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SOCIAL ISSUES

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SOCIAL ISSUES

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1. ISSUES RELATED TO WOMEN

1.1. DISCRIMINATION AGAINST WOMEN

The case for gender parity

- **Economically**-
  - Various studies have suggested that improving gender parity may result in significant economic dividends, which vary depending on the situation of different economies and the specific challenges they are facing.
  - Compared to general public investment into labour market and education programmes, targeted gender equality promotion has been found to create a particularly strong impact on GDP.
  - Further, top performers in the Global Human Capital Index have succeeded in maximizing the development and deployment of their nation's talent by also narrowing their gender gaps.
- **Socially-**
  - Similar to investments in education, investing in health—and specifically in maternal, newborn and child health—has a significant multiplier effect.
- **Politically-**
  - The issues that women advocate, prioritize and invest in have broad societal implications, touching on family life, education and health.
  - Their engagement in public life fosters greater credibility in institutions and heightened democratic outcomes.

Important facts and figures

- **Gender Inequality Index**, puts India at 131 in global ranking with GII of 0.53.
- **Global Gender Gap Report 2017** ranks India 108 amongst 144 countries and mentions that according to current trade, it will take around 217 years by India to close the economic and political empowerment chasm between men and women. India has slipped 21 ranks to 108 behind Bangladesh (47) and China (100).
  - India's greatest challenge lies in the **economic participation and opportunity pillar** where it ranked 139 and **health and survival pillar** where it ranks 141.
  - The main reason behind slipping of India's ranking is its laggard performance on **political participation and empowerment pillar.**

1.1.1. FERTILITY TREND IN INDIA

Why in news?

Recently the fourth round of the National Family Health Survey (NFHS-4) report on the variations in the total fertility rate (TFR) of different communities was released.

Details

- **Geographic variance:** The fertility rate in 23 states and Union territories—including all the southern states—is below the replacement rate while it is higher in a number of states in central, east and north-east India.
  - Bihar has the highest rate at 3.41, followed by Meghalaya at 3.04 and Uttar Pradesh and Nagaland at 2.74.
  - Total fertility rate in rural areas was 2.4 while in urban areas it was 1.8.
  - The nature and scope of the fertility-related public health challenge facing state governments varies widely. The most effective way of combating this variance could be assigning a greater role for local bodies in both urban and rural areas.

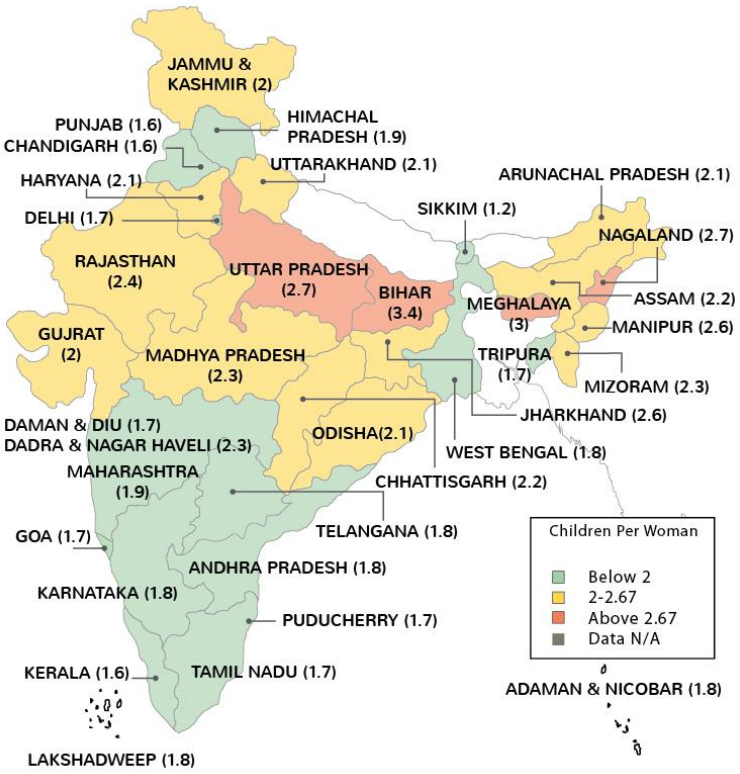
Total Fertility Rate (TFR) may be defined as average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years).

- It is a more direct measure of the level of fertility than the birth rate, since it shows the potential for population change in a country.
- Total fertility rate declined in India from 2.7 in 2005-06 (NFHS-3) to 2.2 in 2015-16 (NFHS-4).

Replacement level fertility is the level of fertility at which a population exactly replaces itself from one generation to the next.

- **Government's Schemes for Family Planning**
- **Mission Parivar Vikas-** for substantially increasing the access to contraceptives and family planning services in the high fertility districts of seven high focus states with TFR of 3 and above.
- Scheme for Home delivery of contraceptives by ASHAs wherein ASHAs are delivering contraceptives from door to door in the community.
- National Family Planning Indemnity Scheme (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.

- **Impact of education:** Women with 12 years or more of schooling have a fertility rate of 1.7, while women with no schooling have an average rate of 3.1.
  - Lack of education robs women of reproductive control, feeding into India's maternal and child health problem.
  - Combined with younger pregnancies and higher childbearing rates, it also constrains women's economic choices. This, in turn, reinforces a lack of reproductive control—44% of women who are unemployed use modern contraceptives while 60% of women who are employed for cash do so—perpetuating a vicious cycle.



- **Skewed pattern of contraceptive usage:** Despite increasing knowledge of contraceptive methods men have not taken up the responsibility of managing fertility. The most popular contraceptive method by far, at 36%, is female sterilization. Male sterilization accounts for a mere 0.3%.
  - There are several reasons for reluctance of Indian men to undergo sterilisation:
    - ✓ A lack of awareness of sexual and reproductive matters;
    - ✓ A paucity of knowledge about appropriate contraceptive methods;
    - ✓ Myths and misconceptions (sterilisation leads to loss of virility);
    - ✓ Social taboo and sheer logistical limitations
    - ✓ Poor access to services, information and counselling on available methods of contraception, their benefits and side effects and management.
    - ✓ Health workers at the village level are usually women and they find it difficult to discuss the socio-culturally sensitive issue with men.
- **Impact of religion:** Cultural and geographical factors and the level of development of different states seem to be more important determinants of TFR. In states with higher TFR, all groups show high levels and vice versa.
- **Impact of income/ wealth:** The section with the lowest income had the highest number of children at 3.2 and the richest had the least, 1.5.
  - Scheduled tribes, the least developed among social categories, had the highest fertility rate of 2.5, followed by 2.3 for scheduled castes and 2.2 for other backward classes. The upper castes had the lowest fertility rate of 1.9.

1.1.2. CHILD SEX RATIO

Why in News?

- Recently, The Ministry of Women and Child Development (WCD) had claimed an increase in sex ratio under BBBP scheme.

Details

- The ministry has claimed that there is an increasing **trend in sex ratio** in 104

Sex Ratio at Birth (SRB): is the number of girls born per 1,000 boys.
Child Sex Ratio: is the number of girls per 1,000 boys between 0-6 years of age.

Other Initiatives to augment the BBBP outcomes

- **'Sukanya Samriddhi Account:** is a small deposit scheme for the girl child with a higher interest rate of 9.1 per cent and income-tax benefit.
- **Selfie with daughter:** An initiative the aim to motivate society to feel proud to be parents of a girl child.
- **Balika Manch:** under BBBP to encourage girl students' participation and improve awareness related to gender issues.

of the 161 districts taken up under the Beti Bachao Beti Padhao scheme, and a declining trend in the remaining districts.

- Similarly, 119 districts have reported progress in **registration of pregnancies** in the first trimester during 2016-17 as compared to 2015-16.
- During the same period, **Institutional deliveries** against the total reported deliveries have improved in 146 districts in comparison to the previous year.
- Many districts that registered an annual decline in **Sex Ratio at Birth** (SRB) between 2015-16 and 2016-17 show an increase compared to the Child Sex Ratio (CSR) of Census 2011.

Beti Bachao Beti Padhao Scheme

- Launched in 2015 at Panipat, Haryana to address the declining Child Sex Ratio (CSR) and related issues of women empowerment over a life-cycle continuum.
- The efforts include;
  - Enforcement of **Pre-Conception & Pre-Natal Diagnostic Techniques Act, 1994**
  - Nation-wide awareness and advocacy campaign and multi-sectoral action in select districts (low on CSR) in the first phase.
  - Emphasis on mindset change through training, sensitization, awareness raising and community mobilization on ground.
- Help from **grass root participants** like, ANM (Auxiliary Nurse Midwife) and ASHA (Accredited Social Health Activists) is prescribed to 'encourage' the community and its members to promote girls' education, nurture their health, etc.
- It is mandatory to display gender disaggregated data related to birth of girls and boys through the '*Guddi-Gudda*' boards which are to be displayed at prominent public places like Panchayats, Anganwadi Centres, etc.

Supreme Court Guidelines for female foeticides

Supreme Court issued a series of directions to control the crime of female foeticide. Barely 3,000 cases have been filed against violators of the act over the past 21 years though half a billion medical crimes have been committed.

- **To maintain a centralised database**– All the States and the Union Territories in India shall maintain a centralized database of civil registration records from all registration units so that information can be made available from the website regarding the number of boys and girls being born.
- **Fast track court**-The Courts which deal with the complaints under the Act shall be fast tracked and the concerned High Courts shall issue appropriate directions in that regard.
- **Constitution of a Committee** having three HC Judges that can periodically oversee the progress of the cases.
- Effective implementation of the the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.
- **The awareness campaigns** with regard to the provisions of the Act as well as the social awareness shall be undertaken.
- **All India Radio and Doordarshan** functioning in various States to give wide publicity pertaining to the saving of the girl child, highlighting the grave dangers the society shall face because of female foeticide.
- **Incentive Schemes**- directed that States and Union Territories, which do not have any incentive schemes for the girl child, shall frame the same.

1.1.2.1. SON META PREFERENCE

- **Son-Meta Preference**- It is measured by the Sex Ratio of the Last Child (SRLC)
  - For India, the sex ratio of the last child for first-borns is 1.82, heavily skewed in favor of boys compared with the ideal

Son Meta Preference

- It is a subtler way of son preference which means that parents may choose to keep having children until they get the desired number of sons.
- It does not lead to sex selective abortion but it may be detrimental to female children because it may lead to fewer resources devoted to them.
- This form of sex selection alone will not skew the sex ratio. However, this kind of fertility stopping rule will lead to skewed sex ratios but in different directions i.e. skewed in favor of males if it is the last child, but in favor of females if it is not.
- A preference for sons will manifest itself in the SRLC being heavily skewed in favor of boys.

sex ratio of 1.05. This ratio drops to 1.55 for the second child for families that have exactly two children and so on. The striking contrast between the two panels conveys a sense of son meta preference.
    - It gives rise to **"unwanted" girls** (girls whose parents wanted a boy, but instead had a girl), computed as the gap between the benchmark sex ratio and the actual sex ratio among families that do not stop fertility. It stands at 21 million for India.
- Reasons for such a son preference include patrilocality (women having to move to husbands' houses after marriage), patrilineality (property passing on to sons rather than daughters), dowry (which leads to extra costs of having girls), old-age support from sons and rituals performed by sons.

1.1.3. WOMEN IN PRISONS

Why in news?

The Ministry of Women and Child Development (MWCD) has published its report titled 'Women in Prisons.'

Condition of women prisoners in India (based on 2015 data):

- There are approximately 4.2 Lakh persons in jail in India, of which, around 18000 (**about 4.3%**) are women. Of these, around 12000 **(66.8%) are undertrial prisoners**.
- The number of women prisoners is showing an **increasing trend** - from 3.3% of all prisoners in 2000 to 4.3% in 2015.
- About 50% of these women are in age group of 30-50 years and the next **31% are in age group of 18-30 years.**
- There are 1,401 prisons in India, and **only 18 are exclusive for women** which can house just around 3000 female prisoners. Thus, a majority of women inmates are housed in **women's enclosures of general prisons.**

Problems faced by women prisoners

- Women are often confined to **small wards inside male prisons**, their needs becoming secondary to those of the general inmate population.
- While several cases of sexual harassment, violence and abuse against women in jails have been observed, the **grievance redressal mechanism** is still weak.
- There is **inadequacy of female staff** which often translates to the reality that male staff becomes responsible for female inmates, which is very much undesirable.
- Their small numbers (4.3%) ensure they remain **low on policy priority** and hence the coverage of facilities such as sanitary napkins, pre- and post-natal care for pregnant mothers is patchy.
- They are not provided with **meals** that are nutritious and according to their bodily requirements.
- Women tend to **lose ties with their children** over the years, due to inadequate child custody procedures (children upto 6 years are allowed in jail with their mothers, after that they are sent away to children home).
- They are abandoned or harassed **post-release**, mainly due to the stigma attached with incarceration.

Details and recommendations of the report

- **Care-giving mothers:**
    - They should be allowed to make arrangements for their children prior to their imprisonment
    - They should be allowed reasonable suspension of detention.
    - If there is no relative/friend, her child below 6 years should be put in a child care institution.
    - Extended visits and frequent meetings should be allowed with the child.

Other Steps taken for women prisoners

Model Prison Manual, 2016

- The manual contains additional provisions for Women prisoners and their children as well.
- These provisions are based on **UN Bangkok Rules** and is drafted by the Bureau of Police Research and Development (BPR&D),
- The manual calls for women doctors, superintendents, separate kitchens for women inmates, and pre- and post-natal care for pregnant inmates, as also temporary release for an impending delivery.
- It also talk about ensuring creche and nursery schools for the children to be looked after.

Swadhar Greh:

This is a scheme for rehabilitation of women victims of difficult circumstances. Among other beneficiaries, the scheme also includes women prisoners released from jail and are without family, social and economic support.

- **Undertrial women:**
  - Bail should be granted to those who have spent one-third of their maximum possible sentence in detention by amending section 436A of CrPC.
  - A maximum time frame may be decided for release of women prisoners after bail is granted but surety is not produced.
- **Post-natal stage women:**
  - A separate accommodation should be provided to them to maintain hygiene and protect the infant from contagion, for at least a year after childbirth.
  - Special provisions related to health and nutrition of such women be made.
  - Instruments of restraint, punishment by close confinement or disciplinary segregation should never be used on pregnant and lactating women.
- **Pregnant women:**
  - They must be given information and access to abortion during incarceration, to the extent permissible by law.
- **Women with sensory disabilities or those with language barriers:**
  - Legal consultations must be conducted in confidentiality and without censorship.
  - Adequate arrangements must be made by the prison administration to ensure that such persons do not face any disadvantage by providing an independent interpreter
- **For grievance redressal:**
  - Apart from the prisoner herself, her legal adviser or family members should be allowed to make complaints regarding her stay in prison.
  - An inmate register can also be placed at an accessible spot in the prison for submitting grievances.
  - All official visitors must hold special one-on-one interviews with prisoners away from prison authorities during inspection visits.
- **For mental needs:**
  - They should be given access to female counsellors/psychologists at least on a weekly basis or as frequently as needed by them.
- **For re-integration of women in society:**
  - A comprehensive after-care programme should be put in place, covering employment, financial support, regaining of child custody, shelter, counselling, continuity of health care services etc.
  - Counselling should also be provided to family members and employers to adequately receive the woman after release
  - Prison authorities should coordinate with local police to ensure released prisoners are not harassed by them due to the attached stigma
  - At least one voluntary organisation should be designated in each district to help with integration of released prisoners.
- Prisoners must be given the **right to vote.**

1.2. WORKING WOMEN'S ISSUES

1.2.1. GENDER PAY DISPARITY

Recently **World Bank report** indicated a bias towards men over women in the workplace, both in terms of hiring and salaries offered.

Related Data

- Globally, the unemployment rate for women stands at 6.2% in 2017, higher than the male unemployment rate of 5.5 per cent.
- In India there exists:
  - **Low Property right:** Women contribute almost 40% of agricultural labour but control only 9% of land.
  - **Financial Dependence:** Nearly half of the women do not have a bank or savings accounts for their own

Monster Salary Index (MSI), 2018

- According to it, women in India earn 20% less than men.
- However, gender pay gap has narrowed by about 5% points from 24.8% in 2016 and there was a marginally inverted pay gap in the experience group of 3-5 years, where women earned more.

Increase in female enrolment in education: According to some research, one plausible explanation for the recent drop in FLFP is that with the recent expansion of secondary education, as well as rapidly changing social norms in India, more working age young females (15 to 24 years) are opting to continue their education rather than join the labour force early.

use, and 60% of women have no valuable assets to their name
- **Low Economic Activity:** Women's contribution to the GDP is only 17% while the global average is 37%.
- **International Labour Organisation (ILO) survey** in 2017 had ranked **India's Female Labour Force Participation (FLFP)** rate at 121 out of 131 countries in 2013.
- **Reverse Trend:** Between 2004 to 2011 Indian economy grew 7%, however, instead of increase in female participation in the country's labour force, there was a decline in from over 35% to 25%.
- India also ranked poorly at 108 on the **World Economic Forum's "Global Gender Gap Report 2017".**
- **According to Monster Salary Index, 2018, women in india earn 20% less than men.**

Steps taken to close Gender Gap in India

Constitutional
- **Article 39 (d) under DPSP**: According to it, the state shall, in particular, direct the policy towards securing that there is equal pay for equal work for both men and women.

Judicial
- **Randhir Singh vs. Union of India and Grih Kalyan Kendra vs. Union of India-** SC held that the principle of "equal pay for equal work" as a constitutional goal and, therefore, capable of enforcement under article 32 of the constitution.

Legislative
- **Equal Remuneration Act of 1976-** aims to provide equal remuneration to men and women workers and to prevent discrimination on the basis of gender in all matters relating to employment and employment opportunities.
- **Maternity Benefit Act** was amended in 2017, to increase the duration of maternity leave from 12 weeks to 26 weeks.
- **Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 [SHW ACT]:** it was enacted to implement the Vishakha Guidelines and to ensure a safe workplace for woman.
- **Other Steps:** Government of India's **MUDRA scheme** to support micro and small enterprises and direct benefit transfers under the **Jan Dhan Yojana** seeks to empower women. Women entrepreneurs account for about 78% of the total number of borrowers under MUDRA.

Challenges Faced by working women

- **Legal Restriction:** According to a study by the International Monetary Fund (IMF), almost 90% of the 143 economies have at least one important, gender-based legal restriction.
- **Patriarchal attitudes**: From NSSO data of 2011, it was found that women from higher castes and higher income families spent less time working outside the house.
- According to the **2012 "Gender Pay Gap in the Formal Sector" report**, pay gap increases with women's age, work experience, educational qualifications and rise in occupational hierarchy.
- **Biased human capital model** in country which focuses on gender differences in skills, education and experience.
- **Workplace insecurity:** The rate of crimes against women in India stands at 53.9%
- **Other challenges**: Lack of attractive job alternatives and income security, inadequate travel and transport facilities, Societal perception of women who work long hours, lack of crèches facility at workplace etc.

Way Forward

- **Formalization of Workforce** to create better job opportunities for women and streamlining labour laws.
- **Skill Development**: Vocational and technical training, life skills and financial literacy programmes for women to help them develop marketable skills and better decision-making abilities.
- **Mandating parental leave** rather than maternal leave will help women to reintegrate into the workforce after childbearing and allowing men to take on the responsibility of parenthood.
- **Step by Companies**: Corporate India need to step up and implement pragmatic policies to bridge the pay gap, change employee perception of a healthy work culture and foster equal opportunities.

1.2.2. SEXUAL HARASSMENT AT WORKPLACE

Why in news?

- A review meeting on implementation of the Sexual Harassment of Women at Workplace **(Prevention, Prohibition and Redressal) Act, 2013** was held recently.
- It was observed that there were various short comings in terms of manner and results of the implementation.
- The Act drew on the 1997 judgment of the Supreme Court (known as the Vishaka judgment) to codify measures that employers need to take to address sexual harassment at the work place

Issues in implementation

- 70% of the women do not report sexual harassment by superiors due to the fear of repercussions.
- According to a 2015 research study, 36% of Indian companies and 25% of multinational companies had not yet constituted their Internal Complaints Committee (ICCs) which is mandatory under the Act.
- Cases remain pending in court for long time enhancing the agony of victims
- The Act does not fix accountability as to who is in charge of ensuring that workplaces comply with the Act.

Steps proposed for better implementation

- The Ministry of WCD will set up **an inter-ministerial committee** headed by a senior official of the WCD Ministry.
- This committee will review the progress of disposal of complaints of sexual harassment, get a standardized training module prepared.
- The committee will also make sure that the heads of ICCs of all ministries/departments are given **training on how to handle the complaints**.
- Ministry of WCD recently launched an online complaint management system titled Sexual Harassment electronic–Box (SHe-Box) for the effective implementation of the SH Act, 2013.
- This will enable a monitorable and transparent system of grievance redressal under the Act.
- Monthly reporting to WCD ministry on the number of complaints received, disposed, pending and action taken etc.

It was also decided that the Act, the rights of a woman official and the responsibility of the ICC must be given adequate publicity through different methods including the websites of the ministries/departments/attached offices.

Provisions of Sexual Harassment Act

- It widens the definition of 'aggrieved woman' to include all women, irrespective of age and employment status, and it covers clients, customers and domestic workers.
- It expands 'workplace' beyond traditional offices to include all kinds of organisations across sectors, even non-traditional workplaces (for example those that involve telecommuting) and places visited by employees for work.
- It mandates the constitution of the internal complaint committee (ICC) — and states the action to be taken if an ICC is not formed — and the filing of an audit report of the number of complaints and action taken at the end of the year.
- It lists the duties of the employer, like organising regular workshops and awareness programmes to educate employees about the Act.
- If the employer fails to constitute an ICC, or does not abide by any other provision, they must pay a fine of up to ₹50,000. If the offender is a repeat offender, the fine gets doubled. The second offence can also lead to cancellation or non-renewal of his licence.

1.2.3. WOMEN RESERVATION BILL

Why in news?

Government is considering to introduce Women's Reservation Bill in the Parliament, which seeks to reserve one-third of seats in the Lok Sabha and state assemblies for women.

Background

- There has been a historical social exclusion of women due to various social and cultural reasons and patriarchal traditions, due to which even after 70 years of independence there is no adequate representation of women in political and decision making realm of the country.
- The percentage of women in the Lok Sabha has gone up by only a small margin from **4.4% in 1951 to 11% in 2014** and at this pace, it will take another 180 years to reach the gender balance.
- **Reservation in Panchayat was more effective** than expected in energising women and has **underscored the need for reservation** in higher bodies such as State Legislatures and Parliament.
- The **Constitution (One Hundred and Eighth Amendment) Bill, 2008** was introduced in Rajya Sabha with an aim to reserve 33% seats in Lok Sabha and state legislative assemblies for women. However, bill lapsed with the dissolution of the 15th Lok Sabha.

Women representation at state level

- The situation is **worse at the state level,** where the average representation ratio of women is around 7%.
- Nagaland or Mizoram for example, have no women MLAs. Other worse performers are Jammu and Kashmir (2.27%) Goa (2.5%) and Karnataka (2.65%).
- India's best performing state is Haryana (14.44%), followed by West Bengal (13.95%), Rajasthan (13.48%) and Bihar (11%).

Highlights of the Bill

- It seeks to reserve one-third of all seats for women in the Lok Sabha and the state legislative assemblies.
- The allocation of reserved seats shall be determined by such authority as prescribed by Parliament.
- One third of the total number of seats reserved for Scheduled Castes and Scheduled Tribes shall be reserved for women of those groups in the Lok Sabha and the legislative assemblies.
- Reserved seats may be allotted by rotation to different constituencies in the state or union territory.
- Reservation of seats for women shall cease to exist 15 years after the commencement of this Amendment Act.

Challenges

- **One-size-fits-all policies designed** in New Delhi without accounting for local and varied granularities have indeed been problematic as can be seen from Nagaland agitation over reservation in local bodies and constitutional protection provided to their unique culture under Article 371(A)
- **Incompetency of candidate**: it would perpetuate the unequal status of women since they would not be perceived to be competing on merit.
- **Diversion from critical issues:** Policy diverts attention from the larger issues of electoral reform such as criminalisation of politics and inner party democracy.
- **Right to choice:** Reservation of seats in Parliament restricts choice of voters to women candidates.
- **Promote Nepotism**: Reservation might promote wives and daughters of politicians whose constituencies fell under the reserved category defeating the purpose of the bill.
- **Panchayat Pati Syndrome**: Male exercising undue influence on the work of their wives elected to power.

Joint Parliamentary Committee (1996) chaired by Geeta Mukherjee recommendations.

- Reservation for a period of 15 years
- Including sub-reservation for Anglo Indians
- Including reservation in cases where the state has less than three seats in Lok Sabha (or less than three seats for SCs/STs
- Including reservation for the Delhi assembly
- Reserving seats in Rajya Sabha and Legislative Councils
- Sub-reservation for OBC women after the Constitution extends reservation to OBCs.

In the Women's bill, first four recommendation were incorporated leaving last two

Parliamentary Standing Committee (2008) recommendation:

- Every political party must distribute 20% of its tickets to women
- Even in the current form, reservation should not exceed 20% of seats
- There should be a quota for women belonging to OBCs and minorities
- To require political parties to nominate women for a minimum percentage of seats.
- To create dual member constituencies, with women filling one of the two seats from those constituencies.

Significance

- **Political empowerment**: Reservation for seats for women is a valid and necessary strategy to enhance women's participation in the decision/policy making process. It would ensure considerable political empowerment of women and pave the way to the achievement of political justice to women as promised in Preamble and Article 38 of the Constitution of India.
- **Social empowerment**: Reservation is certainly needed to enable women to cross the socio-gender hurdles and to give them a level playing ground/ equal opportunities as their male counterparts because inadequate representation of women in Parliament and State legislature is a primary factor behind the general backwardness of women at all levels.
- **To attain Equality:** Reservation is needed for women belonging to the SC/ST communities to enable them to have fair competition with women belonging to the forward classes.
- **True Democratization:** Reservation is a sociological concept evolved to bring about **social reengineering** and reservation for women is needed to make the **democratic process inclusive.** Representation of women in policy making machineries is critical to the nation building process
- **Positive of reservation in Panchayat:**

Reservation in Panchayat Polls

- Reservation of seats for women in Panchayati Raj institutions through the Constitution (73rd and 74th Amendment) was a pioneering step in political empowerment of women.
- According to the 73rd and 74th Amendment Act of the Constitution, passed in 1993, one-third of the seats in all rural and urban local bodies are reserved for women.
- However, 16 states have laws in place that **reserved half their seats** in rural local bodies for women.

- ✓ Through 1/3rd reservation of seats for women in Panchayats and Nagarpalikas, they have been able to make meaningful contributions and that the actual representation of women in Panchayati Raj institutions has gone upto 42.3% i.e., beyond the reservation percentage. This has led the Government to make 50 percent reservation for women in local bodies.
- ✓ Representation & Performance of women in Panchayats is largely due to statutory reservation of seats for them.

Way forward

- **Providing reservation in Upper House**: reservation for women in Rajya Sabha and the Legislative Councils needs to be examined thoroughly as the upper Houses of the Parliament and State Legislatures play equally important role under the Constitution and by applying the principle of equality women should also get their due share in the second or upper chamber of Parliament and State Legislatures.
- **Inclusive development of society**: There is evidence that political reservation has increased **redistribution of resources in favour** of the groups which benefit from reservation. Women elected thus invest more in the public goods closely linked to women's concerns
- **To uphold the principle of our constitution:** Reserving seats for women in Assemblies and Lok Sabha should not be left to the discretion of Political Parties, rather it should be guaranteed in the Constitution itself and enforced by all means.
- **Bill as a Stepping Point:** Bill in itself is not an entirety, rather it is a formula to achieve Political Empowerment of women. Bill only lays down the principle/ basic framework for reservation of women in State Assemblies and Lok Sabha.

1.2.4. WOMEN IN TERRITORIAL ARMY

Why in news?

Delhi High court has paved way for induction of women into TA units by quashing Centre's notification barring the same.

Context

- **Section 6 of the Territorial Army Act,1948** lays down rules on who is eligible for enrolment in the Territorial Army, which is also known as the second line of defense after the regular Army.
- As per the rules, TA recruited only gainfully employed men and thus barring women's entry in infantry units in army.
- A PIL under **article 226 of constitution** (power of HCs to issue writs) was filed in Delhi High Court claiming that not allowing women to join amounted to "institutionalized discrimination" and went against the Constitution's spirit.

Observations of Delhi High Court

- The two judge High Court bench held that policy of restriction on enrolment of women is ultra vires of Articles 14, 15, 16 and 19(1)(g) of the Constitution of India.
- It also held that "any person" in Section 6 shall include both men and women.

Inclusion of women in Defence forces

Pros

- **Ability is not gender specific-** Women soldiers have found to be equally capable as men after proper training. Also, in the 21st century battles aren't always fought with swords and guns.
- Influx of applicants leading to a bigger and **better pool of candidates**.

Central government has also sanctioned the raising of a Territorial Army (TA) battalion to clean Ganga.

- The initiative has been taken under National Mission to clean Ganga aiming to clean it by 2020.
- The task force comprises ex-servicemen, and will be based in Allahabad, Uttar Pradesh.
- The funding for the initiative has been provided by Ministry of Water Resources, River Development and Ganga Rejuvenation.
- Nine **Ecological Task Force (ETF)** battalions of TA have been raised to execute specific environment-related projects as part of Namami Gange Programme till now.
- Some key functions of the task force are going to be:
  - To manage public awareness campaigns
  - Patrol sensitive river areas for the protection of biodiversity
  - Keep a tab on the river pollution levels
  - Assist the government in enforcing pollution control measures,
  - Support local civil administration and police in managing the ghats and
  - Provide support and assistance if and when there is a flood or natural disaster in the region.

- **Effectiveness**- The blanket restriction for women limits the ability of commanders in theater to pick the most capable person for the job.

Cons

- **Physical incapability** for combat is the most common example provided against women joining army.
- **Abuse by** colleagues and, if captured, by the enemy are conditions that lays down an ethical conundrum regarding the issue.
- **The traditional mindset** and belief where men have problems and issues accepting orders from women are yet another hindrance in their acceptance in defence positions.

Current Status of women in Defence forces:

- The Indian Army, the Indian Navy and the IAF allow women in various courses but till recently restricted their entry into combat roles.
- Indian Airforce and Indian Navy in 2015 and Indian Army in 2017 allowed women in combat roles taking cue from various western countries and further instil gender parity in Defence forces in India.

1.3. CRIME AGAINST WOMEN

1.3.1. WOMEN SAFETY IN INDIA

Why in news?

- Recently, Ministry of Home Affairs has created a new division to address issues related to women safety in comprehensive manner in coordination with relevant Ministries/ Departments and State Governments.

This new Division will also deal with

- Crimes against SCs &STs.
- Crimes against children, elderly persons.
- Anti-trafficking Cell.
- Matters relating to Prison legislation and prison Reforms.
- All schemes under NIRBHAYA fund.
- Crime and Criminal Tracking & Network System (CCTNS).

Women safety in India

- Women safety involves various dimensions such as Sexual harassment at workplace, rape, marital rape, dowry, acid attack etc.
- The **United Nation's 'Safe Cities and Safe Public Spaces' programme**, which started in 2010, recognized that cities all around the world were becoming unsafe for women.
- The **latest NCRB data for the year 2016** shows that
  - Overall crimes against women have risen by just about 3%, whereas incidents of rape have gone up by 12%.
  - Majority of cases categorized as crimes against women were reported under '**Cruelty by husband or his relatives' (32.6%).** This draws a bleak picture of women safety in private places or home.

Challenges in addressing women safety

- **Lack of reporting**: It is seen as a major roadblock for creating a safe atmosphere for women.
- **Slow criminal justice system:** The investigation and disposal of cases take long time thereby encourage offenders.
- **Inadequate implementation:** Many employers are yet to establish Internal complaints committee which is a clear violation of law.
- **Poor gender sensitization** of law enforcing agencies like police, judiciary etc.
- **Various social factors** like level of education/illiteracy, poverty, myriad social customs and values, religious beliefs, mindset of the society etc. also pose a challenge.
- **Frivolous complaints**: This is seen mostly in context of domestic violence act.
- **Exclusion by Technology**: Technology though helpful to enhance public safety in certain ways, but **its scope is limited so far** as they **exclude women without access to smartphones**.

Common reasons for failure to report safety concerns

- **Lack of understanding:** Most women perceive that the behavior is not serious enough for them to take the next step and complain.
- **Lack of faith in complaint process**: as they think the process can be embarrassing & difficult.
- **Social stigma**: Fear of being looked down upon in the society.
- **Fear of retaliation:** by the harasser.
- **Fear of repercussions** in promotions and career growth.
- **Non-inclination of family to report** such incident as the offenders are known to victim most of the times.

- **Hinders women development:** For example- Sexual harassment at workplace is one of the most important causes of low labour force participation rate of women in India. Male dominated nature of India's public sphere is being recognized but not challenged.

Some steps taken by government

- **For sexual harassment at workplace**- VISHAKA guidelines by Supreme Court which provide measures to be taken by employers, Sexual Harassment of Women at workplace (prevention prohibition and redressal) Act 2013 by parliament, SHE Box by Ministry Of Women and Child Development for online complaint.
- **For rape cases**: Proposal of *Justice Verma Committee* was accepted to treat juvenile between 16-18 years age as an adult for committing heinous crimes. Recently, the government has brought amendments in PoCSO act 2012 in which Rape of girl child below 12 years will be punished by death penalty
- **For domestic violence**: Domestic violence act 2005 and Section 498A of IPC deals with cruelty by husband or relatives.
- **Other initiatives**: SWADHAR: A Scheme for Women in Difficult Circumstances, GPS tracking, 'panic buttons' etc.
- Government is also planning to set up a dedicated **National Mission on women safety to ensure specified actions by Ministries and Department**

Way forward

- **Strengthening criminal justice machinery:** Strict enforcement of laws, setting up of fast track special courts, strengthening of prosecution machinery, strengthening of Alternate Dispute resolution mechanism like Lok Adalat, implementing **Draft National Policy for Women 2016** in letter and spirit etc.
- **Encourage women to step up and speak** to the relevant committee in the organization in case of any issues such as harassment and improper conduct and situation. Women should also be trained for self-defence.
- **Gender sensitisation** of the law enforcement agencies, especially the police and the judiciary through periodic training as well as instituting gender-sensitization trainings in corporates
- **Development of a community-based strategy** to tackle domestic violence and community policing initiatives such as Mahila Suraksha Samiti and Women State Committee to check crimes
- **Adopting zero tolerance policy** towards any form of harassment at the workplace. It should be embedded in an organization's various policies and principles, such as the code of conduct.
- Civil society in collaboration with all sections of society should organize several grass root movements. Many movements like **'Pinjra Tod'** and **'One Billion Rising'** are contributing significantly via bottom up approach for the cause of women safety.
- **Moral education**: Moral overhauling of the mindset of masses should be attempted through awareness and education.

1.3.2. DOMESTIC VIOLENCE ACT

Supreme Court has upheld that the Domestic Violence Act — meant to punish men who abuse women in a relationship — extends to all man-woman relationships, and also protects divorced women from their former husbands.

Fact File

- Women continue to face **most risks from their families.**
- Among all registered cases of serious crimes against women, the largest share 36% of all cases was under **"cruelty by husband and relatives"**
- The next largest share was "assault on women with intent to outrage her modesty" (24 per cent)
- Increase in rape, kidnapping and abduction and assault on women
- **Rapes** - In 2014, almost 44 per cent of all victims were in the age group of 18-30 years**,** whereas one in every 100 victims was under six years of age.

Recent changes

- The **definition of Domestic Violence has been modified** - it includes ***actual abuse*** or the ***threat of abuse*** that is ***physical, sexual, verbal, emotional and economic*** **and further** ***harassment*** **by way of** ***unlawful dowry demands*** **to the** ***woman or her relatives*****.**

- **Widened the scope of the term WOMEN** - The Act now covers **"live- in partners", wives, sisters, widows, mothers, single women, divorced women** are entitled to get legal protection under this Act.
- **Right to Secure Housing** i.e. right to reside in the matrimonial or shared household, *whether or not she has any title or rights in the household*. This right is secured by a residence order, which is passed by a court.
- The Court can *pass* ***protection orders to prevent the abuser from aiding or committing an act of domestic violence*** like entering a workplace or any other place frequented by the abused, attempting to communicate with the abused, isolating any assets used by both the parties , etc.
- It provides for ***appointment of protection officers*** and ***NGOs to provide assistance*** to the woman for medical examination, ***legal aid and safe Shelter***.
- Punishment of ***one year maximum imprisonment*** and Rs. 20,000 each or both to the offenders is mentioned.
- Provides for ***breach of protection order*** or interim protection order by the respondent as a ***cognisable and non-bailable offence punishable with imprisonment*** which may extend to one year or with fine which may extend to Rs. 20,000 or with both.
- ***Non-compliance or discharge of duties by the protection officer is also sought to be made an offence under the Act with similar punishment.***

Changes in Domestic Violence Act

- The Supreme Court has struck down the words "adult male" from the pertinent provision in the DV Act to lay down that a woman can also file a complaint against another woman, accusing her of domestic violence.
- **Reasoning of Court**
  - Since the perpetrators and abettors of domestic violence can also be women, insulating them would frustrate the objectives of the Act. Under this immunity females and minors can continue to commit domestic violence.
  - It discriminates between persons similarly situated and, thus, violates A.14 of the Constitution.

Significance of the Change

- It makes DV **gender neutral** which according to some experts (including the bench) would help in serving the purpose of the law in a better way.
- However, there are concerns from some corners that it would encourage husbands to file counter cases against their wives through their mothers or sisters.
- There are also apprehensions about putting juveniles under the Act. There is no criminal provision under DV Act and thus no question of dealing with juvenile Board.
- Relief under DV Act is almost always financial - maintenance, compensation and alternate residences – which can all be claimed only against an adult.

Reasons/Issues Involved

- **Urban areas**- more income of a working woman than her partner, abusing and neglecting in-laws etc
- Violence against young widows esp **in rural areas** - most often they are cursed for their husband's death and are deprived of proper food and clothing; they are not allowed or encouraged for remarriage in most of the homes, cases of molestation and rape attempts of women by other family members in nuclear families or someone in the neighbourhood.
- **Other Reasons** - Orthodox & Patriarchal mindset- male domination and control over women; Economic reasons- demand for dowry; infertility or desire for male child; Alcoholism.

Criticism/Misuse of the Domestic Violence Act

- **Gender biased and not gender neutral**- Increasing number of **false cases.**
- Excludes abuses pertaining to martial rape.
- Verbal abuse and mental harassment- scope of subjective interpretation by abused
- Lack of awareness esp in rural areas where there is more need of such Acts.
- Judicial system resorting to mediation and counselling even in cases of extreme abuse. Also, Insensitivity by male police officers, judicial magistrates during hearings, etc
- Absence of economic, psychological and support system for victim women
- Insufficient budgetary allocation to States- the States could not assign 'Protection Officers' because of the already overburdened department.

Way forward

- Protection should be provided to the abused women from domestic violence
- NGOs relating to women empowerment should be encouraged to protect women from domestic violence.
- Women should be financially empowered through various government schemes and programmes.
- Faster delivery of cases

- The PRIs should also play a progressive and empathetic role towards such cases- should participate in stopping domestic violence
- More sensitivity training to be given to officers concerned at every stage.
- More awareness drive esp. in rural areas.

1.3.3. DETERMINING SEXUAL ASSAULT

Why in News?

- A recent Delhi High Court judgment on the issue of sexual consent has raised divergent views in the legal community on the **grey line between consent of a woman and rape**.
- A similar issue of consent was raised in the judgement passed by the Punjab and Haryana High Court, in a rape case in Sonipat.

Rape is a crime against basic human rights and also violates right to life contained in **Article 21**.

Two sections 375 and 376 of Indian Penal Code deal with the offense of rape in India.

Judgements by the High Courts

- The Delhi High Court acquitted director Mahmood Farooqui, accused of rape. One of the grounds for acquittal was that the negation of consent was not clear enough under the circumstances and that the complainant merely resisted "feebly".
- The accused was given the benefit of doubt because he had no intention to rape her and it was unclear that she had refused consent.
- While the Punjab and Haryana HC characterised the victim as a person with a "promiscuous attitude and a voyeuristic mind" and also sought to suggest that the young woman enjoyed a certain comfort level with the offenders.

Laws on Consent in different countries

The **Canadian Criminal Code** states that consent has to be categorically given and nothing short of voluntary consent/agreement would suffice (Section 273). The burden is on the accused to prove that he took steps to ascertain that the victim was consenting.

Similar is the case in the **UK's Sexual Offences Act.**

In **Australia** too, there has been an increasing focus on consent as a determinative factor while deciding on sexual assault offences and the burden is on the accused to prove that he took the consent of the victim.

Defining consent

Consent is what distinguishes sexual intercourse from rape. However, consent is also something that is difficult to determine and prove, especially in rape cases where more often than not, there are no eyewitnesses.

- **The Justice Verma Committee** pointed to the need to define consent**.** This definition given by the committee was added to IPC.
- The explanation states that consent means an **unequivocal voluntary agreement** when the woman by words, gestures or any form of verbal or non-verbal communication, communicates willingness to participate in a specific sexual act.
- Besides this, various SC judgements have stated that to prove an offence of rape, a woman is not required to prove that there was active resistance on her part during the commission of the act of rape. Absence of these factors does not indicate that a woman has given consent.

Arguments against the Judgements

- The judgment is alleged to have created a new defence for the rapist which does not exist in law. There is a double presumption - absence of intention to rape (by the accused) and non-communication by the woman despite a clear 'no' from her.
- The judgment shifts the burden to prove consent or refusal to a sexual act onto the woman
- Also the Punjab HC used language about the young victim that feeds into the tendency of **victim blaming**.

1.3.4. SEX WITH A MINOR WIFE AMOUNTS TO RAPE

Why in News?

The Supreme Court recently held that sexual intercourse by a man with his wife, who is below 18 years of age, is rape.

Section 375 of the IPC- A man is said to commit "rape" who, except in the case hereinafter excepted, has sexual intercourse with a woman under circumstances falling under any of the six following descriptions:

- Against her will.

- Without her consent.
- With her consent, when her consent has been obtained by putting her or any person in whom she is interested in fear of death or of hurt, etc

Exception- Sexual intercourse by a man with his own wife, the wife not being under fifteen years of age, is not rape.

Section 198(6) of the CrPC- No Court shall take cognizance of an offence under section 376 of the Indian Penal Code (45 of 1860), where such offence consists of sexual inter-course by a man with his own wife, the wife being under fifteen years of age, **if more than one year has** passed.

Background

- **Under the IPC**, it is an offence to have sex with a girl below 18 years of age, regardless of consent. However, an exception to this is made if the girl was the man's wife, provided she was not below 15, thereby **treating rape as permissible in marriage**.
- The **age of consent to marry**, since 1978, had been set at 18 years. The **Law Commission**, in its 84th Report had also recommended that this age for a married female under Section 375 of the IPC be made 18 years.
- The Supreme Court **in Independent Thought v. Union of India**, analysed the various laws prescribing the age of a female in that regard, and pronounced that the age of consent being 15 years for a married female, was inconsistent with existing laws as well as violative of the right to life of the minor under **Article 21** of the Constitution.
- However, **the government** had urged the court **not to tinker with the exception** clause as it was introduced keeping in view the age-old traditions and evolving social norms. Also, according to the government, a concern for the misuse of such law for **threatening the husband** remains a possibility.

Child Marriage in India

According to **Census 2011**, the nine-year period to 2011 saw 15.3 million (approx 20% of all females) girls being married before they reached the age of 18 years.

Personal Laws

- Under the Muslim personal law (**Dissolution of Muslim Marriages Act, 1939**), if a minor girl under the age of 15 years is married under Muslim law, she can obtain a decree of dissolution of marriage before she attains the age of 18 years provided that the marriage has not been consummated.
- According to the **Hindu Marriage Act, 1955** a Hindu girl can file a petition for divorce on the ground that her marriage, whether consummated or not, was solemnised before she attained the age of 15 years and she has refused to accept her marriage after attaining the age of 15 years but before attaining the age of 18 years.

Important points of the Judgement

- The court read down **Exception to Section 375** of the IPC, which allowed the husband of a girl child — between 15 and 18 years of age — blanket liberty to have non-consensual sexual intercourse with her. It creates an artificial distinction between a married girl child and an unmarried girl child.
- The exception had **remained an anomaly** because **Section 375** itself mandated that sex with a girl below 18 years of age, with or without her consent, was statutory rape.
- The court, however, clarified that Section **198(6) of the CrPC** will apply to cases of rape of wives below 18 years, and cognizance can be taken only in accordance with this provision.
- It is also clarified that nothing said in this judgment shall be taken to be an observation one way or the other with regard to the issue of "marital rape".

Impact

- This judgement can be seen as trigger **to declaring child marriage void *ab initio*,** the court ended the decades-old disparity between Exception 2 to Section 375 IPC and other child protection laws.
  - These include **the child marriage Restrain Act, 1929, Prohibition of Child Marriage Act (PCMA) of 2006, Protection of Children from Sexual Offences Act and Juvenile Justice Act**, all which define a "child" as someone who is below 18 years of age.
- It is also likely to **have a bearing on the criminality of marital rape**, an issue which has been widely debated both by Parliament and the courts.

Concerns

- Though child marriage is prohibited, it is not automatically void under India's civil laws. The court criticised the fact that **PCMA makes child marriage only voidable,** that is, the burden is placed on the child bride to

approach a court to declare her marriage a nullity. There needs to be changes & amendments in laws to eliminate various anomalies.

- For a minor girl child, good health would mean her right to develop as a healthy woman. This not only requires good physical health but also good mental health which is restricted by child marriage.

1.3.5. AMENDMENTS PROPOSED IN INDECENT REPRESENTATION OF WOMEN (PROHIBITION) ACT (IRWA), 1996

Why in news?

Recently, **Ministry of Women and Child Development** has proposed amendments in IRWA.

Background

- Government enacted the **Indecent Representation of Women (Prohibition) Act (IRWA), 1986** to prohibit indecent representation of women through **advertisements, publications, writings, paintings, figures or in any other manner,** in response to the demand by the women's movement for a legislative action against the derogatory depiction of women in India.
- Under the Act, the term **"indecent representation" has been defined in Section 2(c)** as the depiction in any manner of the figure of a woman, her form or body or any part thereof in such a way as to have the effect of being indecent, or derogatory to, denigrating, women, or is likely to deprave, corrupt or injure the public morality or morals.
- Since then, technological revolution has resulted in the development of new forms of communication, such as internet, multi-media messaging, cable television, over-the-top (OTT) services and applications e.g. Skype, Viber, WhatsApp, Chat On, Snapchat, Instagram etc.
- Hence, the **Indecent Representation of Women (Prohibition) Amendment Bill, 2012** was introduced in Rajya Sabha in December, 2012 which referred the Bill to Department related Parliament Standing Committee for consideration.

Amendments Proposed

The amendments proposed based on the observations made by **Parliamentary standing committee on Human Resource Development** and recommendations from the **National Commission for Women (NCW)** are:

- **Widening the definition** of following terms:
  - **Advertisement** to include digital form or electronic form or hoardings, or through SMS, MMS etc.
  - **Indecent representation of women** to mean the depiction of the figure or form of a woman in such a way that it has the effect of being indecent or derogatory or is likely to deprave or affect public morality.
  - **Electronic form** means any information generated, sent or stored in media, magnetic and optical form (as defined in the Information Technology Act, 2000).
  - **Publish** includes printing or distributing or broadcasting through audio visual media.
  - **Distribution** to include publication, license or uploading using computer resource, or communication device.
- **Expands section 4 of the Act** to include that No person shall **publish or distribute or cause to be published or cause to be distributed by "any means any material"** which contains indecent representation of women in any form.
- **Penalty** similar to that provided under the **Information Technology Act, 2000:** Sections 67 and 67A of the IT Act lay down a punishment of three to five years for circulating obscene material and five to seven years for circulating sexually explicit material, respectively.
- **Creation of a Centralised Authority** under the aegis of **National Commission of Women (NCW)** which is to be headed by Member Secretary, NCW, having representatives from Advertising Standards Council of India, Press Council of India, Ministry of Information and Broadcasting and one member having experience of working on women issues.
  - **Its function** will be to receive complaints or grievances regarding any programme or advertisement broadcasted or publication and investigate/examine all matters relating to the indecent representation of women.

Significance

- **Widens the scope of the Act** to cover new forms of communication such as the internet, satellite based communication, cable television etc which remained outside the application of 1986 Act which focused primarily on print media and advertising.
- **Reduce the complexity in application of the laws** as the Amendment seeks to align the act on the lines of Information Technology Act, 2000.
- **Counter the rising menace of "Revenge Porn":** The proposed amendment is a gender-specific statute and thus, is likely to be an enabling provision for countering the presence of such non-consensual material over the web.

Concerns

- The term "indecent representation" continues to be **defined in a vague manner,** leaving the same open to misinterpretation.
- When the **standard of derogatory portrayal is not categorically defined,** there is always a possibility of the same being interpreted on the benchmark of an **orthodox morality.** For instance the case of **Central Board of Film Certification (CBFC)** controversy in film certification in recent past.
- This may **encourage moral policing of women's bodies** to the extent that any content involving "nudity" would be disallowed or banned, irrespective of the purpose behind its publication, like the **Breast Cancer Awareness Video** which was banned by Facebook, though it later issued an apology for the same. Also recently, a Kerala magazine showed a model breastfeeding a child on cover page was trying to convey a **cause for breastfeeding in public,** however, a case was filed under section 4 of the Act against the magazine.
- **Conflict with Freedom of expression (Article 19(1)(a)) In Ajay Goswami v. Union of India (2007),** while examining the scope of **Section 292 of IPC and Sections 3, 4 and 6 of the Indecent Representation of Women (Prohibition) Act, 1986,** the Supreme Court held that the commitment to freedom of expression demands that it cannot be suppressed, unless the situations created by it allowing the freedom are pressing and the community interest is endangered.

Related Cases

- In **Aveek Sarkar Vs. State of West Bengal (2014)** the Supreme Court while quashing the case under the Act against two magazines which published an article showing Tennis player Boris Becker posing nude with his dark-skinned fiancée Barbara Feltus as a strident protester of the pernicious practice of "Apartheid", said the picture has to be viewed in the background in which it was shown, and the message it has to convey to the public and the world at large.
- Similarly, in **Bobby Art International & Ors. v. Om Pal Singh Hoon (1996),** the Supreme Court while dealing with the question of obscenity in the context of film **Bandit Queen** pointed out that the so-called objectionable scenes in the film have to be considered in the context of the message that the film was seeking to transmit in respect of social menace of torture and violence against a helpless female child which transformed her into a dreaded dacoit.

Way forward

- Unless a standard is set to determine exactly what the legislation attempts to penalise, the regulatory framework proposed to be enforced may remain hollow to a certain extent.
- The Government should regularly conduct **awareness generation programmes** and publicity campaigns on various laws relating to women including the Indecent Representation of Women (Prohibition) Act, 1986 through workshops, fairs, cultural programmes, seminars, training programmes, etc.

Further, advertisements must regularly be brought out in the print and electronic media to create awareness on laws relating to rights of women.

1.4. RECENT GOVERNMENT INITIATIVES TO TACKLE WITH GENDER RELATED ISSUES

- **Suvidha** - Recently, Ministry of Chemicals & Fertilizers has launched 100% Oxo-biodegradable sanitary napkin, under the Pradhan Mantri Bhartiya Janaushadhi Pariyojana.
  - It is an **affordable sanitary napkin** launched to ensure **'Swachhta, Swasthya and Suvidha'** for the **underprivileged Women** of India.
- **Project Stree Swabhiman-** Recently, Ministry of Electronics and Information technology (MeITY) announced a project Stree Swabhiman.
  - It aims to create a sustainable model for providing adolescent girls and women an **access to affordable sanitary products** in rural areas.

Other related schemes

Menstrual Hygiene Scheme (MHS)

- Being implemented by **Health Ministry** as part of **Rashtriya Kishor Swasthya Karyakram**.
- It provides subsidized sanitary napkins among adolescent girls residing primarily in rural areas.
- **Aim:** to reach 15 million girls aged 10 to 19 and in 152 districts across 20 states

Menstrual Hygiene Management National Guidelines, 2015

- Issued by **Ministry of Drinking Water & Sanitation**.
- It covers the aspects of providing adolescent girls with menstrual hygiene management choices and menstruation hygiene management infrastructure in schools and the safe disposal of menstrual waste.

Rashtriya Madhyamik Shiksha Abhiyan

- Under this centrally sponsored scheme of **Ministry of Human Resource Development,** sanitary pads are provided in schools and girls hostels.

- **Online Portals 'Nari' And 'E-Samvaad'-**
  - **Nari Portal** - It is a Mission Mode Project under the National E-Governance Plan (designed and developed by National Informatics Centre (NIC), Ministry of Electronics & Information Technology).
  - **e-samvaad Portal-** It is a **platform for NGOs and civil society** to **interact** with the Ministry of Women and Child Development (MWCD) by providing their feedback, suggestions, put up grievances, share best practices etc.
- **Mission for Protection And Empowerment For Women** - Recently, Cabinet approved the its expansion and introduced a new scheme **Pradhan Mantri Mahila Shakti Kendra**.

About Mission for Protection and Empowerment for Women

- It is a social sector welfare schemes for care, protection and development of women.
- It aimed at improving the declining Child Sex Ratio; ensuring survival. & protection of the girl child; ensuring her education and empowering her to fulfill her potential.

Mission for Protection and Empowerment for Women

- **Aim:** To achieve holistic empowerment of women through convergence of schemes/programmes of different Ministries/ Department of Government of India as well as State Governments.
- It provides expert and technical support in
  - Poverty alleviation economic empowerment,
  - Health and nutrition,
  - Gender budgeting & Gender mainstreaming,
  - Gender rights gender based violence & law enforcement,
  - Empowerment of vulnerable & marginalised groups,
  - Social empowerment & education.
  - Media and advocacy and
  - Information technology
- **Nodal agency**: Ministry of Women and Child Development (MWCD)
- **Coverage area**: All State/UTs will be covered under this Scheme through the State Resource Centre for Women (SRCWs).
- **Implemented** through the States/UTs and Implementing Agencies.

- **Pradhan Mantri Mahila Shakti Kendra (PMMSK)**
  - **Objective:** To provide an **interface** for **rural women** to approach the government for availing their entitlements and for empowering them through training and capacity building.
  - **PMMSK Block level initiatives**: Under it**, community engagement** is envisioned in **115 most backward districts** through Student Volunteers.

2. ISSUES RELATED TO CHILDREN

India is one of the 193 countries that are signatories to the **United Nations Convention on the Rights of the Child (UNCRC).** These rights include-

- promoting healthy lives (addressing survival, nutrition, health care services etc.),
- providing quality education, and
- protection against abuse, exploitation and violence (combating child labor, child trafficking and child sexual abuse).

Ratification of the convention on child rights obligates a country to integrate its articles into national constitutions and legislations.

2.1. CHILD HEALTH

Indicators of health, disease and mortality among the children of our country continue to remain alarmingly poor despite improvement in various arenas. Neonatal and infant mortality rates are high, and preventable diseases – infections, malnutrition and nutrient deficiency disorders – are very frequent. UNICEF annual reports mention that the health status of our children is worse than some of our neighboring countries, and comparable to Sub-Saharan African nations. Although the Government has undertaken several very important measures to address the various health problems of children, their impact has been limited.

The needs and care of children are very different at different ages. The important health needs at various ages can be considered as follows-

- **Newborn:** Maternal nutrition and adequate antenatal care. Safe delivery, immediate care of the neonate and subsequent management during the first 1-3 months.
- **Infancy and pre-school period:** Feeding and nutrition (supplements of iron, vitamins), immunization, proper management of common infections (diarrhea, respiratory, skin, eye, ear, parasitic), and attention to development.
- **Older children:** Adequate nutrition, treatment of acute and chronic diseases (e.g. tuberculosis, malaria, water borne diseases).
- **Adolescents:** Physical and emotional health, treatment of acute and chronic diseases, family life counseling.

Other Issues in Child health

- **Health facility gap between states:** Up to three times as many deaths could have been avoided, had the differences between more developed and poorer states not been there.
- **Rural-Urban gap:** There is an **increase in mortality rates** for premature or low-birth-weight babies in previous 15 years, especially in rural areas.
- **Challenge of tracking Childhood Deaths** because most deaths, especially of children, happen at home and without medical attention.

2.1.1. NEW BORN HEALTH

India has been at the forefront of the global effort to reduce child mortality and morbidity. Its continuous commitment and ongoing efforts have resulted in a **59% reduction in under-5 child mortality since 1990,** yet in 2016, India had the largest number of babies dying in the world. The major **causes of newborn deaths in India** are- pre-maturity/preterm (35%); neonatal infections (33%); intra-partum related complications/ birth asphyxia (20%); and congenital malformations (9%).

A recent report by Lancet- **"Every Child Alive"** highlighted various factors related to Neonatal mortality and need for government plans/actions.

Highlights of the Report

- Two main factors help explain **reasons behind high numbers** of Neonatal Mortality.
  - **Preventable causes** like prematurity, complications around the time of birth, and infections such as sepsis, meningitis and pneumonia require a **system-wide approach** because they cannot be treated by a single drug intervention.
  - **Lack of global focus** on the challenge of ending NM.
- Newborn survival is closely linked to a country's income level. For example, NM in Japan is 1 in 1,000 while in Pakistan it is 46 in 1000.

- However, a country's income level explains only part of the story. The existence of political will to invest in strong health systems that prioritize newborns and reach the poorest and most marginalized is critical and can make a major difference, even where resources are constrained. For example, Rwanda, a low-income country, reduced its NM rate from 41 in 1990 to 17 in 2016.
- NM varies even within a country depending on factors like household wealth quintile, education of mother and whether residing in rural or urban area.
- The country with the lowest NM is Japan and the country with the highest NM is Pakistan.

Important Facts

- In 2016, India had the **largest number of babies dying** in the world. India's neonatal mortality rate (2016) is 25.4/1000.
- The number of **annual under-five deaths** in India has gone below one million for the first time in 2016.
- India's current under-five mortality rate is 39/1000.
- The **under-five mortality** rate for girls was 11 per cent higher at 41 per 1,000 as against 37 per 1,000 for boys.
- Fewer child die in urban areas and in richer states than in rural and poorer states.
- There was a **90 percent drop in neonatal deaths** from **tetanus and measles**, two of the main causes of infant deaths in India.
- **Mortality rates from pneumonia and diarrhea**, the two leading causes of child deaths in the country, fell more than 60 percent.
- Declines were greater in girls, indicating **girls are getting better** health attention in India. This **decline in mortality is attributed to** the introduction of two major national programmes in 2005 – the National Rural Health Mission, which is now the **National Health Mission, and the Janani Suraksha Yojana**.
- With the current rate of decline, India is back on track to meet the Sustainable Development Goals (SDG) target for the under-five mortality of 25 per 1,000 live births by 2030.

Effective Policy Actions for Countries with high newborn mortality

- **Improving access** to maternal and newborn health by having adequate number of health care workers, backed by facilities to deal with the main causes of NM, easily accessed by the community, etc.
- **Providing quality healthcare** which is not just about whether resources and services exist, but how they are deployed.

National Health Mission (NHM)

2 Sub-mission

- National Urban Health Mission (NUHM)
- National Rural Health Mission (NRHM)

The broad objectives of NHM

- Reduce MMR to 1/1000 live births
- Reduce IMR to 25/1000 live births
- Reduce TFR (Total Fertility Rate) to 2.1
- Prevention and reduction of anaemia in women aged 15–49 years.

Newborn health has captured the **attention of policymakers** at the highest level in India. This has resulted in **strong political commitment** to end preventable newborn deaths and stillbirths and recognize newborn health as a national development necessity. The **policy changes for newborn survival** have focused on broader health initiatives such as strengthening health systems; training and equipping more health workers; making proven but underused solutions available to every mother and newborn, including skilled attendance at birth; exempting pregnant mothers and sick infants from all user fees; and providing free transportation from home to health facilities for mothers and newborns. Among various steps taken by the government **India Newborn Action Plan (2014)** provides a larger framework to deal with the issue.

India Newborn Action Plan (2014)

- The India Newborn Action Plan (INAP) is India's committed response to the Global Every Newborn Action Plan (ENAP), launched in June 2014 at the 67th World Health Assembly, to advance the Global Strategy for Women's and Children's Health.
- Its goal is to attain **Single Digit Neonatal Mortality** and Stillbirth Rates by 2030. It lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress, and scale up high-impact yet cost-effective interventions
- It is to be implemented within the existing **Reproductive, Maternal, Newborn, Child and Adolescent health (RMNCH+A)** framework of the National Health Mission (NHM).
- It will serve as a framework for the States to develop their area-specific action plans. **Six pillars** of intervention include:
  - Preconception and antenatal care
  - Care during labour and child birth
  - Immediate newborn care
  - Care of healthy newborn
  - Care of small and sick newborn
  - Care beyond newborn survival

2.1.2. CHILD NUTRITION

- Malnutrition refers to deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients. The term malnutrition covers 2 broad groups of conditions. One is '**undernutrition**'—which includes stunting (low height for age), wasting (low weight for height), underweight (low weight for age) and micronutrient deficiencies or insufficiencies (a lack of important vitamins and minerals). The other is **overweight**, obesity and diet-related noncommunicable diseases (such as heart disease, stroke, diabetes and cancer).

Double Burden of Malnutrition

- **Undernutrition** - About 37% of our under-five children are underweight, 39% are stunted, 21% are wasted and 8% are acutely malnourished, according to a joint study by ASSOCHAM and Ernst and Young
- **Overweight** - India is also ranked as the third most obese nation of the world after US and China, according to a WHO report of 2015.

- It results not just from a lack of food but from a diverse set of interlinked factors linking healthcare, education, sanitation and hygiene, access to resources, women's empowerment and thus requires multi-dimensional interventions.
- India pays an income penalty of about 9% to 10% due to a workforce that was stunted during their childhood.
- Recently released **World Hunger Index report 2017** has also placed India at **100th rank out of 119 countries**.
- It affects **chances of survival** for children, **increases their susceptibility** to illness, reduces their ability to learn, and makes them less productive in later life. It is estimated that malnutrition is a contributing factor in about **one-third of all deaths of children** under the age of 5.
- Lancet study raised concerns about **double burden of malnutrition**, that is, underweight as well as obese children in India. **National Nutrition Monitoring Bureau (NNMB)** also released its report recently, covering 16 states to understand the current nutritional status of urban population in India.

Article 47 of the Constitution mentions the "duty of the state to raise the level of nutrition and the standard of living and to improve public health." In context of this the National Nutrition Strategy and National Nutrition Mission has been launched. Integrated Child Development Scheme (ICDS), and Mid-day Meal schemes are also intended towards reducing malnourishment and undernutrition.

Undernutrition in India

- According to UNICEF, India was at the 10th spot among countries with the **highest number of underweight** children, and at the 17th spot for the **highest number of stunted** children in the world.
- Undernutrition is both a **consequence as well as a cause** of perpetuating poverty, eroding human capital through irreversible and intergenerational effects on cognitive and physical development.
- This **intergenerational cycle of undernutrition**, manifest as low birth weight, is compounded by gender discrimination and social exclusion. Nutrition status of the most vulnerable age group of children is also a **sensitive proxy indicator of human development** and of the effectiveness of national socio-economic development strategies.
- Undernutrition manifests itself in following forms-
  - **Underweight Prevalence in Children**- As per National Family Health Survey (NFHS4) there has been a 16% decrease in the underweight prevalence among children below 5 years. Underweight prevalence in children under 5 years (composite indicator of acute and chronic undernutrition) has declined in all the States and UTs (except Delhi), although absolute levels are still high.
  - **Stunting in Children**- It highlights that stunting in children under 5 years has reduced in all the States, although absolute levels are still high in some States.
  - **Wasting in Children**- The findings highlight that wasting in children under 5 years (weight- for- height) or acute malnutrition is still high.

Childhood Obesity

Recently, a study was conducted about lifestyle diseases, physical activity, and eating patterns of adolescents.

Key findings

- Indian kids have reasonable knowledge about lifestyle diseases yet it does not translate into preventive action, thus, there is a knowledge-practice gap among teenagers.

- About 82% of the adolescents did not perceive themselves to be at risk for future cardio vascular diseases (CVDs) and even those who perceived the risk showed poor dietary practices.
- The trend of poor eating habits was visible more in older students and those belonging to affluent families as compared to low or middle-class.
- About 20% of the participants reported a family history of CVDs while a majority had little information about heart disorders.
- Boys tended more to be involved in physical activity (adequate physical activity as one hour every day) along with those who had better knowledge about risk factors.

Related Information

- India has the second highest number with 14.4 million children with excess weight.
- The incidence of obesity has doubled since 1980 in over 70 countries of the world
- Childhood obesity has grown at a faster rate than adult obesity in many countries.

Reasons of obesity according to NNMB report

- Not taking recommended daily intake (RDI) despite improvement in nutritional status
- Although cereal consumption has reduced in compared to 3 decades ago but intake of fat, sugar and oil have increased
- 63% of men and 72% of women work for 8 hours per day but they lead a sedentary life.
- No proper regime of eating, sleeping & doing physical activity is followed
- Traditional foods are being replaced with packed & processed foods
- Only 28% of men & 15% of women exercised in the surveyed states
- Increasing tobacco & alcohol consumption in men & women.

How to tackle childhood obesity?

- **Awareness** - Promotion of school-based cardiovascular health programs to dispel myths that CVDs are problem of the aged only.
- **Changes in lifestyle –** through inculcating changes in eating habits and physical activity.
- **Regulation of marketing** and promotion of unhealthy foods, particularly those targeted at children, that are high in salt, sugar and fat
- **Labelling -** the role of positive front of pack and standardised global nutrient labelling on packaged foods may help in promotion of healthy foods and lifestyle
- **High tax** - the imposition of high taxes on sugar-sweetened beverages

Challenges in India to tackle obesity

- **Low standards** - standard of 5% (by weight) for trans-fats in fat spreads, hydrogenated vegetable oils etc. is high as compared to global best practices as countries are moving towards near zero.
- **No regulation on advertisements** - Currently there is no regulation for broadcast advertising and celebrity endorsements in India unlike international best practices such as in Norway and Brazil.
- **No basic labelling regulations** - The current nutrition labelling does not declare salt/sodium, added sugar and saturated fats on a mandatory basis. There is no mandatory provision for nutrient declaration per serve. Rather, it is optional with per 100 gm of product.
- **No policy guidelines** to reduce obesogenic environments in schools and promoting healthy foods and lifestyle even after 2015 Delhi High Court order to FSSAI to issue guidelines for the same.

No country has been able to stop the rise in obesity. Countries with burgeoning prevalence should start early to avoid some of the mistakes of high-income neighbours. There is an opportunity to identify – and take – 'double duty' actions which tackle more than one form of malnutrition at once. These will increase the effectiveness and efficiency of investment of time, energy and resources to improve nutrition. For example, actions to promote and protect breastfeeding in the workplace produce benefits for both sides of the double burden of malnutrition.

Ending childhood obesity would also contribute to achievement of Sustainable Development Goals, WHO's global action plan for the prevention and control of NCDs (2013-2020), WHO's comprehensive implementation plan for maternal, infant and young child nutrition etc. For example, urban food policies and strategies can be designed to reduce climate change, food waste, food insecurity and poor nutrition.

2.2. CHILD MARRIAGE

Child marriage refers to the marriage of a child younger than 18 years old, in accordance to Article 1 of the Convention on the Right of the Child. **According to UNICEF,** the proportion of girls getting married in India has nearly halved in a decade. 25 million child marriages were prevented worldwide in the last decade, with the largest reduction seen in South Asia — where India was at the forefront.

Also, according to the Census 2011 reveals that child marriage is rampant in India, with **almost one in every three married woman** having been wed while she was still under the age of 18 years.

Causes of Child Marriage in India

- **Deeply entrenched and widely practised social customs** with wide social approval is a major, often the most critical, driving factor of high prevalence of child marriage in states such as Andhra Pradesh, Rajasthan and Gujarat.
- **Poverty, high wedding costs and other economic considerations:** political economy of child marriage is also determined by high demand for labour and high female work participation in certain geographic areas.
- **Lack of easy access to schooling, especially at secondary level:** According to UNICEF, a girl with 10 years of education has a six times lower chance of being pushed into marriage before she is 18.
- **Political patronage** due to social acceptance as politicians find it difficult to oppose the practice of child marriage as it may mean losing votes and support.
- Child marriage is also widely reported to be used as **a disguise to traffic girls from poor and tribal families** for either the sex trade or as cheap labour.

Basic facts

- Child marriage is **more prevalent in rural areas** (48%) than in urban areas (29%).
- In general, rates of child marriage are **highest in the central and western parts of India** and lower in the eastern and southern parts of the country.
- In certain states like Bihar and Rajasthan, approximately 60% of females are married as children.
- Other states having rate of child marriage higher than national average: Jharkhand, UP, West Bengal, MP, Andhra Pradesh, Karnataka, Chhattisgarh and Tripura.
- However, even in states with overall low prevalence of child marriage, there are often pockets of high prevalence.

Implications of Child Marriage

- Early marriage deprives children of access to education and therefore to better opportunities in the future.
- It limits the child's freedom of decision and contributes to intergenerational cycle of poverty.
- Child marriage is often associated with multiple health risks - young brides have limited access to, and use of, contraception and reproductive health services and information.
- The majority are exposed to early and frequent sexual relations and to repeated pregnancies and childbirth before they are physically mature and psychologically ready.
- Domestic violence thrives in an environment where women feel powerless and lack access to vital resources and decision-making powers.
- Child marriage violates the rights of boys and girls and undermines efforts to achieve sustainable development.
- It also affects society as a whole since child marriage reinforces a cycle of poverty and perpetuates gender discrimination, illiteracy and malnutrition as well as high infant and maternal mortality rates.

UN Convention on Rights of Child

It came into force in 1990. It prescribed a set of standards to be followed by all State parties in securing the best interests of the child.

State parties to the Convention on the Rights of the Child are required to undertake all appropriate measures to prevent:

- The inducement or coercion of a child to engage in any unlawful sexual activity;
- The exploitative use of children in prostitution or other unlawful sexual practices;
- The exploitative use of children in pornographic performances and materials.

Steps taken to Reduce Child Marriage

The Women and Child Development Ministry has taken a number of steps to enhance the status of girl child and to address the problem of child marriage. Special initiatives are taken by State governments every year on Akha Teej- the traditional day for such marriages. The MoWCD has also developed a **"National Strategy Document on Prevention of Child Marriage"** and is currently drafting a plan of action on child marriage to guide all states in the implementation of strategies to prevent the problem. The suggested strategic areas of intervention to prevent child marriage are-

- **Law Enforcement- The Prohibition of Child Marriage Act,** main piece of legislation to prevent child marriage, 2006 makes it illegal for girls to marry under 18 years and for boys under 21 years. Such laws need to be enforced by ensuring appointment of Child Marriage Prohibitioon Officers, awareness of the law among communities and individuals, capacity building for the same, etc.
- **Access to quality education** and other opportunities since Education can be an important refraining factor from early marriage.

- **Changing mindsets and social norms**- Perceptions about gender and the role of women in the family and society, practices around marriage and puberty, and wide acceptance that marriage should be performed after puberty all contribute to child marriage.
- **Empowerment of adolescent girls** through schemes like **SABLA** which promote life skills training among girls.
- **Knowledge and Data** are at the base of shaping evidence-base interventions.
- **Developing Monitorable Indicators** in order to understand the impact of interventions on prevention of child marriage.
- Other laws that may provide protection to a child bride include the Juvenile Justice (Care and Protection of Children) Act, 2000, the Domestic Violence Act, 2005, and the Protection of Children from Sexual Offences Act, 2012.

2.3. CRIMES AGAINST CHILDREN

According to UNICEF violence against children can be "physical and mental abuse and injury, neglect or negligent treatment, exploitation and sexual abuse. It may take place in home, schools, orphanages, residential care facilities, on the streets, in work place, in prison and in places of detention. Such violence can affect the normal development of the child impairing their mental, physical and social being.

A steady upward trend with a significant increase of more than 500% over a period of the past one decade (1,06,958 in 2016 over 18,967 in 2006) has been seen in terms of crimes against children in India. In year 2015 and 2016, Crime against children in India has increased by a sharp 11% as freshly released NCRB data suggests.

Indian penal code and the various protective and preventive special and local laws specifically mention the offences wherein children are victims. The age of child varies as per the definition given in the concerned Acts and sections but age of child has been defined to be below 18 years as per The Juvenile Justice (Care and Protection of Children) Act, 2000.

2.3.1. CHILD SEX ABUSE

Child sexual abuse (CSA) is a serious and widespread problem in India as it is in many parts of the world today. The trauma associated with sexual abuse can contribute to arrested development, as well as a host of psychological and emotional disorders, that some children and adolescents may never overcome. When sexual abuse goes unreported and children are not given the protective and therapeutic assistance they need, they are left to suffer in silence.

Important facts and figures

- The number of identified incidents of child sexual abuse decreased at least 47% from 1993 to 2005-2006.
- According to the National Crime Records Bureau, in 2016, 93,344 cases of crimes against children were registered across India.
- The primary reason is that only about 38% of child victims disclose the fact that they have been sexually abused.
- Nearly 70% of all reported sexual assaults (including assaults on adults) occur to children ages 17 and under.
- About 90% of children who are victims of sexual abuse know their abuser. Only 10% of sexually abused children are abused by a stranger.
- Approximately 30% of children who are sexually abused are abused by family members.

CSA Laws in India

- The Government had acceded to the **Convention on the Rights of the Child** in 1992.
- Crimes against children were protected by section 354, 375, 377, 509 of **Indian Penal Code, 1860,** without any proper legislation until 2012.
- Finally, in the year 2012 the Parliament of India passed **the Protection of Children against Sexual Offences Act (POCSO)** for the victims of child sexual abuse below 18 years of age.
- The issue of pornography, affecting children, was dealt with **Young Persons (Harmful Publication) Act, 1956.**
- There are various constitutional provisions that deal with Rights of Child, viz-
  - **Article 21**- Provides for right to life and personal liberty.
  - **Article 24**- Provides no child below the age of 14 years shall be employed to work in a factory or a mine or engaged in any other hazardous employment.
  - **Article 39(f)**- It makes it obligatory for the state to direct its policy towards security "the health and strength of children and that they are given opportunities and facilities to develop in a healthy manner.

About POCSO

- It protects children from offences of sexual assault, sexual harassment and pornography and provide for **establishment of Special Courts** for trial of such offences and for matters connected therewith or incidental thereto.
- The Act defines a child as any person below the age of 18 years and provides protection to all children under the age of 18 years from the offences of sexual assault, sexual harassment and pornography.
- For the first time it listed aspects of **touch as well as non-touch behaviour** under the ambit of sexual offences (example- photographing a child).
- It incorporated child friendly procedures for reporting, recording of evidence, investigation and trial of offences.
- The **attempt to commit an offence** has also been made liable for punishment for up-to half the punishment prescribed for the commission of the offence.
- It also provides for punishment for abetment of the offence, which is the same as for the commission of the offence. This would cover trafficking of children for sexual purposes.
- For the more heinous offences of Penetrative Sexual Assault, Aggravated Penetrative Sexual Assault, Sexual Assault and Aggravated Sexual Assault, the burden of proof is shifted on the accused.
- The media has been barred from disclosing the identity of the child without the permission of the Special Court.

WHO Guidelines on Responding to Child Sex Abuse

- They put forward **recommendations for the frontline health care providers** who may directly receive a victim of sexual abuse or may identify sexual abuse during the course of diagnosis and treatment.
- The **recommendations are** in terms of disclosure made by the child, obtaining medical history, conducting physical examinations and forensic investigations, documenting findings, offering preventive treatment for HIV post exposure, pregnancy prevention, and other sexually transmitted diseases, psychological and mental health interventions among others.
- It highlights that child sexual abuse has a short-term as well as long-term mental and physical health impacts.
- The guidelines are crucial because of various avoidable mistakes committed during examination like the **re-traumatization of the victim.**
- They also provide recommendations to prevent the recurrence of child maltreatment.

Benefits of the guidelines

- The emotional and other aspects that were inadequately addressed by various legislations in the country are dealt with in the guidelines which are grounded in **human rights standards and ethical principles**.
- It is expected to assist WHO Member States to ensure the health and wellbeing of children and adolescents and implement the **Global Plan of Action** on strengthening the health systems response to violence against women and girls and against children, endorsed by the World Health Assembly in May 2016.

Criminal Law (Amendment) Bill, 2018

The Parliament on Monday passed the Criminal Law (Amendment) Bill, 2018 which ensures stringent punishment for those convicted of raping girls below 12 years of age.

- It proposes to:
  - Amend Section 376 of Indian Penal Code. The amended provision proposes to increase the minimum sentence of rape from 7 to 10 years.
  - Incorporate Section 376 (3) which provides that punishment for rape of girl below 16 years shall not be less than 20 years but may extend to imprisonment for life.
  - Insert Section 376AB to provide that whoever commits rape of women below 12 years of age shall be punished with rigorous imprisonment for life and with fine or with death.
  - Punish gang rape of woman below 16 years of age with rigorous imprisonment for life and with fine.
  - Punish gang rape of woman below 12 years of age with rigorous imprisonment for life and with fine or with death.
  - The ordinance also reduces the time limit of three months of investigation under CrPC to two months and also prescribes six months for disposal of appeals.
  - The Ordinance also prescribes that there will be **no anticipatory bail** for a person accused of rape or gang rape of a girl under 16 years.

Criticism of the Ordinance

- Presently there are a number of laws and acts in place which provide for stringent punishment in cases mentioned above such as **POCSO Act, Criminal Amendment Act of 2013** etc. However, efforts should be made to implement the existing laws properly.
- The delivery of justice for crimes reported against children needs to be expedited by placing more resources (human, budget and through the use of technology) and by making it survivor-centred, by strengthening the existing Integrated Child Protection Scheme and other support services.

Other measures announced

- **Strengthening Courts and prosecution** –
  - **Fast track courts** will be set up for speedy trial in consultation with States/UTs and High Courts.
  - **Special forensic Kits** will be provided to all police stations and hospitals.
  - **Dedicated manpower** for investigation of rape cases in time bound manner
  - Measures to be implemented in **mission mode** within 3 months
- **National Crime Records Bureau** will maintain a national database and profile of the sexual offenders and will share it with states and UTs for **tracking, monitoring and investigation.**
- The present scheme of **'One Stop Centre'** for assistance to victim will be extended to every district in the country.

- Presently, the massive backlog of redressal of rape cases, lack of rehabilitation support and psycho-social counselling to rape survivors -- and their family members -- is the immediate need.
- POCSO and RTE should also be extended to Jammu, Kashmir and Ladakh.
- The focus instead should be on quicker investigation and conviction which is one of the stated objectives of the new law through fast track courts but this was also there in the Act of 2013.
- New penalty will affect the reporting of cases because family members would not like their own relatives, who are often the culprit, to be hanged, putting them in jail for ten years or 20 years was a different proposition.

Child protection in our country cannot be ensured with just having legislations and numerous guidelines. We as a country need to commit in cultivating a culture of zero tolerance for violence against children. We should be vigilant and cognizant of the fact that children are at risk with gaps in infrastructure, processes and systems as well as people.

2.3.2. CHILD LABOUR

Introduction

The Indian Constitution ensures the right of all children (6-14 years) to **free and compulsory education** and prohibits their employment in hazardous occupations; and promotes policies protecting children from exploitation.

Children are employed because they are cheap and pliable to the demands of the employer and not aware of their rights. The risks that these children face can have an irreversible physical, psychological and moral impact on their development, health and well-being.

Nature of work

- They are generally **engaged in manual work**, in domestic work in family homes, in rural labour in the agricultural sector including cotton growing, at glass, match box and brass and lock-making factories, in embroidery, rag-picking, beedi-rolling, in the carpet-making industry, in mining and stone quarrying, brick kilns and tea gardens amongst others.
- **Work is often gender-specific**, with girls performing more domestic and home-based work, while boys are more often employed in wage labour.
- Getting accurate, detailed information about children working in different sectors is a major challenge because, in many cases, children work in informal sectors.

Despite of constitutional rights and several tough legislation **India's 2011 census showed that:**

- There were more than 10.2 million "economically active" children in the age group of five to 14 years - 5.6 million boys and 4.5 million girls
- Eight million of these children were working in rural areas, and 2 million in urban area
- Although in rural settings the number of child workers reduced from 11 million to 8 million between the 2001 and 2011 censuses, over the same period, the number of children working in urban settings rose from 1.3 million to 2 million.
- 50% of child labour is in Bihar, UP, Rajasthan, MP and Maharashtra. Over 20% is in UP alone. So special focus is needed here.

Factors which lead to Child Labour:

- Poverty and Illiteracy of a child's parents
- The social and economic circumstances of the family including the cultural values of the family and the surrounding society.
- lack of awareness about the harmful effects of child labour
- lack of access to basic and meaningful quality education and skills training
- high rates of adult unemployment and under-employment
- Due to conflicts, droughts and other natural disasters, and family indebtedness, children have to contribute their labour to add family income
- Rural poverty and urban migration also often exposes children to being trafficked for work.

National Legislations regarding Child Labour

- Child Labour (Prohibition and Regulation) Amendment Act, 2016
- National Policy on Child Labour (1987) which focuses upon rehabilitation of such children
- Juvenile Justice (Care and Protection of Children) Act 2015
- India has recently ratified two of the ILO (International Labour Organisation) Conventions on Child labour i.e.
  - Minimum Age Convention 1993
  - Worst forms of Child Labour Convention 1999

Impact of ratification of ILO Convention upon Child Labour:

- **Zero tolerance towards exploitation of children** - the government will take immediate, urgent and effective measures to prohibit and eliminate the worst forms of child labour likely to harm the health, safety or morals of children.
- **Fix minimum age** - It requires India to ensure that no one under the fixed age is admitted for work in any occupation except in cases of light work and artistic performance
- **Prohibiting worst forms of child labour** - It will require India to prohibit the worst forms of child labour including slavery, debt bondage, serfdom, forced or compulsory labour etc.

Salient features of Child Labour (Prohibition and Regulation) Amendment Act, 2016

- It amends the Child Labour (Prohibition and Regulation) Act, 1986. The major amendments include-
  - Extends this ban on employment of children under 14 across **all sectors,**
  - Prohibits the employment of adolescents aged 14-18 years in hazardous occupations and
  - Introduces more stringent jail term and fines for offenders: a jail term of six months to two years and a fine upto Rs 50,000
- It **brings down the list of hazardous occupations** from the earlier 83 to just three: mining, inflammable substances, and hazardous processes under the Factories Act, and the centre will decide which processes are hazardous.
- The Act has a provision of creating **Rehabilitation Fund** has also been made for the rehabilitation of children.

Benefits

- The Act is aligned with the statutes of the International Labour Organization (ILO) convention.
- Since there is complete ban on child labour (children under age 14), they can get compulsory primary education in light of Right of Children to Free and Compulsory Education Act, 2009.
- It takes into account the realities of family enterprises where children help their parents in miscellaneous ways.

Criticism

- Children under 14 years will be allowed to work in family businesses, outside of school hours and during holidays, and in entertainment and sports. This can be blatantly misused by many and lead to "victimization of children" in their poverty.
- The definition of 'family' has not been defined. As UNICEF India has commented, this could lead to more children working in unregulated conditions.
- Even in family enterprises, there is no skilling done. It is mostly against child's will and is almost slavery. So, care has to be taken while implementing the law to not go against the spirit of the law.
- Dilution of penalties against parents and guardians who "force" children into child labour can go against the spirit of the law, i.e., to prevent child labour.

Recommendations of Child Rights and You (CRY)

- An amendment in the Right of Children to Free and Compulsory Education to include higher secondary levels in it.
- There is also a need to make gender equality a primary goal of school system and
- Provide free secondary education for families from below poverty line.
- Include the voices of children while formulating policies to know more about their concerns and the issues faced by them.

National Child Labour Project (NCLP)

It is a project of Ministry of Labour with aim to suitably rehabilitate the children withdrawn from employment thereby reducing the incidence of child labour in areas of known concentration of child labour.

Target Group

- All child workers below the age of 14 years in the identified target area.
- Adolescent workers below the age of 18 years in the target area engaged in hazardous occupations.
- Families of Child workers in the identified target area.

The NCLP Scheme seeks

- To eliminate **all forms of child labour through**
  - Identification and withdrawal of all children in the Project Area from child labour,
  - Preparing children withdrawn from work for mainstream education along with vocational training
  - Ensuring convergence of services provided by different government departments/agencies for the benefit of child and their family
- To contribute to the **withdrawal of all adolescent workers** from Hazardous Occupations and their **Skilling and integration** in appropriate occupations through facilitating vocational training opportunities through existing scheme of skill developments
- **Raising awareness** amongst stakeholders and target communities, and orientation of NCLP and other functionaries on the issues of 'Child Labour' and 'employment of adolescent workers in hazardous occupations/processes'
- Creation of a **Child Labour Monitoring, Tracking and Reporting System**.
- However, there has been a meagre 8% increase in its budget this year.

100 Million for 100 Million

The Campaign organized by the Kailash Satyarthi Children's Foundation aims to mobilise 100 million youth for 100 million underprivileged children across the world, to end child labour, child slavery, violence against children and promote the right of every child to be safe, free, and educated, over the next 5 years.

Expected Outcomes

- Contribute to the identification and eradication of all forms of child labour.
- Contribute to the identification and withdrawal of adolescents from hazardous occupations and processes in the target area.
- Successful mainstreaming into regular schools of all children who have been withdrawn from child labour and rehabilitated through the NCLPS.
- Adolescents withdrawn from hazardous occupations to have benefited from skills training wherever required and linked to legally permissible occupations.
- Better informed communities, specific target groups and the public at large as a result of the Social Mobilization Programme and Awareness about the ill effects of child labour.
- Enhanced capacities to address the issue of child labour through training of NCLP staff and other functionaries.

Conclusion

Ending child labour has various positive outcomes such as reduced dropping out rates, reduced stress on children of economic roles, right to adequate playtime and safe childhood etc. But ultimately the success on eliminating exploitation against children depends on the level of social empathy, political will and the implementation of resources invested in the development and protection of children. It can be solved only if the reasons driving exploitation of child, such as poverty unemployment, lack of social security net, inadequate enforcement of law, are resolved. As we see that the number of child laborers decreased by 65% between

2001-2011 is mainly due to programmes like RTE, MNREGA, Mid-Day Meal scheme, etc. So, the scourge of child labour can only be eliminated with overall development and creation of opinion, along with rehabilitation. The Child Labour Bill and penalties are only a spoke in the wheel.

2.4. CHILDREN IN THE DIGITAL WORLD

Digitalization has changed the way children pursue and conduct themselves and others in a major way, both for better and worse. Various changes observed are-

- Too much **time spent** on digital devices. Some studies show the reduction in time spent on **physical activities**.
- Creation of a **new generation gap** where adults fear the impacts of technology on children while children believe that the adults are missing out opportunities.
- A **change in dynamics of friendship** that has turned too passive due to social media, lacking real interactions.
- There is also **a rising debate** on digital dependency, and impact on brain and cognitive processes of brain.

UNICEF has released a report named- 'State of World's Children Report: **Children in the Digital World**, 2017' which discusses:

- The capacity of digitalization to shape children's life experiences grows as the children grow, which offers them limitless opportunities.
- At the same time, lack of access to technology compounds deprivation among children and various other groups, leaving them vulnerable to intergenerational cycles of disadvantage and poverty.
- The report argues for faster action, focused investment and greater cooperation to protect children from the harms of a more connected world – while harnessing the opportunities of the digital age to benefit every child.

Digital Childhoods- Digitalization has changed the way children pursue and conduct themselves and others in a major way, both for better and worse. Various changes observed are-

- Too much **time spent** on digital devices.
- Creation of a **new generation gap** where adults fear the impacts of technology on children while children believe that the adults are missing out opportunities.
- Increasing issue of whether or not can we **trust the machines**.
- A **change in dynamics of friendship** that has turned too passive due to social media, lacking real interactions.
- Some studies show the reduction in time spent on **physical activities**.
- There is also **a rising debate** on digital dependency, and impact on brain and cognitive processes of brain.

Opportunities from Digitalization

- **Access to better education opportunities**- It has allowed children to participate in e-learning and to access a wide range of educational and learning content. The geographical extant of education too has expanded.
- **Education as a personalized experience**- It helps students to learn at their own pace and helps educators with limited resources provide students with better learning opportunities.
- **Training for Teachers for better results**-Blended learning, where ICT is supported by strong teachers can boost learning outcomes. Here, the vocational training programmes, for teachers, are areas where digital connectivity is crucial.
- **Social media activism & overall integration**- Children are also making their voices heard through blogging, for example- Malala Yousafzai. It has also helped minority groups feel more integrated in their communities and opened new windows for expression, networking, political activism and social inclusion.
- **Improve employability**- It improves employability through better educational opportunities as well as training and skill improvement programmes.
- **Opportunity for children with disability**- Mobile applications can help children and young people with disabilities be more independent.

Issues related to Digital Divide

- **Digital divide mirrors socio-economic divides,** between rich and poor, men and women, cities and rural areas, and between those with education and those without.
- **Economic Disparities**- The **usage of internet** in developed countries is double than the use in developing countries and way more when compared to least developed countries.

- These inequalities within countries can **reinforce existing inequities** for children who cannot meet the demands of the digital age by preventing them from accessing opportunities discussed above.

- **Second level digital divide**- Even though the primary digital divide of access is narrowing, digital divides could be shifting to second-level divides **based on growing inequalities in digital skills** and **usage.**
- **While the zero-rating sites have** exempted certain sites from the customer's data limit, they have raised concerns that it may not lead to an inclusive internet but rather the one which people use to upload posts and pictures, thereby not utilizing technology to its full potential.
- **Lack of useful online content in native language**- This may discourage internet usage for many people reducing its approachability, furthering knowledge gap.

Risks are categorized into following forms-

- **Content risks**- Where a child is exposed to unwelcome and inappropriate content. This can include sexual, pornographic and violent images, etc.
- **Contact risks**- Where a child participates in risky communication, such as with an adult seeking inappropriate contact or soliciting a child for sexual purposes, or with individuals attempting to radicalize a child.
- **Conduct risks**- Where a child behaves in a way that contributes to risky content or contact. This may include children writing or creating hateful materials about other children, inciting racism or posting or distributing sexual images, etc.

Concerns from Digitalization

Digital connectivity has:

- Made children more accessible through unprotected social media profiles.
- Allows offenders to be anonymous - reducing their risk of identification and prosecution - expand their networks.

The risks, thus, identified are:

- **Cyberbullying** is defined as "wilful and repeated harm inflicted through the use of computers, cell phones and other electronic devices."
  - In previous generations, children being bullied could escape such abuse or harassment by going home or being alone, no such safe haven exists for children in a digital world.
- **Online child sexual abuse and exploitation**- has been on a rise through-
  - **Peer-to-peer networks (P2P) and the Dark web** continue to facilitate the exchange of child sexual abuse material (CSAM). There are also new challenges, such as live-streaming of child sexual abuse and self-generated sexually explicit material, which are adding to the volume of CSAM.
  - Another factor contributing to the escalation in the live-streaming of child abuse is the **growing use of cryptocurrencies**, and end-to-end encrypted platforms for sharing media.
- **Online Vulnerability reflecting offline vulnerabilities**- Children who are more vulnerable offline are more vulnerable online including girls, children from poor households, etc.

Way Forward

- The internet reflects and amplifies the best and worst of human nature. It is a tool that will always be used for good and for ill. Our job is to mitigate the harms and expand the opportunities digital technology makes possible.
- To leverage the opportunity following steps need to be taken:
  - Provide all children with affordable access to high-quality online resources.
  - Protect children from harm online by proper guidance.
  - Safeguard children's privacy.
  - Teach digital literacy to keep children informed, engaged and safe online.
  - Leverage the power of the private sector to advance ethical standards and practices that protect and benefit children online.
  - Put children at the centre of digital policy.

Steps taken to fight such abuse, like

- **WePROTECT Global Alliance** to End Child Sexual Exploitation Online, leading technology companies, international organizations and 77 countries have made an urgent commitment to end child sexual abuse and exploitation through a coordinated response.
- **Microsoft donated its PhotoDNA technology** to the International Centre for Missing and Exploited Children.

3. OTHER VULNERABLE SECTIONS

3.1. ELDERLY IN INDIA

According to the Census 2011, India has 10.8 million senior citizens (above 60 years of age). This number is expected to increase substantially in the coming years with a rise in the life expectancy to 65 years from 42 years in 1960. In fact, it is predicted that between the years 2000 and 2050, the population of India will grow by 55%. However, the population above 60 years and 80 years will grow by 326% and 700% respectively. The percentage of elderly people, classified as those above 60 years of age, is expected to go up in India from 8% in 2015 to 19 % in 2050.

When populations age rapidly, governments are often unprepared to mitigate the consequences, this has implications for the socio-economic and health status of the elderly. Ensuring the welfare of senior citizens will therefore assume even greater importance in the future given the projected shift in demographic patterns.

Challenges of Ageing in India

- **Migration and its Impact on the Elderly**: Due to the migration of the younger people, elderly are left living alone or only with the spouse. They face social isolation, poverty and distress.
- **Loopholes of Healthcare**: The health system is ill-equipped to deal with surging NCDs; nor is the staff well trained to treat/advise the aged suffering from dementia or frailty, and for early diagnosis and management of conditions such as hypertension. The quality of medical care is abysmal, and hospitalisation costs are exorbitant and impoverishing.
- **Impact of social disharmony**: The proportion of those suffering from NCDs living in villages that experienced inter-caste or other conflicts has more than doubled during 2005-2012. Lack of social harmony induces helplessness, disruption of medical supplies and network support.
- **Digital illiteracy** - Due to inability of older family members to understand the modern digital language of communication and more demanding lifestyle, there is lack of communication between elderly and younger members. They also feel difficulty in getting benefits under schemes which are being digitized.
- **Feminization of Ageing:** Currently all the states have higher life expectancies at old ages for women than for men (sex ratio among elderly- 1033 women to 1000 males in 2011). Outcome of feminization of ageing is the discrimination and neglect experienced by women as they age, often exacerbated by widowhood and complete dependence on others.
- **Ruralization of the Elderly**: According to 2011 Census, 71 percent of the elderly live in rural India. Income insecurity, lack of adequate access to quality health care and isolation are more acute for the rural elderly than their urban counterparts. It is also noted that poorer states such as Odisha, Bihar and Uttar Pradesh have a larger percentage of the rural elderly.

Policy Response to Ageing

- **National Policy on Older Persons (NPOP)**, 1999: It envisages State support to ensure financial and food security, health care, shelter and other needs of older persons, equitable share in development, protection against abuse and exploitation, and availability of services to improve the quality of their lives. Several schemes launched within it are Pradhan Mantri Suraksha Bima Yojana, Atal Pension Yojana, Health Insurance for Senior Citizens, Varishtha Pension Bima Yojana 2017, Scheme for providing Aids and Assisted Living Devices to Senior Citizens below Poverty Line, Senior Citizens Welfare Fund, etc.
- **Maintenance Act 2007**: This act provides a legal framework for the maintenance of the elderly parents & grandparents. Recently, Amendments to **Maintenance and Welfare of Senior Citizens Act, 2007** were proposed comprise, removal of maximum ceiling of maintenance allowance; extension of right to appeal to the respondents also; extension of benefit of revocation of transfer of property to parents also; reckoning of time limit for disposal of applications by the Tribunal from the date of receipt of application etc.
- **Integrated Programme for Older Persons**: provides financial assistance (up to 90 percent) to PRIs/local bodies, NGOs, educational institutions, charitable hospitals/nursing homes etc. for implementing a variety of facilities such as old-age homes, day care centres, physiotherapy clinics, provision of disability aids, etc. for elderly.

- **Health care for Older Persons**: The health care programme for the elderly is being implemented by the MOHFW from 2011 under the **National Rural Health Mission**. The ministry launched **National Programme of Health Care for Elderly (NPHCE)** during 2010-11.
- **Social Pensions**: The **National Social Assistance Programme** was launched to provide social assistance to the poor and the destitute.
- The **National Policy on Senior Citizen, 2011**, also, focused on various aspects related to old age like Income security, healthcare, safety security, housing, productive aging, welfare, multigenerational bonding, etc. it also established a **National Council for Senior Citizens**, to suggest required policy changes for the elderly.
- India is also a signatory of **South Asia Partnership on Ageing: The Kathmandu Declaration 2016** which focuses on the special needs of the elderly population in the region.

Way Forward

- It is crucial to **enhance policy and programme relevance** by adopting various practices like getting feedback from the field, encouraging policy and programme audit, and adoption of good policies and programmes by the state governments.
- Better outcomes can be achieved by **creating a supportive environment** like nourishing better bonding between generations, ensuring their safety & security and that the intended benefits are better availed.
- The schemes pertaining to senior citizens could be brought under the restructured **Department of Disability Affairs and Senior Citizens**. An integrated implementation and monitoring plan should be developed by the Department with inputs from various government and non-government stakeholders.
- The idea of day care (as opposed to residential centres) is more acceptable to a significant part of the elderly population. Setting up of day care/enrichment centres should therefore be prioritised under the Integrated Programme for Older Persons (IPOP).

3.2. PERSON WITH DISABILITIES

Why in News?

The Supreme Court criticized the Centre over non-compliance of its verdict of making public institutions disabled-friendly.

Context

- The Persons with Disabilities (PwDs) experience stigma and compromised dignity in their daily life. Article 41 of the Indian Constitution mandates the state to make effective provisions for securing the right to education, work and public assistance for people affected by disability within the constraints of its economic capacity and level of development.
- According to the Census 2011, there are 2.68 Crore PwDs in India constituting 2.21% of the total population. This, however, could be an underestimate because according to the World Health Organisation, 15% of the world's population faces some form of disability.
- Socio-economic empowerment of PwDs is an inter-sectoral issue. However, it has not received adequate attention from different Ministries and Departments. The Department of Empowerment of Persons with Disabilities (DEPwD) which is the nodal department for issues concerning PwDs at the national level has several schemes.
- However, many of these schemes have a very small allocation and the resources that are allocated do not get fully utilised. The monitoring capacity within the department is also limited which is a major challenge because a number of schemes are implemented through NGOs.

Legislative Reform - The Rights of Persons with Disabilities Act, 2016

Provisions of the Act

- It replaces the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and is in line with the principles of the **United Nations Convention on the Rights of Persons with Disabilities** and aims at encouraging establishments to have a disabled friendly workplace.
- The types of **disabilities have been increased** from existing 7 to 21 and the Central Government will have the power to add more types of disabilities.

- Persons with "**benchmark disabilities**" are defined as those certified to have at least 40 per cent of the disabilities mentioned in the Act.
- **Additional benefits** such as reservation in higher education, government jobs, reservation in allocation of land, poverty alleviation schemes etc. have been provided for persons with benchmark disabilities.
- Every **child with benchmark disability** between the age group of 6 and 18 years shall have the right to free education.
- **Reservation in vacancies** in government establishments has been increased from 3% to 4% for certain persons or class of persons with benchmark disability.
- It has now brought **private establishments** within its ambit. Though it does not require private establishments to mandatorily appoint Persons with Disabilities (**PwD**), there are certain obligations imposed on private establishments under the Act.
- Broad based **Central & State Advisory Boards** on Disability are to be set up to serve as apex policy making bodies at the Central and State level.
- Creation of **National and State Fund** will be created to provide financial support to the persons with disabilities.
- For strengthening the Prime Minister's **Accessible India Campaign**, stress has been given to ensure accessibility in public buildings (**both Government and private**) in a prescribed time-frame.
- It provides for **penalties for offences committed against persons** with disabilities and also violation of the provisions of the new law.
- **Special Courts** will be designated in each district to handle cases concerning violation of rights of PwDs.

Accessible India Campaign

- It is the nationwide flagship campaign of the **Department of Empowerment of Persons with Disabilities (DEPwD)**.
- The aim of the Campaign is to make a barrier free and conducive environment for Divyangjans all over the country.
- It is based on the principles of the **Social Model of Disability**, that disability is caused by the way society is organised, and not the person's limitations and impairments.
- It has been divided into **three verticals**: Built Environment; Transport and Information & Communication Technology (ICT) ecosystem.

Benefits

- **Right based approach:** This Law will be a game changer for the estimated 70-100 million disabled citizens of India and will help move the discourse away from charity to one that is rights based with provisions to enforce implementation.
- **Wider coverage:** The list of disabilities is expanded from 7 to 21 and a wider definition of disabilities has been provided. The concept of mental retardation has also been widened and changed to Intellectual disability, which is more in sync with recent times.
- **Discrimination defined:** Act of 2016 defined 'discrimination' which was missing in the previous legislation. However, the Act strangely makes the clauses on non-discrimination in employment mandatory only in government establishments.
- Earlier the person with intellectual and multiple disabilities were not allowed the reservation in the vacancies.
- The act of 2016 is the step toward the economic and social empowerment of the person with disability by providing property rights and acknowledging the legal capacity.

Criticism

- **Reservation:** When a greater number of disabilities are being brought under the purview of the Act, the percentage of reservation should go up proportionately. However, the Act provides only 4% reservation (5% was proposed in 2014 bill).
- **Financial sources**: Specification of the manner of funding to implement the various aspects of the Act including disability budgets allocated to ministries and organisations at the state and central level. Further, basic social security should be provided free of cost, to the extent possible to persons with disabilities without any income ceiling or below poverty line criteria.
- **Insurance**: Provisions regarding insurance matters of persons with disabilities must be incorporated explicitly in the Bill and the Committee recommends amending the Insurance Regulatory and Development Authority of India Act, 1999 to ensure insurance companies do not charge higher premiums for persons with disabilities as compared to others.
- **Time bound redressal**: Specific time frame to dispose off cases in Special Courts.

Way Forward

- Certain **institutional reforms** should be undertaken.
  - It is important to strengthen the institutional framework at all levels to have a stronger and more direct role for PwDs.
  - Responsibility for specific initiatives for PwDs should be brought under the purview of the relevant line Ministries. For instance, all education related matters should be with the Ministry of Human Resources Development.
  - Number of schemes administered by the DEPwD should be rationalised. It would be prudent to have a limited number of schemes with adequate budgetary allocation that are implemented and monitored well.
  - Financial and human resource capacity of the Central and State Commissioners' offices need to be strengthened so that they are able to perform their functions more effectively. Guidelines on minimum staffing levels should also be introduced.
- **Enhancing employability** - Skill training should be provided to PwDs. One of the ways in which this can be accomplished is by setting up dedicated ITI Centers for PwDs according to the requirements of the private sector. Additionally, five Centers should be established by the **National Handicapped Finance and Development Corporation (NHFDC)** including 1 in the North East for training PwDs for self-employment.
- **Improving Access to Aids/Assistive technologies for PwDs** - Distribution of aids to senior citizens who live below the poverty line should be prioritised as a sizeable percentage suffers from age-related disabilities. The Unique Disability Identity Card (UDID) Project should be rolled-out in states and Union Territories. This will help to eventually create an electronic database of PwDs across the entire country.
- **Strengthening Education** - While the Right to Education Act promised a special focus on admission and retention of children with disabilities, the situation has not seen a major improvement. An NCERT study found that disabled children in schools across states still face serious infrastructure and pedagogy handicaps. These challenges include absence of ramps and disabled friendly toilets as well as special teaching materials and sensitized teachers. It must be ensured that schools have at least one section of each class accessible under the Universal Design Guidelines. Additionally, a module on sensitization should be made mandatory in teacher training courses.

3.3. SCHEDULED CASTES (SC) AND SCHEDULED TRIBES (ST)

3.3.1. SCHEDULED CASTES AND THE SCHEDULED TRIBES (PREVENTION OF ATROCITIES) ACT

Why in news?

Supreme Court has issued directions regarding Scheduled Castes and Scheduled Tribes (Prevention of Atrocities act), 1989.

Background

- In a complaint filed under the Atrocities Act, Supreme Court of India felt the need of procedural safeguards and issued the following directions in Subhash Mahajan vs State of Maharashtra vis a vis PoA act:
  - There is **no absolute bar against grant of anticipatory bail** in cases under the Atrocities Act if no prima facie case is made out or where on judicial scrutiny, the complaint is found to be prima facie mala fide.
  - In view of **acknowledged abuse of law of arrest** in cases under the Atrocities Act, **arrest of a public servant can only be after approval of the appointing authority** (Prior Sanction) and of a non-public servant after approval by the S.S.P.

Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act 1989

- It prohibits the commission of offences against members of the SCs and STs and establishes **special courts** for the trial of such offences and the rehabilitation of victims.
- It outlines actions (by non SCs and non STs) against SCs or STs to be treated as offences.
- The Act specifies that a non-SC or ST public servant who **neglects his duties** relating to SCs or STs shall be punishable.
- **Investigation** of an offence committed under the SC/ST Act cannot be investigated by an officer not below the rank of Deputy Superintendent of Police (DSP)
- For certain offences the Act also provides for capital punishment and confiscation of property. Repeated offences under the Act attract enhanced punishments.

The act was amended in 2016 to add new offences to atrocities such as garlanding with footwears etc., addition of chapter on the **'Rights of Victims and Witnesses'**, **defining 'willful negligence'** of public servants clearly and addition of presumption of offence.

which may be granted in cases considered necessary and Such reasons must be scrutinized by the Magistrate for permitting further detention.
    - To avoid false implication of an innocent, a **preliminary enquiry** may be conducted by the DSP concerned to find out whether the allegations make out a case under the Atrocities Act and that the allegations are not frivolous or motivated
    - Any violation of above directions will be actionable by way of disciplinary action as well as contempt.
- Subsequently, Centre moved to Supreme Court challenging the ruling that prevented automatic arrests on complaints filed under PoA act but Supreme Court upheld the directions it had issued.

Arguments in favour of Judgement

- **Protection of innocents:** The judgement does not stand in the way of the rights of members of the scheduled castes and scheduled tribes but was concentrating on **protecting false implication of an innocent** person.
- **Freedom from arbitrary Arrest:** The Court in Vilas Pandurang Pawar and Shakuntla Devi cases also held that the bar against anticipatory bail was not absolute especially when no case is made out or allegations are patently false or motivated as freedom from arbitrary arrest is one of the fundamental facets of the rule of law.
- **Misuse of the Act:** NCRB data states that 75 % of cases under the Atrocities Act have resulted in acquittal or withdrawal which is evidence of **misuse of the Act**.
- **Standing Committee of Parliament on the Scheduled Castes and the Scheduled Tribes** (Prevention of Atrocities) Amendment Bill, 2014 had also stressed on the need for safeguards against arrest under the Atrocities Act.

Arguments against the ruling

- The judgement led to possible **dilution of the law** meant to protect the marginalized and it would further result in depriving the community of their constitutional rights especially under Article 17 i.e. abolition of Untouchability.
- **Introducing additional procedural** requirements would result in impeding strict enforcement of the 1989 Act which already suffers **impermissible delay** in registration of cases thereby diluting the efficacy of the enactment.
- **Separation of Powers:** The court cannot enlarge the scope of the legislation or the intention of the legislature as it amounts to encroachment of its power leading to Judicial Overreach.
- **Low conviction rates** are high in terror cases as well and it shows poor investigation and incompetence of prosecution because witnesses turn hostile in such cases. Also, filing of false cases has declined and conviction rates under SC/ST act have also improved over time.
- NCRB data shows that over the last ten years (2007-2017), there has been a 66% growth in crimes against Dalits. The judgment may further have an adverse **effect on the already underreported crimes** against Dalits.

Conclusion

Parliamentary standing committees' demand for an inbuilt provision in defence of accuse must be considered to balance the rights of SCs/STs vis a vis Innocents and reforms in criminal justice system must also be undertaken alongside to ameliorate the concerns regarding conviction rates.

3.3.2. SCHEDULED TRIBE

Important facts and figures

- Scheduled Tribe (ST) population represents a heterogeneous group scattered in different regions of India. The differences are noticed in language, cultural practices, socio-economic status and pattern of livelihood.
- STs are confronted with problems like forced migration, exploitation, displacement due to industrialization, debt traps and poverty.
- The level of socio-economic development varies considerably between tribal and non-tribal population, between one region to another region;between one tribe to another tribe; and even among different tribal sub-groups. These disparities and diversities make tribal development more challenging and demanding.

- **Poverty:** In India 52 per cent of the STs belong to the category of Below Poverty Line (BPL) and 54 per cent of them have no access to economic assets such as communication and transport(World Bank, 2011).
- **Literacy rate:** Literacy among the tribes of the north-eastern and island regions is relatively higher but despite that high dropout rate and infant mortality rate is also observed in the north eastern region.
- **IMR and MMR:** Both the indices are high among STs, however, Child and infant mortality rates are higher among the STs in Orissa as compared to other states.
- **Migration:** Large scale displacements and unsatisfactory compensation and rehabilitation are confronted by the STs in India. The eastern region is facing large displacement due to industrialization and development projects.
- **Agriculture:** Dependency on agriculture, natural calamity, crop-failure, reduced access to land and lack of employment are the contributing factor for poverty in the states like MP and Chhattisgarh.
- **Unemployment:** Rates of unemployment are high in the tribals of the island region. Presently the tribes are caught in a situation where they are losing command over the natural resources, and are unable to cope with the new pattern of work and resources for living. Majority of them are dependent on daily wages or labour work because of landlessness.
- **Dependence on MFP:** Minor Forest Produce (MFP) is a major source of livelihood for tribals living in forest areas. Around 100 million forest dwellers depend on MFPs for food, shelter, medicines and cash income.
    - Further, most of the trade related to the MFPs remained unorganized in nature, which has led to low returns to the gatherers and high wastages due to limited value addition. Thus, a more holistic approach with robust institutional mechanisms is required for strengthening the backward and forward linkages of MFP supply chain.

Importance of Minor Forest Produce for the Tribals:

- The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, defines a Minor Forest Produce (MFP) as all non-timber forest produce of plant origin and includes bamboo, brushwood, stumps, canes, Tusser, cocoon, honey, waxes, Lac, tendu/kendu leaves, medicinal plants and herbs, roots, tuber and the like.
- Tribals derive 20-40% of their annual income from MFP and activity has strong linkage to women's financial empowerment as most of the MFPs are collected and used/sold by women.
- Government had earlier launched a scheme named "**Minimum Support Price (MSP) for Minor Forest Produces (MFP) scheme** for safeguarding the remuneration of tribal population.

Recommendations

- Region specific approach is required to bring positive change among the tribes. For example, the unemployment problems of the island region can be resolved by developing fisheries and tourism industry at large scale.
- Awareness generation to avail the existing schemes and programs targeted for tribal community is required. In the states with low rate of literacy; special camps can be organized to make the aware of the schemes meant for educational development.
- To stop starvation deaths as reported among tribes and PTGs in several states including Jharkhand, Madhya Pradesh and Rajasthan, STs need to be trained according to the labour market requirements.
- Access to credit and banking facilities should be made simpler that can benefit the tribes.
- Access to the forest products among the forest dwellers should be facilitated in a positive direction.

Recent initiatives by GoI - Van Dhan Scheme

- Under the scheme, **10 Self Help Groups of 30 Tribal gatherers** (Van Dhan Vikas Samuh) will be constituted. They will then be provided with working capital to add value to the products collected from the jungle.
- Van Dhan Vikas Kendra are **multi-purpose establishments** for providing **skill upgradation, capacity building training** and setting up of **primary processing and value addition facility**.

3.3.3. DENOTIFIED, NOMADIC & SEMI-NOMADIC TRIBES

Why in news?

Recently the National Commission for Nomadic Tribes has submitted its report viz **"**Voices of the Denotified, Nomadic & Semi-Nomadic Tribes".

Background

- Government of India has constituted a **National Commission for Denotified, Nomadic & Semi-Nomadic Tribes** with a mandate to identify and prepare a state-wise list of DNT/NT, apart from assessing the status

of their inclusion in SC/ST/OBC, identification of areas where they are densely populated, reviewing the progress of development and suggesting appropriate measures for their upliftment.

Who are Denotified tribes?

- The people, who were notified as Criminal Tribes during British rule and were denotified after independence in 1952, have been known as denotified tribes, based on the **report of Ananthasayanam Ayyangar** in 1949-50. There are also many nomadic tribes who were part of these DNT communities.
- "These communities were the most oppressed" although they did not undergo the social untouchability as in the case of caste.

Problems faced by these tribes:

- People of these communities **continue to be stereotyped**. A large number of them have been labeled ex-criminal tribes.
- They also face **alienation and economic hardships**. Most of their **traditional occupations** such as snake charming, street acrobatics and performing with animals have been **notified as criminal activity** making it difficult for them to earn a livelihood.
- Many of the denotified, nomadic and semi-nomadic tribes are spread among SC/ST/OBC but are **still not classified anywhere** and have no access to socioeconomic benefits whether education, health, housing or otherwise.
- **Grievances of these groups** include food, drinking water, sanitation, education, health, housing, poor infrastructure, etc. Many also complain about not getting caste certificates, not having ration cards, voter ID cards, aadhaar cards, etc.
- There are many **anomalies in terms of identification** of these communities, from state to state. There is a lack of awareness about these tribes and about authority looking after their grievances.
- As a result of all these problems many communities are facing decline in population.

Recommendations of the report

- Since basic census data is not available on these tribes/communities there is a need to undertake a socio-economic survey through some reputed social science institutes.
- The Centre should carve out sub-categories DNT-SC, DNT-ST and DNT-OBC, with dedicated sub-quota for them. While sub-categorisation of SCs and STs may prove complicated, it can be done immediately among the OBCs since the Centre has already formed a **commission headed by Justice Rohini Kumar** to sub-divide the central list of OBCs according to the developmental status of member communities.

Habitual Offenders Act of 1952
It recommended suitable steps to be taken for amelioration of the pitiable conditions of the Criminal Tribes rather than stigmatising them as criminals. As a result, the Criminal Tribes Act of 1871 was repealed in 1952 and the Habitual Offenders Act was enacted in its place.

- A **permanent commission** may be constituted for the purpose which may take care of these communities/tribes independently on regular basis.
- Seeking "destigmatisation" of denotified tribes, the panel has recommended that the Centre **repeal the Habitual Offenders Act of 1952.**

3.4. BEGGARY IN INDIA

Why in news?

- Recently, union minister of women and child development, emphasized on need to enact a new comprehensive law on beggary.

Current situation

- Currently, there is no central law on begging & destitution and most states have adopted the Bombay Prevention of Begging Act, 1959.
- The act of begging is a crime in 21 states (including Uttarakhand which recently banned begging) and two union territories of India. It is treated as cognisable and non-bailable offense.
- The draft Bill, called the Persons in Destitution (Training, Support and Other Services) Bill, was formulated in 2013 and submitted to the Maharashtra government. It recognised destitution as a situation of extreme

vulnerability and placed a constitutional obligation to protect them and address the vulnerabilities that arise from it.
- In 2016, the ministry of social justice and empowerment came up with a new draft model bill for destitute people, namely, The Persons in Destitution (Protection, Care and Rehabilitation) Model Bill of 2016.
- However, recently centre in its response to Delhi High Court made a U-turn from its stance a year ago and dropped the proposal to decriminalizing beggary through legislation.

Bombay Prevention of Begging Act, 1959
- It considers begging as a crime rather than a social issue.
- Anyone perceived as having "no visible means of subsistence" and "wandering about" in public place can be branded a beggar and detained for a period of not less than one year and up to 10 years for second time offenders.
- If convicted court can also order detention of all those who it thinks are dependent on the beggar.

Issues with current legislations

- **Police powers** - It gives huge discretionary powers to the police to arrest someone on just a hunch. It infringes individual liberties and provides powers to State authorities to round up beggars and imprison them without trial.
- **No distinction between beggars and homeless** - It results in detention of not only poor beggars but also of disabled persons and persons trying to make out a living by offering small articles for sale, rag pickers, people earning paltry sums by singing, dancing etc.
- **Contradicts the Juvenile Justice Act 2015** - as it identifies child beggars as "children in need of care and protection" and provides for their rehabilitation and re-integration in the society through Child Welfare Committees rather than seeing them as criminal
- **Constitutional right** - Under Article 21 of the Constitution, every beggar or juvenile or dependant has a fundamental right to live. Begging is one of the methods of survival of people which should be taken away only when alternative routes are being open for them
- **Different definitions** - For example - Karnataka and Assam keep religious mendicants out of the the definition of beggars while Tamil Nadu does it for street artists, bards, jugglers and street magicians.

Changes done in The Persons in Destitution (Protection, Care & Rehabilitation) Model Bill of 2016

- **Right based approach** - It gives right to the destitute to demand help from the state
- **Decriminalise begging** - It decriminalized beggary except for repeat offences. Rather than criminalizing destitute, it cracks down on those who run organised beggary syndicates.
- **Identifying destitute** - by setting up of outreach or mobilisation units in each district which will identify and provide assistance to those who fit into the category of a destitute.
- **Rehabilitate beggars** - through rehabilitation centres with qualified resident doctors, recreation and other facilities in each district. Some states like Bihar have undertaken such programmes.
- **Setting up referral committees** - to identify the needs of persons in destitution and refer them to the respective institutions according to their requirement, be it medical services, shelter, employment opportunities etc.
- **Setting up counselling committees -** to interact with them & assist them in opting for specific vocational training as per their preferences. It will enhance their skills and make them self-reliant.
- **Constituting monitoring and advisory board** - to coordinate implementation of the schemes and advise the government on matters related to care, protection, welfare and rehabilitation of destitutes.

Way forward

State needs to take a more humane approach towards the destitute. A law is needed which respects the dignity of the destitute rather than penalizes them for being poor. Thus existing anti-beggary laws should be repealed and replaced with welfare and social security laws - on the lines of the MGNREGA to provide employment to beggars. Apart from this following measure should be undertaken:

- **Creating awareness about their rights** such as right of free legal aid to poor
- **Issuing smart cards and Aadhaar numbers to beggars** - to enable easy census, easy tracking, ease in opening bank accounts and low cost insurance policies and policy plans for their welfare
- **Constituting databank -** to make available status of rehabilitation, counselling institutions etc. through visiting committees which periodically visits these institutions
- **Follow-up** after coming out of beggar's home or after skill training to assist in any challenges faced by them in integrating with the mainstream society

- **Sensitizing people and authorities** - Popular perception about begging that it is the preferred way of making easy money, needs to be changed & people need to be sensitive about their circumstances.
- **Access to food** - A mechanism needs to be developed to bring them under the ambit of the Right to Food Act
- Instead of people giving food and clothes on street in an undignified manner, state should provide a helpline for the hungry where the system would reach any hungry person anywhere.
- The government should engage different stakeholders such as NGOs working with street children, traffic policemen etc. to eradicate beggary especially child beggary.

4. HEALTH

4.1. SERVICE DELIVERY: QUALITY AND ACCESS

In terms of Quality and Access to Health facilities, as according to the findings of a recent **Lancet report** on Global Burden of Diseases, **India ranks 145th among 195 countries**, standing behind its neighbours like China, Bangladesh, Sri Lanka and Bhutan. However, the situation has seen **improvement since 1990s**.

Current Status

A recently released Common Review Mission (CRM) report has observed that-

- Most of the Community Health Centres (CHCs) and Primary Health Centres (PHCs) **operate from government buildings** now. However, the **pace of construction is slow**.
- **High risk patients** are now reaching the district hospitals. But still,
  - assured availability of the eight core specialist services is **not sufficient** at the district hospitals.
  - the discourse on district hospitals **needs to shift from** hospitals catering to 'maximum burden of case loads' to hospitals with 'assured emergency services'.
  - **undue referrals** from peripheral institutions also continue to be reported from most states.
- Though several states have outsourced **procurement and supply of drugs and consumables**, but smaller north-eastern states are still facing issues due to which the patients have to incur high out of pocket expenditure (OOPE) on buying medicines.
- Several states have also notified **Free Diagnostic Policy** but, availability of expected range of diagnostics at the peripheral institutions, to eventually reduce out-of-pocket-expenses is still not done.
- A common toll-free **number for registering complaints** is absent. Also, there is time lag between registration and redressal.
- There is provision of **free dialysis services to poor** under Pradhan Mantri National Dialysis Programme. However, the services continue to reach only a fraction of such patients.
- There is an effort towards increasing the **number of blood banks** and BSUs. But, due to lack of human resources and non- functionality of equipments, Blood Banks are non-operational in many states.
- With the launch of **National Ayush Mission**, a degree of disengagement has emerged e.g. many states have shifted the **procurement of Ayush drugs** on NAM. Also, States are not able to increase demand or access to AYUSH services.
- **Mobile Medical Units** (MMUs) are still not functional in many states. Shortage of ambulances also persists. There is a need for ensuring uniformity in trainings of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions.

Recommendations

- **Adequacy of Health Facilities:** There should be dedicated cells/autonomous bodies within states to monitor pace of all public constructions, including hospitals, perhaps with penalty clauses. They should submit their reports annually in the Assembly.
- **Utilisation and Continuum of care:**
  - Policy reforms should be brought in the area of human resources such as in 'bidding' for specialists.
  - Those specialists who chose to stay, must be provided with an option of being absorbed in State's specialist cadre.
  - Dedicated initiatives/programmes on technology driven medical education for peripheral providers and tele-consultations of patients at SHCs (Sectoral Health Care) should be considered to address the issues related to undue referrals.
- **District Hospital Strengthening:**
  - States must be incentivized to propose general ICUs, and High-dependency units for every 10-lac population (could be considered at 5-lac for hilly and NE region).
  - Faculty from nearby government and credible private medical colleges can be sourced-in to meet the demand of trainers.
  - District hospitals and credible not-for-profit missionary/trust hospitals can be chosen as training sites.
- **Procurement and availability of drugs:**
  - Disruptive solutions may be adopted-such as bulk procurement by Centre or prioritizing access to drugs as a special measure in broader agenda of NE development.

- Generic prescriptions must be encouraged, general awareness on use of antibiotics must be increased, and prescription audits must be scaled up.
- Free diagnostics should be provided at PHC level.

- **National Dialysis Program:** It should be linked to Free diagnostics initiative and drugs should be enlisted in an EDL (Essential Diagnostic List) directory.
- **Access to blood:** The sanctioning and licensing of blood units should be brought under a single department of MoHFW and demand for blood should be linked to non-surgical care.

4.1.1. ISSUES WITH PRIVATE HEALTHCARE SYSTEM IN INDIA

According to 71st National Sample Survey (NSS) total private hospitalization share in rural and urban areas is 58% and 68% respectively in 2014. However, the private sector is riddled with various issues like-

- **Cost of care is a major challenge**: According to the Health Profile of India report, 75 % of patients, who visit private hospitals, settle medical bills from their household income or life savings while another 18 % borrow money from private lenders to pay medical bills causing high level of impoverishment.
- **Differential Drug prices**: Differential prices under National List of Essential Medicines (NLEM) and non NLEM category creates ambiguity and widens margin for private hospitals to exploit patients.
- **Variation in Healthcare Delivery across Providers**: due to lack of professional standards in terms of competence and compassion resulting in compromised patient safety and transparency in procedure.
- **Disconnect between patient and doctor**: Due to lack of communication in terms of charges and various related procedural costs in the beginning, there is an apparent disconnect between the two parties that weakens the overall medical procedure.
- **Growth of medical legal jurisprudence** has not been in sync with the rise of private institutions in the country which leaves room for malpractices and corruption in one of the most noble professions. **The Clinical Establishment Act (2010)** also is yet to be properly implemented across the country.
- Recently, **Karnataka Private Medical Establishments (Amendment) Bill**, was passed in state assembly to increase transparency in private medical establishments of the state.

The Clinical Establishments (Registration and Regulation) Act, 2010

- **Objective:** To provide for the registration and regulation of clinical establishments with a view to prescribe minimum standards of facilities and services.
- **Applicability:** All types of clinical establishments, except those run by the armed forces, fall within the ambit of this Act.
- **Implementation:** Through a three-tier structure — the Central Council, the State Council and the District Registering Authority.
- **Penalty**: Running a clinical establishment without registration would be punishable with a fine of Rs 50,000 for the first offence, Rs 2 lakh for the second offence and Rs 5 lakh for the subsequent offence.
- **Monitoring:** The Act permits health authorities to conduct inspections and penalize or cancel licenses of hospitals that are found to be fleecing patients, either by prescribing needless tests and procedures, or overcharging.

Way forward

- Worldwide experience teaches us that the private sector acts responsibly and provides good quality services only if the government provides good quality norms. The private system becomes more abusive when the government sector fails to set good norms.
- Increasing the budget for healthcare is a welcome step but may not be the only one that is required. The existing ecosystem needs to be revamped to integrate concerns of all the stake holders.
- The regulator should insist on transparency — hospitals clearly publicizing their rates for standard treatments and procedures. Also, there should be normative rates for different types of hospitals as not all private hospitals are located in costly cities.
- Hospitals should publicize standard packages and rationale for additional charges levied recorded. The regulator should get regular data on the percentage of deviation from standard packages.
- Finally, the Medical Council of India needs to take up pro-active role in safeguarding the interests of its patients and in regulating doctors.

4.2. RMNCH+A (REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH)

Reproductive/Maternal

- Many states have focused on **operationalization of delivery points** to improve access to healthcare. However, the number of delivery points need to be adjusted as the per population norms.
- There is **improvement in availability of family planning commodities** such as contraceptive pills etc. in all the states.
- Among the various **spacing methods**, IUCD (Intrauterine contraceptive device) insertion remained the top preferred choice. However, very few states provided post-abortion IUCD insertion services.
- There is **lack of awareness about Family Planning Indemnity Scheme** (FPIS) among service providers and the community. Women continue to bear the burden of the terminal methods of family planning and sterilization (as discussed in Gender Section).
- With the launch of Pradhan Mantri Surkshit Matritva Abhiyan (PMSMA) **high risk identification in pregnancy** has improved significantly. Several states have collaborated with private health/non- health organizations (as part of Corporate Social Responsibility) Lions and Rotary Clubs, private nursing colleges and other departments to provide services to PMSMA beneficiaries.
- High risk pregnancies due to **severe anaemia** (Hb<7) remains persistent across the states.
- **Important skills** like Active Management of Third Stage of Labour, Neonatal resuscitation, Maternal complication identification and management are found to be **lacking among the nursing staff**.
- Janani Shishu Suraksha Karyakaram (JSSK) has helped foster the **perception of health care** as an entitlement within the public system and has been able to reduce OOP Expenditure.

About RMNCH+A

- The RMNCH+A strategy is based on provision of comprehensive care through the five pillars, or thematic areas, of reproductive, maternal, neonatal, child, and adolescent health, and is guided by central tenets of equity, universal care, entitlement, and accountability.
- The "plus" within the strategy focuses on-
  - Including adolescence for the first time as a distinct life stage
  - Linking maternal and child health to reproductive health, family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques;
  - Linking home- and community-based services to facility-based care; and
  - Ensuring linkages, referrals, and counter-referrals between and among health facilities at primary (primary health centre), secondary (community health centre), and tertiary levels (district hospital).

Recent Government initiatives in the field:

- **LaQshya Program** launched by the Ministry of Health and Family Welfare to **improve quality of care during delivery** and immediate post-partum period thus providing **Respectful Maternity Care** (RMC) to all pregnant women attending public health facilities. This will reduce maternal and newborn morbidity and mortality.
  - It aims at implementing **'fast-track' interventions for achieving tangible results** within 18 months and is being implemented at all Medical College Hospitals, District Hospitals and First Referral Unit (FRU), and Community Health Center (CHCs).
  - A **multi-pronged strategy** has been adopted such as improving infrastructure up-gradation, ensuring availability of essential equipment, providing adequate human resources, capacity building of health care workers and improving quality processes in the labour room.
  - The Quality Improvement in labour room and maternity OT will be assessed through NQAS (National Quality Assurance Standards).
- **New Contraceptives-** The Ministry has launched two new contraceptives, an **injectable contraceptive** named 'Antara' and a **contraceptive pill** 'Chhaya', to meet the emerging needs of couples.
  - **Antara** is an injection of Medroxyprogesterone acetate (MPA), a birth control hormone and it will be effective for 3 months
  - **'Chhaya'** is a non-steroidal, non-hormonal oral contraceptive pill which will be effective for 1 week.
  - The contraceptives will be **available for free** in Medical Colleges and District Hospitals.
  - Recently Maharashtra has become the **first state in the country** to provide women an injectable contraceptive.

Related Information

- India has come a long way in improving maternal survival as Maternal Mortality Ratio (MMR) has reduced from 301 maternal deaths in 2001-03 to 167 in year 2011-13, an impressive decline of 45% in a decade.

Significance

- Access to contraceptives not only increases **access and choice to quality family planning** in developing countries but also has a **positive impact on indicators** of maternal mortality, infant mortality and women empowerment.
- The newly launched contraceptives will help meet the changing needs of couples and help women plan and space their pregnancies.
- Free distribution of contraceptives will also help in achieving the goal of **Total Fertility Level** (TFR) of 2.1 by 2025 as enunciated in Mission Parivar Vikas and thus attaining **Population Stabilization** by 2045 as desired under India's National Population Policy, 2002.

Related Information

- Currently only 56% of currently married women use some method of family planning in India. A majority of them (37%) have adopted permanent methods like sterilization.
- According to the recent National Family Health Survey (NFHS) IV data, the unmet need of contraceptives is 12.9% and this contributes to undesired fertility due to lack of access.

Neonatal/Child

- **Newborn services** show remarkable improvement and essential newborn care is operational in many states.
- Newborns get **vaccinated before discharge** from most of the facilities. After initiation of MAA (Mother's Absolute Affection) Programme more focus is given on early initiation of breast feeding, counselling is provided to mothers for exclusive breast feeding and complementary feeding.
- There are also **improvements in immunization**, with no reports on gaps in cold chain or availability of vaccines.
- At the community level, **Home-based Newborn Care** (HBNC) yielded good results in identifying and referring the sick newborns.
- Many states have initiated the practice of **Kangaroo Mother care** (KMC) for Low Birth Weight babies. However, the units are poorly utilized and are found overcrowded.

Adolescents

- There is the **complete lack of focus** on adolescent health which has a significant impact on maternal and child health and missing a crucial stage of life cycle. Only a few states have implemented Rashtriya Kishori Swasth Karyakram (RKSK).
- The **Adolescent Friendly Health Clinics** (AFHC), if present, are mostly non-functional or poorly utilized.
- Supplementation of **Weekly Iron Folic Acid** (WIFS) in schools has gathered pace in many states. However, since interdepartmental coordination between Health, Education and WCD is still lacking, this results in poor reporting under WIFS program.
- **Menstrual Hygiene Scheme** and the provision of Sanitary Napkins is not well operationalized in various states. While the **quality and accessibility of services** vary from state to state.

Recommendations

- Better training to prioritized service providers, better logistics to ensure uninterrupted drug supplies, and good quality supportive supervision should be provided.
- There should be a **non-rotation policy for trained labour room staff** to maintain consistent quality of services.
- **Mapping of trained Family Planning (FP) providers** and their performance review need to be initiated, as many FP providers are not used for providing FP services.
- All facilities conducting deliveries should be ensured a **functional newborn care corner**. The staff of Sick Newborn Care Unit (SNCU)/ New Born Stabilization Units (NBSU)/ **Newborn** Care Corners (NBCC) need to be trained in Navjaat Shishu Suraksha Karyakram (NSSK) and the follow up of discharge cases need to be ensured.
- **Nutrition Rehabilitation Centres** require support for effective operationalization especially in states of high need, forward and backward linkages including children with severe acute malnutrition and follow up on discharge.
- **District Early Intervention Center** (DEIC) under RBSK Programme needs to be set up in all states on priority basis as it will better referral practices, patient management and follow ups.

4.3. COMPREHENSIVE PRIMARY HEALTHCARE

Status

- There has been an important **shift in Public healthcare systems** from delivering selective to comprehensive primary health care services.
- The initiative aims to provide assured, free, comprehensive primary health care services, for a package of 12 services that cover reproductive, maternal, child and adolescent health (RMNCH+A), communicable and non-communicable diseases, management of acute simple illnesses, enabling continuum of care for chronic illnesses, including care for the elderly.
- In terms of overall Planning, Selection of Centres and Management to **roll out health and Wellness Centres** (as part of Ayushman Bharat) -
    - Identification of Sub Centres to serve as **Health and Wellness centres (HWC)** has been completed in all states except Punjab. Even Bihar, where sensitization on HWCs has been reported to be low has commenced action with recruitment of few Mid- Level Healthcare providers and implementation of Bridge Programme.
    - **Operationalizing HWCs** necessitates robust assessment and availability of human resources, drugs, infrastructure and logistic support in the centres selected for upgrade. On a positive side, none of the states indicate significant shortage of requisite human resources (Multipurpose workers and ASHAs) at Sub-centre level.
- **Universal Population enumeration Systems:** Most states are undertaking population enumeration with reference to tracking uptake of services limited to family planning, pregnancy/delivery and immunization. Only few states have undertaken efforts to initiate universal population enumeration.
- **Capacity Building and Progress on Bridge Programme on Community health**
    - Of all the input measures, **building the cadre of Mid-Level Health Care Providers**/Community Health Officers and their enrolment in Bridge Programme for certificate in Community Health has been prioritized by majority states

Recommendations

- As states progress towards selection and training of Mid- Level Health Care Providers, there is a critical need across all the states to **address gaps in drugs and logistic support** to operationalize HWCs.
- States should aim for **building logistics systems as first steps**. Supply chain logistics is adversely affected on account of multiple issues such as- lack of adequate financing, absence of autonomous and professionally managed centralized procurement agency, limited district level warehouses that are connected to frontline facilities etc. **Specific evaluation** could be planned for identifying these challenges and remedial measures should be ensured at the outset of rolling CPHC interventions to ensure the fulfillment of key principle, viz. continuum of care.
- While appointment of nodal officers is a positive step forward, states should also plan to build district and block level **capacities in programme management** and supportive supervision to ensure necessary change management for the delivery of CPHC services.

4.4. HUMAN RESOURCES FOR HEALTH

- India has a **severe shortage of human resources** for health. It has a shortage of qualified health workers and the workforce is concentrated in urban areas. Bringing qualified health workers to rural, remote, and underserved areas is very challenging.
- Many Indians, especially those living in rural areas, receive **care from unqualified providers**. The **migration of qualified allopathic doctors** and nurses is substantial and further strains the system.
- **Recruitment and retention of specialists and doctors** still remains a challenge for many states and inadequate remuneration/lack of residential quarters etc was reported as an important reason for recruitment among specialists.
- Instances of **irrational and uneven distribution of HR** is one of the major deterrents in ensuring their uniform and need-based availability at facilities across the states.
- In order to **increase retention of doctors**, states such as Assam, Chhattisgarh, Karnataka, Odisha and Uttarakhand have been offering educational incentives in terms of additional weightage - proportional to their service duration in rural areas.

Loopholes in Workforce Management

- There is **absence of a department specific policy** covering issues such as rotational transfers and career progression.
- The majority of states **do not have a comprehensive HR policy** for contractual NHM staff.
- The implementation of a **systematic Human Resource Management Information System** (HRMIS) has either been delayed or only partially implemented (with only a few parameters entered on to the system). This has made it difficult for states to maintain an accurate record of its workforce and their administration.
- **Irrational deployment of the workforce** (e.g. administrative posts to the specialist doctors) resulted in inefficient use of existing human resources.
- There have been no substantive efforts to establish a **Public Health Cadre** in the states.
- In terms of **training and capacity building** there are no systematic plans in most of the states. There is absence of a proper mechanism for training needs assessment as well. Also, the service delivery staff have lack of clarity with regard to their roles and responsibilities.

Recommendations

- There is a critical **need to fill vacancies** against sanctioned posts by adopting a variety of measures such as walk-in interviews, campus recruitments and the use of separate committees to hasten approval for new posts and their recruitment (as adopted by some states).
- For issues of arbitrary postings and delayed promotions, steps towards **HR policy reforms** in these areas are needed. Where ever possible, a health department specific HR policy should be developed to address department specific issues.
- Flexible norms for **remuneration of specialists** should be utilized by states with specialist shortages.
- To **streamline management and utilization of HR information**, a Human resources management information system (HRMIS) needs establishment/strengthening. In states where these are already established, it should be **linked with the Training Management Information System** (TMIS) - and capacity building of nodal HR should be undertaken for its implementation and utilization.
- **Performance appraisal mechanisms** should be objectively linked to job-specific indicators and the appraisal process should be linked with contract renewal and the award of performance-based incentives.

4.4.1. PUBLIC HEALTH CADRE

Background

- There is an increased demand for a Public Health Cadre after the recent medical mishaps, similar to the one that took place in Gorakhpur.
- **Bhore Committee, 1946**- The Health Survey and Development Committee offers a comprehensive assessment of the state of public health in India and makes recommendations for the training of the public health workforce.
- **Mudaliar Committee** (1959)- This committee, for the first time, suggested that the personnel dealing with problems of health and welfare should have a comprehensive and wide outlook and rich experience of administration at the state level.
- **Kartar Singh Committee** (1973)- The committee suggested that doctors with no formal training in infectious disease control, surveillance systems, data management, community health related problems, and lacking in leadership and communication skills, etc., were ill-equipped and misfits to work in public facilities.

Based on cadre implementation status, **states** can broadly be grouped in **to four categories:**

- Those with a well-established cadre, e.g. Tamil Nadu, Maharashtra;
- Those with some select components of the cadre in place, e.g. West Bengal, Kerala;
- States actively pursuing cadre formation, e.g. Odisha, MP, Chhattisgarh; and
- States still in the contemplation phase; e.g. Karnataka, Haryana, some NE states.

- The 12th Five Year Plan and the National Health Policy, 2017 have also strongly advocated establishing a public health management cadre to improve the quality of health services by having dedicated, trained and exclusive personnel to run public health facilities.
- Despite the creation of a public health cadre finding mention in various reports, such a service at the all-India level has yet not been formed.

Need for such a cadre

The idea is on the lines of the civil service — of having dedicated, professionally trained personnel to address the specific and complex needs of the Indian health-care delivery system.

- **Lack of an apt education model-** The medical education (a concurrent subject) in India is completely based on the western model which does not address the needs of Indian conditions.
- **Lack of managerial & technical skills**- Doctors with clinical qualifications and even with vast experience are unable to handle various challenges like technical expertise, logistics management, and social determinants of health and leadership, thereby hampering the quality of our public health-care system.
- **Varied demands of job**- In the absence of a public health cadre in most States, even an anaesthetist or an ophthalmologist with hardly any public health knowledge and its principles is required to implement reproductive and child health or a malaria control programme.
- **Lack of expertise in public healthcare**- There is a huge gap between planning, execution and follow up of specialized services and generalized services in the government. Both situations urgently need for special breed of administrators that specialize in healthcare, leading to better management and innovation.
- **Lack of regulatory authority to officials**- The absence of a **comprehensive Public Health Act** in most states means that health officials lack the regulatory authority and powers to enforce public health legislation adequately. The lack of a separate public health directorate further compromises their independence, effectiveness, and efficiency.

Advantages

- A Public Health Cadre would mean doctors, who desire to work in Public Health Sector, would go through **proper training in health policy** and work in district level hospitals for a period of time as a pre-qualification for promotions.
- With a public health cadre in place, we will have personnel who can apply the principles of public health management to avoid mistakes such as one that led to the tragedy in Uttar Pradesh as well as deliver quality services. This will definitely **improve the efficiency and effectiveness** of the Indian health system.
- With quality and a scientific implementation of public health programmes, the poor will also stand to benefit as this will **reduce their out-of-pocket expenditure** and dependence on prohibitively expensive private health care.
- In the process, we will also be saving the **precious resources of specialists** from other branches by deploying them in areas where they are definitely needed.
- A dedicated cadre of healthcare professionals can detect **state-specific health hazards** and contain them before they spread.
- The inclusion of professionals from sociology, economics, anthropology, nursing, hospital management and communication, as suggested by the NHP, is a recognition of a multi-disciplinary approach and an acknowledgment that cultural attitudes must be understood if public health strategies are to **gain community acceptance**.
- Filling the higher posts in Ministry from this cadre with similar arrangements at the State level including the posts of mission directors will go a long way in improving planning and providing much-needed public health leadership.

Way Forward

There are many challenges in the creation of such a cadre since health is a state subject 2/3rd of the states have to agree for the proposal to be finally accepted. However, given India's position on the international health indexes and parameters a well-defined Public Health Cadre is the need of the hour.

4.5. COMMUNITY PROCESS

The Community Action for Health, earlier known as Community Based Monitoring and Planning (CBMP), is a key strategy of the National Health Mission (NHM), which places people at the centre of the process of ensuring that the health needs and rights of the community are being fulfilled. It allows them to actively and

regularly monitor the progress of the NHM interventions in their areas. It also results in communities participating and contributing to strengthening health services. Thereby, Bringing Public into Public Health.

The process involves the following steps-

Accredited Social Health Activist (ASHA)

- In the current backdrop of strengthening delivery of primary care services closer to the community, ASHAs are now being viewed as a **key member of the primary health care team** at the Sub centre level. They play an important role in linking community with the health services especially in the areas of Reproductive & Child Health and Communicable Diseases.
- **National Health Policy**, 2017 says that ASHAs will play an important role in addressing issues of Non-Communicable Diseases and provision of palliative care and mental health etc.as well.
- Though ASHAs were found to be equipped with skills to perform many tasks, reports emphasize the need for **refresher trainings to address the gaps** in skills pertaining to identification of danger signs, nutrition counselling, family planning, safe abortion services and adolescent health.

Major Issue

- Despite the fact that nearly 90% of service users of public health system are women and children, 100% of frontline workers are women (ASHAs and ANMs) and almost 50% of the total workforce comprise of women, the gender issue has not received the due attention across several states.

- Despite several initiatives taken in the recent years to address delay in payment of incentives, the issue is yet to be fully resolved especially for **payment of incentives** under National Vector Borne Disease Control Programme (NVBDCP) and Revised National Tuberculosis Control Program (RNTCP).
- Stock out of drugs/equipment with ASHAs and **limited availability of safety measures for ASHAs** are also few critical components of the programme that continue to affect the performance of ASHAs.
- As a state led mechanism to provide motivation for the ASHAs, they will be provided **social security** in the form of medical and life insurance. However, critical components like **operationalizing Grievance Redressal mechanism** and creating rest rooms for ASHAs have not received due attention.
- **Dropout rate for ASHAs** has remained low in rural areas i.e, up to 4-5%. However, attrition is reported to be **high in urban areas of** Banglore in Karnataka and Gurugram in Haryana, on account of better employment opportunities and high level of migration.

Village Health Sanitation and Nutrition committee (VHSNC)

- It is one of the key elements of **National Rural Health Mission**. It has been formed to take collective actions on issues related to health and its social determinants at the village level. They are particularly envisaged as being central to support the process of **Decentralised Health Planning**.
- Thus, the committee is **envisaged to take leadership** in providing a platform for improving health awareness and access of community for health services, address specific local needs and serve as a mechanism for community-based planning and monitoring.
- The pattern emerging from the expenditures of united funds across the states, reflects focus on issues of hygiene, sanitation, support for vulnerable families in seeking healthcare by providing transport in emergencies, and supporting in buying medicines in some cases, and providing loans for medical expenses for very poor households.

Mahila Arogya Samiti (MAS)

- It is a forum of Women Group of the slum who **desire to contribute to well-being of the community** with a sense of social commitment and leadership skill to look after their health and its determinants in holistic manner.
- They **serve as local institutions for health planning and action**. They work closely with Accredited Social Health Activists (ASHAs), or government health workers, and public health institutions to increase uptake of government health services.
- Several states have MAS in place but there are still **major gaps in proportion of MAS** which have bank accounts. States like Bihar report that almost all of the target MAS have formed but only about 50% of them have bank accounts. Capacity building of MAS has been reported from only few states. Strengthening support processes for formation and handholding of MAS, regular training of MAS members and also assessment of adequacy of MAS targets is required.

Rogi Kalyan Samiti (RKS)/Hospital Management Society (HMS)

- This committee, a **registered society**, acts as a **group of trustees for the hospitals** to manage the affairs of the hospital. It consists of **members from local Panchayati Raj Institutions** (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre.
- RKS / HMS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services.
- Almost all states report formation of RKS being in place at all levels of facilities. However, **low functionality in RKS** of facilities at block level and below and low investment in training of RKS members emerge as major concerns.
- **Expenses incurred from RKS funds** are mainly on gap filling in HR, mainly support staff, contracting of services like cleaning, and minor repairs.
- Systems for Patient feedback or Grievance Redressal are clearly not high on agenda of the RKSs, which is reflected in absence of such systems across states.

Recommendations

- Since ASHAs are a key member of the PHC team to jointly deliver an expanded package of services, closer to the community, it is essential that the challenges of slow and varied quality of training, delays in payments, stock out of drug and equipment kits, are resolved.
- There should be a **process of regular refresher training** for ASHAs and periodic modular training to achieve a minimum of 15 days per year.
- In urban areas, the issue of high attrition rate due to high level of migration and better employment opportunities, highlights the need to design urban context-based tasks linked with new incentives to facilitate retention of ASHAs. Extension of all existing programme components viz, training, non-monetary incentives and support measures to urban ASHAs also needs to be prioritized.
- Delays in payment of ASHA incentives across most states despite several initiatives of routing all payments through PFMS, need an urgent action. Larger delays were reported for payment of incentives for activities related to NVBDCP, RNTCP, NLEP.
- The untapped potential of VHSNCs, RKS and MAS in most states on account of limited capacity building initiatives, have highlighted gaps in utilizing these community-based platforms to address social determinants and take collective community actions. Strategies such as proactive engagement with NGOs and building capacities of support structures to effectively supervise VHSNCs, RKS and MAS could be adopted to bridge this gap.

4.6. INFORMATION AND KNOWLEDGE

- Though availability of the relevant, timely and accurate health care data will remain an ongoing challenge, there is **enough health data today**, for good public health decision-making.
- Information technology tools such as medical e-records, telemedicine services, E-raktkosh, E-Aushadhi and Mera Aspataal have also promoted transparency, accountability and easy remote access to the information from the state level to primary care level.
- There is **lack of standardized registers**, training and orientation on handling technology, poor internet connectivity and inconsistent power supply. Also, multiple registers are being maintained under various programmes like Delivery register, Stock register, Immunization, lab register, Line listing. ASHAs and Auxiliary nurse midwife (ANM) spend 5-6 hours completing the registers alone.

Key Constrains in Information and Knowledge:

- **Structural**
  - Lack of infrastructural facilities for storage and maintenance of records
- **Procedural**
  - Excessive information
  - Incomplete, unreliable and intentionally managed information
  - Inappropriate forms/cards and reports
  - Absence of feedback and monitoring
- **Human Resource**
  - Absence or lack of professionally trained person
  - Lack of motivation and extra incentives
  - Staff Nurses/medical officer are collecting and preparing data
- **Technological**
  - Manual paper-based system (Formats)
  - Lack of internet connectivity

- **Capacity building on various portals** including Health Management Information System (HMIS), Mother & Child Tracking System (MCTS), and others is needed. Most of the States were not aware the new data elements and the training needs. Delay in identification and service provision has been a major issue as well.

Recommendations

- As now there is data reporting, a **boost for IT systems to be used as a tool for action** rather as tool for data reporting is required, progressing to Public Health Informatics.
- The distribution of **specific printed registers** is essential at all the facilities. Latest HMIS formats need to be available to all the health facilities. **Training in the new HMIS formats** is required at the SC and PHC level.
- State, District, Block level Monitoring and supervisory visits to be **conducted on regular basis**.
- To ensure data quality before and after uploading of HMIS data, it is suggested that facility in- charge should countersign the hard copy of uploaded HIMS data.
- Though multiple e-initiatives exist, their softwares work in isolation and are often not interoperable. In place of Multiple IT system **one integrated system should be explored**.
- Use of information is lacking in states. All Programme managers should ensure that **HMIS data is reviewed on monthly basis** and optimal feedback is given to the peripheral staff about quality of data and performance of health facility.

Related Information

Echo (Extension for Community Healthcare Outcomes) Clinic is a concept of weekly or fortnightly virtual clinics using teleconferencing by best specialists to reach out to underserved areas.

- It does not provide care directly to patients like in telemedicine. Instead, they **equip primary healthcare clinicians** in remote areas with the knowledge and support to manage complex cases.
- It helps in bringing specialist care and knowledge to areas where there is none.

India's first ECHO clinic **began in 2008** as a collaboration between the National Aids Control Organization (NACO) and Maulana Azad Medical College (MAMC) on managing HIV AIDS patients. Since then, ECHO clinics and handling various diseases in the country.

There are **several other e-initiatives** such as:

- **Mera Aspataal'**- (My Hospital) application is an IT based **feedback system** to collect information on patients' level of satisfaction using a multi-channel approach viz. This application has been implemented only in Karnataka and Uttar Pradesh.
- **e-Raktkosh** is a **biometric Donor Management System** for identifying, tracking and blocking donors based on donor's health, donation history. A **centralized Blood Inventory Management System** for keeping track of the blood stock across numerous blood banks. This application has been implemented only in Uttar Pradesh and Uttarakhand.
- **Kilkari mobile app** launched to create awareness among pregnant women. It has been launched in Haryana to create awareness among pregnant women, parents and field workers about the importance of antenatal care, institutional delivery, post-natal care and immunisation.

4.6.1. NATIONAL HEALTH STACK

Why in news?

NITI Aayog has proposed a **shared digital healthcare infrastructure** with a view to implement the Centre's flagship scheme Ayushman Bharat and other public healthcare programme in the country.

What was the need to bring this structure?

- National Health Policy 2017 envisages creation of a digital health technology eco-system.
- The need for a future-ready digital health system has become even more urgent with the announcement of Ayushman Bharat, which targets establishment of around 1.5 lakh health and wellness centres and financial protection of more than 10 crore households.

About NHS

- **Vision**: a centralized health record for all citizens of the country in order to streamline the health information and facilitate effective management of the same.
- **Scope**: The scope of the National Health Stack includes (and is not restricted) to the following subjects:
  - Induction of Private Hospitals and Private Practitioners into the Primary and Secondary healthcare ecosystem;

- Focus on Non-Communicable Diseases (NCD); Disease Surveillance; Health Schemes Management Systems; Nutrition Management; School Health Schemes; Emergency Management; e-Learning Platform for health, Telehealth, Tele-radiology; Diagnostic Equipment; Health Call Centre(s) etc.

- It will be India's first futuristic nationally shared digital healthcare infrastructure usable by both the **Centre and states across public and private sectors**.
- It is a collection of cloud-based services. Each service provides just one capability across multiple health services, accessible via simple open APIs (application program interface) compatible with global standards. (It is designed along the lines of India Stack)
- It will provide a mechanism through which every user participating in the system can be **uniquely identified**. The registrant may create a virtual health ID to preserve their privacy when interacting with other users or stakeholders in the system.
- It will be built in the context of PM- RSSM (Pradhan Mantri Rashtriya Swasthya Suraksha Mission), but will be designed 'beyond RSSM' to support existing and future health initiatives, both public and private.
- Once implemented, the NHS will significantly bring down the costs of health protection, converge disparate systems to ensure a cashless and seamlessly integrated experience for the poorest beneficiaries, and promote wellness across the population.

Benefits of the National Health Stack

This can be understood in terms of individual beneficiaries, the central and state governments, the private sector; nudge healthcare services and insurance providers.

Benefits to public

The four major challenges of healthcare i.e. availability, accessibility, affordability and acceptability can get resolved (in Phases) as the NHS data gets mature.

- **Phase 1—Improving Affordability**
  - Increased participation of service providers and availability of healthcare services due to justified pricing, instant adjudication and on time payment of claims will result in more widespread cashless care. This will result in significant improvement in:
    - ✓ Financial protection (reduced out-of-pocket payments)
    - ✓ Improved overall health and reduction of wage loss through individuals
  - As all records will be linked, there will be no need to conduct unnecessary tests.
- **Phase 2—Improving Accessibility & Availability**
  - It will allow beneficiaries to avail the policy at any point in time of the year
  - The instant adjudication, payment and claims closure will incentivise the service providers to participate in government-financed health insurance schemes with tremendous energy—increasing access and availability of service providers for the beneficiaries.
  - It will incentivise service providers, via a scorecard mechanism, to set up facilities closer to the beneficiaries (e.g. tier 3 towns)—thus empowering the beneficiaries with choice
- **Phase 3—Improving Acceptability**
  - With enough data at this stage, a Value-based purchasing feature can be introduced to initiate a reward-based program. This will encourage hospitals to:
    - ✓ improve the quality and safety of acute inpatient care for the beneficiaries
    - ✓ eliminate or reduce healthcare errors which result in patient harm
    - ✓ adopt evidence-based care standards and protocols that make the best outcomes for the most patients
    - ✓ increase care transparency for consumers
  - Hospitals that give high-quality care at a lower cost to government-funded healthcare program beneficiaries will get recognised easily.

Benefits to the central government

- It will be able to fulfil its promise of healthcare and health protection anywhere in the country through introducing a feature of portability for migrants, as well as for practitioners.
- NHS will generate vast amounts of data resulting in some of the largest health databases. This has potential to place India at the forefront of medical research in the world.

- Government will be able to get a holistic view across health verticals through integrated national dashboards and adopt data-driven policy making through real-time reports and analytic. This will also enable effective management of schemes and mission to achieve the goals of NHM
- The cost of healthcare to the government will also get reduced through improved fraud detection.

Benefits to the state

- It will allow states to Incorporate horizontal and vertical expansion of scheme and facilitate co-branding.
- States will be able to leverage RSSM funds and customize them based on their needs, as well as maintain control over data.
- It will avoid duplication of efforts and enable ease of adoption for those without systems or with dysfunctional systems in place
- States will be able to continue using their own state system while integrating with RSSM via APIs, making migration simple in case of states with more advanced system.

Benefits to the service providers

- Digitization will standardize empanelment, pre-authorization, claims processes and streamline operations resulting in administration ease for those participating in multiple government-financed health protection schemes
- The combination of Instant adjudication and Fraud detection tools will ensure that the service provider is rewarded immediately for making honest claims and has no incentives to make fraudulent claims
- The analytics on data reported by service providers on actual cost for a procedure will result in establishing scientific packages and pricing of procedures.

Benefits to the insurance providers

- There will be a dramatic reduction in fraud and the cost of operations will get reduced.
- There will be reduction in claims ratio, as the whole ecosystem will work towards management of health rather than management of disease.
- With availability of supply side data, they can expand their market and can offer targeted products as well.

Criticism against proposed NHS

- Digital health records are a great thing but having them accessible via open APIs is very dangerous. Besides, NHS places the onus of control on the user with an assumption that they know how to control the flow of information through APIs, like a software engineer.
- Though the document assures consent-driven interaction, it does not elaborate on whether the health data fiduciaries will be government or private bodies.
- Having a health stack, the base of which is personal health data, throws up more questions about who owns, who can access and who can control such digital data.
- Linking to one unique health identifier (whether Aadhar or something else) is dangerous because if the data is compromised at one point, then it is compromised forever.
- In case of leak of sensitive health data, a person might have to face significant financial and social harm. Insurance companies may also deny claim or raise claims based on health data.
- In the absence of a law, the requirement for consent will be the decision of a company or government department, which will be discretionary, arbitrary and without adequate democratic legitimacy.
- The draft of the **Digital Information Security in Healthcare Act or DISHA** specifies that "digital health data, whether identifiable or anonymised, shall not be accessed, used or disclosed to any person for a commercial purpose and in no circumstances be accessed, used or disclosed to insurance companies, employers, human resource consultants and pharmaceutical companies, or any other entity as may be specified by the Central Government." However, the NHS strategy proposed by NITI Aayog involves a separate platform only for insurance claims and coverage.
- A digital technology architecture does not mean good data will be available as people (both patient and person recording the data) keep fudging depending upon their knowledge and political motives.

4.6.2. NATIONAL HEALTH PROFILE-2018

Government has released the National Health Profile (NHP)-2018.

About National Health Profile

- Objective of this annual publication is to **create a database of health information of India** which is comprehensive, up-to-date and easily accessible to all stakeholders in the healthcare sector.
- National Health Profile covers-
  - Demographic information,
  - Socio-economic information,
  - Health status
  - Health finance indicators,
  - Comprehensive information on health infrastructure and human resources in health.
- It is prepared by Central Bureau of Health Intelligence.
- Health Profile is an important tool as it has helped in designing various programmes and benefitted many initiatives like Free Drugs and Diagnostics and Mission Parivar Vikas.

4.6.3. NATIONAL HEALTH RESOURCE REPOSITORY (NHRR)

- It is the **first ever registry in India** of authentic, standardised and updated geo-spatial data of **all public and private healthcare.**
- **ISRO is the project technology partner** for providing data security.
- It **aims to strengthen evidence-based decision making** and develop a platform for citizens and provider-centric services by secured **Information Technology (IT)-enabled** repository of India's healthcare resources.
- It shall **enable advanced research** towards ongoing & forthcoming healthcare challenges arising from other determinants of health like – disease, environment etc.
- It shall also enhance the coordination between central and state government for optimization of health resources, and decentralize the decision making at district and state level.
- It shall promote convergence between similar programmes by providing interoperability.
- It also seeks to furnish standardized data, distribution of resources and trends on the global platform, using regularly updated health status indicators.

4.7. HEALTHCARE FINANCING

Current Status

- The issue of shortage in finance and accounts staff in National Health Mission (NHM) **seems to be resolved in most of the states**. This could be seen as a major achievement as the issue was highlighted in all the previous CRM reports. However, it is still a challenge for Chhattisgarh, Uttarakhand and Uttar Pradesh.
- Certain **good practices observed** which could be implemented in other states are:
  - simultaneous release of central and state share under NHM to the State Health System (SHS) in Chhattisgarh
  - a mandatory test on financial guidelines and Government Financial Rules (GFR) for all the Finance staff to ensure thorough knowledge of all rules and regulations in Assam
  - use of a new software called ASHA- Soft payments of ASHA incentives, which helps in accurate identification of activity wise incentives and implementation of a group health insurance scheme for all the contractual staff working for various state departments in West Bengal.
- Most of the States have put systems in place for **electronic fund transfers**. This system has helped the states in ensuring faster fund transfer to the beneficiaries and has eliminated certain malpractices.
- **Public Financial Management System** (PFMS) has been successfully adopted by many states leading to a better financial management system that facilitates real time monitoring and reporting of expenditures under the various flexible pools under National Health Mission.
- Household **Out of Pocket Expenditures** (OOPE) still remains a major concern. Despite implementation of various schemes such as free drugs and diagnostics in government hospitals, instances of high OOPE were reported in most of the states. None of the state reports have commented or collected information on measures undertaken by the States to reduce OOPE and on state health insurance programs.
- Delay in **transfer of funds from State treasury to State Health Societies** (SHS) continues to be a major problem for most states.

- **Non-compliance with statutory obligations** also seems to be a prominent issue in many states. The statutory Audits for 2016-17 were observed to complete in most States but the final report were still awaited. However, compliance with concurrent audit was found to be poor across all the states.

Recommendations

- States should ensure **timely release of funds from Treasury** to the State Health Society Accounts along with the State share for effective utilization of funds. Similarly, the **SHS should also release funds** to District Health Societies (DHS) in a timely manner.
- States need to ensure that the flexibility in the diversion of funds between pools is used only when it is necessary and not make it a regular practice by **ensuring better planning and use of resources**. Further, diverted funds should be settled within the same financial year and **permanent diversion of funds should be strictly avoided**.
- States have to address the issue of bank integration and ensure synchronization to **avoid transaction delays**.
- The Northeastern States and Hilly States should **link with Nationalized banks** to increase the number of branches in areas with no banking facilities.
- The States facing problems in Internet connectivity should also link with the concerned Government departments to address the issue.
- The states should ensure **higher allocations to High Priority Districts** as per the government norms.
- In order to address high OOPE, States should **strengthen the implementation of programs** such as free Drugs and Diagnostic Schemes and the JSSK scheme.
- States need to **examine regularly the areas and reasons for underutilization** of funds and provide supportive supervision for making corrective actions for better utilization of funds.

4.7.1. NATIONAL HEALTH PROTECTION SCHEME

It was announced in budget 2018 as a flagship scheme under **Ayushman Bharat programme** for a New India 2022.

Related Information
Ayushman Bharat programme has two components viz.
- **National Health Protection Scheme** &
- **Health and Wellness Centre** (envisioned under National Health Policy, 2017.)

- It will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization.
- It will subsume the on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS).
- It would be a cashless and Aadhaar enabled for better targeting of beneficiary.
- **Finance-** It is **a Centrally Sponsored Scheme** with ratio of contribution towards premium will be
  - **60: 40 ratio** Share between Centre and State in all states and UTs with legislature.
  - **90: 10 ratio** between Centre and northeastern states & 3 Himalayan states.
  - **100% Centre's contribution** in case of union territories (UTs) without legislature.
  - **Central funding**: Initial corpus of Rs 2000 crore was announced and rest will be funded from 1% additional cess (Budget-2018).
- Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country.

Role of the States - It is paramount in smooth implementation, because-
- Public health falls in state list therefore states share responsibility of effective delivery of healthcare services on the ground, including ensuring availability of the health personnel.
- NHPS is seen as consolidating fragmented healthcare market with the background of various states having their own health care schemes, e.g.- Maharashtra, Karnataka, Rajasthan, Andhra Pradesh, and Goa.

Challenges

- **Identification of Beneficiary** will be extremely challenging as criteria, other than family income, will cause a huge discontent.
- **Ignoring Primary Healthcare**- Rural Health Statistics 2016 shows the number of primary and community health centers have stagnated over the last three decades and scheme might further promote unnecessary **tertiarization of healthcare**, leading to a cost spiral.

- **Past experience (Evaluation of RSBY)** shows that India lacks the institutional expertise and capacity to implement public health insurance effectively.
- **International Experience** has also shown that insurance-based health care provision, is an expensive model of financing health care for the government.
- **Poor health infrastructure like** hospital beds, doctors (mainly specialists), healthcare staff, diagnostic facilities, pharmacies, etc are not enough to meet the needs of the population.
- **Against Federalism**- It curtails states' autonomy to design their own policies that is constitutionally mandated to be in their domain.
- **Unethical medical practices** under previous scheme for quick monetary gains through unnecessary hospitalization, extension of hospital stay, etc.
- **Instances of Frauds**- Hospital and Insurance company were found in unholy nexus by charging extra for registration, diagnostics & treatment and claiming false insurance claims by floating ghost beneficiaries under government insurance schemes.
- **Structural Issues remain** as India fares poorly on both disease surveillance and funds utilization on health.

Significance of NHPS

- It would be the world's largest government-funded health programme.
- It is expected to **help in building New India 2022** by enhancing productivity, avert wage losses and impoverishment.
- **Consolidating Fragmented Healthcare Insurance** facility available in different states.
- It might help in achieving **National Health Policy** target of health expenditure to reach 2.5 per cent of the GDP by 2025 and will lead **to Universal Healthcare Coverage**.
- It might **promote equal distribution of patients** in private and government hospitals as scheme will be delivered by a network of public and private hospitals.

Way Forward

- **Expanding scope to achieve Ayushman Bharat** by sharing expenditure on outpatient services for long-duration chronic disease.
- **Diverse disease profile-** Each state must be given the flexibility to curate its own list of medical procedures.
- **Integrating primary healthcare into NHPS** to make the scheme viable and sustainable.
- **Preventive healthcare** be made an integral part of NHPS to reduce the burden of hospitalization caused by disease progression and improving nutritional status, awareness, and maintaining efficient health surveillance systems.
- **Leveraging Technology-** Blockchain technology can be used to develop a seamless patient electronic medical record (EMRs) for insurance-based NHPS to prevent fraud and ensure accountability and traceability.
- **Checks and Balances mechanism** at the ends of both the patient and the providers to measure outcomes and tackle abuse of the scheme.

4.7.1.1. EVALUATION OF RASHTRIYA SWASTHYA BIMA YOJANA

Highlights of Evaluation

- It is **unable to reduce out-of-pocket payment** for healthcare for the poor, thus illness remains one of the most prevalent causes of human deprivation in India.
- **No Revision of scheme:** It continues to be capped at Rs 30,000 since 2008 while the costs of hospitalization have almost doubled and it also does not take into account post-hospitalization costs.
- **Delay in seeking care**: Poor people tend to delay hospitalization until they are more severely ill, due to the fear of losing work days and wages, which is costly both from the perspective of costs and health.
- **Positive Impact**: Due to "virtual income transfer" there has been an increase in non-medical spending by poor after RSBY intervention.

About Rashtriya Swasthya Bima Yojna (RSBY)

- Launched in 2007-08, it is a health insurance scheme for BPL families and workers in the unorganized sector.
- It provides for IT-enabled and smart-card-based cashless health insurance, including maternity benefit cover up to Rs. 30,000/- per annum on a family floater basis.
- **Funding Pattern**: Contribution by Government of India to Sate Government is in ratio of 75:25.
- It is implemented by **the Ministry of Health and Family Welfare.**

Way Forward

- **Promote private health insurance:** as complete tax revenue financing is not feasible for lower and lower-middle income countries.
- **Strict Monitoring:** and using provider payment methods that incentivize providers to reduce unnecessary prescriptions and tests, and establishing an IT system to audit providers.
- **Inclusion of Outpatient Care(OC) in Scheme:** As OC comprises up to 70% of total healthcare utilization in India and 60% of total health expenditure. This would decrease the instances of delay shown by poor in taking medical care.
- **Achieving Universal Health Care (UHC)** through risk pooling and prepayment.

4.8. QUALITY ASSURANCE

Current status

- Significant **progress has been made** under NQAP (National Quality Assurance Program) in past one year and the number of National quality certified facilities have tripled from 13 to 59 in one year (2016-2017).
- **Organizational structure for quality assurance:**
  - State Quality Assurance Committees have been formulated in many states, but District level committees are yet to be formulated.
  - Regular meetings of the committees are not taking place.
  - Also, vacant positions and high turnover of dedicated HR inversely affect the program's implementation.
- **Measurement of Key Performance indicators (KPI):** In comparison to last year, number of facilities capturing indicators has increased. However, one of the important pitfalls is that no action planning is being done using these indicators.
- **Statutory and Legal Compliance:** As per NQAS it is mandatory for a facility to obtain few important approvals or certification. Majorly it was found that compliance to fire safety (NoC from fire department), AERB regulation and in few cases authorisation for BMW (eg. Nagaland) and to PCPNDT (eg. Manipur) does not exist.
- **Bio Medical Waste Management and Infection Control:**
  - As a general finding, staffs lack awareness, knowledge and motivation for waste management and infection control.
- Also, the common issues exist like non-compliance to segregation protocol, no transportation trolley, lack of storage area in facility, non-availability of required supplies (liners and needle destroyer), no regular transportation of waste from facility to Common Waste Treatment Facility (CWTF) (especially at the level of Primary Health Clinics and SC), over filled disposal pits and burning of BMW.

Recommendations

- **Organizational Structure for Quality Assurance**
  - States should expedite the formulation of District level **Quality Assurance** Committee (DQAC) and operationalize the already constituted state and district quality assurance committees and units.

Related Initiatives

- **Kayakalp:** This is an initiative to **promote cleanliness, hygiene and infection control practices** in public health facilities. Under this initiative, public healthcare facilities shall be appraised and such public healthcare facilities that show exemplary performance meeting standards of protocols of cleanliness, hygiene and infection control will receive awards and commendation. States have shown tremendous interest in this program.
- **Swachh Swasth Sarwatra:** States have initiated the process of identification of ODF blocks and are getting funds approved for the initiation of program. However, no awareness about Programme was seen at states like Bihar and Nagaland, also disbursement of funds is taking longer time.
- **Free Drug Service Initiative:** Many states are yet to formulate the scheme.
- **Assessment and Certification:** National and State certifications have increased in current FY. However, common observation is that progress after assessment/gap analysis is slow in terms of prioritization of gaps, development of action plan and gap closures.
- **Patient Satisfaction Surveys (PSS)** are not being done in many states. Also, no analysis and further action planning is done to raise patient satisfaction.
- **Quality Assurance under NUHM (National Urban health Mission):** In the financial year 2016-17, baseline assessments as per DLI target were achieved well in time and by the end of financial year it surpassed the set target i.e. 50% of selected UPHCs in defined 15 States. In financial year 2017-18 baseline assessment process is in continuation to achieve target as per DLI-ADB norm for continuation of assessment reports and apply for NQAS certification.

- **Training and Skill Building**
  - States should utilize their trained human resource to train and conduct refreshers trainings at their level.
- **Patient Grievance Redressal (Conducting Patient Satisfaction Surveys (PSS) and Integration of "Mera Aspataal")**
  - States should ensure formulation of patient grievance committee at each facility and should ensure periodical conductance of PSS. Apart from this state should expedite the enrollment of facilities with "Mera Aspataal". Also, it becomes equally important to analyze and undertake action to close gaps as per the analysis report.
- **Bio Medical Waste Management and Infection Control:**
  - State should ensure that each facility should tie up with nearest CWTF or should have proper disposal pits (after proper authorization).
  - It should also ensure regular training of staff as per BMW management rules 2016 and for infection control protocols.
- **Free Drug Service Initiative (FDSI)**
  - States where FDSI has not been implemented should adopt the plan to ensure provision of quality free drugs to the patients.
  - A centralized procurement body may be constituted to ensure transparency and uniform system of drug procurement.
  - States where facility wise EDL are not present should make and display them in each facility.
  - If required drug ware houses as per the state's requirement may be constituted at regional, district and facility level.
  - State must empanel with lab for quality testing of drugs.
  - Patient's grievance redressal forums and prescription audits should also be implemented at states.

Related Current Affairs

Index for Tracking Performance of Hospitals

- Niti Aayog along with the Health ministry has started ranking district hospitals through **'Health of our Hospitals' index.**
- Its aims to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and to be responsive and sensitive to the needs of people and referring centers.
- The hospitals are assessed on the basis of-
  - Number of functional hospital beds per 1,00,000 population,
  - ratio of doctors, nurses and paramedical staff,
  - stock out rate of essential drugs,
  - blood bank replacement rate and
  - post-surgical infection rate etc.

Significance of the Initiative

- **Focus on Health outcomes**: Despite large amounts of money being allocated to the hospitals there was no comprehensive system to assess their performance. Now, it will help in materializing better healthcare delivery by measuring their outcomes.
- **Fostering competition among government hospitals** & providing incentives for better performing hospitals to uphold higher standards.
- **Reduction in regional inequalities** in access to healthcare once the government hospitals would be nudged towards efficient healthcare delivery.
- **Reduced reliance on private sector** thereby reducing the out-of-pocket expenditures of patients.
- **Improved database of hospitals** which can help policy makers in focusing better on investing in the infrastructure, staffing and funding of various hospitals.
- **Patient's feedback:** The index will capture feedback from patients and a high weightage has been assigned for patient satisfaction thus making them a stakeholder in the public healthcare system.

4.9. NATIONAL URBAN HEALTH MISSION (NUHM)

Current Status

- **Planning and Mapping:** GIS mapping of most of the states is under progress. Most of the states have done slum and facility mapping while vulnerability assessment for almost all the states has not been initiated.
- **Institutional arrangement and Programme management:** Most states have strengthened their institutional arrangement systems like State, district and city PM Units. Key positions are also largely filled. Convergence with Ministry of WCD is satisfactory but involvement of ULBs in NUHM is found to be nill.
- **Infrastructure:** Acquiring land in congested urban areas for establishment of UPHCs and UCHCs remains a challenge for the States and is quoted as the main reason of delay in identifying the sites for construction of the new UPHCs.

- **Human Resource:**
  - Due to low remuneration and more competition for clinical posts in urban localities**, high attrition rates** especially of the clinical staff was observed almost across all the states and their availability remains a challenge.
- **Service Delivery:** Assured population-based NCD screening has not been initiated yet, while integration with National Health programs was found missing in all the States.
- **Outreach Services:** Due to unavailability and non- willingness of specialists the outreach services are lacking.
- **Finance:**
  - Fund utilization under NUHM has been found very low due to various different reasons like non recruitment of HR, pending infrastructure works, non-performance, wrong bookings etc.
  - Many states are still struggling on the formation of RKS. Further the states where Rogi Kalyan Samitis (RKS) are formed, either have not opened their accounts or have not transferred untied funds in their accounts.

Recommendations

- All **types of mapping** including spatial GIS, facility and slum mapping and vulnerability assessment of the identified slums areas should be completed on priority.
- States should make sure that **all the key positions** under the State, district and city Programme management units are filled and functional.
- State level **meetings for strengthening convergence** with ULBs and other concerned departments should be organized regularly and roles and responsibilities of various departments under NUHM should be clearly identified and communicated among all stake holders.
- All **vacant positions under management** and service providers should be filled and state should focus on rational deployment of HR under all category.
- **Urban Primary Health Centres** across the states should be made as hubs for providing comprehensive primary health care which incorporates range of services including NCDs and National health programs and not just limited to RCH services.
- Process of **drug procurement** should be streamlined to ensure assured drug availability at all the UPHCs.
- There is a need to reinforce **coordination among ANM, ASHA and MAS** through regular meetings of ANMs with all ASHAs & MAS of their catchment area. There should be special emphasis on their catchment areas, work profiles and level-wise monitoring.
- Under the PPP arrangements, the MoU must **clearly define the responsibility of private partner** and develop a framework to monitor performance of PPPs in terms of defined time bound deliverables and measurable outcomes.

4.10. GOVERNANCE AND MANAGEMENT

Current Status

- **Institutional Structures for Management, Capacity Building and Monitoring**
  - All the mandated structures and institutions prescribed under NHM e.g. SHS, DHS and RKS/HMS are in place in many states and most of the bodies meet as per the norms except the mission level bodies at below district level.
  - Decentralized planning process is a core system strengthening instrument of NHM which is not robust in many States and has almost come to a standstill.
  - Even a decade after implementation, decentralized planning and allocation of financial resources based on plans from district and sub district levels, is yet to take place.
  - Supportive supervision, maintenance of records and feedback mechanism is weak in almost all the states.
- **Convergence Measures**
  - Intra-sectoral convergence between health sector and non-health sectors e.g. between ministry of women and child development, Ministry of Education, ICDS etc is lacking in states like UP, West Bengal, Jharkhand etc. Even Intra-departmental convergence for particular RBSK program, school health, WIFS and MHS is not happening in few of the states.
  - Integration at the village level (VHSND) between ANMs, ASHAs, MPWs and AWWs is also found to be weak in many states.

- **Accountability**
  - Accountability measures like Social audits or Jan Sunwais are either absent or not taking place regularly in many states.
  - Citizen's charter display for various entitlements, schemes and helpline was found at all visited public health facilities and AWW centres of states.
  - Grievance Redressal system in the form of 104 toll- free health helpline is present in many states. However, there is **no legal power (specific legislation) to community** to complain against any public servant to respective authority and get time bound compliance of all grievances.
- **Regulation:** Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act has been implemented in many states. However, in Chhattisgarh PC&PNDT cell were found to be grossly incomplete and mapping of ultrasound machines has not been done completely. Also, there is not a single case prosecution reported in states where violation is observed.
- **Public Private Partnerships and Outsourcing:** Several states like UP, Uttarakhand, West Bengal have adopted PPP model and have outsourced several key functions like security, diagnostic services, or even surgeries for children. However, Poor quality of contract has been drafted for monitoring, quality of services is not good, and payment of services is not adequate.

Recommendations

- **District Health Mission** should be activated and the existing structure should be leveraged to contribute to the mission objectives. Each issue and action taken should have a person responsible and it needs to be pursued till the time it is implemented/resolved.
- Regular **meeting of state and district health mission** needs to take place on policy decisions and required actions to improve accountability and outcome under NHM.
- **Operationalize State Training Institution** urgently, by adequate staff strengthening & transparent selection of high quality faculty. The state also needs to plan for exposure visit to other better performing states for the PMU staff.
- Enhance **more collaboration across departments**. E.g. encourage Medical colleges to take a lead role in NUHM, engage with Skill India Initiative to train and get technician, physiotherapists etc. The State may strengthen joint reviews and monitoring with all allied departments (e.g. WCD, Education, PRI etc.) which would provide better insights and suggestions and improve performance in the long term.
- State and District health societies should invite all concerned within the department and among various departments so that decision taken has wider acceptability, avoid duplication and has better ownership.
- **Social Audit and Jan Sunwais** should be institutionalized at all the levels, especially at the district level.
- **PCPNDT committee** may take action to zero down on the blocks where the sex ratio is below average. Interdepartmental and interstate coordination meetings need to be more frequent.
- State needs to have a **transparent transfer and recruitment policy** with a defined timeline of posting at various levels. **Tenure of service** shall be fixed for specialist in any facilities for example 3 years for specialist in hard to reach areas with incentive and 5 years for soft areas. The **transfer policy** should be innovative and based on pointing system so that the chances of interference would be minimum.
- **Key Performance Indicators** (KPIs) should be built in PPP contracts and these should be closely monitored to enable accountability while ensuring timely payment.

Recommendations Pertaining to the North Eastern States

- Tenure based transfer posting policy for MOs and other key staff working in difficult and remote locations in order to maintain the morale and improve efficiency and delivery of services.
- Issue of mobile/internet connectivity in these remote areas need to be taken up with Department of Tele-communications, GoI at the senior most level from the State Government.
- Issue of non-opening of zero balance bank accounts and delay in opening of bank accounts for beneficiaries need to be taken up with the Department of Financial Services, GoI at the senior most level to facilitate PFMS/DBT transactions.

4.11. MISCELLANEOUS

4.11.1. INDIA STATE LEVEL DISEASE BURDEN REPORT

About the Report

- It has been prepared by **Indian Council of Medical Research (ICMR)** along with **Public Health Foundation of India, and Institute for Health Metrics and Evaluation (IHME).**
- The findings of the study can be used to
  - plan state health budgets
  - prioritisation of state specific interventions help to deal with the variations among states
  - monitoring health related SDGs of each state
  - forecasting population health under various scenarios
  - form data-driven and decentralised health planning framework
  - track sub-national disease burden in India using DALY.

Disability-adjusted life years (DALYs)

- Years of healthy life lost to premature death and suffering.
- It is composed two components: Years of Life Lost (YLL) and Years of life lived with disability (YLD).
- DALYs instead of causes of death alone provides a more accurate picture of the main drivers of poor health.

Findings of the Report

- **Health Indicators and disparities among States**
  - **Life Expectancy:** As compared to 1990s the life expectancy at birth improved from 58.3 years among men and 59.7 years among women to 66.9 years for males and 70.3 years for females.
  - Disparity among states is also visible with a range of 66.8 years in Uttar Pradesh to 78.7 years in Kerala for females, and from 63.6 years in Assam to 73.8 years in Kerala for males in 2016.
  - **Child and Maternal Nutrition:** The disease burden due to Child and Maternal malnutrition has dropped to 15% but it still remains single largest risk factor in India.
  - The study thus points to the fact high priority needs to be put on nutritional interventions.
- **Non-Communicable Diseases and Epidemiological Transition**
  - Over the past 26 years the pattern of diseases has shifted from communicable, maternal, neonatal, and nutritional diseases (CMNNDs) to non-communicable diseases (NCDs) and injuries.
  - Among the leading non-communicable diseases, the largest disease burden or DALY rate increase from 1990 to 2016 was observed for diabetes at 80%, and ischaemic heart disease at 34%.
- **Reduction in Infectious diseases but prevalence still high in many states**
  - The burden of infectious diseases has reduced since 1990 however five out of ten diseases are from this category i.e. diarrhoeal diseases; lower respiratory infections, iron-deficiency anaemia, preterm birth complications, and tuberculosis.
  - DALY rates for whole of India for this group was 2.5 to 3.5 times higher than the average globally for other countries with similar levels of development, thus shows that the burden can be brought down substantially.
- **Increasing burden of diseases among states**
  - Injuries due to road accidents, suicides etc. are the leading contributors to the injury burden in India.
  - DALY rates for self-harm for India was 1.8 times higher ad compared to other countries of same level of development in 2016
- **Unsafe Water and Sanitation**
  - The Disease burden due to above is improving but it continues to contribute 5% of total disease burden though it has improved since 1990.
  - The disease burden due to unsafe Water and Sanitation is 40 times higher in India than in China.
- **Household air pollution improving and worsening outdoor air pollution**
  - **Outdoor Pollution -** The contribution of pollution remained high during 1990 and 2016 which causes a mix of NCDs and infectious diseases.
  - **Household pollution -** it has considerably decreased due to reduced use of solid fuels for cooking. Household air pollution was responsible for 5% of the total disease burden in India in 2016, and outdoor air pollution for 6%.
- **Rising risk of cardiovascular diseases and diabetes**
  - The contribution of this group has increased from 10% to 25% when 1990 and 2016.

- This includes unhealthy diet, high blood pressure, high blood sugar, high cholesterol, and overweight, which mainly contribute to ischaemic heart disease, stroke, and diabetes.
- Other significant contributor to rising burden of cardiovascular diseases and diabetes is tobacco use which was responsible for 6% of the disease burden.
- All these risks are generally higher in females than males.

Policy Implications

- A major issue with interventions to improve population health in India has been the relative deficiency of the necessary **inter-sectoral collaborations**. An improved understanding of the influence of the variety of sectors on health would help achieve better population health levels in the country.
- Various health goals as indicated in National Health Policy 2017 and the NITI Aayog Action Agenda 2017 can be achieved through- **Increasing health financing** & **Improving human resources for health**.
- **Strengthening the health information system** by introducing a robust cause of death reporting system, improved disease surveillance and better documentation in health facility records and utilisation of these data to understand health outcomes.
- **Other implications include -**
  - **Addressing the major risk factors -** includes focus on child and maternal malnutrition, unsafe water and sanitation, controlling air pollution and addressing risk factors for cardiovascular disease and diabetes.
  - **Addressing persistent and increasing disease conditions -** includes controlling under-5 disease burden, injuries (due to road accidents, suicides etc.), TB and other communicable diseases and non-communicable diseases.

4.11.2. NATIONAL NUTRITION STRATEGY

Why in News?

- A high-level panel under Niti Aayog has drawn up a 10-point nutrition action plan that includes governance reforms in line with the vision for "**Kuposhan Mukta Bharat- Vision 2020**".
- The Government of Indian has approved setting up of the **National Nutrition Mission.**

Related Provisions

- Article 47 of the Constitution mentions the "duty of the state to raise the level of nutrition and the standard of living and to improve public health.
- The Copenhagen Consensus has identified twice several nutrition interventions as some of the most high-yielding of all possible development assessments.
- The National Nutrition Mission, recommended by the Prime Minister's National Council on India's Nutrition Challenges in 2010, was launched in 2014, to address the problems of maternal and child under-nutrition in the country.
- The government recently laid down the **National Health Policy, 2017**, that also talks about Child & Adolescent health and interventions to address malnutrition and micronutrients deficiencies, among other issues.

About the Mission

- It would be executed with the **Ministry of Women and Child Development (WCD)as the nodal ministry** along with Ministry of Drinking Water and Sanitation and Ministry of Health and Family Welfare**.**
- **Implementation and Target**
  - The mission has a target to reduce **stunting, under-nutrition, and low birth weight** by 2 per cent per annum, and **anaemia** by 3 per cent annually.
  - It aims to focus mainly on children up to the age of 6 years, pregnant and lactating women, and adolescent girls.
  - It would also strive to achieve reduction in stunting from 38.4% (NFHS-4) to 25% by 2022 **(Mission 25 by 2022).**
  - It will be implemented in **three phases**: 2017-18, 2018-19 and 2019-20. 315 'high burden' are to be covered in the first phase, 235 in next and the remaining in last.
- **Features**
  - **NNM as an apex body** will monitor, supervise, fix targets and guide the nutrition related interventions.
  - Mapping of various schemes contributing under malnutrition
  - ICT (Information and Communication Technology) based real time monitoring system
  - Incentivising states/UTs for meeting targets
  - Incentivising Anganwadi Workers (AWW) for using IT based tools and eliminating the need for registers
  - Measurement of height of children at Anganwadi Centres
  - Social Audits to track the health progress of the children
  - Setting-up Nutrition Resource Centres.

National Nutrition Strategy Provisions

- **Reducing all forms of malnutrition by the end of 2030.**
- The nutrition strategy envisages **a framework wherein the four proximate determinants** of nutrition – uptake of health services, food, drinking water & sanitation and income & livelihoods – work together to accelerate decline of under nutrition in India.
- **Decentralised Approach-** With this the Strategy aims to strengthen the ownership of PRIs and urban local bodies over nutrition initiatives as subjects allocated to PRIs include those addressing the immediate and underlying determinants of undernutrition like sanitation and water.
- **Governance reforms** envisaged in the Strategy include: (i) convergence of state and district implementation plans for ICDS, NHM and Swachh Bharat, (ii) focus on the most vulnerable communities in districts with the highest levels of child malnutrition, and (iii) service delivery models based on evidence of impact.
- **Nutrition Social Audits** are to be undertaken to track the children and their health progress.
- **National Nutrition Surveillance System-** Undernourished endemic zones of the country will be mapped for identifying 'high risk and vulnerable districts' & the cases of severe under nutrition in children should be included in the routine disease reporting system.
- **Institutional Arrangements**- Institutional arrangements like the National Nutrition Mission Steering Group (NNMSG) and the Empowered Programme Committee (EPC) respectively under the chairpersonship of Minister and Secretary of Women and Children and the Secretary will be constituted.
- **National Nutrition Mission**- The Strategy aims to launch a National Nutrition Mission, similar to the National Health Mission. This is to **enable integration of nutrition-related interventions** cutting across sectors like women and child development, health, food and public distribution, sanitation, drinking water, and rural development.

4.11.3. NUTRITION SECURITY

Why in news?

United Nation has published its report on **"The State of Food Security and Nutrition in the World"** for 2017.

Background

- The focus of this year's report is on the **nexus between SDG 2 and SDG 16** - that is, between conflict, food security and peace.
- The report shows how conflict affects food security and nutrition, and how improved food security and more-resilient rural livelihoods can prevent conflict and contribute to lasting peace.

Key messages of the report

- **Rise in undernourishment:** The number of chronically undernourished people in the world is estimated to have increased to 815 million in 2016 from 777 million in 2015. After a prolonged decline (900 million in 2000), this recent increase could signal a reversal of trends.
  - **Stunting:** Though there is fall in stunting, 155 million children under five years of age suffer from stunted growth globally.
  - **Wasting:** It affects one in twelve (52 million or 8%) of all children under five years of age in 2016, more than half of whom (27.6 million) live in Southern Asia.
- **Coexistence of multiple malnutrition:** under-nutrition among children, anaemia among women, and adult obesity have been found simultaneously.
  - In 2016, 41 million children under five years of age were overweight.
- **Areas affected:** Parts of sub-Saharan Africa, South-Eastern Asia and Western Asia is worst affected, and deterioration is observed in situations of conflict and conflict combined with droughts or floods/climate (due to El Nino and La Nina) related shocks.
  - An estimated 489 million of 815 million undernourished people and an estimated 122 million of 155 million stunted children live in countries affected by conflict.
  - Africa has the highest levels of severe food insecurity reaching 27.4 % of the population - almost four times that of any other region in 2016.
  - In Asia, the prevalence of severe food insecurity decreased slightly between 2014 and 2016, from 7.7 to 7.0 % overall, driven mainly by the reduction observed in Central Asia and Southern Asia.

- The prevalence of food insecurity was slightly higher among women at the global level as well as in every region of the world.
- Addressing food insecurity and malnutrition in conflict-affected situations requires immediate humanitarian assistance, long-term development and sustaining peace.

How does Conflict affect food security and nutrition?

- Conflict can cause deep economic recessions, drive up inflation, disrupt employment and erode finances for social protection and health care, to the detriment of the availability and access of food in markets and so damaging health and nutrition.
- The impact on food systems can be severe if the economy and people's livelihoods rely significantly on agriculture, as the effects can be felt across the food- value chain, including production, harvesting, processing, transportation, financing and marketing.
- Conflict undermines resilience and often forces individuals and households to engage in increasingly destructive and irreversible coping strategies that threaten their future livelihoods, food security and nutrition.

UN's assessment of India between 2014-16

- 14.5% of the total population is undernourished
- 21.5% Children under five suffer from wasting in 2016.
- 38.5% children under five are stunted
- 51.4% women of reproductive age are anaemic
- Obesity among adults has reached 3.6% and is increasing.
- Exclusive breastfeeding has increased rapidly and around 64.9% children are exclusively breast fed for first six months.

Reasons behind such a scenario:

- Insufficient intake of both macro and micro-nutrients cause malnourishment. Since food security in India is primarily focussed on providing rice and wheat only, the diet lacks other essential nutrients and results into stunting etc.
- Only 17% children achieved a minimum level of diet diversity.
- Acute food insecurity in tribal and rural households is due to a loss of their traditional dependence on forest livelihood and the State's deepening agrarian crisis.
- Systemic issues and a weaknesses in public nutrition programmes have aggravated the problem e.g. many of the tribal families do not receive rations (through public distribution system) because they do not have a ration card.
- The nutrition expenditure as a percentage of the Budget has drastically declined in many states.

Can food insecurity and under-nutrition trigger conflict?

- According to WFP, undernourishment is one of the important determinants of the incidences of armed conflict, and that when coupled with poverty, food insecurity increases the likelihood and intensity of armed conflict.
- In countries with low socio-economic indicators - such as higher rates of child mortality, poverty, food insecurity and undernutrition - there is a higher risk of conflict.
- **Sharp increase in food prices tend to exacerbate the risk of political unrest and conflict, as witnessed between 2007-08 and 2011 when food riots broke out in more than 40 countries (Arab Spring).**
- A severe drought tends to threaten local food security and aggravate humanitarian conditions, which in turn can trigger large-scale human displacement and create a breeding ground for igniting or prolonging conflicts as seen in Syrian civil war.
- Competition for natural resources can be detrimental to the food security of vulnerable rural households, potentially culminating in conflict as seen in Darfur and in greater horn of Africa.

Gender dimensions involved in food security and nutrition in conflict zones

- Men and women often have different roles and responsibilities in securing adequate food and nutrition at the household level. **Conflicts tend to alter gender roles and social norms**.
- The engagement of men in conflict **puts greater responsibility in the hands of women** in sustaining the livelihood of the household, including for the access to food, nutrition and health care of household members.
- Conflict situations often are characterized by **increased sexual violence, mostly targeted at women**.
- In crisis situations and among refugees, one in every five women of childbearing age is likely to be pregnant. Conflicts **put these women and their babies at increased risk** if health-care systems falter and their food security situation deteriorates.
- Rural women often have **less access to resources and income**, which makes them more vulnerable and hence more likely to resort to riskier coping strategies which may affect their health and eventually of entire household.

- Conflict leads to **increased female labour participation** particularly in low skilled work which may expose them to unsafe and insecure labour conditions.
- **Child labour** in its worst forms are seen during times of conflict.
- Shifting gender roles can also have **beneficial effects on household welfare**. Where women gain more control of resources, household food consumption tends to increase and child nutrition improve. Their economic empowerment may further give them greater voice in household and community decision-making as seen in Somalia, Colombia, Nepal etc.

Way-forward

- Prevent conflict through addressing its root and immediate causes such as economic exclusion, extractive or predatory institutions, inequitable social services, access to and use of natural resources, food insecurity, and climatic disasters.
- Timely intervention by government and humanitarian organisations.
- Scaling up social protection, Cash-for-work and food-for-assets programmes, creating or rehabilitating critical productive infrastructure, such as roads or irrigation systems.
- Farmers displaced by conflict can be trained in new livelihood skills, with which they can earn an income in camp settings.
- In pastoralist regions, watering points can be built in safe areas to avoid the risk of leading livestock into conflict zones.
- Support can be provided to internally displaced people, refugees and ex-combatants for returning home and resuming productive activities, for example, by providing seeds, tools, livestock, or skills training.

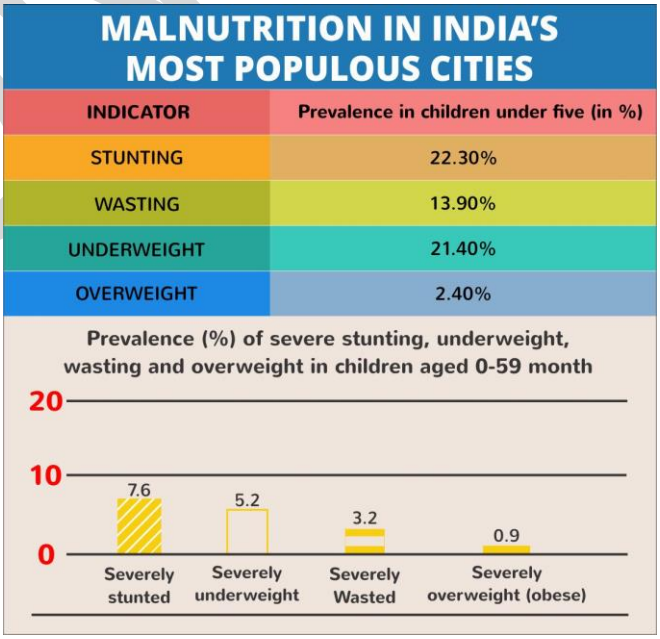
4.11.4. URBAN NUTRITION IN INDIA

Why in News?

The Urban HUNGaMA (Hunger and Malnutrition) **Report on Urban Nutrition** was released based on the survey that was conducted in 2014 by Citizens Alliance against Malnutrition.

Details

- The URBAN HUNGaMA Survey 2014 was conducted to capture essential nutrition data of children aged 0-59 months in the 10 largest cities of India.
- The data collected in the survey was related to Nutrition (weight, height, age) & Household (parent's years of schooling, religion, access to services).



Issues with Urban Nutrition

Urban nutritional problems result in a spectrum of outcomes, from obesity to malnourishment.

- For many of the poor, a lack of food is not the core issue; the deficiencies stem from the lack of nutrients found in many cheap foods they consume to keep themselves and their family out of hunger.
  - These "costs" of poor nutrition contribute to even higher health care costs, creating a dangerous downward spiral.
- Further, excessive intake of energy, coupled with limited physical activity involved in urban lifestyle, lead to rising problems of obesity and diet-related chronic diseases in most cities.
  - Urban diets tend to include foods containing more energy and fat density, which can contribute to chronic health problems.

Due to increasing urbanization in India the challenges related to nutrition loom large which is studied by the survey.

Highlights of the Report

- It showed a small difference between boys and girls for **all indicators of malnutrition**. It shows a very small difference between boys and girls: boys were found to be slightly more malnourished than girls in every measure of malnutrition.
- The findings show a significantly higher prevalence of malnutrition among children whose mothers had **little or no schooling**.
- The prevalence of child malnutrition among households in **the higher wealth quintiles** was significantly lower than among households in lower wealth quintiles. While in terms of over-nutrition, children from the higher wealth households were more.
- Only 37.4% households accessed a public distribution system in the month preceding – lowest being in Surat (10.9%) and highest being in Kolkata (86.6%).
- Less than one in four children was fed a diet that meets the minimum requirements for healthy growth and development.

4.11.5. NATIONAL HEALTH POLICY 2017

Cabinet has recently approved National Health Policy (NHP) 2017 to address the current and emerging challenges in terms of socio-economic changes and epidemics since the last NHP in 2002.

Shifts seen in new policy

- **From communicable to non-communicable diseases:** NHP recognizes need for state intervention to control NCDs as they are reason for more than 60% death in India. Thus policy advocates pre-screening and sets the target to reduce premature mortality via NCDs **by 25% by 2025.**
- **Collaborating & regulating the private sector** which has grown tremendously since 2002, such that over 2/3rd services are provided by it. Although policy seems to be **patient-centric**, as it proposes
  - **National health care standards organization** (NHCSO) to lay down standards and protocol
  - **Tribunals** for redressal of grievances
- **Shift from sick-care to wellness:** NHP seeks to invest in preventive healthcare. For this,
  - **early screening** and diagnosis have been made a public responsibility
  - commitment to **pre-emptive care** to achieve optimum levels of child and adolescent health through school health programmes and focus on health and hygiene in curriculum
  - advocates 2/3rd or more allocation of health budget for Primary Health Care
  - assuring comprehensive primary health care through the Health and Wellness Centers'
- **Intersectoral approach** involving various ministries such as MoEf, MoHWS, MoA, MoUD, MoHRD, MoWCD etc.
- **Urban Health Case:** prioritizes addressing the primary health care needs of the urban population with special focus on poor populations, convergence among the wider determinants of health – air pollution, vector control, reduction of violence and urban stress.

Provisions of health policy, its positive impact and related issues

Provisions	Positive impact	Related Issues
Strengthening role of public sector by increasing public health spending to **2.5% of GDP** by 2025 from current 1.15%. States should spend 8% of more of their budget towards health by 2020.	• Will increase spending which has become nearly stagnant in recent years.	• Lack of capacity to use higher level of funds • Still Much lower than even other developing countries' spending on health • Central budgets also must reflect steady rise annually
Affordable quality healthcare for all by ensuring following • Universal access to drugs and diagnostics, emergency and essential health services • providing every family with a health card for PHC services	• Reduce disease burden of India (from current 1/5th of the burden in world) • would bring people from diverse professional backgrounds acknowledging	• Would require more human resources and funds • Need of more trained doctors and nurses and does not confront the pervasiveness of fake

• secondary and tertiary care services through a combination of public hospitals & strategic purchasing in healthcare deficit areas from accredited non-governmental healthcare providers. • Establish public health management cadre in all states	need for multi-disciplinary approach • Enable detection of state-specific health hazards and contain them before they spread.	doctors constituting 'half' of the doctors here (WHO report) • District hospitals need to be strengthened and sub-district hospitals need to be upgraded
Mainstreaming **AYUSH** systems by **three-dimensional integration** encompassing cross referrals, co-location and integrative practices across systems of medicines in both rural and urban areas.	• Stresses need of backing claims of traditional medicine focusing on pluralism and drawing upon diverse systems of medicine.	• Still treated as subordinate to allopathic professionals

Other issues with NHP 2017

- It leaves too much to the states on maintaining standards. Present situation gives free hand to states to reject even necessary acts such as The Clinical Establishments Act 2010 was passed by Parliament with the aim of regulating clinical standards and ending quackery.
- It does not speak about social determinants of health.
- It does not talk of public health education (which is outside MCI mandate) it just talks about medical education, paramedical education etc.
- Various progressive measures under Draft NHP 2015 such as Right to Health, increasing public spending by 2020 and imposing health cess have been ignored.
- Thus, to achieve SDG on health, i.e., health and well-being to all by 2030, there would be need for greater and stronger Centre-state coordination and commitment for effective implementation.

Targets under NHP 2017

- Increasing life expectancy to 70 years from 67.5 years by 2025
- reduce infant mortality rate to 28 by 2019
- reduce under five mortality to 23 by 2025
- reduce Total Fertility Rate to 2.1 at the national and sub-national levels by 2025
- Maternal Mortality Ratio from current levels to 100 by 2020
- Reduce neo-natal mortality to 16 and stillbirth rate to "single digit" by 2025.

5. EDUCATION

Education is the most important tool for social, economic and political transformation and a key instrument for building an equitable society. A well-educated population, equipped with the relevant knowledge, attitudes and skills is essential for economic and social development in the twenty-first century. Education also acts as an integrative force in society, imparting values that foster social cohesion and national identity. Before 1976, education was the exclusive responsibility of the States. The Constitutional Amendment of 1976 included education in the Concurrent List.

5.1. SCHOOL EDUCATION

The most important goal in front of the Indian school education system today is to **improve learning outcomes.** Through initiatives like the Sarva Shiksha Abhiyan (SSA) and The Right of Children to Free and Compulsory Education (RTE) Act, the Indian school system has focused on measuring and delivering inputs, and in this, it has largely succeeded.

- The Gross Enrolment Ratio (GER) in 2015-16 for grades I-V was 99.2% and for grades VI-VIII was 92.8%. Pupil-Teacher ratio at national level for elementary schools was 24:1 and for secondary schools it was 27:16.
- Unfortunately, this success in getting more children into schools with more teachers has not translated into more education. The proportion of children in grade III who can read at least a grade I level text dropped from 50.6 in 2008 to 40.3 in 2014, before increasing marginally to 42.5 in 2016 according to Pratham's Annual Status of Education Report (ASER) data.
- The proportion of children in grade III who can do at least subtraction fell from 39% in 2008 to 25.4% in 2014, and again increased slightly to 27.7% in 2016. Poor learning outcomes are reflected in multiple other sources as well, including the National Achievement Survey (NAS), which found worse results in Class V Cycle 4 (2015) compared to Cycle 3(2012).

These are not the only results, which suggest that a focus on inputs does not help improve education. The most rigorous and credible evidence available to-date shows that the traditional levers – more or better infrastructure, lower pupil-teacher ratios, higher teacher salaries and more teacher training – by themselves have not been effective in improving student learning outcomes.

The most critical missing pieces that evidence has shown to be effective are - pedagogy that focuses on teaching at the right level, outcome linked incentives, and governance that enables the system to operate smoothly.

Way Forward

NITI Aayog's Action Agenda for School Education calls for focussing on the following points-

- Orient the system towards outcomes:
  - Introduce an independent, state of the art **sample-based outcome measurement system**.
  - Track and support state level improvement through **a School Education Quality Index (SEQI).**
  - Modify RTE requirements on inputs and shift it towards outcome, so that **RTE turns into Right to Learning**, instead of just being a Right to go to School.
- Provide tools to teachers and students for effective learning:
  - Introduce evidence-based **Information and Communication Technology** tools.
  - Focus on **foundational learning**. A time-bound national program with focus on ensuring that all children have such **basic literacy and numeracy skills** should be launched.
  - Pilot a system of **technology aided adaptive "exams on demand"** which test students on absolute competencies instead of relative 'marks' and allow students to take and re-take exams when they are ready.
- Improve existing governance mechanisms:
  - Enrolment in public schools is much lesser than that in private schools. The reason is high rate of teacher absenteeism, limited time spent on teaching when the teacher is in class and generally poor quality of education.
  - Quality improvement through improved governance is one way of slowing or reversing this process. A set of basic governance processes and structural reforms that have the maximum impact have been identified and included in the School Education Quality Index.

- Pilot new governance mechanisms:
  - **Separation of the functions** of policy making, regulation and provision. Currently, all these functions are carried out under the State Ministry of Education which often regulate aspects of private school functioning like school fees in an ad hoc manner.
  - **Giving more autonomy** to the directorate of education and making it accountable through clear, measurable goals; quality of top managers selected; independence and authority for the management to take necessary steps to reach the goals; and oversight and accountability based on credible measurement of outcomes.
- Explore the role for states and private players:
  - A working group should be set up with states' participation to explore and pilot other bolder experiments by interested states. These could include **education vouchers** and **local government led purchasing of schooling services**.
  - Public-Private Partnership (PPP) models could also be explored where the **private sector adopts government schools** while being publicly funded on a per child basis.

5.1.1. SAMAGRA SHIKSHA ABHIYAN

The Union Budget, 2018-19, had proposed to treat school education holistically without segmentation from prenursery to Class 12. An overarching programme for the school education sector extending from pre-school to class 12 called **Samagra Shiksha Abhiyan** has been, therefore, prepared with the broader goal of improving school effectiveness measured in terms of equal opportunities for schooling and equitable learning outcomes.

About the scheme

- This integrated centrally sponsored scheme on School Education envisages the 'school' as a continuum from pre-school, primary, upper primary, secondary to Senior Secondary levels.
- The SSA, RMSA, and TE have been merged in this scheme.
- The Centrally Sponsored Schemes of Sarva Shiksha Abhiyan (SSA), Rashtriya Madhyamik Shiksha Abhiyan (RMSA) and Teacher Education (TE) are the three major school education development programmes of the Ministry of Human Resource development (MHRD), implemented in partnership with State/UTs. The common objectives of all the Schemes are:
  - To enhance access through the expansion of quality school education
  - To promote equity through the inclusion of disadvantaged groups and weaker sections, and
  - To improve the quality of education for all.
- The vision of the Scheme is to **ensure inclusive and equitable quality education** from pre-school to senior secondary stage in accordance with the Sustainable Development Goal (SDG) for Education.
- It is proposed that preference in the interventions would be given to Educationally Backward Blocks (EBBs), LWEs, Special Focus Districts (SFDs), Border areas and the 115 Aspirational districts.

Principles to be followed

They are based on the report of Shri Anil Bordia committee to reform SSA.

- **Holistic view of education**, as interpreted in the National Curriculum Framework 2005, with implications for a systemic revamp of the entire content and process of education with significant implications for curriculum, teacher education, educational planning and management.
- **Equity and Access,** to mean not only equal opportunity or school becoming accessible within specified distance, but also creation of conditions in which the disadvantaged sections of the society – children of SC, ST, Muslim minority, landless agricultural workers and children with special needs, etc. – can avail of the opportunity.
- **Gender concern**, implying not only an effort to enable girls to keep pace with boys but to view education in the perspective spelt out in the National Policy on Education 1986 /92; i.e. a decisive intervention to bring about a basic change in the status of women.
- **Centrality of teacher** to motivate them to innovate and create a culture in the classroom, and beyond the classroom, that might produce an inclusive environment for children, especially for girls from oppressed and marginalised backgrounds.
- **Moral compulsion** is imposed through the RTE Act on parents, teachers, educational administrators and other stakeholders, rather than shifting emphasis on punitive processes

- **Convergent and integrated system of educational management** is pre-requisite for implementation of the RTE law. All states must move in that direction as speedily as feasible.

SDG-4.1

By 2030, ensure that all boys and girls complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.

SDG 4.5

By 2030, eliminate gender disparities in education and ensure equal access to all levels of Education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations.

Important Components of the Schemes

Pre-School Education

- Early childhood care is widely acknowledged as an essential input for girls' education in freeing girls from sibling care responsibilities, leading to their regular attendance in school and in providing school readiness skills to pre-school children.
- Ministry of Women and Child Development is running a comprehensive programme for children under 6 years of age. There is an increased demand for pre-schools even in small towns, but only 1% children are enrolled in it.
- Therefore, the Samagra Shiksha Abhiyan will make efforts to strengthen the area of Pre-school education through greater convergence with ICDS program of MoWCD.

School access, Infrastructure Development and Retention

- **School Access:**
  - This will include an understanding of the educational needs and predicament of the traditionally excluded categories – the SC, ST and other sections of the most disadvantaged groups, the Muslim minority, girls in general, and children with special needs.
  - Access will also mean to address the needs and requirement of other disadvantaged categories of children such as children affected with migration, urban deprived children, children whose families are involved in stigmatised professions, homeless children transgender and all other categories who would require additional support for access to schooling and participation therein.
- **Composite/ Integrated School:** All the levels of schooling from pre to Class XII should be available at one place promoting vertical integration.
- **Child tracking through SDMIS**: The Scheme aims to achieve the goal of 100% retention from pre-school to senior secondary school through tracking of all children. The State/UT may track these students through the **Student Data Management Information System (SDMIS)**.
- **Mapping for Universal Access: It is important to have a** clear picture of current availability of schools, identify the gaps i.e. areas or habitations which are unserved and plan to provide access to school to the identified unserved areas/ habitations according to possible solutions.

According to the National Curriculum framework 2005, for the holistic development of a learner through school education:

- Connect knowledge to life outside the school
- Ensure that learning is shifted away from rote methods
- Enrich the curriculum to provide for overall development of children rather than remain textbook centric.
- Make examinations more flexible and integrated into classroom life, and
- Nurture an over-riding identity informed by caring concerns within the democratic polity of the country.

Quality interventions

- In accordance with **National Curriculum framework 2005**, the new scheme would focus on learners' cognitive development as the major explicit objective and on education's role in promoting values and attitudes of responsible citizenship and in nurturing creative and emotional development.
- There will be in-built monitoring and research components viz; curriculum reform, reform in teacher education, examination and ensuring participation of stakeholders from all the corners.
- Bridge course for **out of school children** may also be envisaged as transitory measures to provide schooling till such time as regular, full time schooling facilities could be provided in the area concerned.
- There will be focus on reducing the rural-urban divide and regional disparities.

Use of ICT tools in school education

- Information and Communication Technology (ICT) has become one of the basic building blocks of modern society. Therefore, the new approach in school education includes Universal equitable, open and free

access to a state of art ICT and IT enabled learning environment, tools and digital resources to all students, teachers and teacher educators

Vocationalisation of Education

- It refers to the inclusion of those practical subjects or courses, which shall generate among the students some basic knowledge, skills and disposition that prepare them to think of becoming skilled workers or entrepreneurs. The scheme will emphasise Kaushal Vikas in schools.
- It may be seen as an instrument for providing diversification of educational opportunities, enhancing individual's employability and enabling individual to pursue higher education.
- The Vocationalisation of School Education shall make funding arrangements for the introduction of vocational courses along with general education subjects from Classes IX to XII.
- The vocational subjects are to be introduced as an additional or compulsory subject at the Secondary level and as compulsory (elective) at the Senior Secondary level.
- Exposure to Vocational Education would also be provided in Classes VI to VIII with an aim to provide opportunities to the students to orient themselves with the skills required for the various occupations in a sector and to equip them to make informed choices while selecting their subjects in higher classes.
- Introduction of vocationalisation of Education may reduce the high drop-out rate of around 18% at secondary level.
- It will also help in reducing the gap between academic and applied learning (industry required skills).

Addressing Gender and Equity issues in School Education

- National Policy on Education states that education should be a transformative force, build women's self-confidence, and improve their position in society and challenge inequalities.
- The scheme will focus on **Beti Bachao Beti Padhao**.
- **Drop-out girls:**
  - Despite significant improvement in the enrolment of girls, girls from disadvantaged communities continue to form the bulk of out-of school children. Therefore, both access and retention are considered to be an equity issue, as SC, ST, Muslim girls are vulnerable, and most likely to dropout.
  - In the Integrated Scheme, with regard to access and retention, the focus would be on older girls, where the need is the greatest.
  - Support measures would include transport, escorts, counseling, helping them negotiate domestic work burdens, community support mechanisms and academic support depending on the nature of the problem.
- Under the Integrated Scheme, the existing KGBVs at upper primary level and Girls Hostels at secondary level would be extended/converged to provide residential and schooling facilities upto Class-XII.
- Monitoring of these institutions will be strengthened and PRIs will also be involved in the monitoring process.

Inclusion of Children with special needs (CWSN) in education

- The scheme will cover all children with special needs with one or more disabilities as mentioned in the schedule of disabilities of the Right of the Persons with Disabilities (RPwD) Act, 2016 studying in Government, Government-aided and local body schools.

Teacher education and Teacher Training

- Several committees such as Kothari Commission (1964-66) and Chatopadhyaya Committee (1983-85), and National Policy on Education 1986, as well as the New Education Policy (Kasturi Ranjan Committee) have highlighted upon the importance of Teacher education.
- In context with recommendations given by these committees, SSA will restructure and strengthen SCERTs (State Council for Educational Research and Training)/SIEs/DIETs (District Institute of Education and Training).
- This will ensure pre-service or in-service training of teachers up to higher secondary level.

5.1.2. LOCATION-SPECIFIC MERGERS OF SCHOOLS

Why in News?

- Many states such as Andhra Pradesh, Rajasthan, Odisha, Himachal Pradesh, and Maharashtra have attempted to consolidate schools (under names such as school rationalisation, mainstreaming, amalgamation, and integration) at primary and upper primary levels.
- The Centre is looking to execute location-specific mergers of nearly 260,000 small government schools as part of a rationalization process to ensure maximum use of resources. Human Resource Development Ministry has released guidelines for public comments regarding the same.

Background

- **Sarva Shiksha Abhiyan (SSA)** has been operational since 2000-2001 to provide for a variety of interventions for universal access and retention, bridging of gender and social category gaps in elementary education and improving the quality of learning.
- SSA interventions include, opening of new schools, construction of schools and additional classrooms, toilets and drinking water, provisioning for teachers, free textbooks & uniforms and support for improving learning achievement levels, etc.
- As part of the Sarva Shiksha Abhiyan, the government created some 367,000 schools. At present, it has more than 1.5 million schools across all levels.

Why consolidation is needed?

- According to the government it is time for a "re-look at the expansion of schooling facilities made in previous years and call for a nationwide consolidation of schools".
- As per the draft guidelines, as of 2015-16, at least 187,006 primary schools (Class I-V) and 62,988 upper primary (Class VI-VIII) schools were running with fewer than 30 students. Besides, 7,166 schools had zero enrolment. Further, some 87,000 schools have a single teacher.
- It has been noted that the surplus small schools adversely affect the:
  - provisioning of resources
  - learning process, and
  - monitoring and supervision

Solution suggested by the Guidelines

- To reallocate the resources in the "best interest of the children" and minimize under-utilization and wastage the ministry will reallocate staff and other resources from schools where they are in excess to the schools where they are needed.
- The children and resources, within a habitation, spread over two or more small schools are suggested to be combined together. It will not only provide a better teaching-learning environment but will also make schools RTE compliant.
- The merged schools post the rationalisation process must necessarily adhere to the neighbourhood norms defined in each state's RTE Rules.

Challenges

- Recently, it was reported that the merging of 4,000 government schools as part of rationalisation has contributed to increasing the rate of girls dropping out. The girls are affected by the distance to their new schools, lack of sufficient classrooms, toilets, difficulties faced during their periods, apart from availability of hostels and drinking water.
- There was no clear policy on providing transportation and facilitating mobility of students to merged schools. Also, there was no local consultation before the closure of schools.
- This can go against the intentions behind Sarva Shiksha Abhiyan and the move of making Right to Education universal.

Way Forward

- Any policy around restructuring of public schooling needs to be crafted carefully with a broader perspective, as the outcomes may have several implications on access, equity, and accountability.
- The following guiding principles could be followed for school consolidation and restructuring:

- **Create before you destroy**: Construct functional school infrastructure and appoint teachers in the consolidated school prior to shutting down schools.
- **No child should be left behind**: School consolidation should not result in denied access to school to any child. Access to every child and means to participate should be ensured. All possible transportation options should be explored, in case consolidation leads to difficulty in physical access.
- **Consult before consolidating**: Consolidation must be based on consultation with the local communities, on issues such as school location and transportation.

5.2. HIGHER AND TECHNICAL EDUCATION IN INDIA

India's higher education system is the world's third largest in terms of students, next to China and the United States. In future, India will be one of the largest education hubs. India's Higher Education sector has witnessed a tremendous increase in the number of Universities/University level Institutions & Colleges since independence.

Challenges of Higher education in India

Enrolment

- The Gross Enrolment Ratio (GER) of India in higher education is only 25.2% which is quite low as compared to the developed as well as, other developing countries.

Equity

- There is no equity in GER among different sects of the society. **GER for males (26.3%), females (25.4%), SC (21.8%) and ST (15.9%).**
- There are regional variations too some states have high GER while as some is quite behind the national GER which reflect a significant imbalances within the higher education system. The college density (number of colleges per lakh eligible population) varies from 7 in Bihar to 59 in Telangana as compared to All India average of 28.
- Also, most of premier universities and colleges are centred in metropolitan and urban city, thereby leading to the regional disparity in access to higher education. However, to fill this gap government has launched **Technical Education Quality Improvement Programme (TEQIP)** for rural areas.
- Social structure biases and prejudices towards downtrodden and women is still rampant even in higher education.

Quality

- Education system is plagued with rot learning, lack of employability and skill development. an assessment of 150,000 engineering graduates in 2016 found that only 18% of engineers were employable in the software services sector in a functional role.

Infrastructure

- Poor infrastructure is another challenge to the higher education system of particularly the institutes run by the public sector suffer from poor physical facilities and infrastructure.
- There are large numbers of colleges which are functioning on second or third floor of the building on ground or first floor there exists readymade hosieries or photocopy shops.
- Recently the government has launched **Higher Education Financing Agency (HEFA) and Revitalization Infrastructure and Systems in Education (RISE)** scheme for infrastructure related challenges.

Political interference

- Most of the educational Institutions are owned by the political leaders, who are playing key role in governing bodies of the Universities.

Faculty

- Faculty shortages and the inability of the state educational system to attract and retain well qualified teachers have been posing challenges to quality education for many years. Shortage of faculty leads to **Ad-hoc expansion** even in premier institution
- Large numbers of NET / PhD candidates are unemployed even when there are lot of vacancies in higher education.

- The Pupil to teacher ratio though has been stable in the country (30:1), however it needs to improve such as compared to USA (12.5:1), China (19.5:1) and Brazil (19:1).

Accreditation

- As per the data provided by the NAAC, as of June 2010, not even 25% of the total higher education institutions in the country were accredited. And among those accredited, only 30% of the universities and 45% of the colleges were found to be of quality to be ranked at 'A' level.

Research and Innovation

- There is a disconnect between the teaching and research enterprise with research being concentrated in specialized research institutes under different government departments limiting universities to largely play a teaching role.
    - This has led to a situation where universities have students but need additional faculty support, while research institutes have qualified faculty but are starved of young students.

> Government has recently launched several schemes such as Teacher Associateship for Research Excellence (TARE) Scheme, Overseas Visiting Doctoral Fellowship (OVDF), Distinguished Investigator Award (DIA) and Augmenting Writing Skills for Articulating Research (AWSAR) scheme for promotion of R&D in higher education system.

Structure of higher education:

- Management of the Indian education faces challenges of overcentralisation, bureaucratic structures and lack of accountability, transparency, and professionalism.
- As a result of increase in number of affiliated colleges and students, the burden of administrative functions of universities has significantly increased and the core focus on academics and research is diluted.

Way Forward

When we look to successful higher education systems across the world, we find that less regulation and more focus on autonomous governance, transparency and outcomes are critical components of a vibrant and successful higher education sector.

In this context, NITI Ayog has provided a Higher Education Action Agenda which includes following key areas:

- **Designation of World Class Universities**
    - Identify 20 universities (10 Private 10 Public) to be free from regulatory regime.
    - Create world-class universities through autonomous governance, focused funding, and oversight based on independent outcomes like world rankings.
    - Adopt the Tiered based funding model for only two out of ten public universities.
    - The most promising candidates should receive the most funds and be accountable for outcomes, while receiving the same flexibility in governance as any university worldwide.
    - Chosen private universities should also be provided the same level of autonomy though no public resources need be offered to them.

> Related News – **Indian Institutes of Management Act, 2017** came into force.
> - It allows IIMs greater autonomy and empower them to grant degrees instead of diplomas.
> - The Board of Governors (not the Central Government) will appoint the Director of each IIM.
> - Further, The Academic Council of each IIM will determine the: (i) academic content; (ii) criteria and process for admission to courses; and (iii) guidelines for conduct of examinations.

- **Autonomy for top colleges**
    - More established colleges should be brought under the autonomous colleges scheme to take them out of the centralized control of their university and provide greater flexibility in academic matters.
    - Selectively, colleges should also be offered with postgraduate teaching, excellent track record and commitment to promoting excellence in teaching and research the option to convert into unitary universities.
    - This will allow the colleges to develop their brand name and compete more effectively for good students and teachers.
- **Reform of the regulatory system - A tiered system of universities**
    - Introduce a system of regulation that focuses on information disclosure and governance rather than micro management of universities. This requires an overhaul of the UGC as a regulatory system and a rationalization of the role of professional councils. Recently, The Ministry of Human Resource and

Development (MHRD) has prepared **a HECI (Repeal of University Grants Commission Act) Bill 2018** and has placed it in public domain for comments and suggestions (discussed below).

- Within the existing legal framework, a tiered system can be introduced whereby
  - ✓ **First tier:** the top research-focused universities, which promise to compete globally, are given full autonomy and promised additional resources based on significant improvements over time.
    - These universities may be subject to high standards of transparency with full freedom granted in operational matters such as courses, curriculum, teaching hours and pedagogy.
    - Quality should be enforced through periodic third-party assessments.
  - ✓ **A second tier of universities**: those with employment-focused education can be subject to light regulation.
    - These universities would be expected to use the flexibility given to them to adjust admission policies, curriculum and courses to respond to shifts in job composition in the marketplace.
    - They will also be evaluated according to their success in job placements of their students.
  - ✓ **The last tier of the universities:** those whose primary function would be to ensure that higher education is available to all should be the most regulated one.
    - This tier will consist of the universities that are currently performing poorly and not likely to perform well on either research or employment dimension.
    - While this tier can receive greater scrutiny from the UGC, there is a need for loosening control here as well with priority given to transparency.
  - Besides these actions, reform at the state level is also required and should be carried out through incentivization by the Rashtriya Uchchatar Shiksha Abhiyan (RUSA). These reforms should also encourage autonomy and good governance practices in universities in the state level regulation of higher education.

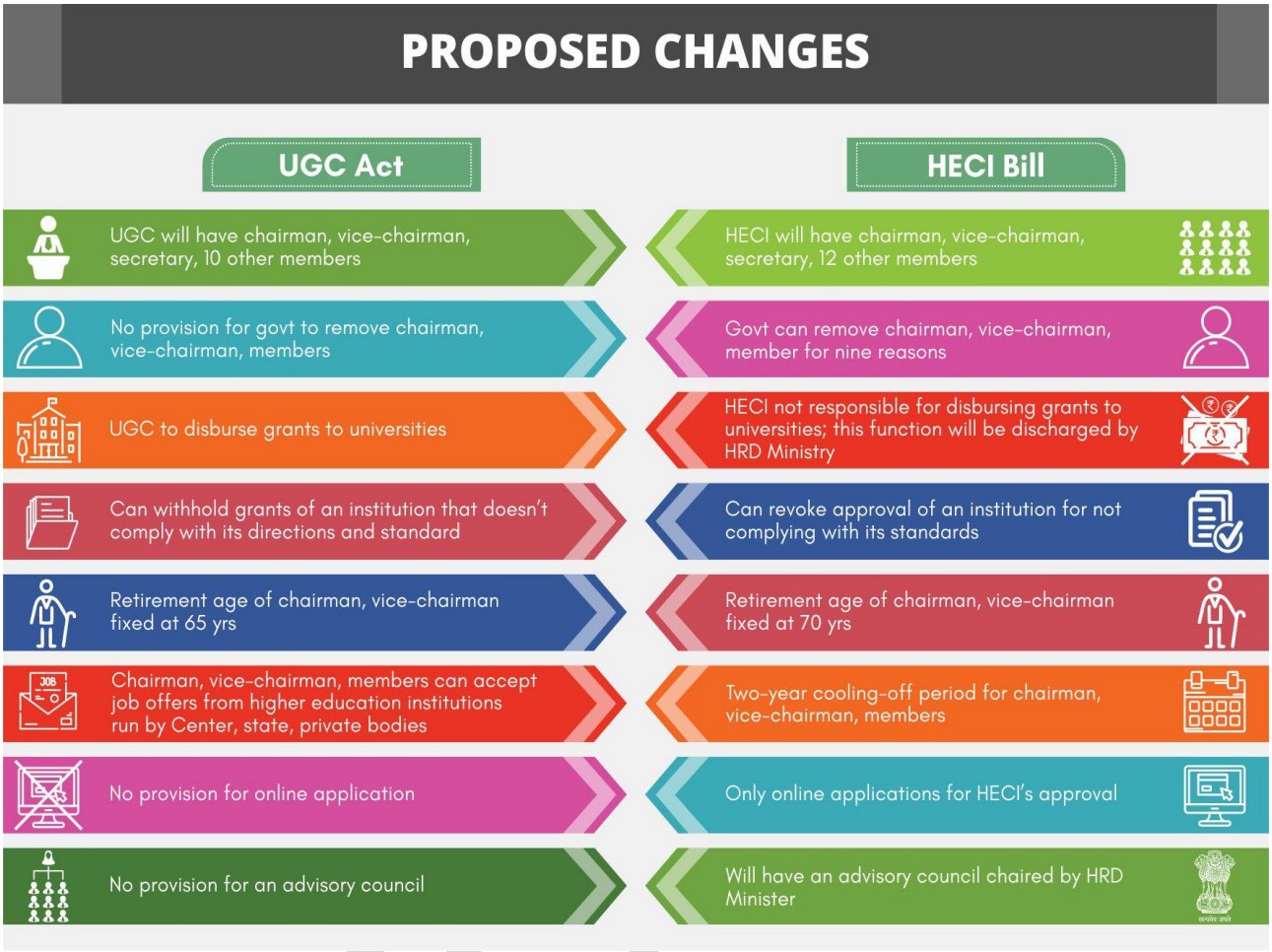
RUSA

- It is an overarching Centrally sponsored scheme, launched in 2013, operated in a mission mode which seeks to provide strategic funding to eligible state higher educational institutions.
- Transformative reforms such as governance, academic, affiliation and accreditation reforms are pre-requisites in the implementation of the scheme in State higher educational institutions.
- Under RUSA 2.0, following initiatives will be undertaken-
  - States will be encouraged to undertake projects in a public-private partnership mode based on viability gap funding
  - It seeks to increase gross enrolment ratio by 30 per cent by 2020, creation of 70 new model degree colleges and 8 new professional colleges.
  - Creation of **National Higher Education Resource Centre (NHERC)** to be a resource centre for Research, Policy Advocacy, Capacity Building and providing well-informed policy and evidence-based research inputs.

- **Establish a system of project- and scholar-specific research grants**
  - A system of public funding for research in specific areas of public importance has driven much of the innovation in science and technology in other countries. A similar system should be set up in India with funding to specific scholars, thus, providing both maximum flexibility and accountability for results.
  - Another model that should be adopted is the 'prize' system with funding going to research/innovation groups that deliver solutions to clearly specified problems. Such a system can be used in the future to drive innovation and research, solve pressing problems, and provide a mechanism for competition and quality assurance.
- **Increased focus on vocational and profession led education.**
  - Establish and promote norms/standards and/or outcome based certification for institutions that focus on skills and trades closely tied to employment.
  - Include vocational subjects in mainstream universities to allow for greater acceptance and utility for vocational learning.
  - Focus more in particular on those skills that are expected to be in high demand from the public sector in the coming years. Examples include public health workers, foundational skills teaching, nursing and paramedics.

5.2.1. DRAFT HIGHER EDUCATION COMMISSION OF INDIA (HECI) BILL, 2018

Arguments in favour of the bill



- The fund-granting process of the UGC and the technical education regulator — All India Council for Technical Education (AICTE) — has been plagued with **allegations of corruption and inefficiency**.
- The **separation of grant functions** will help HECI to focus only on academic matters.
- UGC has been criticised in the past, especially for what has been seen as its restrictive regime. The Professor Yash Pal committee and Hari Gautam committee recommended an education regulator to rid the higher education sector of red tape.
- HECI **could mark the end of "Inspection Raj".** HECI will specify norms and standards to establish, commence or wind up academic operations of an HEI using an online e-governance module. The effectivity of the body will increase through transparent public disclosures, merit-based decision making on matters regarding standards and quality in higher education.
- **The power to ensure compliance** will help in improving standards/quality of the higher educational institutions (HEI).
- The advisory council with the head of all state councils for higher education as its members would also **provide larger opportunity to States** which so far had a negligible role in the formulation of higher education policy.
- Encouraging HEIs to establish code of good practices covering promotion of research, teaching and learning is futuristic.

Criticism against the bill

- Since UGC has been established through an Act of Parliament, it should have been **discussed within the parliament** and with the academicians on how to improve it first, before deciding upon its replacement.
- Transferring all financial powers from the UGC to the MHRD would amount to **imposing direct state control** over higher education institutions. This shift in financial control to the Ministry could be used for regimentation of knowledge.

- The bill talks about promoting autonomy. Several institutions have opposed autonomy as it is a **route towards commercialisation and increased marginalisation** or complete exclusion of students from socially oppressed and economically weaker sections.
- The powers to authorise, monitor, shut down, lay down norms for graded autonomy or standards for performance-based incentivisation, and even recommend disinvestment from higher education institutions have been made **unilateral and absolute.**
- With its mandate of improving academic standards with a specific focus on learning outcomes, evaluation of academic performance by institutions, and training of teachers, the HECI is likely to **overregulate and micromanage universities.**
- The proposed draft has drastically **reduced the presence of teachers in the body**. UGC has 4 teacher members out of total 10 members, while the HECI has only 2 teacher members out of total 12 members.

5.2.2. INSTITUTE OF EMINENCE (IOE)

In budget 2016, The Finance Minister had announced that "It is our commitment to empower Higher Educational Institutions to help them become world class teaching and research institutions. An enabling regulatory architecture will be provided to ten public and ten private institutions to emerge as world-class Teaching and Research Institutions. This will enhance affordable access to high quality education for ordinary Indians. A detailed scheme will be formulated."

In context of this, an Empowered Expert Committee (EEC) chaired by N.Gopalaswami recommended selection of 6 institutions (3 from public sector and 3 from private sector) as Institutions of Eminence.

- **Public Sector:** Indian Institute of Science, Bangalore, Karnataka; Indian Institute of Technology, Bombay, Maharashtra; and Indian Institute of Technology, Delhi.
- **Private Sector:** Jio Institute (Reliance Foundation), Pune under Green Field Category; Birla Institute of Technology & Sciences, Pilani, Rajasthan; and Manipal Academy of Higher Education, Manipal, Karnataka.

Features of such institutions include

- The **UGC (Institutions of Eminence Deemed to be Universities) regulations, 2017** will govern all such institutions that are conferred with this status, ensuring their complete academic, administrative and financial autonomy.
- These regulations will override all other UGC regulations and free the institutions of UGC's restrictive inspection regime, the regulatory control over fee and curriculum.
- It should preferably be multidisciplinary and have **both teaching and research** focus of an exceptionally high quality.
- Apart from the regular courses, it should also offer **various interdisciplinary courses**, including in areas of emerging technology and interest as well as those of relevance to the development concerns of countries like India.
- There should be a reasonably good **mix of domestic and foreign students**.
- There should be a **transparent merit-based selection** in admissions, so that the focus remains on getting meritorious students.
- The **faculty student ratio** should not be less than 1:10 after three years of declaration as a World Class Institution.
- The Institution should have a **world-class library** with subscriptions to reputed journals in the areas of its course offerings.
- It should have **student amenities** comparable with that of globally reputed institutions.
- The Institution should have reasonably **large owned campus** with adequate space for expansion etc.

Benefits of declaration as IoE

- Each public Institution selected as 'Institution of Eminence' will get financial assistance up to Rs. 1000 Crore over the period of five years under this scheme.
- These Institutions shall be provided with greater autonomy to admit foreign students up to 30% of admitted students; to recruit foreign faculty upto 25% of faculty strength; to offer online courses upto 20% of its programmes; to enter into academic collaboration with top 500 in the world ranking Institutions without permission of UGC; free to fix and charge fees from foreign students without restriction; flexibility

of course structure in terms of number of credit hours and years to take a degree; complete flexibility in fixing of curriculum and syllabus, among others.

- They will get more opportunity to scale up their operations with more skills and quality improvement so that they become World Class Institutions in the field of education
- It is expected that the above selected Institutions will come up in top 500 of the world ranking in 10 years and in top 100 of the world ranking eventually overtime.

Issues Involved

- **On Institutes**
  - **Non-applicability of reservation** system would face resentment from particular section of society.
  - In the **absence of supervisory support** from UGC, in the long run these institutes could fall under political influence and might lose its quality of research.
  - **Socio-Economic incentives** for the researcher should be provided in order to avoid brain-drain.
- **On ranking methodology**
  - A heavy emphasis is placed on **subjective perception-based metrics** estimated using independently conducted surveys.
  - The participation of India in general and academicians/researchers **in international ranking surveys** have historically been very low – thereby pulling down India's average performance.
  - **Complex classification of Institutions** of National Importance, Central, State, State Private, and Deemed to Be Universities and overregulation by various bodies such as UGC, AICTE, NBA, NAAC father hampers the ranking prospect for India Universities.

Other opinions

- **High competition**: The entry into the global education race could now become an overriding concern. To gauge institutions principally by their prospective rankings, without regard for the relevance of outcomes, would be reductionist.
- **Transparency:** There is lack of transparency in the selection process as Reliance Foundation's greenfield Jio Institute has been chosen but KREA University, led by former RBI governor Raghuram Rajan and with considerable business and academic eminence on board, has been left out. Public sharing of benchmarks and guidelines may prevent such controversies in the future.
- **Framework:** The knowledge economy does not consist of multi-disciplinary universities alone, but in current scenario universities seem to be the only one eligible for the IoE tag. Both in the interest of parity and for fear of losing opportunity, a separate category could be created to accommodate sectoral institutions, like the Indian Institutes of Management.

5.2.3. NATIONAL TESTING AGENCY

- The Finance Minister in the **Budget speech of 2017-18** had announced setting up of a National Testing Agency (NTA). Now, the cabinet has approved this proposal.
- NTA was actually recommended in the national education policy 1986
- The National Knowledge Commission in its Report to the Nation (2006-2009) also mentions the setting up of a National Testing Service.
- It will be registered as a Society under the **Indian Societies Registration Act, 1860**, and as an autonomous and self-sustained premier testing organization to conduct entrance examinations for higher educational institutions.
- It would be dedicated on the lines of the Educational Testing Service (ETS) in the United States.
- It will conduct entrance tests entrusted to it by **any department or ministry**.
- **Composition:**
  - It will be **chaired by** an eminent educationist appointed by Ministry of Human Resource Development.
  - The **CEO** will be the Director General to be appointed by the Government.
  - There will be a **Board of Governors** comprising members from user institutions.
  - The **Director General** will be assisted by 9 verticals headed by academicians/ experts.
- **Features:**
  - It would initially conduct those entrance examinations which are currently being conducted by the CBSE. Other examinations will be taken up gradually after NTA is fully geared up.

- The entrance examinations will be **conducted in online mode** at least twice a year, thereby giving adequate opportunity to candidates to bring out their best.
- To serve the requirements of the rural students, it would locate the centres at sub-district/district level and as far as possible would undertake hands-on training to the students.
- It will be given a one-time grant of Rs.25 crore from the Government to start its operation in the first year. Thereafter, it will be **financially self-sustainable**.

Need for NTA

- **High level of investment**- Modern testing involves considerable investments in IT and physical infrastructure which are not available with standalone universities or colleges.
- **Ease the process**- Due to varied standards of exams in the country, the burden is imposed on the students in terms of time, money (the examination fees) and the stress caused in scheduling and preparing for each examination is tremendous.
- **Provides margin for contingency**- The secondary school board examinations are one-off affairs and the student is not provided the opportunity to improve upon his/her score. There is, therefore, no margin for any contingency or unforeseen circumstance that could affect performance.
- **Common Pool Asset**- Creation of a dedicated agency can provide assessment services as a common pool asset which can be used by other bodies.
- **Other Benefits**- It is expected to relieve CBSE, AICTE and other agencies from responsibility of conducting these entrance examinations, and bring in high reliability, standardized difficulty level for assessing the aptitude, intelligence and problem-solving abilities of the students.

5.3. ACCOUNTABILITY IN EDUCATION

Why in News?

The 2nd edition of the Global Education Monitoring Report (GEM Report, 2017-18) was recently released by UNESCO with the theme 'Accountability in Education'.

Observations made by the report

- Growing populations gaining access to education, along with evidence of underachievement in learning, have brought into sharp focus persistent deficiencies in provision and quality.
- These, combined with tight education budgets and increased emphasis on value for money worldwide, have countries searching for solutions. Increased accountability often tops the list.
- Ensuring inclusive, equitable and good-quality education is often a collective enterprise in which all actors make a concerted effort to meet their responsibilities. This is because ambitious education outcomes rely on multiple actors fulfilling often shared responsibilities which cannot easily rest with single actors.
- Similarly, no accountability approach can succeed if actors lack an enabling environment or are ill-equipped to meet their responsibilities.
- At the same time, it needs to be realised that if accountability is to help ensure more inclusive, equitable and high-quality education systems, flexible approaches, which make judicious use of available information, are needed. Accountability should be understood as a means to an end – a tool in achieving SDG 4 targets – not a goal of education systems in itself.

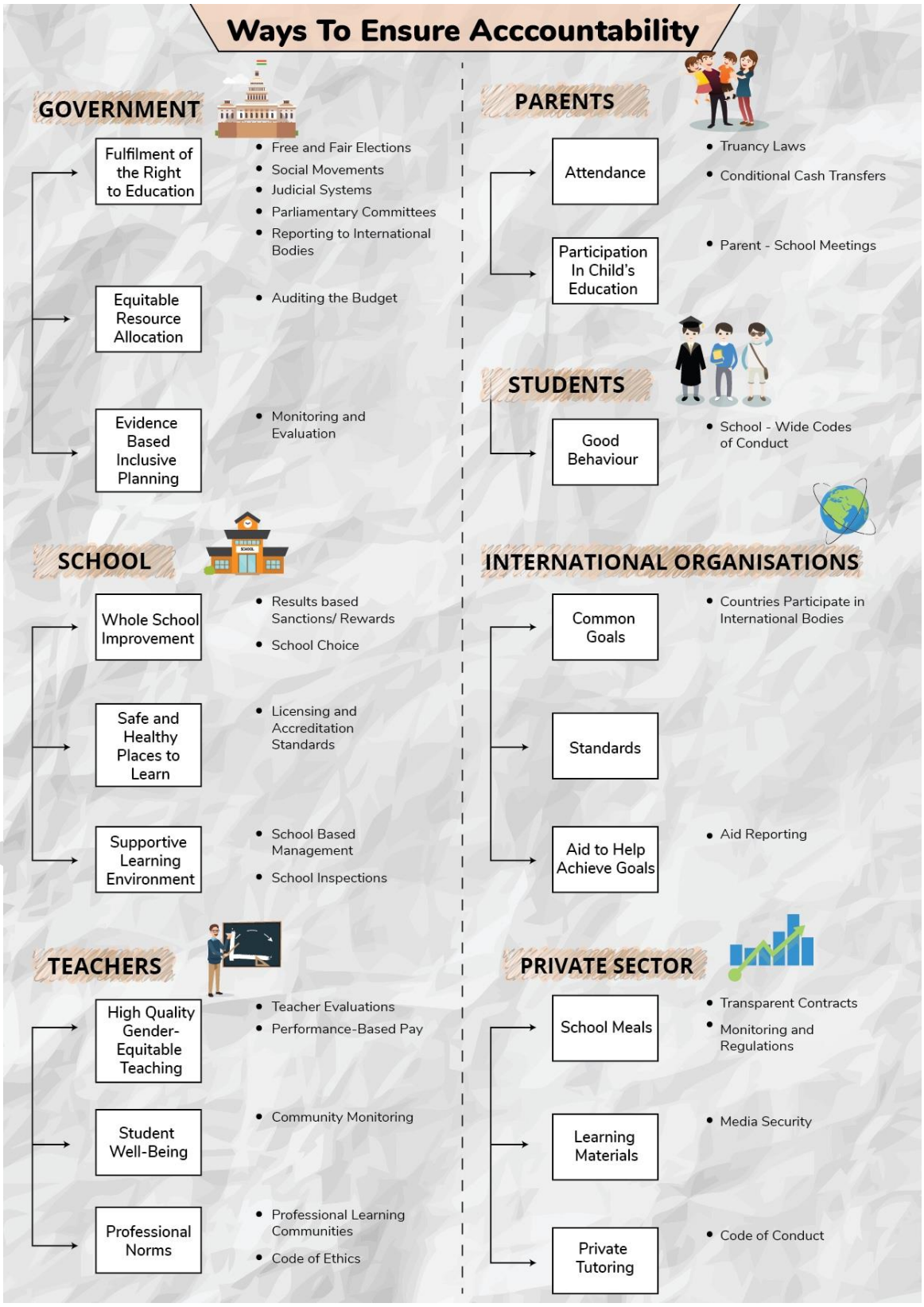
Recommendations

Accountability in education starts with governments, which bear the primary duty to ensure the right to education. Report lays out the following recommendations to help governments – but also other actors with a stake in education – to design and implement robust accountability systems.

- Designing robust accountability systems
  - Governments need to create space for meaningful and representative engagement to build trust and a shared understanding of respective responsibilities with all education actors
  - They should develop credible education sector plans and transparent budgets with clear lines of responsibility and truly independent auditing mechanisms.
  - They should develop credible and efficient regulations and monitoring mechanisms and adhere to follow-up actions and sanctions when standards are not met.

- They should design school and teacher accountability mechanisms that are supportive and formative, and avoid punitive mechanisms, especially the types based on narrow performance measures.
- They need to allow for a democratic voice, protect media freedom to scrutinize education and set up independent institutions for citizens to voice complaints.

- Implementing robust accountability systems
  - **Information:** Transparent, relevant and timely data should be made available to decision-makers.
  - **Resources:** Adequate financial resources should be provided to fund the education system.
  - **Capacity:** Actors should be equipped with the skills and training needed to fulfil their responsibilities.



Conclusion

Education is a shared responsibility and progress can only be sustainable through common efforts. Moving forward requires having clear lines of responsibility, knowing when and where those lines are broken and what action is required in response – this is the meaning of accountability, the focus of this Global Education Monitoring Report. The conclusion is clear – the lack of accountability risks jeopardizing progress, allowing harmful practices to become embedded in education systems.

The report talks about various Accountability Mechanisms that may be effective with certain actors, in certain contexts, for certain ends like- political mechanism, legal or regulatory routes, performance based approaches, social accountability, and professional or internal accountability.

However, some of these accountability approaches have not been applied effectively and may even have led to the opposite of what was intended. For example-

- The performance-based accountability seems to focus on outcomes over inputs and uses narrow incentives. Incentives have often been limited to punishments to force compliance or modify behaviour.
- The market-based approach to accountability is based on a conception of education as a consumer good differentiated by quality and price. This approach creates competitive pressure that marginalizes disadvantaged parents and schools. This leads to increased segregation, undermining efforts towards inclusive, equitable, high quality education.
- In terms of externally funded approach, arrangements are created that depend on temporary actor holding another accountable which are not sustainable in the long run.

6. MISCELLANEOUS ISSUES

6.1. STATE OF SOCIAL SAFETY NETS 2018

Why in news?

Recently, **World Bank** has released State of Social Safety Nets Report, 2018.

Background

- Report is part of efforts to monitor the implementation progress of the **World Bank's 2012-2022 Social Protection and Labor Strategy.**
- Report uses administrative data for 142 countries and household survey data for 96 countries from the **ASPIRE database.**

Highlight of the report

The report focuses on two special themes:

- **Adaptive Social Protection (ASP):** It places an enhanced focus on better enabling social protection to address the impacts of all manner of shocks on households - including natural disasters and climate change, economic and financial crises, conflict and displacement, among others. **Focus Area of ASP**
  - **Building Household Resilience before shocks Occur**: This can be done by:
    - ✓ Diversifying livelihood strategies and access to markets
    - ✓ Increasing access to financial, social, human, physical, and natural capital
    - ✓ Access to quality basic social services.
    - ✓ Access to social protection programs, including safety nets, particularly in difficult periods.
    - ✓ Access to the information and skills needed to adapt to shocks
    - ✓ Local and national institutions able to adapt to changing realities.
  - **Increasing the Capability Of Safety Nets To Respond To shocks after they occur:** By adopting dynamic delivery systems to provide required flexibility and scalability in SSN program to achieve horizontal and/or vertical expansion, depending on post-shock needs.
    - **Vertical expansion: It** increase benefit amounts at an acute time of need to existing social protection beneficiaries.
    - **Horizontal expansion**: It's about increasing the coverage of the program to include those who were not included in regular program but are affected and targeted for assistance.
- **Old-Age Pensions**: It provides an alternative source of income for elderly adults who are not covered by contributory schemes. (old-age pensions have helped the elderly reduce or altogether escape poverty).

Finding of report

- **Increase in SSN Spending:** Globally, developing and transition countries spend an average of 1.5 percent of GDP on SSN programs, where India and Bangladesh public works spending budget share is the highest in South Asia (> 25%).
- **Declining Poverty:** Safety nets help people escape **extreme poverty** (3 6% escaped extreme poverty), close the **poverty gap** by about 45%, and reduce inequality.
- **On India:** Impact of **Productive Inclusion Interventions (graduation models)** that support sustainable exits from poverty by extension, resilience-building is increasing in India.
- **Disaster Safety:** Safety nets build household resilience to respond to shocks across the life cycle, key to building human capital.

Factors Affecting the Impact of SSN Transfer

- **Program's coverage:** High coverage along with high benefit levels lead to higher outcomes in poverty and inequality reduction.
- **Transfer Level:** Sufficient amount is necessary for sustainable and holistic development of household.
- **Beneficiary/Benefit Incidence:** Coverage of scheme must include all possible vulnerable under its target to obtain desired level of poverty gap reduction.

Types of Social Safety Net Program

- **Unconditional cash transfers (UCTs):** It encompass interventions such as poverty alleviation or emergency programs, guaranteed minimum income programs, and universal or poverty targeted child and family allowances.
- **Conditional cash transfers (CCTs):** It aim to reduce poverty and increase human capital by requiring beneficiaries to comply with conditions such as school attendance and health checkups
- **Social pensions:** It aim to overcome loss of income because of old age, disability, or death of the bread winner for individuals who do not have access to social insurance benefits.
- **Public works programs** condition the transfer on participating in a community project/activity
- **Fee waivers and targeted subsidies:** It subsidize services or provide access to low-priced food staples for the poor
- **School feeding programs** provide meals to students generally in poor and food-insecure areas.
- **In-kind transfers** consist of food rations, clothes, school supplies, shelter, fertilizers, seeds, agricultural tools or animals, and building materials, among others.

Related information

World Bank 2012-2022 Social Protection and Labor Strategy

- **Aim:** To help improve resilience, equity, and opportunity for people in both low- and middle-income countries through integrated social protection and labor systems, increasing coverage of social safety nets programs, especially in lower-income countries, and improved evidence.

Aspire: The Atlas of Social Protection - Indicators Of Resilience And Equity - It is the World Bank's premier compilation of Social Protection and Labor (SPL) indicators in order to analyze the distributional and poverty impact of Social Protection and Labor programs.

Social assistance/Social safety net programs

- They are **non-contributory transfers** in cash or in-kind and are usually targeted at the poor and vulnerable.
- They are focused on **improving chronic poverty or providing equality** of opportunity
- They enhance **household resilience** in the long term by promoting human capital development and income-generating activities.
- They lessen the need for **negative coping strategies** adopted by poor household after shocks, where such strategies referred to removing children from school to work for extra household income, availing high-interest loans, and selling productive assets.

6.2. KHAP PANCHAYATS

Why in news?

The Supreme Court recently said any attack against an adult man and woman opting for an inter-caste marriage by khap panchayats or associations is "absolutely illegal".

About Khap panchayats

- They are the traditional social institutions engaged in dispute resolution in village communities. They are formally distinct from the lawfully elected village panchayats and their rulings **have no legal sanctity** in the eyes of court.

- They are most prevalent in Haryana and Western UP, however they exists in whole of North India in different forms. It is generally an all-male organization and its leaders are unelected but based on their social clout.

Controversial aspects of Khap

- Khap Panchayats functions as **extra-constitutional authorities**, often delivering pronouncements amounting to violation of human rights fundamental rights like right to life and liberty, right to privacy , freedom of expression, right of association, movement and bodily integrity among others.
- They have been **linked to honour killings**, forced marriages, female foeticide, excommunication of individuals and families and whimsical ways of delivering justice. They promote a Culture of Silence by **inculcating fear** among people.
- The inherent **weakness of Panchayati Raj** System gives them more strength. They have strong political hold in the region of their operation, hence no political parties could dare to go against their decisions. Even the state machinery like police don't act against them
- They are extremely **patriarchal organisation** and most of the times young women are at the receiving end of their pronouncements. They recommend special kind of dress code for them, put restrictions in their going out, employment choices, and also restricts their right to choose partner of choice.
- Their continued prevalence **hinders social mobility**, growth and development, familial bond and trust and shows general lack of empathy, compassion, brotherhood in the society.

Other related aspects

- They are not illegal organisations per se, they are age-old, social institutions based on the kinship feeling or cultural relativism that gives them strength.
- They sort out a plethora of social and legal issues in villages starting from minor disagreements to grazing land, playground, water and fodder distribution in villages, land disputes, marital disputes, division of ancestral property, and common-resource management in villages.
- They deliver justice quickly than regular courts. The rural-folk lacks money and expertise to handle these situations in a court of law. People readily stand as witness in a Panchayat full of their peers, and speak truth, while they would feel uncomfortable in a court.
- In many cases, especially land dispute, there are no documentary evidence, all the evidence exists is the elders and their witness to the past.
- These panchayats have also frequently made **pronouncements on social issues** in an attempt to combat problems like female abortions, alcohol abuse, dowry, and to promote education.

Government's steps to curb the excesses done by khap panchayats

Two Law Commission's draft bill on khap panchayats specially on prohibiting honour killings

- **The Prohibition of Unlawful Assembly (Interference with the Freedom of Matrimonial Alliances) Bill, 2011**
- **Endangerment of life and Liberty (Protection, Prosecution and other measures) Bill, 2011**

The two bills are **just proposals** and so far no concrete legislative reform has been done to curb the clout of Khaps.

Few **suggested legislative measures** include-

- Constitution of fast track courts to deal with honour killings;
- Amendments to Special Marriage Act to reduce duration of registration of marriage;
- Provide enough protection to couple engaged in inter-caste marriage.

The **Maharashtra Prohibition of People from Social Boycott (Prevention, Prohibition and Redressal) Act, 2016**, disallows social boycott in the name of caste, community, religion, rituals or customs.

Judicial Pronouncements directed towards bringing down the clouts of Khap Panchayats.

- In Laxmi Kahhwaha vs. The State of Rajasthan the Rajasthan High Court held that the Caste Panchayats have no jurisdiction whatsoever and cannot impose fine or social boycott on anyone.
- In Armugam Servai vs. State of Tamil Nadu, Supreme Court said that Khaps are illegal and must be rooted / stamped out.

6.3. DEVELOPMENT IMPACT BONDS

Why in News?

Recently, World's first Developmental Impact Bonds (DIB) for education, have shown successful achievement of outcomes; based on an intervention for improving girls' education in India.

What are Social and Development Impact bonds?

- Social Impact Bonds are financing mechanism in which government enter into agreements with social service providers, e.g. NGOs etc and investors to pay for the delivery of pre-defined social outcomes **(OECD, 2015).**
- Development Impact Bonds (DIBs) are a variation on Social Impact Bonds (SIBs) and differentiated on the basis of outcome funder.
- For a SIB, the outcomes funder is **government** whereas for a DIB is usually an **aid agency** or other philanthropic funder.
- The SIB is known as **'payment for success'** model and it formalizes outcome-based financing or **performance-based payment scheme.**

Related Information

- The first SIB implemented in the United Kingdom (UK) in 2010 aimed at decreasing recidivism.
- **Various Stakeholders** Involved in SIB/DIB: Outcome Funder (Government/Donor Agency), Project Sponsored, Investors, Guarantors, Service Providers, Evaluators, and beneficiaries.

Other Impact Bonds in India

- **Utkrisht Impact Bond**
  - Launched by United States Agency for International Development (USAID).
  - It is a **world's first Development Impact Bond (DIB)** in healthcare.
  - **Target:** To reach up to 600,000 pregnant women with improved care during delivery and save lives of up to 10,000 women and new borns by the next five years.

How Impact bonds work?

Government contracts an intermediary to implement a social/environmental project in **exchange for a promise of a payment contingent** on the social outcomes.

→

The intermediary will raise the capital for the project. It will then contract a service provider to deliver the project's outcomes.

→

If the project fails to deliver, the Government does not pay and the investors will lose part or all of their capital. If the project is successful, the Government pays the intermediary and investors.

Assessment: Developmental Impact Bonds (DIB) for education

- The impact bond was judged against two metrics: student enrolment and learning outcomes.
- **On Enrolment:** In year one, the intervention was nearly halfway to this target, with 38 percent of out-of-school girls enrolled, and by year two, the target had nearly been achieved, with an enrolment rate of 73 percent against the target of 79 percentage.
- **On learning Outcome:** Assessment was based on ASER test, only 52 percent of target of learning outcome has been achieved, however, in the last year learning levels, it reached to 160 percent of the target.

How Impact Bonds are different?

- Financing is provided **upfront** rather than when results are attained.
- These are intended to improve the delivery of services as opposed to physical infrastructure (e.g. support services for the homeless or prisoners, child care, ecosystems conservation, etc.).

Advantages and Disadvantages of SIB/DIB

Advantages	Disadvantages
• It reduces the financial/ operational risk and stimulates social-economic innovations. • For service providers, the SIB offers access to upfront funding for the delivery of the services. • Investment rigour can help to achieve higher standards in design and delivery of projects.	• Requires **verifiable quantitative metrics**, which are difficult to derive for a number of projects and might take several years to develop. • The intricate structure of negotiations, coordination and implementation generate comparatively high administrative costs.

Challenges

- **High Risk for Investors:** The SIB is indeed a risk sharing mechanism where the Government transfers the risk of project execution to private investors. If the outcomes are not achieved, the investors will lose their investment.
- **Risk Assessments:** The underlying project risks are specific to the project (e.g. technology, counterpart, etc.) and require thorough assessment and management.
- **Breed ill-practices:** Investors may demand and lobby for lower 'success thresholds' so that they are sure to be repaid.

- **Reduce the importance of Social Project:** Profit as incentives for investors may compromise social impact in exchange for greater revenues or lesser risks.
- **Trade-offs exist** in terms of the self-selection of projects by either the public commissioner or the intermediary between the need to attract investors versus achieving more ambitious goals and among investors when required to select which SIB to fund.

Step can be taken in Context of India

- The promotion of such instruments in India would require the existence of **local institutional frameworks** that allow and promote all the necessary stakeholders to perform properly.
- A **dedicated fund by government** to finance impact bonds would promote evidence-based programmes in line with current policy priorities.

- **People-State relationship:** The introduction of a profit incentive may negatively change the relationship between the service providers (government) and beneficiaries (population).
- **Privatisation:** Critics of SIB/DIBs underline risks that they may be used to promote privatisation of critical social services.

Way forward

- **Balance approach:** Impact project should drive a balance between projects that are innovative and projects that have a larger impact.
- **Intended Beneficiary:** Clear identification of target beneficiaries can help simplifying the outcome metric and delivering more focused and impactful interventions.
- **Payment-Outcome relations:** Ensure that the payments directly relate to the intended outcome (and include a longer-term outcome evaluation if necessary). This includes ensuring that the right metrics are in place to reward genuinely better outcomes.
- **Government Role:** Impact project architects will need to think carefully about the role of the government, and the sustainability of outcomes after the end of the contract.