission by Narendra Modi Government. The National Education Mission itself is made of four umbrella schemes as follows:

- National Education Mission – Sakshar Bharat
- National Education Mission – Sarva Shiksha Abhiyan
- National Education Mission – Rashtriya Madhyamik Shiskha Abhiyan (RMSA)
- National Education Mission – Teachers Training

National Education Mission – Sakshar Bharat

Saakshar Bharat programme

This comprises the schemes of Literacy campaigns Adult Education & Skill Development.

Support to Jan Shikshan Sansthan etc

Support to NGOs/Institutions/SRCs for Adult Education & Skill Development scheme assimilates the two existing schemes of Support to NGOs in the field of Adult Education and Jan Shikshan Sansthan (JSS). Under the scheme, financial support is being provided to NGOs for imparting literacy to adult non-literates in the age group of 15-35 years. The State Resource Centres (SRCs) managed by the NGOs also receive support under this programme.

Directorate of Adult Education

Directorate of Adult Education (DAE) has been functioning as the National Resource Center in the

field of Adult Education. The Directorate was set up as subordinate office of the Department of Elementary Education & Literacy under the Ministry of Human Resource Development to provide academic and technical resource support to various government and non-government agencies implementing Adult Education Programme in the country. The DAE is fully funded by the central Govt.

National Literacy Mission Authority (NLMA)

National Literacy Mission Authority was set up in 1988 as an autonomous wing of the Department of School Education & Literacy for implementation of the programmes of the National Literacy Mission.

National Education Mission: Sarva Shiksha Abhiyan

Sarva Shiksha Abhiyan (SSA) focuses on *universalization of elementary education in the country*. The NDA Government has also launched a new initiative Padhe Bharat, Badhe Bharat under this to focus specially on **language and math.**

National Education Mission: Rashtriya Madhyamik Shiksha Abhiyan (RMSA)

While focus of SSA is elementary education, the focus of RMSA, which was launched in 2009-10, is secondary education.

National Education Mission: Teachers Training

It comprises the following three schemes:

- **Strengthening of Teachers Training Institutions:** This scheme aims to prepare teaching staff of global standards. The Scheme envisages integration of teacher education with the overall education development in the States in keeping with the mandate of RTE. It will also help in the expansion of the capacity of the Teacher Education Institutions specially in some of the deficit States of East and North-Eastern Region and also address the problem of large number of untrained teachers.
- **Appointment of Language Teachers:** The financial assistance under the scheme is given for appointment of Hindi Teachers in schools in non-speaking States/Uts, Urdu teachers in any locality where more than 25% of the population is from Urdu speaking community and Modern Indian Language Teachers to teach a third language in those schools of Hindi speaking States/Uts that demand them.
- **School Assessment Programme:** This Programme for assessment of schools performance.

Pandit Madan Mohan Malviya National Mission for Teachers Training

The government was planning to rename the teacher training umbrella after Pandit Madan Mohan Malviya to create synergies among the various ongoing initiatives on teachers and teaching. The scheme will address all issues related to teachers, teaching, teacher preparation, professional

development, curriculum design. It also aims to develop a strong professional cadre of teachers by setting performance standards and creating top class institutional facilities for innovative teaching. The scheme will also address the need to induct qualified teachers, attracting talent into teaching profession and raising the quality of teaching in schools and colleges.

Topic 8. Right to Education and No-detention Policy

On 31 December, 2015, a Centre-appointment panel, led by Rajasthan education minister Vasudev Devnani, has recommended revocation of the 'no-detention policy'. Here is a backgrounder on the issue.

What is RTE?

The Right to Education Act (RTE), 2009 makes provisions for free and compulsory education for children between 6 and 14 under Article 21A of the Indian Constitution. This article was inserted into Jain_winner.rajasthan.surabhi@gmail.com | www.gktoday.in/ias-ias-general-studies into Part-III (Fundamental Rights) in the constitution via the 86th Constitutional amendment of the constitution.

What is No Detention Policy?

Under this policy, the students up to class VIII are automatically promoted to the next class without being held back even if they do not get a passing grade. The policy was implemented as part of the Continuous and Comprehensive Evaluation (CCE) under the RTE Act in 2010 to ensure all-round development of students. The concept of CCE imported from the West, which emphasises on evaluating a child through the year, and not just based on performance in one or two term exams.

What is the Class X Board exams policy?

Class X board exams are optional for all CBSE students. The students can choose either school-based exams or board-based ones. In case of school-based exams, the exams are conducted within their own school and answers are evaluated by the teachers of the school. In case of board-based exams, the exam is conducted at an allotted centre and answers are evaluated at designated centres.

Why were these policies implemented?

Several surveys conducted by the government and various NGOs had revealed that the detention system led to increased dropouts among students, especially from economically and socially weaker sections, who cannot afford costly private education. In order to overcome this, the no-detention policy was brought in to provide elementary school children an environment free from fear, anxiety and stress and allow them to learn and grown on their own pace. The main idea was to reduce the undue stress of competition among students, parents and the educational institutions.

What are the issues with NDP?

After few years of implementation of no-detention policy, it was found to be counter-productive. Many government school teachers and principals conceded that it became a big challenge to ensure

minimum learning levels among the children. They complained that the policy led to students developing a lackadaisical attitude towards their studies. Parents also didn't bother as their children cannot be held back in the class. The system makes no difference between good and bad students. Several studies have showed that learning outcome in schools have been poor over years. The 2014 Annual Status of Education Report (ASER)brought by the Pratham, an education non-profit organisation said that every second Class V student in rural India can't read the text of a class three levels below.

What is the government's view?

In 2012, a sub-committee set up by the Central Advisory Board of Education (CABE) under then Haryana Education Minister Geeta Bhukkal, had come up with a conclusion that *no-detention policy has had a "very bad" impact on the children.* The committee recommended that the no-detention policy be implemented in a phased manner so that all stakeholders understand what it entails *instead of interpreting it as zero assessment*. The committee was of the view that it should be applied *only till Class V* instead of Class VIII. The committee also recommended that government should make it mandatory for students to register minimum attendance of 80 per cent in their classes so that they are benefited by the CCE under the RTE Act.

Since the report was finalized in the last year of the UPA-government, no action was taken. The present HRD Minister held a series of meetings including with school children and the general opinion favoured for examinations for lower levels as well as for Class X. In August 2015, at a meeting of CABE chaired by HRD Minister, a broad consensus emerged on scrapping of the NDP and bringing back the board exams in Class X. The Ministry asked all states to give their views. While most of the states are in favour of scrapping of NDP, few states are against it.

Vasudev Devnani Panel

On 31 December, 2015, a Centre-appointment panel, led by Rajasthan education minister Vasudev Devnani, has recommended revocation of the 'no-detention policy'. The panel had sought opinion of 22 states, of which 18 favoured revoking the policy. The key recommendations of the panel are as follows:

- Introduction of state level compulsory exams for classes V and VIII. Students, who fail to achieve the required learning level, will be given one more opportunity to clear the exam in one month time. In case they fail to achieve the learning level again, they have to repeat the respective class.
- No-detention policy should be applicable to classes I to IV, VI and VII subjected to required learning levels. Those who fail to achieve the learning level will be marked as unsuccessful in

their report cards.

How can these policies be reversed?

The NDP can be revoked by amending the RTE Act. The Class X board examinations can be re-introduced through an executive order.

What are the arguments in favour of no-detention policy?

Several educationists and academics have asserted that the NDP and CCE are based on sound principles of pedagogy and assessment and are recognised world-wide. They are welcome change to the exam-centric education culture prevailed in India. The no-detention policy embraces the concept of equity especially for children from low-income groups and girls. High repetition and high dropout rates have been a major issue since the 1990s. The NDP seeks to address that concern. There is no research evidence to suggest that the repeating a year helps children perform better rather it leads to more dropouts from the system. Research does say that repeating has adverse academic and social effects on the child.

There is a common misconception that no-detention means no assessment. CCE is the assessment system under RTE and it should go hand in hand with no-detention policy. CCE allows for assessment of students on non-cognitive and non-academic areas of learning. Here a child need not be failed just because of non-performance on a narrowly defined and rigid set of indicators. There is lack of awareness regarding the implementation of CCE. The failure of implementation process is equated with failure of policy itself. The CCE failed to take off in most schools due to lack of basic capacity and awareness. In the absence of CCE, a no-detention policy has no meaning. There are also assumptions that students can only learn under the threat of failure. As long as there are such beliefs, the groundwork for reforms will not be ready. The failure of a child is the failure of the system as a whole, rather than that of the child. Instead of proposing the changes in the learning process, we are victimising the children.

What is the way forward?

The poor learning outcomes of schools are caused by many factors of learning. One of them is the pupil-teacher ratio. Many government schools in India are facing acute shortage of teachers. And the available teachers are burdened with non-school activities. Until the desired pupil-teacher ratio is achieved, it is unreasonable to expect CCE and NDP to succeed. Other factor responsible for poor learning outcomes is the lack of trained teachers. Lack of training has caused the confusion among the teachers on what their role is in implementation of CCE guidelines. Teacher training must be revised in line with the requirements of CCE. Instead of strengthening the foundation to implement the reforms, bringing back the old pass-fail system threatens to undermine the egalitarian promise of the RTE.

Topic 9. Global Initiative of Academic Networks (GIAN)

Global Initiative of Academic Networks (GIAN) in Higher Education is a new Government scheme that aims to increase footfalls of reputed international faculty to Indian academic institutes; and thereby bring in international academic excellence in India's higher education institutions.

This programme was initially conceptualized as an Indo-US collaboration but was later its scope was extended. The programme is initially to be confined to IITs, IIMs, NITs and some central universities with 'A' Grade.

ISWT

The Guest lectures are arranged under GIAN via its International Summer/Winter Term (ISWT) programmes. These terms are either short term or long term.

Current Status

It has been reported that number of academics from Germany, US, Canada, France, England, Australia have shown interest in the GIAN scheme. The first GIAN backed course by a foreign faculty is expected to start in NIT Surathakal in November 2015.

Key Issues

There are two major issues that might challenge the implementation of this scheme viz. Copyright and Funding. Some American universities have raised issue of intellectual property related to recording of the lectures and copyright concerns. The Smriti Irani led Ministry is doing its best to ensure that the scheme is made workable.

Further, funding may also be an issue. The government will pay a very high remuneration (for example USD 12000 for a 2 weeks contact programme). The duration of such guest courses can be mutually decided by the host institution and the visiting faculty. Such high financial incentives have been kept at par with China, which offered around same monies to global academics to teach at their universities. The Government has reportedly set aside Rs. 35 Crore for GIAN scheme to conduct 500 courses across Indian Institutes by global experts from top foreign universities by end of 2016.

But, since IITs and IIMs don't take any financial support from the Centre, they have argued their inability to pay such as high remuneration. According to reports, the Central Government is pitching in with additional funds for such institutions.

Comment / Analysis

Although our country has not been able to set up campuses of Foreign Universities here via the Foreign Universities Bill; this scheme must be able to be a turning point in higher education. The Government's interest in proper implementation of this scheme can be gauged from the fact that it

roped in Fields Medalist Dr. Manjul Bhargava, R. Brandon Fradd Professor of Mathematics at Princeton University as its brand ambassador. The scheme connects India's top institutions and Central universities with global faculty. It will be helpful for adoption of new methods in teaching, boosting research and cutting edge technologies and building stronger academic networks. However, success of this initiative depends on coordination and management capacities of the MHRD and the concerned higher education institutions.

Topic 10. Education Qualification Issue in Panchayati Raj Elections in Rajasthan

Rajasthan schools have been in a state of neglect and many successive governments did not pay attention to the dismal state of affairs. In addition the government has shut as many as 17,000 schools mostly in remote areas. The eligibility criteria for contesting elections of Panchayats were announced a few days before the elections. This would directly disqualify about 95 percent women and 80 percent men. The experts see the reason behind the ordinance is to capture democracy at grassroots level. It will ensure the power continues to remain in hands of a few people. The most affected lot will be of women and dalits.

- The people who come from rural and illiterate backgrounds may not have a tinge of formal education but have enough learning gathered from life's experiences that they can make sound decision of difficult matters of villages which have long-term and widespread repercussions. These people are more open to knowledge and have a knack for learning newer techniques which they can pass on to the general masses. The point that illiteracy does not always come from lack of formal education but also from the apparent ignorance of highly specialised modes of governance which someone with a Masters degree cannot match.
- Literacy is definitely essential and every state has the duty to ensure education to all its residents. However, literacy and intelligence go hand in hand and neither can replace the other. If there are many examples of illiteracy which led to unreasonable activities, there are also many unintelligent and feudal acts which were led by literate men in Rajasthan. Literacy thus may not turn the balance of power but is the indiscriminate power which leads to bad governance.

The bureaucratic system needs reforms to ensure accountability so there is an accurate balance of power between the technocratic executive and the elected representative.

Topic 11. Technical Education Quality Improvement

Programme (TEQIP) Phase III (2016-20)

The Cabinet Committee on Economic Affairs recently approved the third phase of the Technical Education Quality Improvement Programme—a joint effort between the central government and the World Bank for improving the quality of education in engineering colleges. The total project outlay for this would be Rs 3,600 crore.

Technical Education Quality Improvement Programme (TEQIP) was conceived and designed as a long term Project to be implemented in 10 to 12 years in 3 Phases in order to support excellence and transformation in Technical Education in the country.

Each Phase of the Project was to be implemented on the basis of success achieved and lessons learned in the earlier Phase.

- The Phase – I of the Project started in 2003 which lasted till 2009.
- The second phase was from 2010 which lasted till October 2016.

Both projects have had a positive impact on the infrastructure and educational standards in the technical institutions where they were taken up. Institutions in the central, eastern and north-eastern region and hill States are at present in need of similar and specific interventions. The initiation and implementation of the project TEQIP-III will help to bridge this gap.

TEQIP Phase 3

The third phase would be implemented as a 'Central Sector Scheme'.

- *Funding*- The total project outlay of Rs. 3600 crore. The project would be initiated with a cost of Rs. 2660 crore, with the possibility of additional financing of Rs. 940 crore at later stage. Out of the Rs.2660 crore, the Central share will be Rs.1330 crore and external assistance from the World Bank through International Development Association (IDA) Credit of Rs. 1330 crore. The project will be implemented with the facility of Direct Funds Transfer to the accounts of beneficiary institutes.
- *Duration*-The project will be initiated in 2016 and would be co-terminus with Fourteenth Finance Commission (2019-20).

Major outcomes of the project-

- Better academic standards, through accreditation, filling up faculty positions, training faculty in better teaching methods, improved research outputs in institution in Focus States/UTs.
- Better administration of the institutions with improved financial/academic autonomy.
- Better systems for assessment of Student Learning, higher transition rates.
- Transparent and expeditious release of funds to institutes by way of Direct Funds Transfer (DFT) System.

Focus States

The Focus States are 7 Low Income States (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh), 3 Hill States (Himachal Pradesh, Jammu & Kashmir and Uttarakhand), 8 North-Eastern States (Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura) and Union Territory of Andaman and Nicobar Islands.

Topic 12. Massive Open Online Courses (MOOCs)

Massive Open Online Course (MOOC) is aimed at unlimited participation and open access to education via internet. Apart from traditional course materials such as filmed lectures, readings, and problem sets, many MOOCs provide interactive user forums to support community interactions among students, professors, and teaching assistants. MOOCs are a recent and widely researched development in distance education which were first introduced in 2008 and emerged as a popular mode of learning in 2012. Government of India has launched SWAYAM (https://swayam.gov.in/) as a Massive Open Online Course (MOOC). Swayam is a platform that would bind Indian higher education, both online and offline.

This topic should be analyzed in the light of below questions for your mains examination.

Can expansion of MOOCs solve the fundamental inadequacies of Indian Higher Education?

MOOCs can provide the Indian students an edge required to compete in the global market. MOOCs can enhance the edge of Indian students in the global job market and improve their chances of admission to top US and European colleges and graduate schools. However, expansion of MOOCs may not solve the fundamental inadequacies of Indian higher education in near future. This is because there are technological, educational, and cultural hurdles restricting access to these courses.

Can MOOCs Help Expand Access to Higher Education in India? What are the challenges?

MOOCs can help to a great extent to overcome higher education challenges and in fact they have done so in many other countries. Some of the leading universities around the world have partnered with MOOC provides such as courseera, EDX and tried to deliver high quality online courses to millions of students around the world. But there are several issues.

- MOOCs will be able to make substantial impact only when the universities are able to upgrade their technical infrastructure.
- The major issue with MOOCs is their evaluation mechanism. They are student focussed but in most cases the assessment mechanism is not very strong.
- MOOCs are provided free but creation of content as study material is not free. The cost of creating the content can burden the universities with extra costs. Thus, there needs to be a mechanism to handle the financial requirements of creating MOOCs.

- In due course, MOOCs may undermine the physical classrooms and local colleges and exacerbate educational inequality.

For MOOCs to provide equitable path addressing India's high education challenges, following are some of the ways ahead – Firstly, the technological infrastructure of universities and colleges needs to be upgraded; Secondly, the MOOC provides should be able to leverage the mobile phone revolution; Thirdly, the largest demand for courses in India is of technical and professional fields. MOOCs that are geared towards these disciplines can really ease the burden over existing institutions. Lastly, there is a need of greater investment in the field considering the fact that India has one of the largest number of students accessing the MOOCs.

Topic 13. Role of Private Sector in Education

Education is very important as it makes an individual empowering. Self-help is easier for an educated person than one who is not educated.

Most of our premier institutions of education have been funded by the government (State or Central) and they are all run as not-for-profit enterprises.

Entry of private sector in the field of education began with professional courses such as engineering, dentistry, medicine, pharmacy, etc. The avenues for the private sector increased overtime as it was realised by the private sector that there was reasonable supply of interested students who could afford the cost of education.

How can private sector participation be increased in the field of education?

In order to encourage private players entry into the field of education, following measures could be undertaken by the government:

1. Simplifying regulations by reducing input-based constraints that stifle operational autonomy.
2. Introducing student-side financing to ensure a level-playing field between high quality public and private institutions.
3. Creating enabling legislations at the state level to encourage private players to set up universities in those states.
4. Expediting passage of the Innovation Universities Bill to encourage private players to invest significant amounts in setting up innovation universities which are independent of geographical constraints.
5. Allowing players to set up of for-profit institutions, while putting in place a regulatory framework to ensure quality and transparency.

Merits of private players role

1. Qualitative education is provided to the children as there is disciplined and efficient

functioning of the institutes.

2. The private institutes are always involved and up to date for the upgradation of the technologies in their institutes.
3. Public has a mental satisfaction that they are having value for the money they are spending.

Demerits of private players role

1. The main disadvantage of private institutions is that education provided by the private institutes is very costly. It is not feasible for the poor or even for ordinary people.
2. Private institutions turn education institutions into private business firms and this makes the value of education go down.
3. There is a concern over huge capitation fees demanded by the private institutes.
4. The gap between poor and rich widened due to privatization. This brings about disparity.

Conclusion

It must be borne in mind that what is most important is imparting education, be it through private sector or public sector. It has been alleged that public institutes are not in good condition therefore, efforts must be made to make public schools as good as private ones. Private schools are important keeping in mind the urgent need of good schools in accordance with rising expectations and population.

Topic 14. Improving Learning Outcomes

In India, there is high level of inequality in learning wherein only a small proportion i.e., the privileged students are able to acquire good learning. Some of the promising strategies which have been identified by various education experts are summed up below-

Experiments on learning innovations, including remedial programmes

It is needed that alternative pedagogies be implemented which would be able to yield improvements in basic skills with existing resources, whether with volunteers, existing teachers or contract teachers. Designing appropriate class-level training, teacher training and conducting campssuch as summer camps can be very innovative methods to increase the learning outcome of the students.

Teacher incentives

There can be small financial incentives given to teachers which would be able to lead to improvements in teaching quality of the teachers and ultimately the teachers would be able to deliver better and learning outcome from the students end would be enhanced.

Teaching according to a child's ability

The problem with the education system is that the teaching method is very text book oriented. This generally bores the children and they are not attentive. Ultimately, it is the students who have learnt nothing but were simply sitting in the class. Therefore, it is needed that activity oriented classes be

undertaken wherein teaching is done as per the needs of the child. Therefore, to increase the learning of the child, it would be better if the children are grouped by level rather than by class, and taught accordingly.

School choice

This measure is especially for the parents of the children. It would be necessary for the parent to make the right choice of school for the child according to the level of the child. In India, there is a trend to follow the bandwagon of admitting a child to a school due to the pressure from the society in order to just look good in public. This is however a wrong technique as this would only burden the child wherein the performance would not be met and learning would be zero.

Topic 15. Education: Issues Related to Minorities

Article 46 of the Constitution states that, "*The State shall promote, with special care, the education and economic interests of the weaker sections of the people, and, in particular of the Scheduled Castes and Scheduled Tribes, and shall protect them from social injustice and all forms of social exploitation.*"

Articles 330, 332, 335, 338 to 342 and the entire Fifth and Sixth Schedules of the Constitution deal with special provisions for implementation of the objectives set forth in Article 46.

Similarly, Articles 30 (1) provides for the rights of the Minorities to establish and administer educational institutions of their choice.

These constitutional provisions need to be fully utilized for the benefit of the weaker sections in our society.

Status of Minorities in education

According to 'Sachar Committee Report' "one-fourth of Muslim children in the age group of 6-14 years have either never attended school or are drop-outs. For children above the age of 17 years, the educational attainment of Muslims at matriculation is 17%, as against national average at 26%. Only 50% of Muslims who complete middle school are likely to complete secondary education, compared to 62% at national level". The Report has also drawn attention to the low levels of educational attainment among Muslim women, Muslims in rural areas as well as in technical and higher education.

The High Level Committee under the Chairmanship of Justice RajinderSachar has also made a number of recommendations for improvement of the educational status of the Muslim communities.

Initiatives for the education of Minorities

- A total of 15% of the outlay under the Sarva Shiksha Abhiyan is targeted for the Minority Concentration Districts (MCD)/Areas to achieve the goal of universalization of elementary education, to meet infrastructure gaps for schools, classrooms, teachers and providing access

by opening new schools.

- Scheme for Providing Quality Education in Madarsas (SPQEM)
- Scheme of Infrastructure Development in Minority Institutions (IDMI)
- Jawahar Navodaya Vidyalaya Scheme (JNV)
- Setting up of Girls Hostels
- Model Schools under the Rashtriya Madhyamik Shiksha Abhiyan (RMSA)
- Mid-Day-Meal Scheme
- Jan Shikshan Sansthan (JSS)

Also the University Grants Commission (UGC) is implementing the following schemes for minority communities in Central Universities during XI and XII Plan:-

- Centre for Professional Development of Urdu Medium Teachers in three central universities.
- Establishment of Residential Coaching Academy for Minorities, SC/ST and Women in four Central Universities and one in Deemed University.
- Establishment of Satellite Campus for undergraduate, Postgraduate, Programmes in Arabic and Persian.
- Establishment of two Campuses of Aligarh Muslim University.
- Establishment of Model School, Industrial Training Institutes (ITIs), B.Ed. Colleges, Polytechnics under the ambit of Maulana Azad National Urdu University.
- Since 2009, the UGC has been implementing the scheme of Maulana Azad National Fellowship for Minority Students which is being funded by Ministry of Minority Affairs. Under this scheme, the UGC provides financial assistance to selected candidates belonging to minority communities for pursuing M.Phil./Ph.D. research in University/College/Institution and Non-Institutions in the country.

Why Muslims lack in education?

The major factors contributing to lack of education by the minorities especially the Muslims is poverty and accessibility. Besides this, geographical disparity also acts as a hindrance. It is observed that Muslims are generally located in interiors and backward areas because of which they lack education.

Besides this, occupational disparity wherein Muslims chose to undertake trade and therefore less importance is given to education. The other contributing factors could be- higher fertility rates and gender disparity.

Topic 16. National Eligibility cum Entrance Test (NEET)

The Supreme Court has recently restored the National Eligibility cum Entrance Test (NEET)

examination for students who wish take under graduate and post-graduate studies in medical science, dental or PG medical education.

NEET Advantages

The NEET basically frees the students to prepare for multiple entrance examinations and tests. There are around 100 different entrance tests which were conducted every year, each levying a fee of Rs. 1200 to Rs. 6000. This led to an escalation of expenditure for students. With NEET, all these expenditures are done away with. This exam also tackles the Capitation Fee issue to a great extent.

Thus, the advantages of NEET are:

- There would be one common examination for admission into almost all of the MBBS colleges in India.
- The students will be free and relaxed after appearing in only one exam.
- No need to apply for several entrance examinations.
- Stress-level will be considerably reduced.
- There would be substantial financial savings for parents.
- NEET will avoid unnecessary wastage of time, effort & money.
- Since the admission criteria does not include Board marks (apart from minimum eligibility), a student must prepare in a focused manner for NEET.

Criticism of NEET

Firstly, there is an overarching fear that NEET will provide a huge advantage to students of Delhi-headquartered boards such as the Central Board of Secondary Education. *Secondly,* with NEET, the government is making one exam applicable for entry into MBBS or BDS. This would build up psychological fear in the student's minds. This would create pressure on many students as they have only one chance of getting into a medical college. The pressure might lead to bad performance on the actual day of the exam. Earlier the students had an opportunity of other exams wherein they had a second chance to perform well. *Thirdly,* conducting and managing one exam at all India level might lead to errors and mismanagement on various parts and delay into the rank list resulting in delay in admission procedure. *Fourthly,* on one hand we talk about co-operative federalism and on the other hand the government declares NEET which is totally under the central government control. This would to decrease in the role of State government.

NEET versus Private Colleges

NEET is said to have a devastating effect on the multi-crore 'capitation fees' industry which is run by private medical colleges. There are more than 250 private medical colleges in the country where mostly admission processes are a 'farce' and 'capitation fees' is what decides the entry of the

candidates. This would definitely be stopped and therefore the introduction of NEET is not welcomed by the private medical colleges.

Way Forward

NEET is a welcome move as it would curb the capitation fee market and would also bring about uniformity. However, being practical in this approach is much more needed. There must be a time lag of around 5 years for NEET to be introduced formally so that students who do not study in CBSE board can get accustomed to the pattern and do not feel left out of the process.

Topic 17. Skill Development: Challenges and Way Forward

By 2022, India will have the maximum number of working age population in the world; however, skilling has been a roadblock to reap this opportunity. What are the reasons and what can be done to bridge the skilling gap in the country? Discuss. Skill development refers to all the efforts to improve the effectiveness and contribution of labor to the overall productivity as well as production, which lead the economy to a higher trajectory.

The skill development has been a hot topic in current times in our country. What triggered such focus? Mainly two things as follows:

- Demographic dividend
- Expansion of knowledge based economy

Demographic dividend was indicated by the changing demographic profiles of India vis-à-vis some other countries such as China. The changing demographic profile indicated that India has a unique 20-25 years window of opportunity. This opportunity comes to us because of increased ratio of young and working population, lesser dependency ration due to declining birth rates and improvement in life expectancy. More working people means more savings which, in turn, means more money for investments. As the number of working people grows, it also reduces the dependency ratio, which is the proportion of non-working population to the working.

The expansion of the talent based economy worldwide indicated that global economy is witnessing an acute shortage of skilled manpower.

Efforts till UPA-2 regime

On the basis of an 11th plan recommendation for creation of a comprehensive **National Skill Development Mission**, a Coordinated Action on Skill Development was envisaged in UPA-2 regime. In 2009, the government launched a **National Policy on Skill Development** to train 500 million people by 2022 by empowering all individuals through improved skills, knowledge and nationally and internationally recognized qualifications to gain access to decent employment and ensure India's competitiveness in global market. It also aimed to increase produce workforce in

organized and unorganized sectors especially among youth, women, disables, disadvantage sections.

In this way, a three tier institutional structure came up in India in last decade which had the following three tiers:

PM's National Council on skill development

↓

National Skill Development Coordination Board (NSDCB)

↓

National Skill Development Corporation (NSDC)

In the above structure, the functions were as follows:

- The PM's National Council spelt out vision to create 500 million skilled people by 2022 through skill systems.
- NSDCB was given the task to cooperate with a large number of central ministries, departments and state governments.
- NSDC was charged for preparing comprehensive action plans and activities which would promote PPP models of financing skill development.

The National Skill Development Corporation was set up as a public-private-partnership project, and the then prime minister Manmohan Singh brought in S. Ramadorai, the then vice-chairman of Tata Consultancy Services Ltd, to be his skill adviser.

However, so far, India is marred with various problems in the skill development sector.

Problems with Skill Development Programmes

- The UPA regime is known for tedious governance structures. The biggest problem that occurred was of lack of coordination. Government was preoccupied with financing and implementation lost track. The Employment Exchanges, NCVT SCVT etc. were not utilized properly for training and information dissemination. The skill development programmes were implemented by ministries, departments and state governments. For example,
  - In UPA regime, 20 different ministries handled 73 different skill development schemes.
  - There was not centralized curriculum or certification.
  - NSDC was kept under the Finance Ministry. It had hardly succeeded in coordination among various ministries and departments.
- Involvement of Industry and employers in the skill training structures (such as ITIs) is almost nothing. They could not be brought forward to proactively participate in the skill development. They were not brought forward because this would entail larger autonomy to institutions.

- India has a fragmented vocational education system, managed by multiplicity of bodies under the NCVT, DGET and the SCVTs. Lack of coordination among them has resulted in ineffectiveness of any top down approach to skill development. The quality of vocational institutes is also low.
- Funding of vocational education in India is restricted largely to government, where little attention was paid to quality. Once an institution begins to receive funding, subsequent funds are assured regardless of the institution's performance. Moreover, Education being a state subject, the implementation of any vocational; education would be in the domain of respective state governments. While the student fees in ITI's/polytechnics go to the State treasuries, the institution itself does nothing to cater to the market requirements.
- For now, far too much of young India learns on the job. It learns well but lacks the stamp of authority, and languishes in low-paid jobs or in the informal sector.
- A large number of students with vocational education need to look for placement in private organizations or for self employment. The condition of private industrial employments and self employment are inferior in India in comparison to other countries. Subsequently, only a smaller fraction of students (~5%) opt for vocational education.

The Efforts under New Government : Separate Ministry

The incumbent NDA government has established a separate ministry for skill development. This central ministry takes the core elements from various ministries and pools them under one minister, Sarbananda Sonowal, and under one budget, which could be in the region of Rs 25,000 crore. In June 2014, the ministry had begun negotiations with two dozen ministries, however, most of them had apparently objected to losing their turf. The current position is as follows:

- The 73 schemes remain (as of now) with the respective ministries and the skill ministry to work as coordinator
- The new ministry will devise training curriculum in key sectors and issue certificates to trained personnel.
- Three key agencies — National Skill Development Corporation, National Skill Development Agency and National Skill Development Trust — which used to be attached to the department of economic affairs under the ministry of finance are now under the administrative control of new ministry.

Whether the government will continue to fund individual ministries for skill development as it did earlier or, the new ministry finally gets a mandate of handling all skill development work across sectors, thereby trimming work assigned to other ministries—this question remains unanswered as

of now.

Challenges to Skill Development in India

By 2022, India will have the maximum number of working age population in the world. The FICCI-KPMG Global Skills Report has noted that if properly skilled, they can contribute to economic growth. But there are many challenges to skilling in India. Some of them are:

- **Problem in Mobilization**
- Student mobilization to get trained has been a major concern due to the traditional mindset, low willingness to migrate, low salaries at entry level.
- **Issues in Employers' Buy-In**
- The employer does not distinguish whether an employee has picked up skills on the job or he has acquired them through formal training,
- **Problems In Scalability**
- Scaling up aspirations to current jobs as well as getting the right kind of training partners and effective stakeholder management are important.
- **Mismatch between youth aspirations and jobs**
- Finding students to fill the classrooms and getting people to accept new kind of jobs have been difficult,
- **Ensuring Minimum Wages**
- At present, wages are linked with categorization of 'skilled', 'semi-ski lied' or 'unskilled', but these have to be aligned with skill levels defined as per National Skill Qualification Framework (NSQF) and recognition of higher level of skills in terms of minimum wages is noted.

What can be done?

- With just about 2% of the country's labour force having formal skill certification, government and industry must create pull factors to attract workers to get vocational training. For this, there is a need to create the macro and micro policies to encourage workers.
- The government should include a minimum percentage of certified skilled work forces in the tendering process of every manpower intensive project and increase the minimum percentage every year.
- At a local level, the industry can enforce it by ensuring that ancillary service providers like drivers, housekeeping and security staff have skill certification.
- Minimum wages need to be re-looked and aligned to the levels defined in the National Skills Qualification Framework.

Topic 18. Choice Based Credit System

Choice Based Credit System (CBCS) allows the students to choose courses from the prescribed courses comprising core, elective/minor or skill based courses. The courses will be evaluated by following the grading system, which is regarded to be better than the conventional marks system. CBCS seeks to abolish marks-based evaluation in all universities. These guidelines are applicable to all undergraduate and postgraduate level degree, diploma and certificate programmes run by Central, State and deemed universities in India.

Why there is a need for CBCS?

- It becomes necessary to introduce uniform grading system in the entire higher education in India.
- CBCS becomes necessary in order to bring uniformity in evaluation system and computation of the Cumulative Grade Point Average (CGPA) based on student's performance in examinations.

Salient features of CBCS

- There will be three main courses: Core, Elective and Ability Enhancement courses.
    - Core Course: A course, which has to be compulsorily studied by a candidate
    - Elective Course: A course which a student can be choose from a pool of courses, which may be very specific/specialized/advanced/supportive to the discipline/ subject of study or which enables an exposure to some other discipline/subject/domain.
    - Ability Enhancement Course: These are of two kinds:
        - Ability Enhancement Compulsory Courses (AECC): it is based upon the content that leads to knowledge enhancement.
        - Skill Enhancement Courses (SEC): value-based and/or skill-based. It aims in providing hands-on-training, competencies, skills etc.
    - It introduces Research Component in under graduate courses.
    - Number of core papers for all Universities will be same for both UG Honors as well as UG Program.
    - It adopts Credit and Grading System of Evaluation. UGC has recommended a 10 point grading system:
        - (Outstanding): 10
        - A+ (Excellent): 9
        - A (Very Good): 8
        - B+ (Good): 7

- B (Above Average): 6
- C (Average): 5
- P (Pass): 4
- F (Fail): 0
- Ab (Absent): 0

- Each course is assigned a certain credit. When the student passes a particular course, he/she earns the credits which are earmarked for that course. The students earn credits according to their pace of study.
- It has reduced the existence of wide disparity among discipline wise enrolment.

What are the other global grading systems?

Major higher education institutions across the world are implementing a system of credits. Examples are:

- European Credit Transfer System (ECTS) in Europe.
- National Qualifications Framework in Australia.
- Pan-Canadian Protocol on the Transferability of University Credits in Canada.
- Credit Accumulation and Transfer System (CATS) in UK.

Advantages of CBCS according to the UGC

- This will enable the students to move across institutions within India and across countries.
- The uniform grading system will help the potential employers to assess the performance of the candidates.
- It follows the student centric approach rather than the teacher-centric.
- Student can undertake as many credits as they can cope with. Also, in this system if the students fail in one/more courses, it is not necessary for them to repeat all courses in a given semester.
- CBCS provides more flexibility for students by enabling them to choose inter-disciplinary, intra-disciplinary courses, skill oriented papers as per their learning needs, interests and aptitude.
- CBCS will make education broad-based and at par with global standards. It enables students to take credits by combining unique combinations. For example, Physics with Economics, Microbiology with Chemistry or Environment Science etc.
- CBCS offers more flexibility to the students and allows them to study at different times and at different institutions to complete one course. Credits earned at one institution are transferrable.
- It provides enhanced learning opportunities.

Criticisms

- There will be difficulty in estimating the exact marks.
- There will be fluctuation in the workload of teachers.
- The implementation of CBCS needs good infrastructure for effective dissemination of education.
- It is feared that the homogenization under CBCS will do grave in injustice to India's vast diversity.
- It tends to curb the autonomy of universities and has implications with respect to the quality of education.
- It is likely to kill specialization across different fields as all would follow the same beaten track.
- Most of the universities have abysmal infrastructure in terms of material or human resources.
- It gives an all-India scale for conversion of marks into grades and the system disregards the fact that there exist radical differences between the "standard" maintained in different colleges and universities.
- The CBCS has imposed uniform syllabi on universities. The universities are permitted to effect only minimal changes. Teachers will not have any role in designing the courses they teach.
- As opposed to uniform excellence, the CBCS tends to promote uniform mediocrity and a lowering of academic standards.
- It may lead to lack of recognition to academic work and demoralization of professors.

Topic 19. Techno-centered development approach and Higher education

Higher education is critical for developing a modern economy, just society and a vibrant polity. It equips the young people with skills relevant for labor market and opportunity of being absorbed to prominent positions. It provides people already in employment with skills to negotiate rapidly evolving career requirement. It prepares its citizens as responsible citizens who value a democratic and pluralistic society. Thus higher education creates huge repository of human capital to meet the country's need and shapes its future. Higher education is the principal on which our national goals and development priority can be examined and refined.

Health of higher education in India

India's higher education is world's 3rd largest in terms of students, next to US, China and equivalent to Australia's population. Gross enrollment ratio is a mere 11% as compared to china's 20% and US's

83%. Overall standard of education does not match global standard where quality is determined by profile and quality of faculty, number of journals in the library, an ultra-modern campus, efficient use of resources and highly satisfied employable graduates.

Critical appraisals

Increasing educated unemployment leaves the young graduate with low morale and motivation. Increasing unrest and indiscipline on the campus and the frequent collapse of the administration further deteriorates performance. Deteriorating standards and poor quality of teachers in most of the private institutes lowers the quality of graduates. Most of the Indian Institutes lacks in high-end research facility, which are not funded well. Also there is a little or no contribution from the industry for the research projects, although they reap the fruits of technological development. The gap between industries and the higher education and research oriented institutions worsen the situation which is likely in case of developed countries like Germany and USA where 50% of their projects are funded by the industries. The government spending is low with 0.9% in the field of development of science, which is further slashed recently.

The country is not able to absorb the graduates from the apex institutes like the IIT's and IIM's. In general higher education became so profitable a business that the quality is lost along with quota system and politicization further adds fuel to the boiler. Teaching as a profession is not so attractive in the country is another reason for poor quality of delivery.

Recent proposals

Common entrance test, credit transfers, faculty and student mobility and a common syllabus are some of the recent measures taken to enhance the enrollment. Nationwide schemes like Swayam, Kushal, Gian etc are introduced along with online courses, e-libraries.

Suggested Reforms

A move towards a learning society requires a contribution from experts, highly skilled and best of the talent of the country to make the country a centre of global standard. Industry-academia connection ensures upgraded curriculum and necessitates skill development in the right direction. It will also attract funding for the projects which would encourage the culture of research and development in the country. Better incentivizing teachers and researchers, encouraging innovative practices and best utilization of science and technological development to contribute the growth of economy, improving health and making life easier for common people. Mobilizing the funds and investing more in research and development. It needs student centric education and dynamic curriculum, updating it with the changing global requirement.

Topic 20. Short Notes

Obstacles in Girls' Education

It is rightly stated that "*Educating a boy is educating a person... Educating a girl is educating a nation*".

Some of the major barriers which stand for girls education are as follows-

- Lack of consciousness amongst the female members to be educated.
- Lack of safe transportation for girls to go to school.
- Financial constraints in the family.
- Conservative mentality.
- The task of performing domestic duties at home such as cleaning, washing, etc.
- The lack of women teachers in primary and middle schools has been a major factor for low enrolment of girls.
- Unwillingness of many parents to send their daughter to mixed schools.
- Early Marriage age in many states acts as an obstacle.

Some of the major initiatives for promotion of girls' education include Beti Bachao, Beti Padhao; **Kasturba Gandhi Balika Vidyalayas (KGBV); Sarva Siksha Abhiyan. Further, the following suggestions you may write in your answers:**

- Serious efforts must be made by the government in collaboration with civil society wherein awareness must be created amongst the parents for promoting girls education.
- Use of media in portraying a positive image of women.
- Financial assistance to poverty stricken families.
- Counselling of parents and children from unprivileged families.

Community Schooling in India

The concept of community schooling can be traced back to ancient India. Social institutions like Ashram, Gurukula, Pathasala, Vihara,Vidyapeeth, etc. existed and still do exist which promote community schooling.

In community schooling, besides education, the all-round cultural development of the person, and formation of integrated moral character were the aims and objectives of educational processes.

Advantages of Community Schooling

- Community schools are run by local communities. Therefore, the possibility of corruption gets reduced greatly.
- In community schools, it is the community which will be responsible for recruiting the teachers and they can put it in their own money to recruit a better teacher if they can. The selection of teachers will be merit based and the teachers will be under continuous

monitoring by the community and there is a high level of accountability which comes inherently along with the concept of community schools.

- The needs of the children are the highest priority in community schools because it is largely parents or neighbours or relatives of the children who will be running the school.

Examples of Community Based Education

Muktangan

Muktangan was founded in the year 2003. It is a community-based education model, operating within the mainstream school educational system. Being more inclusive and child centric in nature, it is offering quality education to children in poor communities – those who are most likely to be left out in the rapid urban growth of India.

Global Pathways School

Village Community Schools (VCS) based in Toronto operates Global Pathways School (GPS) in India. It helps in building a new model for sustainable education and development.

Way Forward

Civil Societies and NGOs can help the communities to undertake community schooling much more efficiently.

No Detention Policy (NDP)

Recently, the Subramanian committee observed that the no detention policy in schools should be applicable till Class V and exams be held from Class VI onwards. Prior to this, the Vasudev Devnani committee had also recommended for its revocation.

Information about the Policy

Under this policy, the students up to class VIII are automatically promoted to the next class without being held back even if they do not get a passing grade. The policy was implemented as part of the *Continuous and Comprehensive Evaluation (CCE) under the RTE Act in 2010* to ensure all-round development of students. The concept of CCE imported from the West, which emphasises on evaluating a child through the year, and not just based on performance in one or two term exams.

How the policy backfired?

The basic objective behind this policy was to *prevent drop-outs*. The no detention policy in the RTE does not mean the abolition of assessment rather it calls for replacement of the traditional system of evaluation with continuous and comprehensive assessment that is non- threatening. The policy also intends to free the students from the pressure and fear of examination and give them a stress free academic environment and childhood.

However, somehow the policy has backfired on primary education system. The policy resulted in remarkable improvement in enrolments but then academic standard dropped down. No pass fail system means there is a negligence of children to study. Even parents started taking primary

education for granted because they know that their wards would be promoted to next class irrespective of their performance in examination. Same is with teachers. Earlier, failure of students would put a question mark on teacher's performance also; but now it does not make any difference, inviting a lax attitude in teachers too.

Public Expenditure in Education Sector

As per the norms of National policy on education (1986), at least 6% of the GDP must be spent on education. However, successive governments have failed to achieve this target and remained at around 4%. The Union Budget has allocated Rs 72,394 crore to education in 2016-17. Out of which, Rs 43,554 crore is allotted for school education and Rs. 28,840 crore for higher education.

- As education sector needs to be adequately funded, there should be a clearly defined pattern of sharing of funding between the Union and state governments. While central governments are increasing the allocation of funds to the education sector, many state governments are not substantially increasing the allocation for the education sector. It is the time to revise the goal, the central and state governments should spend at least 6% of the GDP towards this sector.
- It has to be ensured that the existing institutions are well developed and on sound resource base in terms of financial, physical and human resources before further expanding the education system with new schools, colleges and universities.
- Reasonable resources have to be allocated to teacher training, modern technology based equipments, libraries, laboratories and quality research.
- Resources to the educational institutions should be allocated in a way that it fulfils the basic needs on the one hand and rewards the performance of the institutions on the other hand.
- In the advanced regions of the world, high quality education systems have been developed exclusively by the state in case of school education. For Higher education, heavy public funding coupled with liberal funding by the society at large, especially through philanthropic donations and endowments from the corporate sector are relied upon. In these societies, fees paid by the students' forms a minor source of funds. In India too, this framework can be implemented by linking some of the provisions of the Corporate Social Responsibility Act to the education sector and innovative measures to promote individual and corporate donations has to be searched for.
- The profit seeking private institutions should not be promoted by the state as even though these institutions may be good but they may not help in building nation with values.
- The government should devise a 10-20 year national plan of funding of education. The plan

should be developed based on the principles of financing of education (adequacy, equity and efficiency) and should be capable of assuring steady flow of funds for the education sector at least for a period of 10-20 year with provisions for rewards and punitive action.

Keeping in mind, the historical and contemporary experience of many countries especially the developed, it is imperative for the state to play an active role in financing education at all levels. It should rely on resources from non-state actors only when needed and treat them only as a supplementary source of funding.

Suggested Amendment of RTE in Draft NEP 2016

There are several recommendations in the NEP 2016 which will call for amendment to the RTE Act. Some of the imbalances include-

- The draft NEP proposes merging of small, non-viable schools. This however clashes RTE's concept of neighborhood schools which must be located within one kilometer for children attending classes 1-5.
- NEP talks about school mapping which is in totally opposition of RTE's concept of child mapping but stresses that transportation must be arranged for children attending non-viable schools.

- The proposal to extend the 25 per cent economically weaker section quota in private schools to minority institutions will also need an amendment. The committee notes that number of schools claiming religious or linguistic minority status has increased tremendously. The proposal to extend the 25 per cent economically weaker section quota in private schools to minority institutions will also need an amendment. The committee notes that number of schools claiming religious or linguistic minority status has increased tremendously.The policy talks about extending 25 percent quotas for economically weaker section which is applicable in private schools to minority institutions.
- The RTE bans grade repetition till class VIII whereas the draft NEP wants to limit till Class V.

For successful implementation of the NEP, it is necessary to create a harmonious balance between the popular RTE Act. Also as it is a Constitutional obligation on the part of our country to ensure qualitative universal education, the NEP must strongly and visibly reaffirm the importance of public education.

General Knowledge Today

GS-II-18: Current Issues Related to Poverty and Hunger

Integrated IAS General Studies:2016-17
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Contents

Model Questions

1. Why defining poverty line is a controversial issue in India? Explain.
2. Why the calorie based model of estimation of poverty has been discarded in recent approaches? Discuss.
3. At present, whether a person is below the poverty line or not is measured on the basis of daily expenditure. What are flaws in this model? Do we have any other models to handle our flawed understanding of poverty? Discuss.
4. "In comparison to rural poverty, the urban poverty in India is both underestimated and inadequately addressed by public policy". Do you agree with this statement? While supporting your view with arguments, give policy suggestions.
5. "Poverty is a multidimensional concept". Discuss while elucidating about the Multidimensional Poverty Index (MPI).
6. Examine India's performance towards Millennium Development Goals related to poverty. What lessons can be learnt for achieving SDG-1 {End Poverty} from past performance? What are challenges India would be facing in achieving the SDG-I? Discuss.
7. Analyze the impact of Globalization, Liberalization and Privatization upon poverty in India.
8. "Terrorism will not end unless and until poverty is not taken care of". Discuss.
9. What are the differences between the SECC and NSS consumption-based poverty estimates? What is the rationale for having poverty estimates based on consumption estimates?
10. Have MGNREGA and TPDS (targeted public distribution system) done any good to poor in India? In what way can these schemes be harnessed better to reduce rural poverty?
11. Growing population is the cause of poverty or poverty is the main cause of population increase? Discuss.
12. What is the role of Self Help Groups in poverty alleviation? Explain.
13. Though here have been several different estimates of poverty in India, all indicate reduction in poverty levels over time. Do you agree? Critically examine with reference to urban and rural poverty indicators.
14. Establish relationship between land reforms, agriculture productivity and elimination of poverty in the Indian economy. Discuss the difficulties in designing and implementation of agriculture friendly land reforms in India.

Definition of Poverty and World Bank Benchmark

The Copenhagen Declaration at the "World Summit on Social Development" describes poverty as "*a condition characterized by severe deprivation of basic human needs such as food, shelter, safe*

drinking water, sanitation, health, education, and information".

Traditionally, World Bank has used $1.25 per person a day benchmark for "extreme poverty. This benchmark is based on the average of the national poverty lines of the world's 15 poorest countries. The $1.25 line was originally defined as the simple average of the national poverty lines for fifteen very poor countries. In 2015, the benchmark poverty line has been updated to $1.90 per person per day.

Estimation of Poverty Line in India: Background and Issues

India is home to over one-third of poor people in the world. If we add the poor of Pakistan and Bangladesh into it, we find that almost half of world poverty exists just these three nations. The next big concentration of poverty is in the sub-Saharan Africa. However, estimation of poverty has been a contentious issue in India. Historically, first estimation of a poverty line was done by Dadabhai Naoroji in 19th century, though he himself did not use the word "poverty line".

Dadabhai Naoroji

The history of poverty estimation in India goes back to 19th century when Dadabhai Naoroji's efforts and careful study led him to conclude *subsistence based poverty line* at 1867-68 prices, though he never used the word "poverty line". It was based on the cost of a subsistence diet consisting of 'rice or flour, dhal, mutton, vegetables, ghee, vegetable oil and salt'.

According to him, subsistence was what is necessary for the bare wants of a human being, to keep him in ordinary good health and decency. His studies included the scale of diet and he came to a conclusion on the subsistence costs based poverty line that varied from Rs.16 to Rs.35 per capita per year in various regions of India. At that time, per capita income of England was at Rs. 450. However, since necessities in India cost only about one-third as compared to England at that time, the real difference in terms of purchasing power parity was not fifteen times but only five times.

National Planning Committee

In 1938, Congress president Subhash Chandra Bose set up the National Planning Committee (NPC) with Jawaharlal Nehru as chairman and Professor K. T. Shah as secretary for the purpose of drawing up an economic plan with the fundamental aim to ensure an adequate standard of living for the masses. The Committee regarded the irreducible minimum income between Rs. 15 to Rs. 25 per capita per month at Pre-war prices. However, this was also not tagged something as a poverty line of the country.

First Planning Commission working group

The concept of the poverty line was first introduced by a working group of the Planning Commission in 1962 and subsequently expanded in 1979 by a task force. The 1962 working group

recommended that the national minimum for each household of five persons should be not less than Rs 100 per month for rural and Rs. 125 for urban at 1960-61 prices. These estimates excluded the expenditure on health and education, which both were expected to be provided by the state.

Y K Alagh Committee

Till 1979, the approach to estimate poverty was traditional i.e. **lack of income**. It was later decided to measure poverty *precisely as starvation* i.e. in terms of how much people eat. This approach was first of all adopted by the YK Alagh Committee's recommendation in 1979 whereby, the people consuming less than 2100 calories in the urban areas or less than 2400 calories in the rural areas are poor. The logic behind the discrimination between rural and urban areas was that the rural people do more physical work. Moreover, an implicit assumption was that the *states would take care of the health and education* of the people. Thus, YK Alagh eventually defined the first poverty line in India.

Lakdawala Formula

Till as recently as 2011, the official poverty lines were based entirely on the recommendations of the Lakdawala Committee of 1993. This poverty line was set such that anyone above them would be able to afford 2400 and 2100 calories worth of consumption in rural and urban areas respectively in addition to clothing and shelter. These calorie consumptions were derived from **YK Alagh** committee only.

According to the Lakdawala Committee, a poor is one who cannot meet these average energy requirements. However, Lakdawala formula was different in the following respects in comparison to the previous models:

- In the earlier estimates, both health and education were excluded because they were expected to be provided by the states.
- This committee defined poverty line on the basis of household per capita **consumption expenditure**. The committee used CPI-IL (Consumer Price Index for Industrial Laborers) and CPI- AL (Consumer Price Index for Agricultural Laborers) for estimation of the poverty line.
- The method of calculating poverty included first estimating the per capita household expenditure at which the average energy norm is met, and then, with that expenditure as the poverty line, defining as poor as all persons who live in households with per capita expenditures below the estimated value.

The fallout of the Lakdawala formula was that number of people below the poverty line got almost double. The number of people below the poverty line was 16 per cent of the population in 1993-94. Under the Lakdawala calculation, it became 36.3 per cent.

Suresh Tendulkar Committee

In 2005, Suresh Tendulkar committee was constituted by the Planning Commission. The current estimations of poverty are based upon the recommendations of this committee. This committee recommended to shift away from the calorie based model and made the poverty line somewhat broad based by considering *monthly spending on education, health, electricity and transport* also.

- *It strongly recommended target nutritional outcomes i.e. instead of calories; intake nutrition support should be counted.*
- *It suggested that a uniform Poverty Basket Line be used for rural and urban region.*
- *It recommended a change in the way prices are adjusted and demanded for an explicit provision in the Poverty Basket Line to account for private expenditure in health and education.*
- *Tendulkar adopted the **cost of living** as the basis for identifying poverty.*

The Tendulkar panel stipulated a benchmark daily per capita expenditure of Rs. 27 and Rs. 33 in rural and urban areas, respectively, and arrived at a cut-off of about 22% of the population below poverty line. However, this amount was such low that it immediately faced a backlash from all section of media and society. Since the numbers were unrealistic and too low, the government appointed another committee under Prime Minister's Economic Advisory Council Chairman C. Rangarajan to review the poverty estimation methodology. Brushing aside the Tendulkar Committee. Rangarajan committee raised these limits to Rs. 32 and Rs. 47, respectively, and worked out poverty line at close to 30%. With estimates of Rangarajan committee, Poverty stood at around 30% in 2011-12. The number of poor in India was estimated at 36.3 crore in 2011-12.

Current Status: Arvind Panagariya Task Force

The discussion about Lakdawala Formula, Suresh Tendulkar Committee and Rangarajan Committee make it clear that defining a poverty line in India has been a controversial issue since 1970s. The latest poverty line defined was by Rangarajan Formula. However, this report also did not assuage the critics. The new NDA Government turned down this report also.

To define the poverty line, The NDA Government had constituted a 14-member task force under NITI Aayog's vice-chairman Arvind Panagariya to come out with recommendations for a realistic poverty line. After one and half years work, this task force also failed to reach a consensus on poverty line. In September 2016, it suggested to the government that another panel of specialists should be asked to do this job {if defining poverty line}. Informally, this committee supported the poverty line as suggested by Tendulkar Committee.

Why defining poverty line is a controversial issue?

Most of the governments have mothballed the reports of commmittees and panels because this issue is not only politically sensitive but also has deeper fiscal ramifications. If the poverty threshhold is

high, it may leave out many needed people; while if it is low, then it would be bad for fiscal health of the government. Third, there is a lack of consensus among states too. We note that some states such as Odisha and West Bengal supported the Tendulkar Poverty Line while others such as Delhi, Jharkhand, Mizoram etc. supported Rangrajan Line. Thus, no one, including NITI aayog wants to bell the cat when it comes to count number of poor in the country.

How poverty is measured in other countries?

In most of European countries, a family with net income of less than 60% of a median net disposable income is counted as poor. In United States, poverty line represents the basic cost of food for a family multiplied by three. A family is counted as poor if its pre-tax income is below this threshold.

Issues with Calorie Based Model

Average per capita calorie intake has been extensively used to assess the extent of poverty in India. The 1993 Lakadawala Committee used this approach and fixed a threshold daily calorie intake per capita at 2,400 and 2,100 calories for rural and urban populations, respectively. The definition of the poverty line, in nominal terms, is the per capita expenditure which enables a household to afford that specified poverty line basket. Households with a lower income are categorized as calorie-deprived and, hence, under the poverty line. This approach has been discarded now because of several limitations of this approach.

Firstly, the most important limitation of this approach is that there is hardly any consensus on the subsistence calorie threshold. Then, there is a change in calorie norms over time, which makes it harder to press for a uniform calorie threshold. It has been demonstrated that the per capita calorie consumption has been declining in India for last 3 decades despite of increase in real wages. Thus, the calorie requirements norms would need frequent changes. Moreover, the absorption of calories from food items depends on various characteristics of an individual, for example his health status, metabolic rate and fitness level etc. Most of these characteristics are unobservable and difficult to measure. For example, a person with some stomach disorder may have to consume a larger amount of food items compared to a healthy individual for obtaining a definite level of calories. If we use the same calorie threshold for a person suffering from a stomach disorder and a healthy individual, we either underestimate the extent of poverty among the persons with stomach disorder or overestimate the degree of poverty among the healthy individuals. *Secondly*, this threshold calorie approach also does not take into account the non-nutritional attributes of the food such as taste. It is not the calorie content that makes a householder select her food basket, taste also matters a lot. Thus, what may be a sufficient item with respect to calorie content, may not be suitable with respect to taste or some other non-attributable aspect. *Thirdly*, it has been indicated that there is not a very

strong link between the income of a household and calories consumed by members of this household.

Thus, the poverty estimates could be arbitrary if we consider the poverty line basket and per capita calorie consumption.

Multidimensional Aspect of Poverty

Poverty is multidimensional. It extends beyond money incomes to education, health care, political participation and advancement of one's own culture and social organization.

The major issue with the simplistic one-dimensional approach to the poverty line measures is that it reduces to *consumption expenditure alone* and does not tell anything about the nature of poverty. Being poor is being poor in capabilities and not in income only. If the freedom and capabilities of poor are enhanced, they can come out of poverty on their own by eliminating deprivations.

Further, when poverty is seen as an income issue, it seems that economic growth can only eradicate it. But, it has been seen that economic growth alone is not sufficient to eradicate all poverty. In this context, the ideas of Amartya Sen are worth note here.

In his book Development as Freedom, Amartya Sen offered a comprehensive approach to development, regardless if it is a rich or poor society because there is always scope for expansion of freedom and capabilities. For example, the US need to "develop" further by expanding the freedoms of the black and Hispanic by eliminating discrimination, promote drug, arms, violence and terror free society, and expand people's capabilities by encouraging higher education. It also needs to promote good health to eliminate what is called lifestyle diseases of the rich and improve capabilities of its 15% poor.

Similarly, for sub-Saharan Africa, development should mean galvanizing economic and industrial growth and ensuring freedom from hunger and malnutrition. For a large democracy like India, development should focus on removing economic, social and gender inequalities and providing universal education and food security.

Thus, in last two decades, a new perspective has emerged which says that poverty must be seen in a more comprehensive manner as a **lack of human development.** Economic growth is certainly important, but only as a tool and not as an end in itself. According to this thinking, poverty is not just "low consumption". It can cause early death, chronic under nourishment, illness and illiteracy. Unemployment is yet another deprivation because it contributes to social exclusion…to losses of self-reliance, self-confidence and psychological and physical health. Thus, Poverty is multidimensional. It extends beyond money incomes to education, health care, political participation and advancement of one's own culture and social organization.

Thus, poverty is a state of deprivation which has multiple dimensions. Trying to measure it in terms of income alone is grossly inadequate. The poor are in fact deprived of capabilities which may originate from several sources: personal, social and political. It can only be measured using some multidimensional approach, for example the multidimensional poverty index (MPI).

Multidimensional Poverty Index (MPI)

The UNDP views poverty as a state of **multiple deprivations** and measures it with a multidimensional poverty index (MPI). This approach recognizes that the poor experience several forms of deprivation for example poor health, lack of education, inadequate living standard, lack of income, social exclusion, disempowerment, poor quality of work and lack of security from exploitation and violence etc. etc.

Thus, UNDP assesses *three vital dimensions of poverty* viz. **education, health, and living standard** – through ten indicators and provides both the extent and nature of simultaneous deprivations people are facing. It uses **micro data from household surveys**, as basis of deprivation of Cooking fuel, Toilet, Water, Electricity, Floor, Assets. Each person in a given household is classified as poor or non-poor depending on the number of deprivations his or her household experiences. These data are then aggregated into the national measure of poverty.

Poverty and SDG-I {End poverty}

Amongst the 17 sustainable development goals (SDGs), the goal 1 relates to ending poverty in all its forms everywhere by 2030 and transform the world.

Background

More than 700 million people still live in extreme poverty and are struggling to fulfil the most basic needs like health, education, and access to water and sanitation, to name a few. The overwhelming majority of people living on less than $1.90 a day live in Southern Asia and sub-Saharan Africa and they account for about 70 per cent of the global total of extremely poor people. Lower middle-income countries, including China, India, Indonesia and Nigeria, are home to about half of the global poor. Right now there are 30 million children growing up poor in the world's richest countries.

MDGs and Poverty

The Millennium Development Goals (MDGs) were the eight international development goals for the year 2015 that had been established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration. Amongst the 8 goals, eradicating extreme poverty and hunger was the first goal.

India has been moderately successful in reducing poverty. In 1990, the all India Poverty Head Count Ratio (PHCR) was estimated to be 47.8%. In order to meet the 2015 target, the PHCR level has to be

23.9%. In 2011-12, the PHCR was 21.9%. This indicates that, India has achieved the poverty reduction target, however, progress is uneven. This was a result of both: economic growth (including in agriculture) as well as increased social spending on interventions such as MGNREGA and the National Rural Health Mission (NRHM). Nevertheless, estimates from 2012 reveal that, over 270 million Indians continue to live in extreme poverty – making the post-2015 goal of eliminating extreme poverty by 2030 challenging, but feasible.

Takeaways from MDGs

- A high-level political commitment globally and nationally was integral to the much achieved success of the goal of eradication of poverty to some extent.
- The MDGs did not capture the economic benefits of good health nor the direct financial consequences of ill-health. As in when people fall sick there is high out-of-pocket expenditures on healthcare which leads to financial hardship and diminish the ability of the population to contribute to the economy.
- Also, the MDGs did not capture the importance of prevention, early detection and response to disease threats.

About SDG-1

The SDG-1 is all about the following:

- By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day
- By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
- Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable
- By 2030 ensure that all men and women, particularly the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership, and control over land and other forms of property, inheritance, natural resources, appropriate new technology, and financial services including microfinance
- By 2030 build the resilience of the poor and those in vulnerable situations, and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters
- Ensure significant mobilization of resources from a variety of sources, including through enhanced development cooperation to provide adequate and predictable means for developing countries, in particular LDCs, to implement programmes and policies to end poverty in all its dimensions

- Create sound policy frameworks, at national, regional and international levels, based on pro-poor and gender-sensitive development strategies to support accelerated investments in poverty eradication actions

Challenges India would be facing in achieveing the SDG-1

- ***Defining Indicators***: Setting up of relevant indicators to measure outcomes.
- ***Financing SDGs***: Implementing of SDGs in India by 2030 would be costing around US$14.4 billion. There has been a cut by the union government in the social sector schemes, this would be creating an issue. For SDGs to be a reality, states devotion would be a necessity.
- ***Monitoring and Ownership:*** It is noted that NITI Aayog would play a significant role in tracking progress of the SDGs. However, NitiAayog is burdened with a lot tasks, therefore monitoring becomes an issue.
- ***Measuring Progress***: Measuring of progress or achievement of the SDGs is also a question mark.

Therefore, for the SDGs to be a success, co-operative federalism in true spirit would be required. SDGs belong to everyone. Therefore an active role by academics, civil societies, media, volunteers, etc can be played to make the dream a reality.

Analysis: Urban Poverty versus Rural Poverty in India

Earlier, poverty was only looked upon as a rural phenomenon. However, India faces problem of both rural poverty as well as urban poverty. *This was one of the grounds on which Rangarajan Committee reported on urban poverty and rural poverty separately and did not construct a same basket like the Tendulkar Committee.*

Income poverty is defined as not having enough money to provide basic food, shelter or clothing. The cumulative harmful effects of poverty include greater exposure to environmental toxins such as, alcohol, tobacco and lead, less nutrition, excessively crowded and noisy living arrangements, less parental involvement in school, less cognitive stimulation, residential instability, negative, harsh and unresponsive parenting, exposure to aggressive peers, family instability and divorce, lack of parental monitoring, lack of maternal emotional support and weaker social ties.

In rural areas, there is less sophisticated medical care, the towns are spread out, further away from intervention services and often there is little to no public transportation. People living in these areas are less likely to have strong academic backgrounds- they may not have graduated from high school.

The International Monetary Fund (IMF) states that poverty involves deprivation, vulnerability and powerlessness. These characteristics are felt by some immensely and by some in a mild form.

The IMF in 2014 had stated that 63 percent of the world's impoverished live in rural areas.

Education, health care and sanitation are all lacking in rural environments. This all causes rural poor to move to cities, which further leads to a phenomenon of urban poverty.

The pay in rural areas is low and erratic. The rural poor often suffer more than the urban poor because public services and charities are not available to them.

Several factors tend to perpetuate rural poverty. For example, political instability and corruption, customs of discrimination, unregulated landlord/tenant arrangements and outdated economic policies often make it impossible for the rural poor to rise above poverty lines.

The World Bank had found that urban populations in developing countries is growing rapidly. Residents of rural areas flock to cities for the perceived wealth of economic opportunities, but often, those dreams fall short. This leads to urban poverty, crime, development of slums, trafficking, etc.

Also in urban areas the jobs require certain skills which the migrants from rural areas usually lack. This further deteriorates their conditions. Their dreams fall short and the vicious cycle of poverty perpetuates.

Without an income, the urban poor often find themselves in inadequate housing with poor safety and sanitation. Additionally, health and education packages are limited. Crime and violence are also much more rampant in urban settings than in rural ones, threatening the authority of law enforcement and the peace of mind of city dwellers.

The World Bank Group adopted two goals that will drive its work going forward: ending extreme poverty by 2030 and promoting shared prosperity for the poorest 40 percent in developing countries. However, for this dream to be a reality, within the national borders, the urban poverty and rural poverty must end.

Therefore, it can rightly be said that poverty is urbanising and is no longer limited to rural boundaries.

Government's efforts through National Rural Livelihoood Mission which is targeting the rural poor and National Urban Livelihood Mission which targets the urban poor need to be channelized more vigorously and poverty must be destroyed.

Poverty and Globalization

India embraced liberalisation, privatisation, globalisation (LPG) in 1991. Embracing globalisation has been a mixed experience for India.

Poverty & Globalization

It is observed that Poverty rates around the world have decreases as more countries continue integrating into the global economy.

Globalization opens markets, spreads the use of new technology, and expands division of labour.

Division of labour helps societies grow economically. When countries become a part of a more globalized economy, they are able to more finely tune their comparative advantage. This leads to greater productivity and unlocks flourishing in the long run as countries are able to trade goods and services with one another freely. Large numbers of people have been raised out of extreme poverty over the past few decades, particularly in India, China, and Indonesia. Between 1981 and 2001 the percentage of rural people living on less than $1 a day decreased from 63 to 42 per cent in India. Globalization has helped these countries develop by integrating their economies with the rest of the world. The openness of these countries has provided their poor with greater access to capital, knowledge, and opportunities.On the positive side, Globalization gives rise to the creation, production, distribution and consumption of goods and services on an unprecedented scale. That process is meant to increase economic activity for people, enterprises and countries through free international trade, direct foreign investment, and capital market flows.

For a capital deficient economy globalisation means opening up new avenues of investment and utilization of untapped natural resources and latent energies.

Globalization makes the world closer and creates a lot of opportunities for many people.

However, industries and jobs may be displaced in the short run as a result of globalization and trade as economies begin to experience growth, but, in the long run, both employment opportunities and consumption will increase.

On the flip side, globalization created opportunities only for the skilled or wealthy people. This increases the inequality between the rich and poor. This has made urban poor lives much harder, and caused the creation of slums. On top of that, unhealthy process of urbanization is causing the deficiencies in the basic services such as housing, water supply, sanitation. This eventually made the poor as worst victims.

With globalisation, a trend of establishing industries in the rural areas has started as the availability of land is cheaper as well as unorganized labour. This may sound fruitful but because of the pollution from the industries, lives of the rural people have deteriorated.

On the whole, globalisation has a lot to offer especially for the developing countries due to it providing more job opportunities and experience has shown that countries which take part in the global economy are experiencing more economic growth and poverty reduction than those countries which remain in isolation.

Analysis: Poverty and Terrorism

Experts have noted recently that the failure to provide opportunities which leads to poverty coupled with misreading of religion has helped fuel terrorism worldwide. Extreme poverty is

the greatest humanitarian crisis of our time and a fundamental contributing factor to 21st century terrorism and insurgency.

Nobel Peace Prize Laureate Archbishop Desmond Tutu said, "*You can never win a war against terror as long as there are conditions in the world that make people desperate — poverty, disease, ignorance.*" Also the Former U.S. Secretary of State General Colin Powell stated, "*We can't just stop with a single terrorist or a single terrorist organization; we have to go and root out the whole system. We have to go after poverty.*"

In the aftermath of 9/11, World Bank had stated that terrorism will not end unless and until poverty is not taken care of.

One of the motive behind terrorist activities is money which is due to poverty. Lack of opportunities employment wise leads to anger and frustration and is compounded by a sense of injustice. When the gap between rich and poor widens, the impoverished majority are more likely to consider their situation as a function of either indifference or criminality by those controlling the wealth. A classic example of such an offshoot is of Nigerian terrorist group, Boko Haram.

Extreme poverty is more than the lack of material resources necessary to meet an individual's basic needs. It is the lack of opportunity for the individual to make meaningful choices that will sustainably improve her life. Choice is powerful and opens the door to hope, opportunity, change, and a better future.

The reality is that terrorists and insurgencies cannot function without the support of the communities in which they operate. Studies have shown that they earn this support by providing social services for their often impoverished constituency. But the services provided by these organizations come at a great cost to the community – including economic oppression and coercion into violent activities – which perpetuates the cycle of extreme poverty. For instance, the Terrorist organizations have the tactic of organising community development activities. Example can be cited of Taliban build madrassas to offer free education to the poor in Pakistan and Afghanistan.

However, terrorist activities cannot be only linked to poverty. Osama bin Laden was the son of a wealthy Saudi construction magnate. But the soldiers who blow themselves up along with innocents around them – are disproportionately drawn from the poor underclass, the idle youth with few prospects for employment.

The need of the hour is to support democracy in true spirit. Reformists projects must be undertaken and importance must attributed towards investments in order to create job opportunities, stressing the necessity of adopting new policies and setting a good environment for investment to flourish.

Efforts such as *Nuru International* which exists in Kenya must be undertaken. Nuru International is a holistic community-based development model. Its mission is to end terrorism by ending extreme

poverty.

Poverty and Socio Economic Caste Census (SECC)

The 1st ever post independence Socio-Economic and Caste Census (SECC) was conducted in 2011. Government released the results of SECC-2011 in July 2015. SECC-2011 was first caste based census of Independent India. Earlier, caste based data was collected in 1931 Census. Government would use SECC-2011 data in all programmes such as NFSM, MGNREGA, Deen Dayal Upadhyaya Grameen Kaushalya Yojana etc and to identify the beneficiaries of direct benefit transfer (DBT) under the JAM (Jan Dhan-Aadhaar-Mobile) Trinity.

Objectives

The key rationale behind conducting a socio-economic and caste census was to assess the population that is actually below the poverty line (BPL).

Key Findings

- Out of the 24.4 crore households in India, 17.9 crore live in villages, which is 73.3% of all households in India. Out of these, 10.7 Crore households are deprived. Close to 30% rural households are landless and do the manual causal labour for bread winning.
- 13% live in one room huts (with kacha walls or roof) and 22% of them are from SC/ST category.
- More than half (56%) rural households in India are landless.
- 36% rural people are illiterate in India. This figure was recorded 32% in Census 2011. Out of the remaining 64% literate, around 20% have not completed primary school.
- 35% of urban Indian households qualify as poor Around 1.80 Lakh households are still engaged in manual scavenging for livelihood.

Discussion

Our country has always struggled to define who is poor. Despite of so many committees formed over the last many decades, there has never been a correct insight into who are the legitimate beneficiaries of the welfare schemes. Further, the official estimates of the poor have always tended to underestimate the number of poor in comparison to the estimates done by international organizations such as World Bank. In this context, the SECC data seems to quite enlightening and innovative. The use of various deprivation factors and automatic exclusion make it free from controversy. Further, its finding are different from what official estimations of rural as well as urban poor by different committees had been so far.

Extent of Rural Poverty

The key finding of the SECC-2011 is that rural India is poor. The main breadwinner of the 74.5%

rural households in India earns less than Rs. 5000 per month. This ratio is even higher in states such as West Bengal (82.4%), Madhya Pradesh (83.52%) and Chhattisgarh (90.79%). However, SECC data needs to be adjusted for tendency of the rural people to not to tell correct income in fear of losing some entitlement benefits. However, despite we do all adjustment, there is no doubt that deprivation levels in rural India are still far too high. Extent of Urban Poverty According to SECC-2011, 35% of urban households are poor (below BPL). This figure is in striking contrast with the earlier estimates that ranged from 13.7% as per Tendulkar committee methodology, while 26.4% as per Rangarajan formula. Here, we should note that SECC numbers have greater credibility as the data has been collected via door-to-door enumeration. However, in urban areas also, there may be a tendency to understate income and asset ownership. How SECC can help? The decadal Census focuses on individuals while SECC has focussed on households. The data would be helpful for states and centre to target the most needy of the DBT and other schemes. Since SECC has also included the homeless, there is a chance that a large number of hitherto excluded people are brought into the welfare schemes of the government. Further, the caste data might be helpful on if the policy of reservation has really helped the most downtrodden of India. Further, with SECC data, the writing on the wall is clear. The SECC makes case for a paradigm shift in the economic policy making and budget allocation both by central and union governments. At the core of it, the policy making needs to be decentralized and include the most downtrodden people.

Questions & Answers

Poverty and SECC Link must be analyzed in the light of the below questions:

- *Do we really need caste census data to estimate poor?*
- *What are the differences between the SECC and NSS consumption-based poverty estimates?*
- *Is SECC is an innovation to determine the poverty levels?*
- *What is the rationale for having poverty estimates based on consumption estimates?*
- *What necessitates the conduction of SECC?*

Do we really need caste census data to estimate poor?

Experts have stated that the SECC is an unreliable and time-consuming strategy there already exists a whole lot of information available through the National Sample Surveys on consumption expenditure, undertaken every five years—very useful for identification of the poor. T

Also the Tendulkar committee (2009) and the Rangarajan Committee (2014) have come out with poverty lines and NITI Aayog is in the process of making further improvements on them.

What are the differences between the SECC and NSS consumption-based poverty estimates?

In 2015, the government had released data from the Socio-Economic Caste Census (SECC) 2011 stating that SECC data will alone be enough to estimate poverty and deprivation. However, there

already exists consumption-based poverty estimates using NSS (National Sample Surveys) data.

NSS-based estimates are per capita, while the SECC data refer to households.

The SECC would be important for the identification of beneficiaries of programmes while NSS-based estimates would be useful for assessing changes in levels of living at the macro level over time.

Is SECC is an innovation to determine the poverty levels?

In India, we have a long history of studies on the measurement of poverty. The methodology for the estimation of poverty used by the erstwhile Planning Commission was based on recommendations made by various expert groups.

In June 2012, the government of India appointed an expert group with C. Rangarajan as chairman to take a fresh look at the methodology for the measurement of poverty.

The Rangarajan expert group has gone back to the idea of separate poverty line baskets for rural and urban areas, unlike the Tendulkar Committee, which took urban poverty as a given and used it as the common basket for rural and urban households.

Poverty estimates provide the proportion and size of the poor population and their spread across states and broad regions. But they cannot be used for identification of the individual poor, which is necessary to ensure that the benefits of programmes and schemes reach only the deserving and targeted group.

With respect to the identification of the poor, BPL (below poverty line) censuses were conducted. The first two BPL censuses (conducted in 1992 and 1997) and the third BPL census was conducted in 2002.

Therefore, SECC 2011 is simply a continuing process and there is nothing new about it.

What is the rationale for having poverty estimates based on consumption estimates?

Firstly, it is the mindset of the people. According to people, being rich or poor is associated with levels of income. *Secondly,* historically, the number of identified poor based on successive BPL censuses in rural areas has differed widely from the measured poverty. For example, the percentage of households identified as poor in the first BPL census in 1992 was nearly twice the poverty ratio estimated by the Planning Commission. Usually, the poor households identified through these censuses contain a mix of poor and non-poor, for which there could be several reasons. One of the main reasons behind such a mix-up is the fact that people know beforehand that the census is going to decide the status of the household as poor or non-poor, and therefore its entitlement. *Thirdly,* the deprivation criteria by themselves do not indicate the level of poverty. A judgement has to be made as to whether the number of deprivations taken together constitute a measure of poverty. This can be highly subjective.

What necessitates the conduction of SECC?

The only reason why a SECC becomes important today for India is it is broader and dynamic definition of poverty. The SECC measures deprivation along seven criteria — households with only one room with no solid walls and roof, those with no adult member aged 15-59, female-headed households with no adult male aged 15-59, those with differently abled members and no able-bodied member, SC/ST households, those with no literate member above the age of 25, and landless households deriving a major portion of their income from manual casual labour.

Such a broader outlook was not held before and therefore a SECC becomes important for the India today.

Poverty and State Of Food and Agriculture (SOFA) by FAO 2015

FAO had released the SOFA in 2015. It highlights the status of agriculture and food in the counties. Through the SOFA, FAO brings out a positive co-relation between social protection measures and eradication of poverty and hunger and agriculture.

Background

- The Millennium Development Goals (MDGs) pertaining to reducing poverty have been met by most of the countries. However, many are lagging behind and the post-2015 challenge remains to be full eradication of poverty and hunger.
- FAO noted that a majority of 72 out of 129 of the countries have achieved the Millennium Development Goal target of halving the prevalence of undernourishment by 2015. However, developing regions as a whole are missing the target by a small margin.
- FAO has also noted that 29 countries have met the more ambitious goal laid out at the World Food Summit in 1996, wherein the governments committed to halving the absolute number of undernourished people by 2015. World Bank in 2015 has stated that the share of people in developing countries living in extreme poverty has fallen from 43 per cent in 1990 to 17 per cent in 2015.
- Some 795 million people continue to suffer from hunger according to The State of Food Insecurity in the World 2015 stated FAO and almost one billion people live in extreme poverty as noted by World Bank in 2015.
- In 2013, social protection helped lift up to 150 million people out of extreme poverty.

Questions and Answers

Few questions and answers related to this topic are as follows:

- *What is social protection?*

- *What are recommendations of SOFA on Fertilizer subsidies?*
- ***Have MGNREGA and TPDS (targeted public distribution system) done any good to India? In what way can these schemes be harnessed better to reduce rural poverty?***
- ***Social protection Measures can lead to women empowerment. Discuss.***
- ***How the SOFA report points out to Gender differentiation emanating from social protection measures?***
- *What is importance of Social Protection measures?*

What is social protection?

Social protection incorporates those initiatives which provide cash or in-kind transfers to the poor, protect the vulnerable against risks and enhance the social status and rights of the marginalized. The overall goal of social protection remains reduction of poverty and economic and social vulnerability. The major components of Social protection include:

- Social assistance
- Social insurance
- Labour market protection

It is believed that throughout the developing countries in the world, about *2.1 billion people, or one-third of the population*, receive some form of social protection. However, there remains to be variation among regions in receiving social protection and therefore these vulnerable regions live in abject poverty.

What are recommendations of SOFA on Fertilizer subsidies?

The SOFA Report 2015 by FAO has stated that Fertilizer subsidies need complementary interventions in order to effectively promote pro-poor growth. Fertilizer subsidies are no doubt a success story in Asian countries like India, Bangladesh and in fact a necessity to promote agriculture. It is stated that Asian countries spend large amounts of public funds on subsidizing fertilizer as it contributes to rapid growth in food production and the noted Green Revolution.

However, what is focussed is only input subsidies, what is needed is that it is needed to be accompanied by large-scale expenditures on research and development, extension services, irrigation, rural roads and development of fertilizer markets.

Therefore, the need of the hour is that fertilizer subsidies should not be seen as a magic bullet for sustained agricultural growth. Rather, they should be made a part of a package of investments to be effective.

Have MGNREGA and TPDS (targeted public distribution system) done any good to India? In what

way can these schemes be harnessed better to reduce rural poverty?

MGNREGA is considered to be the world's largest anti-poverty programme which is meant to provide adult members of rural households willing to do unskilled manual work a number of days of employment. In 2010-11, the programme covered 55 million rural households.

However, MGNREGA's performance varies significantly across states. For instance in Bihar, a study has proved that the programme could potentially reduce poverty in the state by 14 percentage points, but that its actual impact was only a meagre one percentage point.

Coming to India's Targeted Public Distribution System which is an example of food price subsidy, it is noted that the TPDS reached about 45 per cent of the population in 2010–11.

To make such flagship programmes a success, a nationwide commitment is needed accompanied with awareness of the schemes amongst the masses and curbing the loopholes in the system which pose as obstacles for successful delivery of the benefits.

Social protection Measures can lead to women empowerment. Discuss.

It is largely believed that social protection schemes help to empower women and make them self-sufficient. It is largely due to the inclusion of women in the programmes and the monetary assistance they receive. In rural households, women receiving the transfers can play a significant role towards agriculture and other allied activities.

An example can be cited of Bangladesh Rural Advancement Committee's (BRAC's) CFPR-TUP (Challenging the Frontiers of Poverty Reduction—Targeting the Ultra Poor). This programme targets poor rural households and provides women in these households with productive assets, primarily livestock.

In this programme, the rural households are provided with savings services, weekly home visits and training on as to how to use assets, health and hygiene matters, basic skills and literacy, as well as general support and counselling which includes how to handle gender violence, early marriage and dowry pressures.

How the SOFA report points out to Gender differentiation emanating from social protection measures?

The SOFA report has pointed out the differences of social protection gender wise wherein the women and men use social protection transfers differently. It generally is observed that social protection programmes target women because the report believes that when a women is receiving the social protection transfer, she is in better position of controlling household expenditures and would invest the transfers on food, health, education, children's clothing and nutrition, which ultimately would improve overall human resources.

Also, the report has highlighted that transfer programmes have unexpected impacts that vary with

gender. For instance, men and women may not invest in the same type of livestock. While women generally seem to prefer small livestock such as goats, sheep, pigs and poultry, men prefer larger livestock such as cattle, horses and camels.

What is importance of Social Protection measures?

The SOFA 2015 has pronounced the importance of social protection in order to reduce poverty and improve agricultural productivity. Its importance is summarised below:

- Social protection programmes help to reduce poverty and food insecurity if it is accompanied by effective targeting and adequate transfers.
- Social protection stimulates investment in agricultural production and other economic activities.
- Social protection enhances nutrition, health and education, with implications for future productivity, employability, incomes and well-being.
- Social protection gives beneficiaries greater choice, and many shift time previously dedicated to casual agricultural wage employment of last resort to own farm work or non-agricultural employment.
- Social protection has an impact on local communities and economies. Public works programmes can provide important infrastructure and community assets and, when designed and implemented properly, contribute directly to the local economy.
- Cash transfers increase the purchasing power of beneficiary households.

Looking Forward

The State of Food and Agriculture (SOFA) 2015 advocates the need of social protection measures in order to break the cycle of rural poverty and vulnerability. However, it will be a success when combined with broader agricultural and rural development measures supported by political commitment.

A national vision is needed of how agriculture and social protection can gradually move people out of poverty and hunger. National vision and commitment, supported by permanent domestic resource mobilization, must support coordinated action at the national and sub-national levels.

Global Hunger Index 2015

The 2015 GHI was calculated for 117 developing countries and countries in transition, 80 of which with alarming or serious hunger levels. The focus of GHI 2015 was on armed conflict and its relation to hunger. The Index was adopted and further developed by the International Food Policy Research Institute (IFPRI), and was first published in 2006 with the Welthungerhilfe, a German non-profit organization (NGO). Since 2007, the Irish NGO Concern Worldwide joined

the group as co-publisher.

What is the Global Hunger Index?

The Global Hunger Index (GHI) is a tool designed to comprehensively measure and track hunger globally, regionally, and by country. Every year, the International Food Policy Research Institute (IFPRI) calculates GHI scores in order to assess progress, or the lack thereof, in decreasing hunger.

Interpreting a GHI score

An increase in a country's GHI score indicates that the hunger situation is worsening, while a decrease in the score indicates improvement in the country's hunger situation.

Four components in the GHI formula

The four components in the GHI are:

- **Undernourishment**
- **Child wasting**: the proportion of children under the age of five who suffer from wasting (low weight for their height, reflecting acute undernutrition);
- **Child stunting**: the proportion of children under the age of five who suffer from stunting (low height for their age, reflecting chronic undernutrition);
- **Child mortality**: the mortality rate of children under the age of five (partially reflecting the fatal synergy of inadequate nutrition and unhealthy environments).

Conflict trap and poverty

- Eleven million people were uprooted by violence in 2014.
- An average of 42,500 people per day fled their homes in 2014. A
- Displaced people spend an average of more than 17 years in camps or with host communities.
- It is observed that conflict has ripple effects on human welfare. Countries which repeated violent conflict experience higher levels of under-nutrition, reduced access to education, and much higher infant mortality than stable countries of similar economic standing.

India and GHI

- India is ranked 29 score in 2015 from 38.5 in 2005 and ranked at 80 out of 104 countries in the Global Hunger Index 2015. A lower number means fewer people are going hungry.
- Wasting in children in the country fell from 20% in 2005 to 15% in 2014, and stunting fell from 48% to 39% in the same period.
- It is largely due to the efforts of the government of India through its nutrition-specific interventions over the past decade, including expansion of Integrated Child Development Services (ICDS) program which aims to improve the health, nutrition, and development of children.
- However, the progress is not even throughout the country. It is observed that in India open

defecation contributes to illnesses that prevent the absorption of nutrients.

Hunger Leads to Conflict

The GHI 2015 has stated that there is a strong co-relation between Conflict and hunger. According to the 2014 Global Hunger Index, countries Burundi, Comoros, Eritrea, Sudan and South Sudan, and Timor Leste which are engaged in continuous war like situation are facing under-nutrition.

Hunger in the form of famine, chronic malnutrition, or general deprivation also leads to conflicts.

The solution to end hunger and ultimately conflict is to improve the governance structure which will ultimately end conflict, poverty, and hunger.

Two tasks stand out for eliminating conflict-related hunger. First, we need stronger mechanisms to prevent and resolve conflicts. Second, we must activate the international emergency relief system to dispatch large-scale food aid where it is needed most. We also need political leadership to strengthen international food security policy.

What is making India as a country go hungry

In India, largely people are going hungry due to administrative set up. The Indian government, as well as its state-level counterparts, does not have sufficient cold storage facilities and as a result almost 40% of all vegetables and fruits produced in India and 20% of the food grains rot and never reach the market. This forces the sellers to raise the prices and put it beyond the reach of most. The below poverty line (BPL) families spend 70% of their income on food. In case of families that are above poverty line (APL) the amount goes up to 50%.

India talks about co-operative federalism between centre and state. If India wants to come out of the hunger trap, it is the need of the hour that co-operative federalism is practiced in spirit. Also infrastructure facilities need to be put in place such as cold storage facilities in order to store the food grains and deliver to the needy.

2016 Global Nutrition Report

The 2016 Global Nutrition Report (GNR) was released recently providing an independent and annual review of the state of the world's nutrition. The vision of the GNR is "From Promise to Impact- Ending malnutrition by 2030.

Background

The recently announced Sustainable Development Goals (SDGs) and the United Nation's declaring of the coming decade as the 'The Decade of Action on Nutrition' shows that there is renewed awareness and commitment to tackling the varied challenges of malnutrition.

India and the issue of nutrition

According to the Global Nutrition Report:

- India ranks 114th out of 132 countries in stunting among children aged less than five years.

- Anemia among women is also a cause of concern as India ranks 170th among 185 countries.
- India is off the track on all targets related to malnutrition, except overweight among under-5 children.
- Overweight and obesity among adults has been increasing and is a matter of grave concern. In India, 22% of adults are either overweight or obese and 9.5% suffer from diabetes.
- Under-5 stunting (low height for age) is 38.7%, putting India in the 34th position among 39 Asian countries. Even for under-5 wasting (low weight for height), India ranks 35 out of 38 countries in Asia.
- Nearly 48% of women in India are anemic, which is better than only two other countries in Asia.

Suggestions to tackle Malnutrition in India

- political commitment
- setting targets and accountability standards
- addressing social exclusion
- the need for an India Nutrition Report (INR)
- finding solutions in Indian way

- a new generation Integrated Child Development Service (ICDS) to tackle malnutrition.
- Creating a Nutrition Secretariat as part of the Prime Minister's Office with responsibility for ensuring multi-sectoral alignment on priorities, sequencing and timelines.

Discussion

In India, there is Integrated Child Development Services (ICDS) since 1975 and the mid-day meal scheme since 1995. Both the schemes have a well established national coverage. However, fault lies in the fact that there is no structure for multi-sectoral coordination which is very much essential to address the inter-generational and multifaceted nature of malnutrition.

It must be borne in mind that poor nutrition will fracture the dreams and aspirations of India to become a global player in manufacturing and other industries. The demographic dividend which India possesses will go in waste if sufficient nutrition is not provided.

Article 47 of the Constitution states that it is the duty of the state to raise the level of nutrition and the standard of living and to improve public health. Therefore, the onus lies on the state to raise the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

Schemes such as Swachh Bharat, Beti Bachao, Beti Padao, etc. are welcome moves by the government in the direction to fulfil the promise made in Article 47. However, to make the schemes much more effective, India needs to have a viable infrastructure and the mechanism to make the

benefits reach the targeted population effectively.

India must convert its young population to a competitive advantage, and nutrition and health are foundational to that outcome.

India falls in the bracket of having the maximum young age population and this puts us ahead amongst all the countries in terms of demographic dividend.

There are three important schemes which relate to nutrition significantly:

- The ICDS, which caters to the needs of pregnant and nursing mothers and children under the age of six.
- The mid-day meal scheme, which directly feeds approximately 120 million schoolchildren every day.
- Public distribution system, which makes available subsistence rations to above and below poverty line families.

These three are an excellent platform wherein there can be effective public-private partnerships and CSR programmes can also make a huge contribution in this regard and raise the level of nutrition.

However, to make the schemes much more effective, some measures can be undertaken. For instance, investing in the training of the Anganwadi workers so that they can work much more effectively in the case of ICDS. In the case of Mid-Day Meal scheme, addition of micronutrients to cooked food or by adding universally liked and accepted products such as milk, biscuits, etc. fortified with micronutrients as a mid-morning or afternoon snack can be a good initiative to tackle the issue of malnutrition.

If efforts in this direction are undertaken, India can definitely harness the benefits of its demographic dividend.

Some Questions from Previous Papers

Growing population is the cause of poverty or poverty is the main cause of population increase? Discuss.

Poor countries tend to have a high population growth and high population growth rate can lead to poverty. Both these phenomenon are visible in India leading to a vicious cycle. It is true that rapidly growing population can exacerbate poverty. A high population increases the pressure on resources as they can support only a small number of people. It strains the ability of the government to provide for every citizen. It increases the competition for a limited number of jobs. Poverty on the other hand can also lead to an increase in population. Poor people tend to have more children so as to put them to work and support them economically.

Poor also have lower access to education and healthcare and thereby are not able to do family

planning properly.

They also tend to get married early and therefore have more time to have children. In the context of India, we can see that both the factors are at work, but none of them can present the true picture on its own. The states in India with a high population density and fertility rate tend to be poorer. But then there is Kerala with a high population density and still doing quite well on the human development index. States with lower per capita income such as Bihar, Uttar Pradesh etc, have a high fertility rate while states with a higher per capita income such as Punjab, Delhi, Kerala, Tamil Nadu have a low fertility rate.

Globally, many European nations with a high population density such as Belgium, Holland, etc, are highly developed while nations with a low population density such as in Africa can be poor. Thus, we can say that overpopulation can exacerbate poverty by putting pressure on resources such as land, government services etc, but it is poverty which is the root cause of high population growth.

What is the role of Self Help Groups in poverty alleviation? Explain.

Self Help Groups (SHGs) are informal associations of people who choose to come together to find ways to improve their living conditions. They help to build social capital among the poor especially women.

Consequently, SHG have emerged as the most effective mechanism for delivery of micro-finance services to the poor.

Self Help Groups play today a major role in poverty alleviation in rural India. Growing number of poor people (mostly women) in various parts in India are members of SHG and actively engage in saving and credit, as well as in other activities income generation, natural resources management, literacy, child care and nutrition.

There is ample evidence that the SHG approach is a very effective, efficient and relevant tool for organising and empowering the poor. The SHG bank Linkage Programme helps this SHGs to get easy access to loans at low interest rate. The Loans can be returned in number of instalment. There is also no requirement of collaterals. After repayment they can avail much larger amount. There are several agencies that regulate the finances to the SHG. Other bodies like Small Industries Development Bank of India (SIDB!), Rashtriya Mahila Kosh (RMK), SEWA in Ahmadabad, MYRADA in Karnataka, Nav Bharat Jagriti Kendra and Ram Krishna Mission in Jharkhand and ADITHI in Bihar are some of the names which took the lead in promoting SHGs mostly of women.

Though here have been several different estimates of poverty in India, all indicate reduction in poverty levels over time. Do you agree? Critically examine with reference to urban and rural poverty indicators.

Poverty is one of the major impediments to the human growth and development. The problem of

poverty has taken a gigantic form and creates a vicious cycle, which entraps the individual into poor conditions. The extent of poverty is depicted by the following measures like – Head Count Ratio or Poverty

Ratio, Poverty Gap Index, Sen Index of Poverty, Multi-Dimensional Poverty Index, Human Poverty Index (HPI), Fisher Price Index (FPI) and Conditional Cash Transfers (CCTs).

Several different expert groups have been estimated poverty in India. Suresh Tendulkar Committee in its finding has moved away from just calorie-criterion definition to a broader definition of poverty that also includes expenditure on health, education and clothing in addition to food. As per Tendulkar Committee

Report, poverty has declined on an average by 1.5 percentage points per year between 2004-05 and 2009-10.

Uniform Recall Period (URP) and Mixed Recall Period (MRP) is another estimates of poverty in India. Dr NC Saxena Committee reviewed the methodology for conducting BPL census in rural areas. The committee has recommended automatic exclusion of some privileged sections and automatic inclusion of certain deprived and vulnerable sections of society and a survey for the remaining population to rank them on a scale of 10. Based on the above methodology, the committee estimated the population below the poverty line at 50% of the total population.

SR Hashim Committee determined the methodology and identification of BPL families in the urban areas. Hashim suggested methodology for identifying urban poor, households having three of four items like refrigerator, motorised two wheelers, land line telephone or washing machines should not be treated as poor. The expert group recommended that the urban poverty has been declined.

According to Rang Rajan estimate the poverty ratio has come down from 38.2% in the 10th Plan to 29.5% in the 12th Plan. The rural poverty has declined from 39.6% to 30.9% and urban poverty form 35.1% to 26.4%. Thus, we can say that the different findings regarding the poverty declining in India is true, which can be seen in villages and towns both.

Establish relationship between land reforms, agriculture productivity and elimination of poverty in the Indian economy. Discuss the difficulties in designing and implementation of agriculture friendly land reforms in India.

Land reforms have led to the abolishment of the exploitative land tenure system in the agrarian system to a large extent. It was an essential promise of the freedom struggle and a requirement of social justice. Land reforms led to the distribution of land to the previously landless and weaker sections. They brought a fundamental change in the rural power structure. Provision of land to the poor helps in eliminating poverty to a large extent by providing a baseline economic and food security. Land ownership also eliminates exploitation of labour.

Zamindari abolition and tenancy reforms led to many land owners taking up capitalistic farming and focusing on increasing land productivity. This increased farm yields. Land reforms by their nature lead to smaller sized land holdings. Small holdings have a higher productivity, but lower profitability due to intense use of labour. Land reforms also brought in large areas of wasteland under cultivation. This led to increased production.

After a point of time, however, further land reforms would have led to smaller and uneconomic holdings particularly in states such as West Bengal. On the other hand, there are a large number of landless still existing in the rural areas as evidenced by the Jan Satyagaraha of a few years ago. This creates a problem of design and implementation of agriculture friendly land reforms. One of the obstacles is that land is a state subject and many states rave not implemented land reforms in earnest. Land ceilings are still very high in many states.

Another problem is to carry out land consolidation along with the land fragmentation which takes place along with land reforms. While small holdings may have higher productivity, many of them lead to subsistence farming and prevent the diversification and growth of agriculture. Success of land reforms also depends on provision of agricultural inputs such as credit, fertilizers etc along with training and guidance.