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Let noble thoughts come to us from all sides

Rig Veda

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Chief Editor's Desk

Health: Priority in National Development Goals

The policy directions of the "Health for All" declaration became the stated policy of Government of India with the adoption of the National Health Policy Statement of1983. India's health. sector has always posed major challenges to policy makers, with increased budgetary spending not always yielding commensurate returns in terms of a more healthy nation. And, it is an accepted fact by experts that there is a strong relationship between economic growth and better health – it being a two way relationship. A population with major health problems cannot become part of the Nation's growth process. On the other hand, a nation beset by health problems can have a retarding effect on the country's development goals.

Both the Millennium Development Goals and later the new set of Sustainable Development Goals had appreciated this fact and integrated Health Goals into their agenda. India, as a signatory to the SDGs needs now to gear up its policies and work out its health priorities to achieve those targets. Equally importantly, it needs to work towards greater cohesiveness in integrating its policies and actions in the health sector to its developmental programmes in other sectors.

Our policy makers had appreciated this fact and launched several health programmes which have been immensely successful over the years. There has been a successful reduction in infant and maternal mortality rates, our immunization programmes, specially for pulse polio have been lauded the world over and we have almost won the war against small pox, once a deadly killer disease. Our medical system can compete globally with the best in the world.

Financing of health care is one of the key factors in delivery of health care. Total health care expenditure in India is about 4 per cent of GDP and the government does run a large public health care services system. However, a large proportion of the population is forced to look for health care outside the system. Health care has become one of the most expensive services for a person belonging to middle and lower classes. So, while the government is, of course, continuing its effort to improve the primacy health care services, it should not ignore the large private sector. A policy of mixed health care systems may be a better and more feasible option to ensure access and affordability of health care to the vast Indian population. Health insurance is one of the best ways of ensuring the involvement of private players in a more effective health care system and meet public health goals. The government would, of course, have to put in place a regulatory system to ensure that publicly financed health insurance offers sufficient financial protection and access to health care. The draft Health Policy 2015 has tried to rectify some of the lacunae in earlier policies by firstly putting it on public domain for feedback and also understanding the change of context for health care in various sectors. It has recognized that huge expenditure in health care cost is a big drain on the resources of many a family and is a major contributor to poverty. The policy should focus on provision of Universal Health Care including provision of drugs and diagnostic care to poor and marginalized population, financial risk protection, et al.

The health care challenges for tribal populations, adolescents and young people, women and the North East region are somewhat different from those of the general population. Health care services in tribal areas require a different approach, namely, they may be area specific and tribe sensitive, participation and empowerment of local population may be fully ensured and health literacy and communication may be undertaken in a big and strategic way to bridge the knowledge and behavior change gap.

Similarly, gender health is critical to a nation's well being. Addressing malnutrition in women, especially pregnant mothers and children is necessary to ensure gender justice in the country. When a major part of the population remains malnourished, economic development of the country is definitely impacted.

India has had a tradition of health care, with many notable physicians like Dhanvantari, Jivika, Charaka and Susruta. This tradition has been carried on through various government schemes and programmes over the years. The situation demand now is to intensify primary health services and expand workforce. There is also need to engage private sector in big way, at the same time also have strong regulatory mechanism to tackle conflict of interests and empower people to make the right choices.

"Health is Wealth" may be an oft quoted dictum. But, it is also a reality that a healthy person is more able to take care of himself/herself and his/her family. As also, the nation. A Nation with a healthy population is more capable of contributing to and achieving its development goals and making India vivid and vibrant.

Health Sector in India: Perspective and Way Forward:

T Sundararaman

While there has to be a major effort in engaging the private sector in health care, this has to be based on stewardship and facilitatory efforts that address different forms of information asymmetry and conflicts of interests – and empower people to make the right choice. A premature and unprepared shift to purchasing care without first putting in place, the regulatory mechanisms and getting politically ready for much higher levels of public investment is fraught with danger

The health sector in India is at the cross-roads. This is partly due to an interesting relationship between development and health, which is known as the Preston Curve. In 1975, Samuel Preston showed that if the health of nations as measured by life expectancy is plotted against the wealth of nations as measured by GDP per capita, then up to a point, there is a sharp increase in life expectancy for even the modest increase in GDP per capita. Then the curve suddenly flattens out – and after this point, large increases in public health expenditure are required for modest increase in life expectancy (Deaton 2013).

In his book " The Great Escape" this year's Nobel Prize winning Economist Angus Deaton explains that even after the bend in the Preston curve, there is a sustained correlation between health outcomes with growth– only that now it is a logarithmic relationship- for the same degree of increase one requires a fourfold increase of the GDP per capita (Deaton 2013). He also points out that it is a two way relationship- that not only is economic growth related to better health, this bend in the curve also represents the point of epidemiological transition- when non-communicable diseases start becoming the main cause of death, increasingly dwarfing persistent contributions from the declining deaths due to maternal and common childhood diseases.

In the 2010 version of the Preston Curve, India today is at or near the bend on the curve, and this has major implications for policy. At the bend in the curve, the past problems of reproductive and child health and of communicable disease persist, but new problems have got added on. If public investment in health care does not increase, private investment would, but there is no certainty that this would lead to better health outcomes. If public investment increases, a choice has to be made between deploying it to strengthen public health system and purchasing care from private sector. If the case is latter then one needs to be ready to impose a strong regulatory regime and also increase public expenditure far above the 2.5 per cent of GDP that the current national health policy draft calls for (Sundararaman, Muraleedharan, and Mukhopadhyay 2016). All of these are difficult decisions – and this article elaborates and discusses these issues and challenges.

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Progress in Reproductive and Child Health

In earlier decades, a major proportion of deaths were related to deaths in the young child- most of this happening below the age of 5. Pregnancy related deaths were also high. Both of these have decreased sharply, partly because the number of deaths per live birth have decreased greatly and partly because with fertility control, the number of children or pregnant women has itself declined sharply.

There are many reasons why India has been successful in achieving such a reduction. One important reason is the focused attention on the reduction of infant and maternal mortality over the last 25 years. First we had the child survival and safe motherhood programme in the early nineties, and then the reproductive and child health programmes in the late nineties and early part of the last decade. Then in 2005, there was a revised and much more successful RCH- II programme, and this time it integrated with the National Rural Health Mission. Despite the adverse impact of the financial crisis and structural adjustment programmes in the nineties, these projects ensured that the RCH programme was relatively better protected from the crisis.

The declaration of the Millennium Development Goals and India's race to reach these goals has also contributed in small measure to achieve this. The Draft National Health Policy states: "The MDG target for Maternal Mortality Ratio (MMR) is 140 per 100,000 live births. From a baseline of 560 in 1990, the nation had achieved 178 by 2010-12, and at this rate of decline is estimated to reach an MMR of 141 by 2015. In the case of under-5 mortality rate(U5MR), the MDG target is 42. From a baseline of 126 in 1990, in 2012, the nation has an U5MR of 52 and an extrapolation of this rate would bring it to 42 by 2015(Draft National Health Policy 2015)." As the 2015 figures become available by next year, we would know whether we did or did not reach the targets, but we did get close. In the year 1990, India lagged far behind the global averages in maternal and child mortality rates- by about 47 per cent and 40 per cent respectively. By 2015, India figures were marginally better than the global average- India had finally caught up and is now going ahead.

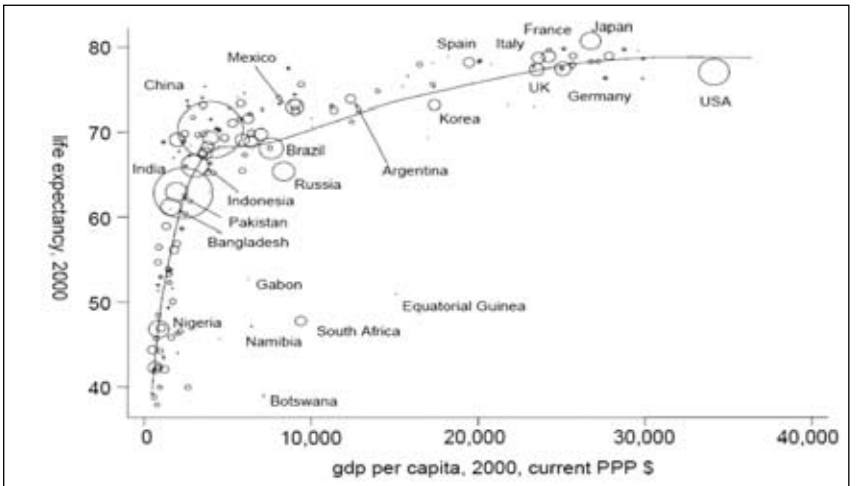

Figure 1: The Millennium Preston curve

Source: Deaton, Angus. 2004. "Health in an Age of Globalization." National Bureau of Economic Research. Author's calculations based on World Development Indicators 2003 (life expectancy and Penn World Table (GDP.)

It is important to note that these achievements were made without comparable improvements in sanitation or in child nutrition- two of the most important social determinants of health- where Indian levels of achievement lag far behind the global averages. In most nations infant mortality rates are seen as closely linked to levels of poverty and inequality. Indian reduction in poverty in these years is contested- with views expressed in both directions. However, what is clear is that these reductions in child and maternal survival had to be achieved by the health sector in the face of continuing adverse social determinants.

On the positive side, on two social determinants, India did some serious catching up with global standards. One was the supply of safe drinking water where over 94 per cent of hamlets are now covered (WHO 2015) and the other is women's literacy where the latest census reveal that 65.04 per cent of females are literate now (Census 2011).

The achieving of improved female literacy is closely linked to the great ongoing demographic transition. Decadal population growth rates are now falling and most states have now achieved a crude birth rate compatible with population stabilization. (less than 21 per 1000). Growth rates would continue to be high for some more years- due to what is known as the population momentum. This refers to the fact that there would be many more women now entering and passing through the reproductive age due to past high fertility rates- and therefore more children continue to be born, even though the small family norm has been achieved. Only seven states still continue to face a seriously high fertility rate-Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan- and to some extent in Jharkhand, Chhattisgarh and Meghalaya- but even in these, the rates of decline are encouraging (MOHFW 2011).

Much of the credit for the declines should go to the combination of health systems strengthening and maternity focused programmes like the JSY, JSSK, ASHA, Dial 108 and 104

ambulance services, and appointment of additional nurses and ANMs at the periphery- that happened with NRHM.

This is not to state that the challenges in reproductive and child health are over. There are still close to 46,500 maternal deaths and about 1.5 million deaths of children under 5 deaths each year, which is a high proportion of global maternal and child deaths. Quality and safety of health care is an issue. Though proportion of childbirths happening in a facility have improved dramatically, quality of care remains a challenge. And though, the demand for contraceptive services is well established in most population groups and states, the delivery of safe sterilizations services remains a challenge, as the tragic sterilization deaths in Bilaspur, Chhattisgarh exposed. Abortion services have not kept pace with developments.

With the NRHM acting as the driver, the Eleventh Five Year Plan did lead to a two fold increase in health care spending (in real terms) and about a 3 times increase in nominal terms- but this is about 40 per cent less than its own financing targets. No doubt it could have done much better with better financial outlays- and with a greater and more sustained deployment of human resources, and with greater action on the three important social determinants- poverty, nutrition and sanitation.

Mixed Progress with Communicable Diseases

The impact of NRHM and the previous two decades of public health systems interventions on the control of communicable disease is mixed. One programme that did relatively well was the National Aids Control Programme. A systematic campaign that addressed both preventive and curative aspects and that grounded itself on good quality health information and estimates was able to cap- and to a fair extent, reverse the epidemic. It is still too early to celebrate, the achievements are fragile, and set back is easy- but only has to compare with what the epidemic did to sub-Saharan Africa to appreciate how narrow and fortunate our escape has been from a similar fate. The single success against polio is another great achievement of this period, but here the challenge is the exit policy from the campaign mode and the rising costs of sustaining the gains. Less remarked about – but equally impressive is the major reduction in leprosy- reducing the prevalence of the disease to below the threshold which defines elimination. In this disease also, the programme struggles to articulate a strategy that can address the new case incidences and disabilities that will continue to occur for many years after it has been "eliminated".

Progress in vector control is mixed. Filaria has decreased dramatically and new cases of elephantiasis are negligible. Malaria has also seen significant declines and with a range of new tools becoming available, a confidence is gathering to transit to a malaria elimination programme. Potentially this is a disease that could fall below the elimination threshold in 10 to 15 years. Kala-azar is an anachronism. It should have been eliminated by now, the deadline having been re-set repeatedly. However, it festers in some deep pockets in a few villages of two to three states, cocking a snook at all attempts to get rid of it. About 20,000 cases annually occur across four states- but the majority are from Bihar. Meanwhile, new vector borne diseases have emerged- notably Dengue and Chikungunya. The good news is that deaths both in absolute numbers and as a proportion of all deaths, and even of all cases have declined significantly (MOHFW 2011).

Greatest concern amongst the national disease control programmes is with regard to tuberculosis. Even in this there has been signficant reduction in deaths- but reductions in new cases is less dramatic- and the spectre of multi-drug resistant tuberculosis is now raising its head in more and more states (MOHFW 2011).

However, deaths due to all diseases under these national disease control programmes are less than 6 per cent of all mortality. Most deaths due to infectious disease are due to diarrhea and respiratory infections especially in children and a number of other germs that do not have the same epidemic potential- but have significant

Table 1: Comparison of Mortality due to NCD in India with other selected countries

Indicator		Sweden	UK	Thailand	India
Proportion of NCD deaths due to 4 main causes that occur before age 70	M	23.4	29.1	45.5	62.0
	F	14.7	19.2	38.7	52.2
All NCDs Deaths per 100,000 population (age standardized rates)	M	390.3	425.9	559.6	785
	F	286.3	302.2	358.3	586.6
Cancer Deaths per 100,000 population	M	124.9	133.9	127.8	79.0
	F	100.5	112.5	82.6	66.3
Chronic Respiratory Illness Deaths per 100,000 population	M	17.3	37.2	87.7	188.5
	F	13.8	23.7	29.1	124.9
Cardio-vascular disease Deaths per 100,000 population	M	162.8	140.6	215.8	348.9
	F	105.7	86.7	156.9	264.6
Diabetes: Deaths per 100,000 population	M	10.6	5.0	23.5	30.2
	F	6.1	3.6	27.9	22.7

Source: (WHO,2014)

prevalence. Taking all communicable deaths together, they still account for less than 30 per cent of mortality.

Rise of Non-Communicable Diseases: A Public Health Challenge

The major and increasing proportion of mortality is due to non-communicable diseases which now account for over 60 per cent of all deaths and due to injuries which account for almost 12 per cent of all deaths. (WHO 2014) The probability of dying during the most productive years (ages 30-70) from one of the four main NCDs is estimated to be as high as 26 per cent. To understand its gravity, compare with Sweden where the corresponding figure is 10, UK where it would be 12, Thailand where it would be about 17. Expressed in another way, 62 per cent of male deaths due to the main NCDs would occur before the age of 70 in India, as compared to only 24 per cent in Sweden, 29 per cent in UK and 45 per cent in Thailand. The proportions are similar in women with about 52 per cent of deaths in women due to NCDs taking place below the age of 70 as compared to only 15 per cent in Sweden.

Age standardized death rates tell the same story. India would have about 785 male deaths per 100,000 due to the main 4 NCDs- of which about 80 would be due to cancer, 30 due to diabetes, 189 due to chronic respiratory disease and 349 due to cardio vascular disease. Sweden death rates for cancers are about 50 per cent higher than India- but for chronic respiratory illness, it is only about a tenth, about a third for diabetes and about half for CVD. Most other nations of the industrialized world and the developing nations with more universalized health care systems would have rates in-between Sweden and India (WHO, 2014).

So, in addition to having serious persistent problems with infectious diseases, India finds itself challenged by a very high and rising prevalence and premature deaths due to non-communicable disease- even as compared to most developed and developing nations. In injuries per 1akh population also India does very poorly.

The Challenge of Addressing NCDs in India

But there is another major difference between India's ability to address non communicable diseases and its ability to address infections and reproductive and child health. The requirements in terms of financial and human resources and management of care is much higher. More important due to having consciously excluding these diseases from all government provision of primary health care for over two decades, even the perception of how to address these problems at the primary health care is low. Most conversations about primary care get limited to IMR, MMR, immunization rates, and family planning. The system is not even geared to conceptually see these diseases as primarily part of a primary and not tertiary care mandate.

One must also note the contrast between communicable diseases and non-communicable disease with respect to risk factors. India's progress in communicable disease is due to lack of significant gains in poverty, nutrition and sanitation- in all of which we are doing much poorer than the developed world and even many developing nations. But when it comes to major risk factors for NCD- whether it is overweight and obesity, physical inactivity, alcohol or smoking- these risk factors are far more prevalent in the developed world. Why then does India have much higher prevalence rates of the disease? The answer lies not only in identifying the pathways through which social determinants play out with respect to NCDs in the developing world, but also in complete absence of primary health care that addresses these diseases. Private sector has no doubt expanded to fill these gaps- but market forces largely promote curative and preferably tertiary care. Market driven growth is unable to meaningfully address the needs of primary and secondary prevention - and it falls on the government to take up this role.

The government has initiated a National Disease Control Programme against non –communicable diseases- but these are far from universal. In contrast, the RCH Programme and the National Disease Control Programmes against TB, HIV, leprosy etc. are universal. Public health systems seek out every pregnant woman and guarantee appropriate care, they seek out every infant and ensure immunization, they seek out every TB case and ensure cure and so on. In non-communicable diseases except in sporadic instances, such a clear strategy for universal access to care has yet to be implemented.

Part of the problem in building a strategy against NCDs, is that the list of non-communicable diseases is long- and it is not easy to construct multiple vertical programmes the way the major communicable diseases were addressed. Even for communicable diseases there was an increasing realization on the need to shift from vertical programmes to horizontal integration. To be effective with non-communicable diseases horizontal integration is mandatory. It would be quite impractical to expect separate clinicians and support staff for each NCD, or even for all NCDs together.

But this in turn means strengthening district health systems in a comprehensive manner. There is a lot that one could learn from the NRHM in this regard.

Strengthening Health Systems under the 11th Five year Plan

The main vehicle of health systems strengthening was the National Rural Health Mission, now with integration of the National Urban Health Mission- renamed as the National Health Mission. Though health is a state subject, it was clear that a central push –both in financing and ideas was needed to break the logjam and get states moving onto strengthening their health systems. To respect the federal nature, states were required to draw up their annual project implementation plans, which

would be sanctioned under a joint center- state coordination committee. Though, over time the rules got more and more rigid, states had considerable flexibility in drawing up their plans.

One of the innovations that most states opted for was the creation of a workforce of close to 900,000 community health volunteers, the ASHAs. They made a major contribution to bringing public health services closer to the community, and increasing its utilization and in health education. Another important National Health Mission (NHM) contribution was the addition of over 178,000 health workers to a public system that had depleted its workforce to sub-critical levels over a long period of neglect in the nineties. The NHM deployed over 18,000 ambulances for free emergency response and patient transport services.

Across states, there were major increases in outpatient attendance, bed occupancy and institutional delivery. However, these developments were uneven and more than 80 per cent of the increase in services were likely to have been contributed by less than 20 per cent of the public health facilities- and they were largely focused onto a limited range of RCH services.

NHM in the 12th Plan Period

From 2012 onwards, the increase in funding did not keep pace with requirements- and this was the time when the neediest states were developing the institutional capacity to absorb the funds. The lack of increase in financing was attributed to inefficiencies in fund utilization, poor governance and leakages that gave NHM a bad name in some policy circles. While no doubt the NHM faced such problems, but these are not new and are reflective of governance deficits which would equally plague other approaches also. Another explanation that could be offered is the reluctance to invest more in public systems, because policy attention had shifted to encouraging the rapid surge in private sector which was now re-creating itself as the private health care industry. In the latter understanding, the NHM did not lose funding because it was failing - rather it lost support because it was in danger of succeeding. This may be over-stating the case, but one notes that The National Health Policy Draft does appreciatively details the government efforts at creating favorable conditions for the growth of health care industry.

In 2013, the National Urban Health Mission was approved- but even this did not lead to any significant increase in central funds. The National Health Policy draft mentions that "Strengthening health systems for providing comprehensive care required higher levels of investment and human resources than were made available. The budget received and the expenditure thereunder was only about 40 per cent of what was envisaged for a full re-vitalization in the NRHM Framework."

Other than political will, there are three other factors that are a major challenge or barrier to increase investments that would strengthen public health systems. The first of these is the flow of funds has changed from direct transfers from center into empowered state health societies to routing it through the treasury and state budgetary mechanisms. There are good political reasons to support such a routing, but the bottom line is that political correctness has to be matched with administrative pragmatism- or else what we would have is a failure to absorb funds. The second problem is that financing of public health facilities is based on rigid multiple line item supply side budgeting which is ridden with transaction costs and inefficiencies. A move to demand side responsive resource allocation as happens for example in Thailand can greatly improve efficiency of fund flows and absorption. Though this is mooted in the draft health policy, this has yet to take off. And the third and perhaps the greatest barrier is the reluctance to invest in increasing the skilled public health workforce on a regular and reliable terms of employment. In all healthcare systems, payments to providers would account for about 50 per cent of the total public health expenditure, more so, when it is primary care in less developed nations. All nations successfully moving towards universal health care- irrespective of their road maps share one common feature- adequate number of well skilled and salaried health workers in the frontline. If the systems are based on purchasing care from the private sector, then it is likely that they are spending far more- not less on salaries.

Health care Industry and Increasing Impoverishment due to Health Care Costs

Further, the National Health Policy 2015, draft notes that "the failure of public investment in health to cover the entire spectrum of health care needs is reflected best in the worsening situation in terms of costs of care and impoverishment due to health care costs." As the burden of diseases shifted to non-communicable diseases and as these were not covered by public health systems, except perhaps in the highly overcrowded government medical college hospitals, people had to shift to private health care. The shift is most pronounced in urban areas and for chronic illness. The immediate impact of this shift- which occurs even in relatively well performing states like Kerala and Tamil Nadu is a huge rise in out of pocket expenditures for health care.

This shift was also a cause and consequence of a rapid growth of private sector in health care as in industry. Whereas private health care had largely consisted of one doctor clinics or small nursing homes where owners were the investors and managers – and there were little differences between top management salaries and profits, a new type of private health care which is based on funds from investors whose main concern is maximizing return on investment gained ground. This private health care industry grows at almost

15 per cent CAGR- which is twice the growth rate of the service sector and about thrice the overall national growth rate. It even attracted considerable venture capital. Close on its heels is the private health insurance industry which after lowering of Foreign Direct Investment caps are bound to grow even faster. The private health care industry is valued at $40 billion and is projected to grow to $ 280 billion by 2020 as per market sources. Of this, about 50 per cent goes to hospital care that patients pay for- the rest to the pharmaceutical, medical device and insurance segments.

The growth of the private health care industry ensure that the top decile of the population has now access to health care which is comparable to the best global practices. The segment of the health care industry that caters to this 10 per cent is also able to attract clients/patients from overseas- since for such care it is competitive. However, this attracts specialists to shift employment to this segment of the health sector, which in turn means that those who need specialized consultation, even if not by income or wealth belonging to the top decile have to go these corporate hospitals. This adds to the incidence of catastrophic health expenditure for private health care industry, by global standards a market consisting of just the top one or two deciles is a very large market- larger than most European nations. But it leads to an internal brain drain of specialists- who are becoming increasingly hard to attract or retain in the public sector- even if the sector pays them on par with the highest salaries of the public sector.

There is also the danger that the business model on which many of these hospitals are based- like giving incentives to those doctors who are referring, or giving incentives to doctors for prescribing more of certain drugs or diagnostics, or excessive use of diagnostics- could all become standard professional practice and lead to wrong public perception of what constitutes good care.

Government Efforts at Financial Protection

How has the government responded to the challenge of impoverishment due to health care costs?

The main government efforts in this direction are to ensure that at least all the national programmes aim to provide health care that is free to all and universally accessed with fairly good rates of coverage. Thus, the national policy draft points out that "India has one of the largest programmes of publicly financed ART drugs for HIV anywhere in the world. All drugs and diagnostics in all vector borne disease programmes, tuberculosis, leprosy, including rapid diagnostic kits and third generation anti-microbicidals are free and so are insecticides treated bed nets that cover the population of whole geographies. This is also true for all of immunization and much of the pregnancy related care. Private markets have little contribution to make in most of these areas."

In addition, the central government has recently introduced a scheme for supporting states to provide free drugs and diagnostics in public health facilities. This will help further to reduce the out of pocket expenditure that the poor face even in public hospitals. Though the OOPE in public hospitals is typically less than one thirds or even up to one tenths of what it costs in private care, this residual amount is still impoverishing for most Indians. And there is growing consensus that one of the most effective ways of providing greater access and financial protection is the removal of user fees, and the provision of free drugs and diagnostics in the public hospital and health care facility.

Government Financed Insurance Programmes

A third measure that the government has introduced is publicly financed health insurance schemes that cover the costs of hospitalization of the poor. The major central government scheme in this regard is the Rashtriya Swasthya Bima Yojana which largely addressed secondary care. In addition eight or more states have introduced insurance programmes that cover tertiary care needs. The nominal population coverage under these various schemes is about 370 million in 2014 (almost one-fourth of the population). Nearly two thirds (180 million) of this population are those in the Below Poverty Line (BPL) category. However, there have been doubts raised about what the effective coverage is - meaning whether those who are covered as per official records are actually able to avail of cashless hospital services when they need them.

One option the ministry is considering is to bring these insurance programmes together into a single platform. The ministry of health could consider integrating publicly financed insurance programmes, more closely with public health care provisioning, thus re-imagining insurance form of tax based demand driven financing that supports and complements public provisioning rather than acts as an alternative to it.

Engaging the Private Sector

Given the size of the private sector- there is of course an urgent need to engage with it and ensure that it contributes to public health goals. Insurance is of course one of the best ways of doing so. But this requires to be complemented by much greater effort at regulation. All nations that have a health system based on purchasing health care from private providers have an extensive regulatory regime in place. To put such a system in place in India, is a challenge. The Clinical Establishments Act has made a very modest start- but even for implementing this, it has still to win the trust of the medical profession. Much larger trust and cooperation would be needed between the private provider and the government to put in place a regulatory structure that is adequate to ensure that publicly financed health insurance translates into meaningful levels of financial protection and access to care.

Beyond insurance and regulation there are other ways of guiding the growth of private sector. Grievance redressal mechanisms for private sector could help. So also would provisions of training and updating skills for the small providers and nursing homes. Engaging the not- for –profit sections in partnerships that require a less rigorous regulation can also provide considerable benefits. Partnerships for ancillary or support services which complements rather than substitutes public care provisioning – like for example, the dial 108 services have also done well.

Conclusion

There is a need to persist, intensify and expand the efforts that were initiated under the National Health Mission, if we have to sustain the progress that the Mission achieved. In particular, we need to focus such expansion both in urban primary care and in the four large Hindi speaking states.

While there has to be a major effort in engaging the private sector in health care, this has to be based on stewardship and facilitatory efforts that address different forms of information asymmetry and conflicts of interests – and empower people to make the right choice. A premature and unprepared shift to purchasing care without first putting in place, the regulatory mechanisms and getting politically ready for much higher levels of public investment is fraught with danger.

In strengthening public health systems, the challenge is of expanding the workforce, increasing investment and the quality of governance so that the challenges of Non- communicable diseases can be addressed without compromising the fragile advances we have made in RCH and communicable disease control.

Readings:

Census 2011. 2016. "Literacy Rate of India - Population Census 2011." Accessed January 17. http://www.census2011.co.in/literacy.php.

Deaton, Angus. 2013. *The Great Escape: Health, Wealth, and the Origins of Inequality*. Princeton University Press.

Draft National Health Policy 2015. Accessed January 17. http://www.mohfw.nic.in/WriteReadData/l892s/3536797344141993775 4.pdf.

MOHFW 2011. "Annual Report To The People On Health (December 2011) :: Ministry of Health and Family Welfare."

Sundararaman, T, V Muraleedharan, and Indranil Mukhopadhyay. 2016. "NSSO 71st Round Data on Health and Beyond." *Economic and Political Weekly* 51 (3): 7, January 16th 2016.

WHO. Global Status Report on Non-communicable Diseases 2014, Geneva.

WHO. Non- communicable Diseases Country Profiles 2014." *WHO*. http://www.who.int/nmh/publications/ncd-profiles-2014/en/.

———. 2015. "WHO | World Health Statistics 2015." *WHO*. Accessed January 17. http://www.who.int/gho/publications/world_health_statistics/2015/en/. ❑

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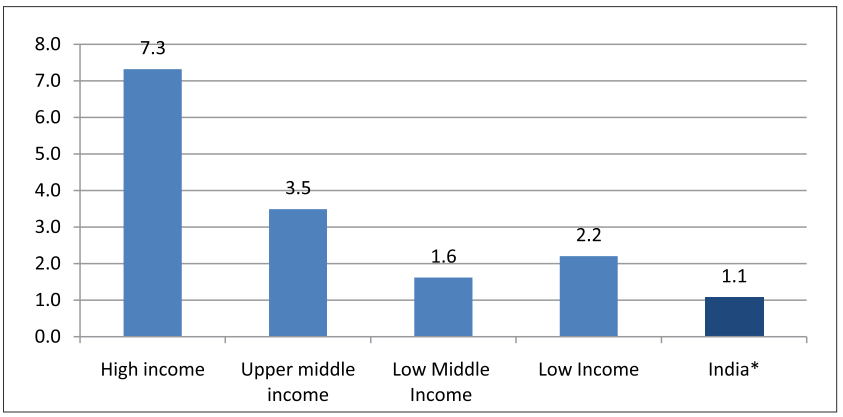
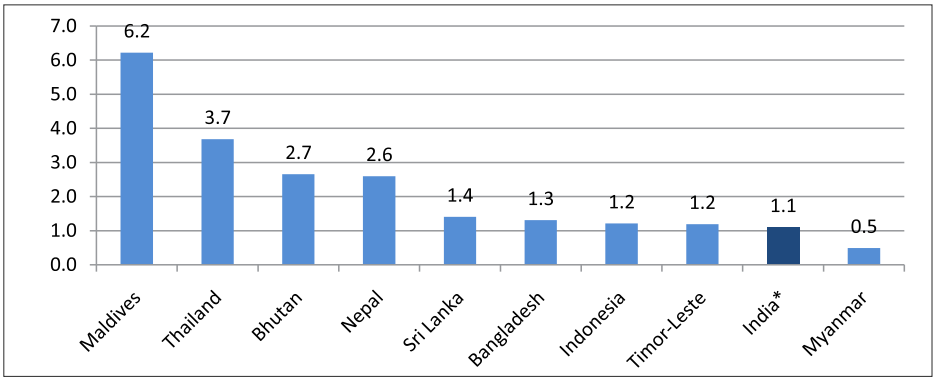
Health Sector in India - Some Data

Public Expenditure on Health as a % of GDP across World Bank Income Groups-2013



Source: WHO: Global Health Observatory, WHO Database

Public Expenditure on Health as a % of GDP for SEARO Counrties-2013

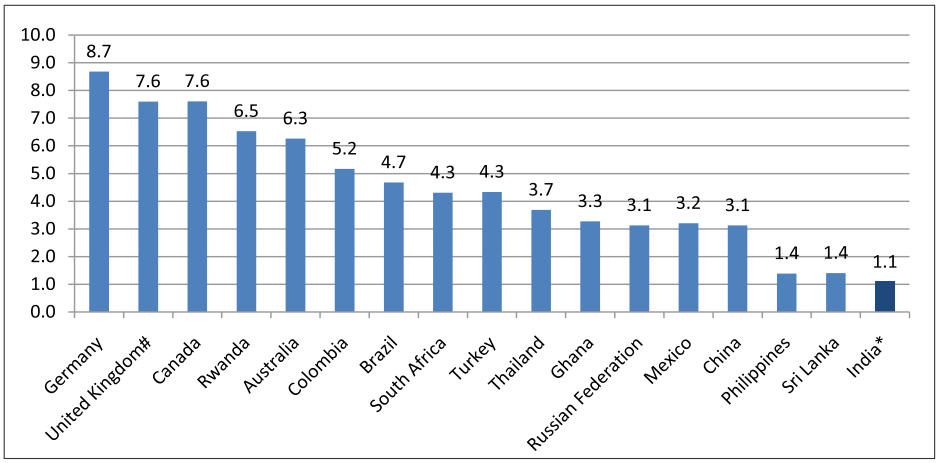


Source: Global Health Observatory, WHO Database

Note:

** SEARO countries exclude Democratic People's Republic of Korea due to data being unavailable.

Public Expenditure on Health as a % of GDP among Countries with significant UHC Coverage-2013



Source: Global Health Observatory, WHO Database

Note:

United Kingdom includes Great Britain & Northern Ireland

(Source: National Health Portal 2015)

PERSPECTIVE

Evolution of National Health Policy in India

J V R Prasada Rao

Providing universal access to fully funded health care services including provision of drugs and diagnostics to poor and marginalised populations coupled with financial risk protection schemes like medical insurance for lower and middle income groups would be the right formula mix to universalise health coverage for the entire population

The draft National Health Policy 2014 is the third to be announced in the last six decades of governance of health sector in India. The National Health Policy of 1983 was formulated with the global vision of 'Health for All by 2000' set in the aftermath of the Alma Ata Declaration. It laid strong emphasis on infrastructure development, primary health care and development of a well trained cadre of health care professionals. But it remained more as a vision document as it fell short of defining clearly the achievable targets matched by requirement of resources. And by 2000,the country was nowhere near achieving the objective of health for all.

The Millennium Declaration 2000 and adoption of a number of health related Millennium Development Goals (MDGs) at global level gave impetus for formulation of a new National Health Policy in 2002. The NHP 2002 clearly identified the shortcomings and challenges in attaining the goal of health for all and adopted a more practical approach to improve the health standards of the people. It has broken new ground in identifying suboptimal resource base as a serious impediment to secure minimum health standards for the people. It recommended that the health spending as a proportion of GDP should be doubled from 1 per cent to 2 per cent within a period of 10 years. It laid emphasis on primary health care suggesting that at least 50 per cent of health expenditure should be incurred on primary health care. It has for the first time listed out clearly the identified targets for various health outcomes to be achieved within the next 10 years.

Despite its strong push for greater emphasis on public spending on health, public expenditure on health remained stationary for the next 10 years at around 1 per cent of GDP only. Even though, the country has done well in achieving some of the targets set in the Policy in the areas of disease control and maternal and child health, it has fallen short of achievements in a number of areas like control of non- communicable diseases, securing equitable access to health care services for the poor and marginalised sectors of population and meeting the chronic shortage of qualified health care professionals in the country.

The new draft National Health Policy 2014 has been refreshingly different in its approach in many ways.

The author is former Union Health Secretary, Government of India, and Special Envoy to the Secretary General United Nations on HIV/AIDS for the Asia Pacific region. He was closely associated with the development of the National Health Policy 2002 in which importance of Public Health education and access to quality health care were strongly emphasized.

Government has adopted the principle of transparency in policy formulation by putting it in public domain for extensive feedback from experts and general population alike. The draft Policy has taken into consideration the change of context for health sector in many ways. Most importantly, it has recognised that incidence of catastrophic expenditure due to health care costs is growing and is now estimated to be one of the major contributors to poverty. 'The drain on family incomes due to health care costs can neutralize the gains of income increases and every Government scheme aimed to reduce poverty ',the Policy acknowledges. It observes that an increasing number of households are facing catastrophic expenditures due to health costs (18 per cent of all households in 2011-12 as compared to 15 per cent in 2004-05).It has also recognised that much of the increase in service delivery was related to select reproductive and child health services and to the national disease control programmes, and not to the wider range of health care services that were needed to improve the health standards of general population. The major shifts in disease burden from communicable diseases and maternal and neo natal ailments to non-communicable diseases and injuries have been given due weightage in the new draft Policy which attempts to balance the emphasis between the two.

The primary aim of the new National Health Policy draft is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions by following certain key principles including equity, universality and inclusive partnerships.

There is, however, a basic difference between a vision document and a national policy. A national policy should be result focussed and should have a specific time frame with clear articulation on resource needs. It should essentially concentrate on what Government intends to do, both in its regulatory and developmental roles.

The objectives set in the present draft are aspirational like in a vision document. They need to be transformed into a Policy which should have clear cut goals and targets to achieve, a time frame in which these will be achieved and resources, financial and technical that would be needed to achieve the goals.

The Policy should aim at a 10 to 15 year time frame and the goals should be harmonised with the Sustainable Development Goal on Health (SDG 3) adopted by India along with other countries in the UN General Assembly in September 2015. The SDG 3 should be adopted as an overall objective for various components of the health goals to be achieved by 2030.There should be stronger emphasis on equity as a basic principle. The global principle of 'no one should be left behind' as a post 2015 development agenda needs to find its echo in the national policy framework.

The SDG 3 should be adopted as an overall objective for various components of the health goals to be achieved by 2030.There should be stronger emphasis on equity as a basic principle. The global principle of 'no one should be left behind' as a post 2015 development agenda needs to find its echo in the national policy framework.

The National Health Policy 2002 for the first time, indicated the level of investment that is needed to deliver optimum level of health services as a percentage of GDP. If it were to be achieved, India would have been compared favourably with regard to the health status of its people with countries like Brazil and Sri Lanka, which spend more than 2 per cent of GDP on health. The present policy offers a great opportunity to correct this imbalance. In fact, the policy reiterates the commitment to increase investments to 2.5 per cent of GDP but no specific time frame has been set to reach this target. There should also be a target set for the state governments as well on the health expenditure as a percentage of total government expenditure. In developed economies and even in neighbouring Sri Lanka and our own Kerala state, it is about 11 per cent of government expenditure which can be considered as optimal.

Improved governance mechanisms and a legal framework for creating an enabling environment for providing accessibility to health services should be important components of an effective health policy.

Under the Constitution, health is a state subject but central government is also concurrently responsible for implementation of a number of disease control and eradication programmes and population stabilisation programmes. The responsibilities of central and state governments need to be more clearly delineated and lines of accountability clearly drawn for performance. With the Government at the Centre devolving more resources to states for social sector programmes, accountability of states for delivering health care services to people has to be greater. But these are still very hazy and not well understood. The wide differential in the health status of people living in different states is a direct result of the lack of accountability at the state level to deliver a minimum set of health care services to the people. The present policy would be trend setting if it can include these minimum accountability standards for the centre and the states for delivering on a set of physical and financial targets to achieve the health outcomes set in SDG 3 on health.

Decentralisation of programme implementation to the lowest level of effective service delivery should be an important feature of the new National Health Policy. The National Health Mission (NHM) which is a giant step in securing universal access to health services should work on a decentralisation model which does not merely stop at devolution of resources but empowers the field level

organisations to effectively perform the decentralised functions and be accountable for performance.

The present legal environment surrounding health sector is very confusing with a plethora of laws at different levels of adoption and implementation by the centre and the states. It is necessary to harmonise and align them to the overall objective of providing equitable access to health services, especially to poor and socially disadvantaged sections of the society. Access to affordable health care should be an inalienable right of every one in the country. The present draft Policy sets an ambitious goal of enshrining health as a fundamental right and giving the option to the states to adopt it. This aspect of the policy needs a larger debate and discussion with not just the state governments, but also with community leaders and legal experts. The implementation challenge such a provision would create, should be carefully evaluated and understood by the central and state governments before taking such a bold step.

The policy focus on providing Universal Health Coverage (UHC) is in line with the globally agreed target of UHC as a part of SDG on Health. Government of India agreed in principle to adopt UHC as a national goal, but is yet to provide adequate resources to make it happen on the ground. Providing universal access to fully funded health care services including provision of drugs and diagnostics to poor and marginalised populations coupled with financial risk protection schemes like medical insurance for lower and middle income groups would be the right formula mix to universalise health coverage for the entire population.

It is very reassuring to see that the present draft speaks about the need to integrate international health and health diplomacy into the policy framework. India should reassess its role in the international arena as a leader in pharmaceutical production, as a major supplier of life saving medicines to countries in Africa and Asia, and as a major advocate for developing trade and intellectual property regimes which are supportive of development of national economic growth and improved health standards. India's transition from a recipient nation of external aid to a net donor of financial and technical support to other countries in South also casts upon it new responsibilities which should find reflection in the health sector as well. It will be timely if the new Health Policy can assess this new role and make it an integral part of the document.

India is passing through a period of transition in its own developmental path, built on the three pillars of economic development, social inclusion and environmental sustainability. The new National Health Policy should be visionary in its approach to fulfil these objectives, and at the same time, be practical in goal setting and providing financial, technical and administrative support to achieve those goals. ❑

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Health Spending in India: Increasing Efficiency

Alok Kumar

while Government continues to improve its efforts at building a strengthened primary care system which is publicly financed and delivered, it cannot continue to ignore the large private sector. Strategies aimed at engagement and mutually beneficial partnerships within properly regulated architectures must be developed, tested and evaluated to determine how best the resources of the Indian mixed health systems can be leveraged to improve the health status of the population and achieve desirable health and development goals

Any discourse on the health sector in India remains incomplete without a mention of the financing of the sector. For the last few years, Governments have been repeatedly criticized for insufficient spending on health. Moreover, even informed commentators have, perhaps unfairly, criticized the Government of India for reducing allocations on the social sector in general and on health, in particular. Fears have been expressed that these cuts in the health budget would adversely affect the population health outcomes. We would like to show in this article that such an assertion is not borne out of facts and is an incorrect appreciation of the increased devolution of untied resources to the State Governments, who have been mandated to deliver health, nutrition, drinking water, sanitation to the people as per our constitutional scheme.

Table 1 presents the Budget figures of central allocations under various budgetary heads upon the various determinants of health including health care.

The table totals (including supplementary commitment and cess for SBA during the year) indicate allocations for 2015-16 were at the same level as revised estimates of 2014-15. However, the total budget estimates must be interpreted in the context of the change in Central-State fund sharing pattern from 70:30/75:25 to 60:40, indicating a higher proportion to be contributed by States which is not reflected in these figures. Moreover, the States taken as a whole have been devolved an additional amount of Rs 1.78 lakh crore as a result of the acceptance of the recommendations of the Fourteenth Finance Commission. A part of the additional devolution will be contributed by the States as their share of the Centrally Sponsored Schemes in these sectors. The balance will be untied resources available with the States to be committed to the sectors to reflect their individual priorities, rather than being prescribed by the Central Government. Even if 10 per cent of this untied resource is allocated to Health and its determinants-not an unreasonable assumption- a back of the envelope calculation would show that there is hardly a reduction in resources in the sectors that have a bearing on the health outcomes.

What is imperative therefore, is the need for measures to encourage States to prioritize spending from the untied funds on health and social development, as per local priorities. The fund flow therefore, has not been decreased, but the pattern of

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Table 1. Budgetary Allocations to Health and some of its determinants

	Component	RE 2014-15	BE 2015-16
1.	Total Health (Dept of Health and Family Welfare, Dept. of Health Research, Dept of AIDS Control)	31274.00	32068.17
	National Health Mission	17627.82	18295.00
2.	AYUSH	691.00	1214.00
3.	Nutrition	17529.74	8883.56*
4.	Swachh Bharat Abhiyan (Sanitation and Drinking Water)	12107.31	6243.87#
	Grand Total (Health+Nutrition+Water Sanitation)	**61602.05**	**48409.6**

Source: Expenditure Budget, GoI. 2015-16.

*We are given to understand that an additional amount of INR 7100 crore was sanctioned under the Supplementary budget during the year in addition to an additional commitment of 9000 crore over five years under the restructured ICDS in partnership with the World Bank.

The Swachh Bharat cess is expected to generate an additional 3700 crore for the financial year 2015-16.

its devolution has been modified for greater autonomy and thereby, better efficiency.

Of equal importance is the analysis of achievements in health outcomes at the current levels of spending. A comparison of India with countries at similar income levels and stages of development indicates that our progress in achievement of outcomes has been slower than these countries. For example, IMR in India declined by 50 per cent from 1990 to 2012. However, the decline was steeper for countries such as Bangladesh (67 per cent) Nepal (66 per cent) and Cambodia (60 per cent)[1] during the same period. In terms of public expenditure on health as a percentage of GDP, Bangladesh and India currently spend around 1.3 per cent of their GDP. However, the achievement of outcomes has been much faster for Bangladesh which showed an annual rate of decline for Under-5 mortality rate of 5.4 per cent from 1990 (144) to 2013 (41) as compared to the rate of decline for India which was 3.8 per cent (126 in 1990 to 53 in 2013).[2] Therefore, at comparable levels of spending, the achievement of outcomes for India has been slower, indicating that merely raising the quantum of finance is not guaranteed to achieve the desired health outcomes. Within public financing, allocative efficiency can be improved to reduce fragmentation as well as focus largely on primary and preventive care, which is vital for reducing disease burden as well as providing the highest returns on investment in terms of maintaining a healthy population. Methods to improve autonomy to public health facilities to generate additional funds and manage their funds as per requirement on their own must be further developed.

Additionally, methods to link finance to outcomes in the area of payments to health care workers may be looked into. Public health facilities are staffed by less than optimally motivated workers. Recent data from the NSSO shows that despite the availability of services in the public sector, private providers were the preferred source of health services due to reasons of unsatisfactory quality (45 per cent), long waiting times (27 per cent) and distant location of facilities (9 per cent), among other reasons.[3] Like, item budget payment methods for public health facilities limit, the responsiveness of the system. Responsive payment mechanism to increase accountability such as incentive payments/performance-linked incentives may be piloted and evaluated for public sector managers and health personnel on the basis of performance indicators/ better coverage of services/achieving measurable health outcomes. Capitation payment methods for providers introduces incentives for ensuring service delivery. For ex: Ghana decided to offer 22 per cent of services under its National Health Insurance Scheme under capitation method of payment and only serious health cases which need referrals are reimbursed under the DRG method. Under and over provision of services is monitored through a strong regulatory system of quality controls and audits coupled with a reliable information system. This allowed Ghana to use the capitation system to control costs while not limiting needed care.[4]

Thirdly, India spends a total of 4 per cent of its GDP on health, which in itself is a significant amount. However, it is the fragmentation of financing and the regressive mode, which is predominantly, out-of-pocket at the point of care that raises the major concern. The large quantum of out-of-pocket expenditure at the point of care which constitutes 86 per cent of private financing of health is shown to have pushed an estimated 37 million into poverty each year.[5] A reorganization of this money into pre-payments and pooling of funds is necessary to convert these large sums of money into a more progressive and efficient mode of financing of care.

This does not take away from the need for increasing the proportion of public funding as part of the total funding for health. Catastrophic health expenditure incurred by households is primarily on care delivered in the private-for-profit health sector. This sector is responsible for delivering 72-79 per cent of outpatient care and 58-68 per cent of inpatient care as per recent data of the NSSO[3]. However, it has been largely ignored by the Government as a stakeholder

in health, as also to be held accountable for health outcomes. Resultantly, the lack of a stewardship function has resulted in a predominantly curative health system that is in a great measure, privately financed and delivered.

Therefore, while Government continues to improve its efforts at building a strengthened primary care system which is publicly financed and delivered, it cannot continue to ignore the large private sector. Strategies aimed at engagement and mutually beneficial partnerships within properly regulated architectures must be developed, tested and evaluated to determine how best the resources of the Indian mixed health systems can be leveraged to improve the health status of the population and achieve desirable health and development goals. Pilot studies that integrate innovative financing and delivery strategies must be implemented on priority to build evidence for what works in the respective States to ensure efficiency of spending and achieve commensurate outcomes.

In conclusion, what remains ignored to a large extent is the reality that current health outcomes in India are not commensurate with spending, even at its current levels. This reality does not take away from the fact that health spending should increase gradually, but it asks the question as to whether improvements in health outcomes are solely dependent on increases in public finances and what are the allocative inefficiencies that must be addressed to spend the available money in a smarter way.

Footnotes

1 World Health Statistics, WHO

2 Committing to Child Survival: A Promise Renewed- Progress Report 2014. UNICEF

3 National Sample Survey 71st Round, NSSO, Ministry of Statistics and Programme Implementation

4 Marquez PV. Ghana's innovative step toward Universal Health Coverage: Expanding Capitation. World Bank blogs. Available at : http://blogs.worldbank.org/health/ghana-s-innovative-step-toward-universal-health-coverage-expanding-capitation

5 Van Doorslaer E et al. 2007. Catastrophic payments for health care in Asia. *Health Economics* ❑

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KAYAKALP SCHEME

To recognise efforts of ensuring Quality Assurance at Public Health Facilities, the Ministry of Health & Family Welfare, Government of India has launched a National Initiative to give Awards 'KAYAKALP' to those public health facilities that demonstrate high levels of cleanliness, hygiene and infection control. The Objectives of award scheme are to promote cleanliness, hygiene and Infection Control Practices in public Health Care facilities; To incentivize and recognize such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control ;To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, cleanliness and sanitation and to create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

Health Care in Tribal Areas : Present and the Future

Abhay Bang

Ministry of Health and Family Welfare and the Ministry of Tribal Affairs, Government of India, unsatisfied with the present state of tribal health and health care, have jointly constituted an Expert Committee on Tribal Health. The group is assigned with the responsibility of reviewing the present health status of the tribal people, the state of health care in tribal areas in the states, and to recommend the corrective solutions including designing a framework for a district health plan in tribal areas(5). The expert committee has reviewed the present situation, and is exploring the possible solutions

The Scheduled Tribes (ST) constituted 8.6 per cent of the total population of India in 2011, amounting to about 10 crore in absolute number[1]. Health of the ten crore marginalized and vulnerable people should become an important national concern. Their poor socio-economic and educational status is well known[2]. What is their health status?

The mortality indicators of ST population have certainly improved during the past decades. However, these are significantly worse thanoff the general population. A comparison on a few child mortality indicators is as follows[3] –

		ST	Other	per cent diff.
1.	Infant Mortality Rate	62	49	27 per cent
2.	Under Five Year Child Mortality Rate	96	59	39 per cent

The infant and child mortality rates (most likely to be underestimates) in the STs are higher by about one-third than in the other population. Moreover, these show a huge variation between the states, and are particularly high in 7 states.

The nutritional status of ST children as well as of adults reveals a sad picture[4].

i) 53 per cent boys and 50 per cent girls in pre-school age were underweight, and 57 per cent boys and 52 per cent girls were stunted in height.

ii) 49.0 per cent of ST women had a Body Mass Index less than 18.5 indicating chronic energy deficiency.

iii) Dietary intake of tribal households showed large deficiencies in protein, energy, fats, iron, vitamin A and riboflavin.

The under-nutrition in children and adults have in ST population certainly decreased over time period (1985-87 to 2007-08), yet the present levels of deficient food intake and under-nutrition should be unacceptable.

The diseases prevalent in tribal areas can be broadly classified into following categories.

A) The diseases of underdevelopment (malnutrition , communicable diseases, maternal and child health problems), B) Disease atypically common in ST population (Sickle cell disease, animal bites, accidents) and C) Diseases of modernity (Hypertension, addiction, mental stress).

Public Health Service to ST population is one of the weakest links. It suffers from several handicaps.

The author is the Founder Director of SEARCH, a well known non-government organization. He is currently Chairman of the Expert Committee on Tribal Health, Government of India. His work on childhood pneumonia and home-based newborn care (HBNC) have shaped global policies. He was a member of Government of India's High Level Expert Group on Universal Health Coverage (2011), of the High Level Committee on Tribal People (2014). He has extensively written and published in the national and international journals including the Lancet. He and his organization have received more than sixty awards, including the 'Global Health Hero' of the TIME magazine.

i) It is often inappropriate for the scheduled areas, being a rubber stamp version of the national model primarily designed for the non-tribal areas. It does not take into account the different belief systems, different disease burden and health care needs as well as the difficulties in delivering health care in a geographically scattered, culturally different population surrounded by forests and other natural forces. It is surprising that no serious thought was earlier given to design a separate public health care plan for scheduled areas.

ii) The other major difficulty in delivering public health care to tribal population is the lack of health care human resource willing, trained and equipped to work in scheduled areas. There is a shortage – vacancy, absenteeism or half heartedness – of doctors, nurses, technicians and managers in public health care system in scheduled areas.

iii) Though buildings are built and health care institutions created in the form of health sub-centres, PHCs and CHCs – they often remain dysfunctional resulting in poor delivery of health care. This is further compounded by inadequate monitoring, poor quality of reporting, and accountability.

iv) Unfriendly behaviour of the staff, language barrier, large distances, poor transport, low literacy and low health care seeking, - all lead to lower utilization of the existing health care institutions in scheduled areas.

v) Access to hospital care for serious cases remains very low in tribal areas.

Thus, the public health care system in scheduled areas is characterized by low output, low quality and low outcome delivery system often targeting wrong priorities. Restructuring and strengthening it should be one of the highest priorities for the Ministries of Health and FW in states and at the centre.

One reason for the inappropriately designed and poorly managed health care in scheduled areas is the near complete absence of participation of ST people or their representatives in shaping policies, making plans or implementing services in the health sector. This is true from the village level to the national level.

In addition to the various handicaps listed above, there is a common perception and complaint that funds for health care in tribal areas are underutilized, diverted to other areas, or utllized inefficiently, and worst, siphoned off through corruption.

How to Redesign ?

1. The first principle of any policy or program for tribal people is the participation. Tribal people as a population segment are not politically very vocal. However, they have different geographical, social, economic and cultural environments, different kind of health cultures and health care needs. Hence, their views and priorities must get due place in any health care program meant for them.
2. In view of the enormous diversity among nearly 700 tribes in India, the second principle to be followed, is of the area specific and tribe sensitive local planning. The PESA provides an institutional basis for this. Local tribal health assemblies, district level tribal health councils and, at the state level, Tribes Advisory Councils can be the institutional mechanisms which when created and made operational will allow local planning.
3. **Social determinants of health** – literacy, income, water, sanitation, fuel, food security and dietary diversity, gender sensitivity, transport and connectivity – play a very important role in determining the health outcomes. Hence, intersectoral coordination for improvement in other sectors is as important, if not more, as health care.

ANM nurse crossing the river Lohit for vaccination (Picture courtesy: Karuna Trust)

Some specific suggestions for improving health are –

i) The construction of drainage system, village sanitation infrastructure, personal toilets and the environmental measures to control mosquito breeding can be included in the MG-NREGA scheme and completed on a priority basis in scheduled areas.

ii) To reduce the household use of unclean fuels and biomass burning, the solar energy, especially the solar cooker, water heaters and lights can be promoted in scheduled areas. This will also help to save trees.

iii) Improving nutrition of children, adolescents, pregnant and lactating women is critical for the ST population. The nutrition awareness and feeding programs in the scheduled areas can be better implemented in collaboration with the National Rural Livelihood Mission and the Women's saving groups in the villages.

iv) Health and income available for family will show improvement by controlling alcohol and tobacco.

4) Empowerment of the ST population is another cardinal principle. Building their capabilities to care for their health is the long term solution for superior to a perpetual dependence. This however, does not mean that the government or the rest of the society can abdicate their responsibility towards tribal people. But this responsibility can be better served in the long run by building local capacity. In other words, instead of 'giving' health care, the policy should be to build 'capacity to care for health'. This principle should guide in planning

A hut where the mother is kept for delivery and later the newborn joins her Picture (Courtesy: SEARCH, Gadchiroli)

health care – especially in the choice of who will provide health care, where, when and how.

5) To bridge the scientific knowledge gap of centuries, health care for scheduled areas should give paramount importance to spreading 'health literacy' by way of mass educational methods, folk media, modern media and school curriculum. Enormous scope exists for communication in local dialects and for the use of technology.

6) A large number of ST children and youth – more than one crore – are currently in schools. This provides a great opportunity – both for improving their health and for imparting health related knowledge and practices. Schools, including the primary schools, middle schools, high schools, ashram shalas and also the Anganwadis, should become the Primary Health Knowledge Centres.

7) Traditional healers and Dais play an important role in the indigenous health care. Instead of alienating or rejecting them, a sensitive way of including them or getting their cooperation in the health care must be explored.

8) Apart from the physical distance, a huge cultural distance separates the tribal population from others. Health care delivery to ST population should be culture sensitive and in the local language to overcome this distance.

9) Health care delivery system for scheduled areas must keep as its guiding principle the Chinese axiom – How far a mother on foot can walk with a sick baby? Health care must be available within that distance. This, for the tribal communities living in forests, means health care must be available in their village/hamlet. Sixty years of failure should teach us that health care from outside is not a feasible solution. The design of health care in scheduled areas should be such that major share of health promotion and prevention and a sizable proportion of curative care is generated and provided in the village or hamlet itself.

10) Addiction is a big drain on the ST population. It not only affects health but also affects productivity, family economy, social harmony and ultimately development. Hence i) The Excise Policy for Scheduled Areas, approved by the Ministry of Home Affairs, Govt. of India in 1976 and accepted by the states should be implemented effectively. ii) Moreover, the availability and consumption of tobacco and drugs should be severely controlled. These efforts should become a critical part of the Tribal Sub Plan. iii) The availability and use of alcohol and tobacco products in ST population, and the implementation of control policies by the states should be monitored on selected indicators.

11) The Tribal Sub Plan (TSP) budget, in proportion to the ST population, should be an additional input and not a substitute to the regular budget for the routine activities of the health department in the scheduled areas. At least fifteen per cent of the total TSP budget should be committed to the health sector, the Tribal Health Plan, in the scheduled areas, in addition to the regular health budget for these areas.

12) Data on ST population is a basic ingredient for planning, monitoring and evaluating health programmes in the scheduled areas. All national data systems – the Census, SRS, NFHS, NSSO, DLHS can be asked to plan for and generate ST specific estimates on specific health indicators at the district level and above. One per cent of the total budget for ST population (TSP) be allocated to generating reliable, timely, relevant segregated data on ST population at the local to national level. This will provide the crucial instrument like the facts necessary to guide the program managers, policy makers and the ST populations.

The Way Forward

Ministry of Health and Family Welfare and the Ministry of Tribal Affairs, Government of India, unsatisfied with the present state of tribal health and health care, have jointly constituted an Expert Committee on Tribal Health. The group is assigned with the responsibility of reviewing the present health status of the tribal people, the state of health care in tribal areas in the states, and to recommend the corrective solutions including designing a framework for a district health plan in tribal areas[5]. The expert committee has reviewed the present situation, and is exploring the possible solutions. A national workshop on Best Practices in Tribal Health Care was organized recently in SEARCH, Gadchiroli, probably for the first time in the country. 23 best practices were presented and discussed.

We should look forward to the report of this expert group. Hopefully, it will show us the way forward.

Readings

1. Census of India (2011)
2. Report of the High Level Committee on the Socio-economic status of the Tribal People, Ministry of Tribal Affairs, Government of India. (2014)
3. Census (2001 & 2011)
4. National Nutrition Monitoring Bureau, Technical Report 25, National Institute of Nutrition, Hyderabad.
5. Ministry of Health and Family Welfare, Govt. of India, Constitution of the Expert Committee on Tribal Health (2013)

[The author gratefully acknowledges that this article heavily draws from the chapter on Health he wrote for the Report of the High Level Committee on Tribal People, Ministry of Tribal Affairs, Government of India (2014)] ❑

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SPECIAL ARTICLE

Health In The Era of Sustainable Development

K Srinath Reddy

Whether it is continued commitment to the MDG agenda, initiation of effective action on new elements like non-communicable diseases and mental health or earnestly implementing a well planned programme of universal health coverage, India's health priorities resonate well with the SDG targets. We need to gear up the performance of our health system to reach those targets. Equally important, we need to work towards greater policy coherence in harmonising actions across the different development sectors, so that they enable and not erode each other. Only then can we create a healthy future for ourselves

Is health a predictable beneficiary of a country's economic development? Is health of the people a valuable investment for economic growth? How is health related to other areas of development which often seem unconnected and even compete for resources? What are the health priorities that feature in the global development agenda that are relevant to India?

While these questions have been discussed for several decades, greater clarity has emerged in recent years. The prominence of health in the Millennium Development Goals (MDGs: 2000-2015) and in the Sustainable Development Goals (2016-2030), sequentially adopted by the United Nations, arises from the recognition that health is pivotal to equitable and sustainable development and is closely interconnected to other development sectors.

Health status of a population does improve with the country's economic development. As the frequently cited Preston curve shows, life expectancy rises sharply as the average per capita income rises from low levels over time in any country. This benefit tends to plateau at high of per capita income with only small incremental gains of life expectancy, with a further rise in income. However, Kate Pickett and Wilkinson showed that, at similar levels of per capita income, countries with lower levels of income gaps within the population (greater equality) have better life expectancy and other health indicators than countries with higher income gaps within the population (lower equality). In their book *The Spirit Level*, they provide evidence of how even the rich in countries with less equality fare worse than their counterparts in countries with greater equality.

While conventional economic wisdom through a great part of 20th century tended to view health and improved nutrition as passive beneficiaries of economic growth, the latter part of that century recognised population health and nutrition as levers of accelerated economic growth. In his 1993 Nobel Prize lecture, economist Robert Fogel explained how 50 per cent of Britain's economic growth during 1790- 1980 was attributable to improved nutrition, which reflected the social policies adopted during 1790-1930. *The World Development Report* of 1993, titled *Investing in Health*, made a strong case for greater economic investment in health to reap the benefits of greater economic growth.

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In late 1990's, the World Health Organisation (WHO) constituted a *Commission on Macroeconomics and Health* which presented evidence on the key contribution of health to economic development. The bidirectional relationship between health and economic development was now firmly established. *The Lancet Commission on Investing in Health* (2013) later projected that low and middle income countries could gain 9 to 20 fold returns on economic investments in health.

The relationships between poverty and health, and education and health are even sharper than those for overall income and health. Poor people are more likely to suffer from a variety of diseases than the rich, with higher rates of maternal and child deaths, undernutrition, infectious diseases, mental illness, injuries, tobacco consumption and exposure to air pollution. Even diseases usually associated with the rich, such as heart diseases, diabetes and cancers become increasingly common among the poor as societies advance economically and a progressive reversal of the social gradient sees these diseases more frequently affecting the poor than the rich, as countries move to the upper middle and high income groups. This is the situation now in USA, Australia and Western Europe, with urban China and urban India also beginning to show a reversal of the social gradient for 'non-communicable' diseases. The poor are more exposed to illness causing agents such as unclean drinking water or tobacco and they lack the protection of good nutrition, have inadequate health information and limited access to health care services, especially because of unaffordable health care costs. A low level of education is particularly a major determinant of poor health status, independent of income.

Illness, in turn, often leads to impoverishment or financial shocks among the economically vulnerable sections (which includes a large segment of the middle class), if most of the health care costs are borne by families as 'out of pocket spending' (OOPS). It is estimated that nearly 100 million persons are pushed in to poverty world over each year by unaffordable expenditure on essential health care. About half of them are Indians. Illness also leads to loss of jobs or earnings, often leads to distress sale of valued possessions and adversely affects the family spending on children's education and nutrition. Similarly, a sick child is unable to fully access the benefits of education, with resultant disadvantage for later employment and income.

The social determinants of health range beyond income and education to include water, sanitation, nutrition, environment, gender, social stability and social status. Policies in agriculture and food systems as well as urban design and transport too profoundly affect health. So does the lack of energy security, especially in India where many women and children are badly affected by indoor air pollution from burning of solid biofuels like wood and dung. Many of these relationships were delineated by the *WHO Commission on Social Determinants of Health* (2005), which recommended that health equity gaps must be bridged within a generation, through determined action on the social determinants of health so that conditions conducive to health are created in all societies. Merely providing equality of opportunity to access health services is not enough, if social deprivation has already created a large lag in health status and limits real and ready access to health services. As British economist Tawney pointed out in his seminal book *Equality*, over 80 years ago, people need "not just an open road, but also an equal start" in a society that promises social justice.

All of these considerations led to the formulation of the MDGs and later the SDGs. There are, however, considerable differences in the vision and values that shaped these two sets of global development goals. The MDGs were principally developed by technocrats assisting the United Nations and were unreservedly adopted by all countries at the euphoric dawn of the new millennium in 2000. They were principally guided by the views of developed countries which vowed to reduce poverty and poverty related diseases and hunger in the low and middle income countries. The targets that were set applied only to low and middle income countries. There was no integrated vision of development and no commitment to multi-sectoral action on many of the social determinants.

Health was directly targeted in three of the eight MDGs, even though others like poverty reduction and education were also clearly related to it. The health MDGs specifically addressed maternal mortality, child mortality and major infectious diseases like HIV-AIDS, TB and Malaria. These were seen as the major public health challenges of the low and middle income countries. The already considerable and rapidly rising burdens of non- communicable diseases, and a major killer like tobacco that killed 100 million in the 20th century, were not considered worthy of inclusion, due to a perverse value judgement that viewed them as ' not the problems of the poor' despite mounting evidence to the contrary.

The three MDGs on health did serve a very useful purpose in mobilising national attention and action on very relevant areas of public health, as well as galvanising global support for targeted actions. They led to the creation of the Global Fund for AIDS, TB and Malaria and funding partnerships for maternal and child survival. However, they fragmented health by disease and segmented it by age. Many major threats to health were missed out, like non-communicable diseases, mental illness and injuries. Older children, adolescents, adult men, non- pregnant women and the elderly were excluded. Only reduction of mortality (death) was considered, while reduction of morbidity (non-fatal illness) and disability did not come into the ambit of MDGs. Most important, these vertical approaches did not take into consideration the need to create strong health systems which could effectively deliver on these promises without neglecting other public health functions. It was not recognised that vertical programmes, however noble in intent and detailed in design, could not be force fitted into weak or dysfunctional health systems. Indeed, they created the risk of disrupting the health system through vertically funded programmes which demanded undivided attention and full dedication

from the limited institutional and human resources in low and middle income countries. While aiming for health equity, the MDGs sought to measure only aggregate national indicators, without looking at equity gaps across income, education, rural-urban, gender and other socio-demographic divides within a nation.

The SDGs are a distinct improvement in many ways. First, the text was negotiated through an open and democratic inter-governmental process. Second, the goals are relevant to all countries. The goals cover several domains of development but integrate them within a framework of sustainable development that recognises the linkages. Fourth, environmental protection receives much needed attention, reminding us that the path to economic growth and global development need not and should not be detrimental to planetary health. Fifth, the health SDG corrects the shortcomings of the health MDGs by taking a life course approach to health and emphasising the role of health systems in delivering universal health coverage to promote health equity and provide financial protection against costs of health care.

The lone but lofty health goal of the 17 SDGs calls for "*Healthy Lives for All and Wellbeing At All Ages*". While this sounds a bit vague, it does reflect a universal approach that extends to all people and promotes health in a positive way. The nine targets attached to the health goal are specific in guiding action. They call for: reducing maternal mortality to 70 (per 100,000 live births), under -5 child mortality to 25 and neonatal mortality to 12 (per 1000 live births) by 2030; ending the epidemics of AIDS, Malaria and TB, reducing premature deaths from non-communicable diseases (in the age group 30-70 years), halving deaths from road traffic accidents, reducing substance abuse and harm from air, water and soil pollution. It also calls for universal health coverage, with financial protection and access to essential drugs and vaccines, as well as unimpeded access to reproductive and sexual health services. Further, it calls for effective implementation of the WHO Framework Convention for Tobacco Control.

The relationship of the health goals to the other SDGs is very clear, whether they relate to reduction of poverty, ending hunger, providing universal access to education, promoting gender equity, planned urban growth, providing clean energy, protecting ocean life and forestry, reducing consumption, promoting peace and, most importantly, protecting the planet. The impact of the environment on health is a big concern as air pollution levels mount across the world and chemical pollution also degrades water and soil quality. Climate change, with accelerated global warming, poses public health challenges through heat waves, floods, extreme weather events, spread of vector borne diseases as mosquitos breed at higher altitudes and latitudes, decreased production and nutrient quality of several crops, stress related mental illness and climate related migration. Health is now firmly positioned within this interconnected matrix of development domains. While the indicators for measuring the targets linked to different goals will be adopted in March 2016, countries also need to build capacity for conducting health impact assessment of policies in other sectors.

India signed up to the SDGs in September 2015, at the United Nations. The health agenda set by SDGs is highly relevant to India, as is the broader development agenda. Whether it is continued commitment to the MDG agenda, initiation of effective action on new elements like non-communicable diseases and mental health or earnestly implementing a well planned programme of universal health coverage, India's health priorities resonate well with the SDG targets. We need to gear up the performance of our health system to reach those targets. Equally important, we need to work towards greater policy coherence in harmonising actions across the different development sectors, so that they enable and not erode each other. Only then can we create a healthy future for ourselves. The leap year of 2016 provides a good augury for making a great leap forward on our path to sustainable and equitable development. Health is the best summative indicator of success in all of the SDGs. Let the health of our people be the talisman of our success in this era of sustainable development. ❑

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Draft Guidelines for Kidney Donors Issued

The National Organ and Tissue Transplant Organisation (NOTTO) under the Ministry of Health & Family Welfare issued draft guidelines for Allocation Criteria for Deceased Donor Kidney Transplant. This will be a major step towards easing rules and procedures to encourage organ donation among the masses. The draft guidelines have been posted on the website of NOTTO- www.notto.nic.in

This initiative will promote organ donation in the country. The guidelines will be finalised after Ministry reviews various suggestions & comments regarding the same"

The draft guidelines include issues like = recipient registration, listing and scoring system in the waiting list scoring system for making priority, allocation principles, allocation algorithm, including criteria for urgent listing, and inter-state issues.

A list of the government and non-government hospitals in Delhi along with those in the neighboring area of the NCR (Gurgaon, Ghaziabad, Faridabad, Noida) have also been listed in the draft guidelines. The hospitals in the NCR cities will be included in the networking along with hospitals of Delhi for the purpose of organ sharing and allocation with the concurrence and MoU with the respective State Governments and institutions in due course of time.

Health for All: A Critical International Perspective

Subhash Sharma

..infant mortality rate in India (43.8 per thousand) is 20 times that in Japan (2.3per thousand), ten time that in OECD and Canada (4.1 and 4.4 respectively), 11 times that in Switzerland (3.8), 7.5 times that in US (6.1) and 4.5 times that in Thailand (9.9). Kerala has achieved the level of many developed countries both in health and education due to its priority to social sector over the years. Why can't the rest of India achieve that?

The very conception of 'health for all' (HFA) is based on a 'holistic paradigm of social development' where human wellness (more than well-being) is accorded priority. Even the concept of human development, which is far less comprehensive and transformative than social development, comprises of three components :growth in personal income, improvement in education, and health (more longevity). It is not only broader and more comprehensive than 'Universal Health Coverage' (UHC), but also differs from the latter in quality and depth because in UHC, the focus is more on 'coverage' while in HFA, focus is on wellness and care. Second, UHC emphasizes more on a health financing system based on the pooling of funds from public, private and joint sectors in order to provide health coverage to all people of a country (implying some personal contribution from people too), while conception of 'health for all' implies public financing (by state) for health care of all. Third, UHC presumes a 'package' of primary health services through insurance companies, mainly private (through competition in open market) but sometimes both public and private, while HFA implies delivery through government facilities at different administrative levels.

To put the conception of HFA in a historical perspective, UN envisaged a comprehensive and integrated primary health care for all in Alma Ata Declaration in 1978 to promote equity and was driven by the community needs.

The constitution of World Health Organization (WHO) mentions 'that health, well-being, standard of living, medical care, right to security in case of sickness as well as special care and assistance for mothers and children are quite significant and notable in the context of HFA. In addition, Article 3 of UDHR clearly provides that everyone has 'the right to life, liberty and security of person'. Obviously, right to life includes right to food and health (as interpreted by Supreme Court of India). The Alma Ata Declaration in 1978 was thus, in consonance with UDHR and WHO's constitution. In fact, at Alma Ata (now Almati in Kazakistan) International Conference on 'primary health care' expressed the need for 'urgent action by all governments, all health and development workers, and the world community to protect and promote the health for all the people of the world'. Its main resolutions are as follows:

i) health, which is 'a state of complete physical, mental and social well-being', not merely the

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absence of disease or infirmity, is a fundamental human right and that the attainment of 'the highest possible level of health' is a most important worldwide social goal;

ii) 'the existing gross inequality in the health status of the people, particularly between developed and developing counties as well as within countries is politically, socially and economically unacceptable;

iii) economic and social development is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries;

iv) people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare;

v) governments have a responsibility for adequate health of their people, to be attained by 2000;

vi) primary health care is key and essential, to be made available at a cost that community and country can afford;

vii) primary health care provides *promotive, preventive, curative* and *rehabilitative* services, and promotes maximum community and individual self-reliance and participation in planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources;

viii) all governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as a part of comprehensive national health system;

ix) all countries should cooperate in a spirit of partnership and service to insure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country;

x) an acceptable level of *health for all* for the people of the world by 2000 can be attained through a fuller and better use of world's resources, a considerable part of which is now spent on armaments and military conflicts; a genuine policy of independence, peace, détente and disarmament could and should release additional resources, to be used for socio-economic development including primary health care.

WHO time and again reiterated for *Health for All*, especially in 2005 and 2011 too, though it used 'universal health coverage' with health financing system including a method for prepayment of financial contributions for health care, with a view to share risk among the people, under the influence of World Bank in particular and the processes of liberalisation, privatization and globalisation in general. UN resolution in December 2012 further emphasized it for overall human development and to be included in post-2015 development agenda. However, World Bank in its World Development Report (1993) ranked common health care interventions according to *cost-effectiveness*; its minimum health package for low income countries considered to avert 1/3rd of estimated disease burden and 1/5th of that in middle income countries. But, unfortunately, many common ailments (moderately severe injuries and chronic conditions like diabetes, cataract, hypertension, mental illness and cervical cancer) were excluded from public funding in low income countries (as found by M. Segall in 2003). Consequently due to 'structural adjustment' or economic reforms during 1980's in the poorest 37 nations, public spending on health per head the declined by half due to cuts-e.g. in Mexico, it declined up to 60 per cent during 1982-87.

Due to the adverse impact of liberalisation, privatisation and globalisation in 1980's and 1990's, most of the developing countries have faced following problems regarding health:

a) Since state retreated from development interventions, there was a massive decline in public investment in health sector like other social sub-sectors (education, welfare of the deprived sections, etc.); e.g. In 1991, Peru spent $ 12 per capita on health and education while in 1980, it spent about $ 50 and in 1991, it paid $ 25 per head to Western banks as debt repayment;

b) There accrued a huge shortage of doctors and supporting medical staff, hence availability of doctors and staff decreased, leading to patients bound to go to private clinics;

c) There was a shortage of medical equipment, drugs and pathological facilities in public health institutions – hospitals were reduced to mere writing of prescriptions and patients were compelled to buy medicines from the open market and to get pathological tests done at private labs at higher costs;

d) Private doctors not only indulged in charging exorbitant fees but also prescribed unnecessarily more and costlier medicines as well as avoidable pathological tests;

e) Due to laxity of the state apparatuses, even government doctors and supporting staff started giving more time at their private clinics, even during official duty hours, with the profit and commercial motive;

f) Due to the retreat of state in providing subsidised food, nutrition, safe drinking water and sanitation facilities, there was a rise in communicable and non-communicable diseases among the poor people who are unable to afford the required medical treatment, leading to long duration of morbidity and finally death;

g) The phenomenon of free market ('invisible hand') was based on the 'individual care', considered as a 'private' good but in most of Latin American countries like Chile and Colombia, there was no improvement in quality of health care, equity and efficiency for the local people while the private

insurance companies, consultancy firms, private pharmaceutical companies and private hospitals earned great profits.

Nowadays, public-private partnership, modernisation, value for money, health insurance etc are the buzzwords in most of developed and developing countries. However, there are some alternative health systems in Cuba, China, Costa Rica, Malaysia, Sri Lanka, Rwanda, Venezuela and Thailand. Since 2002, there is Universal Health Care coverage in Thailand for all people without any charge and now 77 per cent of all hospital beds in that country are in public sector (2012). Cuba has been famous for a long and sustained drive to ensure cataract operation of all old people at public facilities. There is equitable health service delivery with regulations like three years of compulsory rural service for doctors and nurses, and a radical shift in funding away from urban hospitals to primary care across Thailand. Health expenditure there increased from 1.7 per cent of GDP in 2001 to 2.7 per cent in 2008 but is still quite low; and there are only three physicians for every 10,000 patients compared to 9.4 in Malaysia, 11.5 in the Phillipines, 12.2 in Vietnam and 18.3 in Singapore. There is also shortage of nurses due to less salary (and attractive salary results in their flight to Singapore).

Consequently, Millennium Development Goals (MDGs) were declared by member-nations of UN unanimously of which following relate to health:

a) To halve, between 1990 and 2015, the proportion of people who suffer from hunger;
b) To reduce by two-thirds, between 1990 and 2015, the under-five mortality rate;
c) To reduce by three-fourths, between 1990 and 2015, the maternal mortality ratio;
d) To achieve, by 2015, universal access to reproductive health;
e) To have halted by 2015 and begun to reverse the spread of HIV/AIDS;
f) To have halted by 2015 and begun to reverse the incidence of malaria and other major diseases;
g) To halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation.

According to World Health Organisation (2015), under-nutrition or malnutrition is the major cause of death in 45 per cent of all deaths among children below 5 years. During 1990-2013, the proportion of underweight children in developing countries declined from 28 per cent to 17 per cent and expected to be 16 per cent in 2015 (globally declined from 25 per cent in 1990 to 15 per cent in 2013) against the target of halving the proportion of people suffering from hunger. The MDG target for this indicator was met in WHO's North and South Americas, European region and Western Pacific region but not in Eastern Mediterranean region, South-East Asian region and African region. In India, about 47 per cent children are underweight. Similarly during 1990-2013, the number of stunted children declined globally from 257 million to 161 million, a decrease of 37 per cent. We could not achieve this target.

Second, during 1990-2013 under-five child mortality rates declined by 49 per cent (against the target of reducing by two-thirds), falling from 90 deaths per 1000 live births to 46 per 1000 live births (it was 42 in 2013 in India) – that is globally 17000 fewer children died daily in 2013 than in 1990. Globally, total number of neo-natal deaths decreased from 4.7 million in 1990 to 2.8 million in 2013 and neo-natal morality rates per 1000 live births declined from 33 to 22 during that period (39 per cent). Looking at the achievement regarding under-five mortality rate by region, it transpires that till 2013 in African region (comprising of 47 countries), 6 countries achieved the target of reduction by 2/3^{rds} and two countries are on track while 25 countries are at least halfway and 14 countries are less than halfway. In both Americas (35 countries), 5 countries achieved the target and 3 countries are on track, while 24 countries are at least halfway and 3 countries are less than halfway. In South-East Asia region (11 countries), 5 countries achieved the target and 2 are on track while 4 are at least halfway and none in less than halfway. In European region (53 countries), 23 achieved the target and 4 are on track while 26 countries are at least halfway and none less than halfway. In Eastern Mediterranean region (21 countries), 6 achieved target and 2 are on track while 12 are at least halfway and 1 is less than halfway. In Western Pacific region (27 countries), 3 achieved target and none on track while 18 are at least halfway and 6 are less than halfway. Globally (194 countries), 48(25 per cent) achieved the target and 13(7 per cent) are on track while 109 (56 per cent) are at least halfway and 24(12 per cent) are less than halfway, thus most of the countries (133) could not achieve the target of reducing under-five mortality by 2/3^{rds}by 2015. Major causes of under-five mortality are: (a) preterm birth complications (17 per cent), (b) pneumonia (15 per cent), (c) birth asphyxia (11 per cent), diarrhoea(9 per cent), malaria (7 per cent), congenital anomalies (7 per cent) and neonatal infections (7 per cent). In fact, 'neo-natal period' (first 28 days) is the most vulnerable period for child's survival. In 2013, about 44 per cent of under-five deaths took place during neo-natal period, up from 37 per cent in 1990. Yet immunisation has increased considerably all over the world, e.g. during 2000-2013 incidence of measles decreased by 72 per cent (from 146 to 40 cases per million population). During 2000-2013, global number of measles deaths in children below 5 years decreased by 74 per cent (from 4,81,000 to 1,24,000).

Third, during 1990-2013 the maternal mortality ratio per lakh live births declined globally by 45 per cent (from 5,23,000 to 2,89,000) against the target of 2/3^{rds} reduction – thus, it has lagged behind the target. Unfortunately in 89 countries, with the highest maternal mortality ratio in 1990 (100 or more), 13 have made insufficient or no progress at all, with an average annual decline of less than 2 per cent. Major cases of maternal

deaths are haemorrhage (27 per cent), hypertensive diseases of pregnancy (14 per cent) and sepsis (11 per cent). Thus, we have not achieved this target.

Fourth, regarding universal access to reproductive health during 1990-2012, prevalence of contraceptive use by women (15-49 years) increased globally from 55 per cent to 64 per cent and 'unmet need' (not using contraceptive) declined from 15 per cent to 12 per cent - but African region has the highest level of unmet need at 24 per cent. Further, 83 per cent of pregnant women globally received antenatal care at least once during pregnancy but only 64 per cent pregnant women received minimum four antenatal care visits. In African region and low-income countries, only 51 per cent pregnant women received services of skilled nursing staff during delivery. Thus, we have not achieved this target.

Fifth, in 2013, about 12.9 million people with HIV/AIDS received anti-retroviral therapy (ART) globally (of these 11.7 million lived in low and middle income countries) against 32.6 million affected with HIV/AIDS. Due to such treatment, HIV mortality declined from 2.4 million in 2005 to 1.5 million in 2013.Thus, we could not achieve the target of halting spread of HIV by 2015 nor could we achieve the target of universal access to treatment of HIV/AIDS.

Sixth, globally 3.20 billion people are at risk of being infected with malaria and other major diseases, with 1.2 billion at high risk. In 2013, 198 million cases of malaria occured globally (against 227 million in 2000) leading to 5,84,000 deaths- of which 90 per cent in African region and 78 per cent malaria deaths occur in children below five years. During 2000-2013 malaria mortality rates decreased by 47 per cent globally, and decreased by 54 per cent in African region, and by 53 per cent globally in children below 5 years. In sub-Saharan Africa, 44 per cent of population at risk were sleeping under insecticide-treated net in 2013 compared to only 2 per cent in 2004. In total, 64 countries have met MDG target of reversing the incidence of malaria. Further during 2000-2013, globally the number of new cases of tuberculosis (incidence) has fallen at an average annual rate of 1.5 per cent and during 1990-2013, global tuberculosis prevalence rate fell by 41 per cent with a decline of 45 per cent in mortality rate. Since 2007, high global treatment success note (85 per cent) has been sustained but in 2013, about 1.5 million people died from tuberculosis globally. Thus, MDG target of halting incidence of malaria and tuberculosis by 2015 has been achieved globally. Regarding elimination of leprosy by 2020, 75 per cent reduction in incident cases is recorded since the launch of the programme in 2005. Regarding lymphatic filariasis, since 2000, more than five billion treatments have been delivered to stop its spread and of 73 endemic countries 39 are on track to achieve its elimination by 2020.

Seventh, MDG target of halving the proportion of population without sustainable access to safe drinking water by 2015 was achieved globally in 2010 but at national level, only 116 countries met the target and 45 countries are still not on track. In 2012, 748 million people still lacked it and there was inequality among different regions, between rural and urban areas, and between different socio-economic classes. On the other hand, MDG target of halving the proportion of population without basic sanitation could not be achieved. About one billion people (14 per cent of world population) have no toilets/latrines, hence go for open defecation. In India, about 55 per cent people go for open defecation. This results into high level of environmental contamination and exposure to microbial infections, cholera, trachoma, hepatitis, and schistosomiasis. About 90 per cent of people globally going for open defecation live in rural areas.

Eighth, we have not achieved the MDG target of providing access to affordable essential drugs in developing countries because selected essential (generic) medicines in 21 low-and middle-income countries were available only in 55 per cent of public sector facilities. The common patients in low-and middle-income countries are paying two to three times the international reference prices. In developing countries like India, many medical practitioners, mostly private (but also many government ones), connive with medical representatives of various pharmaceutical companies and, therefore, prescribe costly and unnecessary more medicines and pathological tests, often combined with negligence, hence there are many cases in consumer courts in this regard.

In view of the above, we may safely conclude that all the developing countries (including India) should accord topmost priority to 'health for all' in letter and spirit because it ensures not only human resource development, but also the well-being of our future generations, without any restriction on caste, class, gender, religion or area basis, whose interests cannot be compromised at all. Therefore, developing nations have to increase their budget on health (as proportion of gross domestic product, and as share of public expenditure to total expenditure per capita on health). In India, we spend just about 1 per cent of GDP on health and our public expenditure is just 30 per cent whereas Japan spends 82 per cent, OECD (average) 73 per cent, Canada 70 per cent, Switzerland 65 per cent, US 48 per cent and even Thailand 72 per cent. Consequently, the life expectancy at birth in Japan (82.7years), OECD (80.1), Canada (80.4), Switzerland (82.8), US (78.7) and Thailand (74.3) is much higher than that in India (66.3years).On the other hand, infant mortality rate in India (43.8 per thousand) is 20 times that in Japan (2.3per thousand), ten time that in OECD and Canada (4.1 and 4.4 respectively), 11 times that in Switzerland (3.8), 7.5 times that in US (6.1) and 4.5 times that in Thailand (9.9). Kerala has achieved the level of many developed countries both in health and education due to its priority to social sector over the years. Why can't the rest of India achieve that? ❑

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Stand Up India Scheme - A Boost to Promote Entrepreneurship Among SC/ST and Women

The Union Cabinet, chaired by the Prime Minister, approved the "Stand Up India Scheme" to promote entrepreneurship among SC/ ST and Women entrepreneurs. The Scheme is intended to facilitate at least two such projects per bank branch, on an average one for each category of entrepreneur. It is expected to benefit atleast 2.5 lakh borrowers. The expected date of reaching the target of at least 2.5 lakh approvals is 36 months from the launch of the Scheme.

The Stand Up India Scheme provides for:

- Refinance window through Small Industries Development Bank of India (SIDBI) with an initial amount of Rs. 10,000 crore.
- Creation of a credit guarantee mechanism through the National Credit Guarantee Trustee Company (NCGTC).
- Handholding support for borrowers both at the pre loan stage and during operations. This would include increasing their familiarity with factoring services, registration with online platforms and e-market places as well as sessions on best practices and problem solving.

The details of the scheme are as follows:

- Focus is on handholding support for both SC/ST and Women borrowers.
- The overall intent of the approval is to leverage the institutional credit structure to reach out to these under-served sectors of the population by facilitating bank loans repayable up to 7 years and between Rs. 10 lakh to Rs. 100 lakh for greenfield enterprises in the non farm sector set up by such SC, ST and Women borrowers.
- The loan under the scheme would be appropriately secured and backed by a credit guarantee through a credit guarantee scheme for which Department of Financial Services would be the settler and National Credit Guarantee Trustee Company Ltd. (NCGTC) would be the operating agency.
- Margin money of the composite loan would be up to 25 per cent. Convergence with state schemes is expected to reduce the actual requirement of margin money for a number of borrowers. • Over a period of time, it is proposed that a credit history of the borrower be built up through Credit Bureaus.

The "Start up India, Stand up India" initiative was announced by the Prime Minister in his address to the nation on 15th August, 2015. The Stand up India component is anchored by Department of Financial Services (DFS) to encourage greenfield enterprises by SC/ST and Women entrepreneurs.

NORTH EAST DIARY

TRAINING FOR NORTH-EAST STUDENTS ABROAD

From next year, selected students and youth from the North-east Region will be sponsored for professional training abroad in some of the best institutions outside India. Initially, eight youths will be sent for training in Fashion Technology and Hospitality/Protocol courses .This has been done by MDoNER so that youth can gain access to quality high education and can have the option to go back to their native place and serve. The main concern behind this was the mass exodus of youth from North-east who initially leave their region to pursue higher education and later take a job and settle in other parts of the country. ❑

DESTINATION NORTH EAST – 2016

The festival "DESTINATION NORTH EAST – 2016 will be organised by the Ministry of DoNER during 12-14 February, 2016 in New Delhi. The main focus of the festival is to bring mainstream India closer to the north east and showcase its inherent economic, social and cultural strength at National Level. MDoNER is also working for promoting Public Private partnership in north east. The Ministry is also liasoning with other ministries to coordinate the development work in the north east region. The north east will be taken in the first phase of skill development programme. Sikkim is on its way to be declared the first 'Organic state' in the country. ❑

ROAD CONSTRUCTION AGENCY FOR NORTH-EAST

An exclusive road construction agency for Northeast has been introduced which would be known as "North-East Road Sector Development Scheme" (NERSDS). Its prime focus will be on inter-State roads, popularly called as "orphan" roads that connect one State with the other and are often found to be neglected. NERSDS is unique and the first of its kind introduced with the primary objective of promoting inter-State roads in the region which were earlier being maintained randomly by different agencies including the North-Eastern Council (NEC). The first meeting of the Inter-Ministerial Committee for this scheme was held recently in which five neglected inter-State roads were recommended for funding, which include Daimukh-Harmuti Road in Arunachal Pradesh and Assam, Tura-Mankachar Road in Assam, Assam portion of Sherkhan-Bagha Bazar Road, Wokha-Merapani-Golaghat Road in Nagaland and Assam and Jamai-Taning Road in Manipu. The National Highway Infrastructure Development Corporation Ltd. (NHIDCL) will be the project implementing agency for the road projects undertaken by NERSDS. ❑

Realizing the Power and Promise of Health Communication

Sanjeev Kumar

The growing burden of disease both of communicable and non communicable diseases can be reduced through prevention and behaviour change communication initiatives that are creative, compelling, based on evidence, done professionally and leverages partnership and monitored, tracked and evaluated for their attribution and contribution to the positive change in health seeking behaviours as well as adoption of desirable health practices. The power and promise of health communication need not lie just at potential and rhetorical level but actualized and realized to make a big difference to achieving 12th plan goals and SDGs

Communication for Social and Behavioral change has been accepted as one of the critical strategies for improving health status and performance of the health programmes. The power and potential of the communication has long been understood since early days by the Government of India in its plans and actions. Although, a lot has been achieved over the years in a number of health programs (e.g. polio, small pox) and interventions but even today, India faces huge challenges as far as key health status and indicators are concerned. There are several factors for the current situation which are related to "supply side" including inadequate infrastructure, gaps in human resources, challenges to funding release and utilization, quality of services, access, and managerial and operational challenges and health being a state subject. The challenges from "demand side" have also been enormous which includes a very large and diverse population, tradition and customs, myths and misconceptions, beliefs and perceptions, habits and attitudes, values and norms, and, of course, gaps in information and knowledge and awareness issues. With the new Health Policy under consideration as well with the advent of SDGs, it is useful to explore the journey of health communication efforts from awareness to behavior change and try to locate the key challenges in both supply as well as demand side and proposes a roadmap and way forward that could make a real and big difference and real fast.

For a very long time since their inception in early fifties, the health communication programs were focused on awareness, i.e. increasing knowledge, information and education without perhaps clearly and specially looking at or understanding that there are other factors sometime even much more stronger than "knowing" that prevented or restricted people from "doing" or changing behavior. This journey from "knowing" and "doing" is the crux of communication for Social and Behavior Change. Although, the statement of the health communication problem has been realized but understanding the dimensions and layers in the Indian context has not been understood properly and that misalignment has occurred because we have applied the theories of change as it is, as it came from the west or from the developed economies. The basic distinction of Individualism vs social being was not factored in the earlier models and frameworks which focused on Health education and Health promotion constructs. The supply side "knew" and the people did not, so the flow of communication was one way - from

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the system to the people. The simple belief was that people will know that it was for their own benefit and logic and rationale will make them adopt those new behaviors and practices. This is not to discredit the efforts that were done during that time. Infact, the health promotion programmes and people were very earnest and sincere and put in a lot of hardwork. The next nomenclature, Information Education and Communication (IEC) expanded a little but still remained with a large focus on information and from a supply side perspective with an assumption that people will "see" things for themselves or from the examples of other's behaviour. Following the learning of the challenges but still not being able to achieve the real breakthrough in terms of scale as well as in several critical health behaviours (like in family planning and nutrition related behaviours) the paradigm shifted to the framework of Behaviour Change Communication (BCC). Although, there were several advantages and benefits in this approach wherein a specific unit of behavior was targeted with specific change in that behavior being worked upon based on evidence and environmental perspective, this approach soon further expanded to formally incorporate the implicit "Social" part explicitly and graduate to the Social and Behaviour Change Communication (SBCC) framework. The SBCC framework does take into account the critical importance of norms and values as well as the ecological variables.

So frameworks, models, approaches, theories have changed names, shapes and contours but have we cracked the critical question yet? Have we changed in our understanding of and investment in the tools and power of communication? Have we demonstrated that it is worth investing in communication as a central critical strategy and not just as a support strategy that is good for showcasing the materials and activities and campaigns that go along with it? Have we been able to accelerate the pace and quality of change in the lives of people at scale? Has the communication design and delivery systems geared up to the new tools and techniques based on deeper and wider understanding of people, families and communities as well as the dynamics that come along with societies and systems? Have we grown over people as number to people as change makers? Have we been able to cut through the jargon and empowered our field level functionaries to engage and change the world? Apparently, there have been changes at the policy level but it has not reached the institutions and flowed down to the field levels and functionaries. The power of communication can be fully realized if it reaches the grassroots and results in an empowered, competent and compassionate functionary and an informed citizen who has embraced the self-efficacy to take up action that actually reduces demand as preventive and promotive efforts could ensure that health services are needed for critical incidences or emergency situations.

The shift to performance based allocation to communication would probably resolve two gaps-one that of accountability and second, that of quality of the communication efforts. The focus would not just be one spending the money but spending it well for clear results or impact which could be attributed to the communication efforts. There could be performance incentives to the communication department and people at all levels from policy, program to field level functionaries.

The road map for health communication needs to have a more serious and significant consideration in six clear ways in coming years in the National Health Policy.

One, there has to be a strategic shift in terms of how the budgetary provisions are made for the communication efforts at the center and states. The funding for the communication efforts is grossly inadequate. The difficulty the planners sometimes face is that the states are not even able to utilize the given budgets so what is the justification to call for provision of more funds? While that may be true to a certain extent that should actually alert the system to investigate the challenges and gaps the state or institution is facing in its ability to use the funds for health communication judiciously. There are two aspects here, one, the allocation is made on what basis, is it need based or performance based? The shift to performance based allocation to communication would probably resolve two gaps-one that of accountability and second, that of quality of the communication efforts. The focus would not just be one spending the money but spending it well for clear results or impact which could be attributed to the communication efforts. There could be performance incentives to the communication department and people at all levels from policy, program to field level functionaries.

Second, the capacity of the communication department personnel and training institutions should be thoroughly augmented. They are the drivers of change and if they are not empowered with new, innovative tools and techniques and constantly sharpened and chiseled to deliver faster and better, they will not be able to do so. This is a massive but urgent task that would require communication specialists and communication curriculum designed in the raining institutions such as NIHFW, SIHFW, ANTCs and AWTCs. There is an urgent need to infuse new energy and vibrancy in the training institutions with a focus on communication competencies. These training could also be based on performance enhancers linked to results. There is a need to go beyond simple Inter Personal Communication (IPC) which needs to include specific competencies in persuasion, negotiation and influence strategies and not just counseling and motivation. Partner units from Ministry of Information

and Broadcasting such as DFP, Song and Drama Division, DD, AIR, DAVP could be more actively partnered with.

Third, improved monitoring, tracking, assessment, evaluation and research efforts for health communication need to be well in place for better outcomes and accountability. This aspect is not so seriously taken and only Ultilisation Certificates (UCs) and some documentation in terms of photographs and press reports are done as evidence. The formative and summative researches are few and far between. The program managers and officers should be empowered and capacitated with these skills and also for engaging partners and agencies to conduct these research and assessments quickly and qualitatively. The other aspect is of monitoring indicators for health communication activities. As of now, most of these are input or process or output indicators that need to change to capture the "change" continuum. The feedback loop and follow up mechanism for health communication activities also needs to be strengthened.

Fourth, the creative conceptualization and rendition of health communication materials and activities need to drastically change. There are limited capacities individually as well as institutionally for inhouse design of communication products. The quality of messaging, designing, layout as well branding has been a challenge in this area. There are two ways the communication products are designed and delivered, one, inhouse and two, outsourced. Outsourcing has its own issues and challenges in terms of procurement and management as well as costs. The important consideration of the matter has to be whether they connect with the audience and in tune with their aspiration and needs. The additional challenge sometimes that these are used as publicity and propaganda for the state and critical space gets taken up compulsorily by those elements. Unless that endorsement and authoritative voice and presence is required, they should be avoided. Compared to commercial communication, the social communication (read government communication) is many a times seen as routine or boring. This needs to change and that would make a big difference to not only the communication, but also to the "image" of government services and personnel. New framing and positioning of messages is required to catch the attention and get people interested and engaged for the initiation into the change process.

Fifth, the health communication set up at the center and states needs to change. The so called IEC division (or unit) at the center or IEC bureaus inter states or BCC cells in some districts are small sets ups sometimes made up of a few officers and other resources. These units are largely seen as IEC material production and distribution units instead. The Communication division has not changed its structure and function ever since it got installed so many decades ago. So the people, the terms of reference and scope of work of the unit has remained in either producing, or procuring and distributing materials. They are also seen as event and press managers reports or write press releases for the officials and the departments. The hard core and professional business of strategic communication for social and behavior change is sometimes on the back burner and the administrative, logistical and operational aspects take over. Adequate resources communication units with specializations and equipment to carry out their critical deliverables with accountability is called for which will also take care of the previous four desirable elements.

Sixth, the health communication efforts need to forge and harness partnerships at all levels. These partnerships could be NGOs and CBOs as they are closer to the community and have trust and access which could be a great plus point for their engagement. The partnership with media need to be cultivated and nurtured for positive stories and proper coverage. The media can be a great advocacy partner as well information disseminator which could maximize the reach and effect to larger populations. The partnership could also be with private sector and corporates who could provide their expertise in management, operations, technical expertise as well as CSR funds which could support the communication campaigns. The partnership also need to be forged with faith based organization, opinion leaders, academic and research organizations, international bodies, UN and Multilateral organizations,, foundations and charities who could partner to facilitate dialogue and influence for behavior change.

Attention to the demand side must also not lead to the neglect of supply side failure or dysfunctionalities. Raising expectations on the demand side that cannot be met is a recipe for further cynicism and despair among both providers and users. It is simplistic, for instance, to see demand side instruments as an alternative to health system reforms rather than as an approach that entails significant supply side interventions. There are real resource and institutional constraints on the supply side that must continue to be addressed.

In conclusion, strategic Health communication efforts in India need to be strengthened in order to significantly accelerate the results and impact of the health mission actions. The growing burden of disease both of communicable and non communicable diseases can be reduced through prevention and behaviour change communication initiatives that are creative, compelling, based on evidence, done professionally and leverages partnership and monitored, tracked and evaluated for their attribution and contribution to the positive change in health seeking behaviours as well as adoption of desirable health practices. The power and promise of health communication need not lie just at potential and rhetorical level, but actualized and realized to make a big difference to achieving 12th plan goals and SDGs. ❑

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Universal Health Coverage and Sustainable Development Goals

Chandrakant Lahariya

India has been at the forefront of policy discourse and has done some background work and seems to be ready to take a giant leap towards UHC and contribute to achieve SDG3 and other SDGs, both at national and global level

Universal Health Coverage (UHC) aims that 'all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services'. UHC received global attention as an idea and aspiration with the World Health Assembly 2005 resolution urging member states to develop their health financing systems for transitioning to UHC. Subsequently, 2008 World Health Report titled 'Primary Health Care: More Than Ever', and then 2010 World Health Report on 'Health Systems Financing: The Path to Universal Coverage' further delved into the UHC and sustained the focus. During this period, a number of countries (i.e. Brazil, Mexico, Kyrgyzstan, Thailand and China) made progress towards providing access to health services to additional populations, alongside health financing reforms.

UHC continued to receive attention at global fora and was well supplemented by additional resolution on UHC by WHA in 2011 and then United Nations General Assembly discussed about UHC and passed a resolution on UHC on 12 December, 2012. The UNGA resolution was a landmark step as it broadened the scope of UHC agenda from the ambit of health ministers to the heads of state and ministers of foreign affairs. To commemorate UNGA resolution on UHC, since 2014, 12 Dec. is used as a day to organize commemorative events on UHC and 12 Dec, 2014 was the first ever Universal Health Coverage Day or UHC Day. The advocacy and momentum on UHC in the last 10 years has been sustained, supported by advocacy, discourses and resolutions at various fora (WHA, UNGA, regional and country levels), which possibly reflects an emerging consensus regarding the need and importance of UHC. The World Health Organization Director General Dr Margaret Chan has said that "Universal Health Coverage is the single most powerful concept that public health has to offer."

UHC has three dimensions – population coverage, health services coverage and financial protection coverage– and is often represented by a cube, referred as 'UHC Cube' or 'UHC coverage box' (Figure-1). The 'inside cube' reflects the existing status in the countries, where only a proportion of the population has access to health services, only a few

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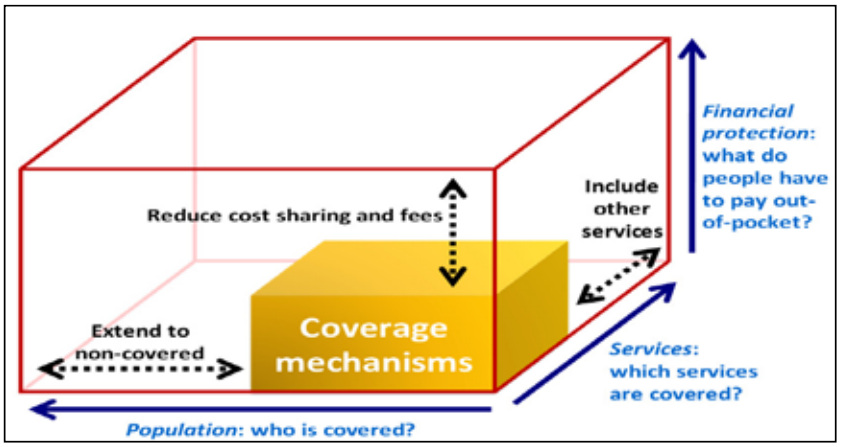
services are available and not all who receive services can afford the cost. The 'outer cube' is the aspirational goal for the countries, as defined by UHC, and proposes that all countries should strive to fill the box by extending coverage of quality services with affordable cost. Interestingly, as the services provided leads to improved health outcomes, which in turn leads to a change in disease pattern in the countries, and availability of newer technologies would affect service need and utilization. Thus, there would always be a need for addressing the changing epidemiological realities and there would always be some gap in inner and outer boxes. These are some of the reasons that UHC is considered a 'journey' rather than a 'destination'. UHC is a dynamic process and the idea is to make an attempt to fill the 'UHC coverage box' as much as possible. Experience from the countries has shown that it takes 10-15 years to make reasonable progress in this direction and UHC is not possible in a year or two. While UHC is the aim, the health system reforms and strengthening are foundation and tools, on which progress in the direction of UHC could be made.

Figure 1: Universal Health Coverage (UHC) Coverage Box



UHC and India

India was part of the resolution on UHC at the 2005 World Health Assembly as a member state. Though, the UHC was not being discussed in the country at that time, India had launched the National Rural Health Mission (NRHM) in April 2005, to improve health systems in India and improve health status of the people. *Rashtriya Swasthya Bima Yojana* (RSBY), which intends to provide financial coverage to below poverty line population for the cost of secondary level hospitalization and a few other financial protection schemes were launched by Indian states starting 2007-08. Soon after the launch of the World Health Report of 2010, the erstwhile Planning Commission of India constituted the High Level Expert Group (HLEG) on Universal Health Coverage in India. The HLEG submitted its detailed recommendations and report in October 2011, which was used for drafting of 12th Five Year Plan(2012-17) of India. The 12th Five Year Plan had proposed UHC pilots in 2 districts of each state of India and work had also started for launch of these proposed pilots to derive learning from full scale UHC in the country. In May 2013, to provide health services in urban areas, the National Urban Health Mission (NUHM) was launched and two sub-missions (NRHM and NHM) were merged as the National Health Mission (NHM). The NHM vision of "Attainment of universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinant of health" is very much in alignment with the concept of UHC. Starting mid-2014, there has been a lot of ground work on providing universal health assurance (UHA, in short) with components and intentions matching to UHC. A blueprint was reportedly prepared to implement UHA through the launch of National Health Assurance Mission (NHAM) in India. The RSBY scheme has been shifted from the Ministry of Labour and Employment to the Ministry of Health and Family Welfare in April 2015; a new (draft) National Health Policy is at the last stage of finalization and has all key aspects of UHC captured in the policy document. Broadly speaking, the initial ground work for advancing UHC in India has been done; however, it awaits approval and accelerated implementation.

Sustainable Development Goals (SDGs) and UHC

The Sustainable Development Goals (SDGs) were endorsed on 25 September, 2015 at the UN Sustainable Development Summit, attended by the heads of state and governments, to carry the work done under Millennium Development Goals (MDGs) forward and to guide global development over the next 15 years. The UNGA formally adopted the universal, integrated and transformative 2030 Agenda for Sustainable Development, along with a set of 17 Sustainable Development Goals and 169 associated targets. The 17 SDGs focuses upon poverty, hunger, health education, gender equality, water and sanitation, energy, work and economic growth, industry and infrastructure, inequalities, cities, responsible consumption, climate, life below water, life on land, peace and strong institutions, and the partnership.

The final text of the 2030 agenda for sustainable development in its preamble states: "To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health

coverage and access to quality health care. No one must be left behind" and that signifies the relevance of health in overall development agenda. One of the goals in SDGs, the goal 3 (or SDG-3) addresses health challenges and aims to"ensure healthy lives and promote well-being for all in all ages". The target 3.8 is to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicine and vaccines for all". UHC is at the core of health related SDG3 and three of the 13 targets under SDG3 (Target 3.8, 3.b and 3.c) are very specifically related to advancement of UHC.

In the global discourse, the target 3.8 on UHC is being considered

Table 1: Universal Health Coverage as Core of Health Related Targets in Sustainable Development Goals

Sustainable Development Goal 3 (SDG3) and its targets	**SDG 3: Ensure healthy lives and promote well-being for all at all ages**	
Target 3.8: ACHIEVE UNIVERSAL HEALTH COVERAGE Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all		
MDG unfinished and expanded agenda	**New SDG 3 Targets**	**SDG 3 Means of implementation targets**
3.1: Reduce maternal mortality: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	**3.4: Reduce mortality from NCDs and promote mental Health:** By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.	**3.a: Strengthen implementation FCTC:** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
3.2: End preventable newborn and child deaths: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.	**3.5: Strengthen prevention and treatment of substance abuse:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	**3.b: Provide access to medicines and vaccines for all, support R&D:** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
3.3: End epidemics of HIV, TB, Malaria and others: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	**3.6: Halve deaths and injuries due to Road traffic accidents:** By 2020, halve the number of global deaths and injuries from road traffic accidents.	**3.c: Increase health financing and health workforce in developing countries:** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.
3.7: Ensure universal access to sexual and reproductive healthcare services: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	**3.9: Reduce deaths and illnesses from hazardous chemicals, pollution and contamination:** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.	**3.d: Strengthen capacity for early warning, risk reduction and management of health risks:** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Interactions with economic, other social and environmental SDGs and SDG 17 means of implementation	
	Goal 1: End poverty Target 1.3: Implement social protection systems for all
	Goal 2: End hunger, achieve food security and improved nutrition Target 2.2: end malnutrition, achieve targets for reductions child stunting and wasting
	Goal 4: Ensure inclusive and equitable education Target 4.2: ensure access to early childhood development, care and pre-primary education
	Goal 5: Achieve gender equality and empower all women and girls Target 5.2: end all forms of violence against all women and girls
	Goal 6: Ensure availability and sustainable management of water and sanitation for all Target 6.1: achieve universal and equitable access to safe and affordable drinking water
	Goal 7: Affordable and clean energy Ensure access to affordable, reliable, sustainable and modern energy for all
	Goal 8: Decent work and economic growth Labour markets in health (and other social sectors) can stimulate economic growth, productive employment, youth employment and decent work
	Goal 10: Reduced inequities
	Goal 11:Sustainable cities and communities
	Gola 13: Climate actions
	Goal 16: Promote peaceful and inclusive societies for sustainable development, Target 16.1: Reduce all forms of violence and related death rates everywhere
	Goal 17: Partnership Use of institutional partnership for capacity building and link with the means of implementations

overarching and as a tool to achieve health goals in SDGs. The targets in SDG3 are being looked as three broad groups of: MDGs unfinished and expanded agenda; New SDG 3 targets, and SDG 3 means of implementation targets. The achievement of health goal and targets is also dependent upon (and would contribute to) the actions taken under other 16 goals and related targets (Table 1).

Conclusions

Health is at the center of development discourse and looked at as a cornerstone for economic growth of any nation. It can contribute to alleviate poverty and lead a nation to a more productive and financially secure status and SDGs and UHC well interwoven in the fabrics of social and economic development. UHC is a new unifying force for health sector, with linkage to overall development agenda. UHC builds upon learnings of the past and carries the healthcare agenda forward including concepts of primary healthcare and initiatives during MDG period. As the global leaders and agencies should build upon the momentum for achieving SDGs, the national governments need to take concrete policy measures to address inequities in health sector by ensuring that more people have access to quality health services without financial hardship. There is a global discourse on this area and nearly 100 countries are taking a few or more steps to advance towards UHC. India has been at the forefront of policy discourse and has done some background work and seems to be ready to take a giant leap towards UHC and contribute to achieve SDG3 and other SDGs, both at national and global level.

The SDGs and UHC together provide, another and perhaps bigger than ever, opportunity to bring public discourse on health to a level of critical threshold to accelerated health system reforms and strengthening. It is possible that UHC becomes a shining star in SDG period when global leaders reconvene to take stock of SDGs achievements in 2030.

Readings

United Nations. Open Working groups Proposal on Sustainable Development Goals. Accessed at https://sustainabledevelopment.un.org/content/documents/1579SDGs per cent20Proposal.pdf

World Health Organization. World Health Report 2010: Universal Coverage: health Financing. WHO, Geneva, 2010.

World health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010

World health report 2008. Primary health care: now more than ever. Geneva: WorldHealth Organization; 2008

United Nations. Transforming our world: the 2030 agenda for sustainable development. New York (NY): United Nations; 2015 (https://sustainabledevelopment.un.org/post2015/transformingourworld ❑

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Reducing Malnutrition: Women's Health Holds The Key

Meera Mishra

Improving maternal nutrition offers important opportunities to improve both the health and well-being of the mother herself, as well as of her children and in turn benefits the country. India's cohort of 26 million babies each year deserves better life conditions that those that await them at present

Disease and malnutrition have close links; in many ways, malnutrition is the largest single contributor to disease in the world, according to the UN's Standing Committee on Nutrition (UNSCN). In some instances, ill health or disease could be a direct consequence of malnutrition, while in others, a key contributor.

Impact of Malnutrition

Malnutrition at an early age leads to reduced physical and mental development during childhood. Stunting, for example, affects more than 147 million pre-schoolers in developing countries (UNSCN 5). Worldwide, under-nutrition is responsible for 45 per cent of child deaths, directly or through diseases made more severe because of it. Even mildly under-weight children face twice the risk of death as compared to well nourished children. Among micronutrients, Vitamin A deficiency compromises the immune system and leads to the death of approx. 1 million children each year. Globally, severe iron deficiency is the cause of more than 60,000 deaths per year of women during pregnancy. Similarly, maternal folate deficiency leads to 250,000 severe birth defects and iodine deficiency in pregnancy causes mental impairment of almost 18 million infants per year and a lowering of `0-15 IQ points in school children. (India Health Report: Nutrition, 2015).

Iron deficiency weakens the maternal body, impairs intrauterine growth and increases the risk of both maternal and foetal morbidity and mortality (World Health Organization 2000a).Malnutrition also has widespread economic ramifications. Problems related to anaemia, for example, including cognitive impairment in children and low productivity in adults, cost US$5 billion a year in South Asia alone. (Ross & Horton, 1998)

> "Women's deprivation in terms of nutrition and health care rebounds on society in the form of ill-health of their offspring — males and females alike."9
>
> —Siddiq Osmani and Amartya Sen

Links between Health and Nutrition

The intergenerational cycle of growth failure, first described in 1992 explains how growth failure is transmitted across generations through the mother, thereby highlighting the importance of addressing women's health and well being to bring about a significant change in the situation of malnutrition. Undernourished girls

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are likely to reach adolescence in disadvantaged physical conditions, and this may in turn, have severe implications for their overall health, in particular when they experience early pregnancies. Stunted and/or anaemic adolescent mothers are more likely to have complications during childbirth and the postpartum period, as well as to give birth to premature and low-weight babies. Closely-spaced pregnancies and repeated childbearing, along with heavy physical work, poor diets, discrimination and inadequate health care, may severely undermine the nutritional status of many women, with consequences for both them and for the health and nutrition of the next generation (World Health Organization 1997, 2000a; United Nations Population Fund 1997, 2000).

Criticality: The First 1000 Days

Child nutrition in the 1000 days between a woman's pregnancy and her child's second birthday sets the foundation for all the days that follow. Right nutrition during this window has a profound and lasting impact on the child's ability to grow, learn and thrive, thereby contributing immensely to the country's health and well being too. Nutrition during pregnancy and in the first years of a child's life provides the essential building blocks for brain development, healthy growth and a strong immune system. In fact, a growing body of scientific evidence shows that the foundations of a person's lifelong health, including their predisposition to obesity and certain chronic diseases, are largely set during this 1,000 day window.

Right Nutrition in the 1,000 day window helps:

- Build a child's brain and fuel their growth.
- Improve a child's school-readiness and educational achievement.
- Reduce disparities in health, education, and earning potential.
- Reduce a person's risk of developing chronic diseases such as diabetes and heart disease later in life.
- Save more than one million lives each year.
- Boost a country's GDP by as much as 12 per cent.
- Break the intergenerational cycle of poverty.

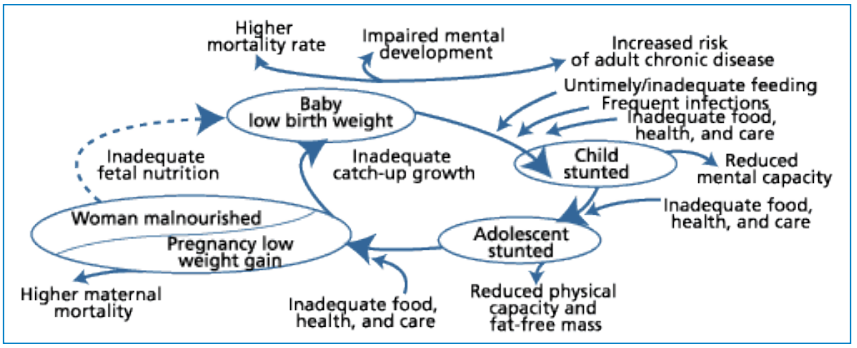
Source:http://thousanddays.org/the-issue/why-1000-days/

India: Situation and Response

Despite its commitment to reduce malnutrition levels and its sustained economic growth, India lags behind on all key nutrition indicators. The Rapid Survey in Children shows that 38.7 per cent children under the age of 5 are stunted, 19.8 per cent are wasted and 42.5 per cent are under weight. Stunting is a measure of chronic under nutrition, wasting indicates acute under-nutrition and under-weight is a composite of these two conditions. Until 2006, the rate of decline in these figures was rather slow. However, progress accelerated since NFHS-3, with the average annual rate of stunting declining by 2.3 per cent per year from 2006-14 compared with 1.2 per cent per year between 1992-2006. (RSoC, 2014)

Many efforts are underway to address malnutrition in the country. The Government has been at the fore front with a number of Departments/ Ministries implementing a range of schemes and programmes that have direct and indirect bearing on nutrition. Notably, the ICDS, a flagship programme of the Ministry of Women and Child Development, works towards improving the nutrition and health status of children and expectant mothers through a package of services- supplementary nutrition, immunization, health check ups, referral services etc. through a cadre of frontline workers at the Anganwadi Centres. Ministry of Food &Civil Supplies manages the mega Public Distribution System (PDS) providing affordable food to households while the Ministry of Rural Development implements the MGNREGS with the aim to enhance household level incomes and thereby enable better access to food. The Mid-day Meal Scheme being implemented under the Ministry of Human Resource Development is the world's largest school feeding programme. Ministry of Tribal Affairs manages a range of initiatives for addressing multiple needs of tribal populations including hunger and nutrition. A large number of initiatives are also being undertaken by the private sector, civil society organisations and other development partners including the UN agencies.

Nutrition deficiencies throughout the Life Cycle



Adapted from the ACC/SCN-appointed Commission on the Nutrition Challenges of the 21st Century.

State Level Innovation: A Case Study from Uttarakhand

In three districts of Uttarakhand, women's federations are supplying *Mandua* (Finger Millet), and other traditional cereals and pulses in

the form of Take Home Rations for ICDS. They do grading, sorting and packaging for which federation pays them Rs.1 per packet. One member packs about 150 – 200 packets in 4-5 hours everyday. With a profit margin of over 10 per cent, ICDS rations are making an important contribution in improving the viability and sustainability of federations while at the same time, ensuring clean and nutritious supply to ICDS. Federations are paying farmers Rs.10 to Rs. 15 per kg for Mandua, against Rs.5 to Rs.8 per kg earlier. With this opportunity, farmers are now much more interested in growing traditional crops, and there has been a big increase in demand for millet seeds. Finally, the work of processing and packaging creates paid employment for federation members. In 2014-15, a formal MoU was signed between ICDS and the women's federations and a business of INR 25.30 million was done with the profit of INR 2.3 million. From April 2014 to December 2014, federations directly benefitted nearly 7,500 pregnant/ lactating women and 22,430 children. This initiative is being implemented under the Integrated Livelihood Support Programme of the Government of Uttarakhand.[1]

Conclusion

This recently released India Health Report on Nutrition communicates 6 critical messages:

- Stunting, wasting and under-weight rates of India's children has declined, especially during the last decade, but still exceed levels observed in countries at similar income levels.
- The rate of improvement in nutritional status has not kept pace with India's significant gains in economic prosperity and agricultural productivity during recent decades. Stunting rates may decline with economic progress but economic growth cannot, by itself, reduce under nutrition and may contribute to over-weight and obesity.
- Nutritional status and progress on reducing stunting vary markedly across India's states indicating that state specific approaches are necessary to achieve further gains in reducing stunting.
- The underlying reasons for India's high rates of stunting and variability in progress are complex and inter-twined. Some of the drivers such as complementary feeding, women's status and health, sanitation and social/ caste inequality are the major challenges.
- India will ignore the problem of under nutrition and its impact on child development at its peril and risk large economic, health and social consequences for future generations.
- India's under-nutrition problem is a serious threat to child development. Accelerating action at the state level is essential to change the course of the future for India's children.

With high prevalence of low maternal height, low body mass index and anaemia, India's women are at great peril of having small babies and remaining mal-nourished themselves. For the past decade or more, health service delivery has concentrated on improving maternal and child survival. Where this has been successful, there is an urgent need to revisit the neglected area of maternal nutrition, especially for improving weight gain prior to and during pregnancy as a way of improving birth weight (RWNS 6). A lifecycle approach which focuses on improving nutrition throughout women's lives is needed. Data on women's nutritional status can be a powerful tool for informing communities and governments about the nature, extent, and consequences of female malnutrition, but data needs to be collected regularly, analyzed, and disseminated. Improving maternal nutrition offers important opportunities to improve both the health and well-being of the mother herself, as well as of her children and in turn benefits the country. India's cohort of 26 million babies each year deserves better life conditions that those that await them at present.

Readings

UNSCN's World Nutrition Situation 5th and 6threports.

India Health Report: Nutrition, 2015. http://www.transformnutrition.org/wp-content/uploads/sites/3/2015/12/INDIA-HEALTH-REPORT-NUTRITION_2015_for-Web.pdf

Rapid Survey in Children (RSoC, 2014)

Women and Health Learning Package: Nutrition and Women's Health www.the-network.tufh.org

Nutrition of Women and Adolescent Girls: Why It Matters.Elizabeth I. Ransom and Leslie K. Elder

http://www.prb.org/Publications/Articles/2003NutritionofWomenandAdolescentGirlsWhyItMatters.aspx

Jay Ross and Sue Horton, "Economic Consequences of Iron Deficiency" (1998)

References

1 The project is financed by a loan from the International Fund for Agricultural Development. ❑

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Mission Indradhanush: Ray of Hope for Child Immunization in India

Rakesh Kumar

In India, the insights and inputs of Mission Indradhanush can be the guiding points in designing innovations and drafting best practices, as they are the best repositories of experience and knowledge at the cutting edge of implementation of any program. Moreover, the full immunization against vaccine preventable diseases is an imperative step towards ensuring healthy lives for the children

Finding evidence of water on Mars is a significant scientific progress, and being able to travel by a train at speed exceeding 400 kmph is a noteworthy technological advancement. However, a truly global progress would be achieved when children of our society are ensured of basic rights like living healthy lives. For any nation, children are their most important asset and their development is as important as the development of other national resources.

Globally, more than 70 per cent of almost 1.1 crore children die every year due to diarrhoea, malaria, neonatal infection, pneumonia, preterm delivery or lack of oxygen at birth. A more notable fact is that these deaths occur mainly in developing countries. As per the latest statistics, India contributes to about 21 per cent of the global burden of child deaths (Source: Progress for Children report, UNICEF).

While India has made laudable improvement in Infant Mortality Rate, even today, over 7,60,000 children die every year and many of these deaths occur due to preventable diseases. According to the Rapid Survey of Children (RSOC 2013) data, India had 89 lakh spartially or unvaccinated children.

The Government of India recognizes immunization as a crucial aspect in the country's child survival strategy and has been working to strengthen its routine immunization program. The Government is trying to make sure that vaccines under Universal Immunization Programme (UIP) are available to each and every child.

In December 2014, the Ministry of Health & Family Welfare (MoHFW) launched Mission Indradhanush (MI) as a special nationwide initiative to cover all unimmunized and partially immunized children that are left out during the routine immunization program. What makes the Mission particularly unique is that it is a focused and systematic immunization drive. It is conducted under a mission mode as a catch-up campaign, with the goal of covering all children who have been left or missed out for immunization.

Illustrating the seven colours of rainbow, Mission Indradhanush covers seven diseases including diphtheria, pertussis, tetanus, polio, tuberculosis, measles and hepatitis-B. Vaccination against tetanus is being provided to pregnant women. In addition, vaccination against haemophilusinfluenzae type B (HiB) is being given in the states and UTs as per the program. Besides, vaccination against Japanese Encephalitis is being provided in the selected endemic districts of the country.

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Mission Indradhanush targets all children below the age of two years and pregnant women with all available vaccines. Under Mission Indradhanush Phase I, the Government identified 201 high focus districts across the country that have the highest number of partially vaccinated and unvaccinated children. To achieve full immunization coverage, the first phase of Mission Indradhanush was initiated on 7th April, 2015 on World Health Day and intensified immunization drive was conducted for seven days every month from April - July 2015.

The Government undertook meticulous planning of sessions at all levels and enabled effective communication and social mobilization efforts. Also, intensive training of the health officials and frontline workers was conducted, along with establishing accountability framework through task forces. At the end of the four rounds, about 20 lakh children were fully immunized and over 190 lakh antigens were administered to more than 96 lakh beneficiaries comprising of over 75 lakh children and about 21 lakh pregnant women. In addition, 20.2 lakh doses of Vitamin A were administered, 57 lakh Zinc tablets and 17 lakh packets of ORS were also distributed. In addition to sturdy framework of planning and monitoring, Mission Indradhanush has also resulted in expanding the basket of services. A noteworthy component of MI was the strong countrywide IEC campaign launched to create awareness about full immunization.

Seeing the success of Mission Indradhanush, states such as Haryana, Rajasthan, Delhi, Bihar and Punjab extended Mission Indradhanush drive to all districts of the states. India is a country with wide geographical terrains; heavy rains and floods in states like Jammu and Kashmir and North-Eastern states affected the immunization activity during Mission Indradhanush but states continued their best efforts in all four rounds which is highly commendable. To further improve the full immunization coverage, states like Madhya Pradesh undertook innovative measures to ensure and encourage parents to get their children vaccinated. In fact, the IEC activities of Shahdol in Madhya Pradesh have been showcased at international forums also.

During Mission Indradhanush, the central and state Governments, development partners worked together and helped in identification and leveling of the gaps in existing routine immunization program, development of human resource and a sustainable effort in expansion of micro-plans for routine immunization. The programme was monitored very vigorously by the Ministry of Health and Family Welfare. The national level monitors were deployed to all focused districts and WHO-NPSP did monitoring of program operations and implementations through its network of Surveillance Medical Officers (SMOs), field volunteers and monitors. In addition, UNICEF and other Reproductive, Maternal, Child and Adolescent Health (RMNCHA+) partner organizations focused on monitoring of communication and IEC activities. Mission Indradhanush has witnessed an unparalleled participation of people as health workers, agencies and organizations.

The preparation and learning during the implementation of the first phase led to health systems strengthening in terms of drawing up detailed micro plans; designing sturdy framework for stringent monitoring and evaluation of the immunization rounds in the states (more than 3600 state and central level monitors were deputed); training of frontline workers; identification and analysis of limiting factors in different states leading to creating effective structures to mitigate them.

While the outcomes and gains have been significant during the first phase of Mission Indradhanush the Government of India launched phase II of Mission Indradhanush in selected 352 districts, of which 73 districts are from Phase I districts, where large number of missed out children were detected during monitoring of phase I of Mission Indradhanush. The second phase commenced from 7th October, 2015 and was subsequently repeated on 7th of each month till January 2016. The data collected from all the four rounds of Phase II of MI indicate that a total of 8.1 lakh sessions were held in which 13.1 lakh children have been fully immunized and 6.1 lakh pregnant women have received vaccination.

With Mission Indradhanush, the MoHFW, Govt. of India took an innovative approach and it was the first time that an immunization drive was focused on the social media, apart from the conventional ways of reaching the community. A special series to thank health workers called, 'Thank you ASHA' around Mission Indradhanush was conducted on social media. Real time conversations with journalists, bloggers and key influencers were initiated on social media platforms to highlight the importance of full immunization. This led to considerable change in the perception towards full Immunization, especially on social media. Today, we have medical practitioners and health workers who share updates on immunization with us. We are also being recognized in global immunization conversations, especially on Twitter.

The scale and breadth of this initiative is unmatchable, and the lessons from the success of this initiative can be leveraged in other Asian and African nations with low immunization coverage to benefit their immunization program and thus, end child deaths from preventable diseases.

In India, the insights and inputs of Mission Indradhanush can be the guiding points in designing innovations and drafting best practices, as they are the best repositories of experience and knowledge at the cutting edge of implementation of any program. Moreover, the full immunization against vaccine preventable diseases is an imperative step towards ensuring healthy lives for the children.

As we re-commit to the global agenda with the new set of sustainable development goals, let India be a shining example in bringing alive these commitments towards a healthier and more secure future for our children. ❑

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Lessons from HIV Programme

Alka Narang

AIDS is an extraordinary epidemic and requires an extraordinary response. The lessons from the HIV are relevant for many development sectors. As much as there have been successes, still many areas where work needs to be done, especially in the field of legal forms and many a gap needs to be filled. India must continue to innovate and explore if it has to meet the target of 90-90-90 by the end of 2020

Here are about 21.17 lakh Indians living with HIV, according to the 2015 National HIV estimates. This makes it the nation with the third largest population of people living with HIV. Ever since the detection of the first case of HIV in 1987 in Chennai, India has exhibited extraordinary political will and urgency in responding to the emerging crisis. This single minded focus and dedication has made India's AIDS response one of the most comprehensive responses world-wide. The HIV epidemic, though relatively small in terms of burden compared to other diseases like tuberculosis, malaria and leprosy, has benefitted from sustained priority and political will, despite changing leadership.

This has resulted in consistently declining rates of transmission and infection-from 0.41 per cent in the last decade to 0.26 per cent in 2015.

India has so far completed three five-year phases of the National AIDS Control Programme. The fourth phase is being implemented. With each successive phase of the national program, the response has modified itself to address the prevailing context.

There are several lessons that can be learnt from the HIV response in India, especially from the success of the National AIDS Control Programme in being able to contain the progression of the epidemic despite the astounding diversity and adversities. Several elements are behind the success of the HIV Response.

India's National AIDS Control Programme (NACP) laid the foundation of its response early by clearly articulating its guiding principles. These principles have guided the national response over the years thus institutionalising fundamental values for engagement. These principles were based on rights, equity, inclusion, multi-sectoral response as well as assuring dignity and respect to the most marginalised and disenfranchised making it a model worth emulating.

The kind of issues HIV brought up required a decentralized approach. State AIDS Control Societies (SACS) were established earlier on in the response. As the HIV infection moved from urban to rural areas, further decentralisation was done through the formation of District AIDS Prevention and Control Units North East Regional Office (NERO) was established to address the region specific issues in the North East including exceptional infrastructure and resource challenges.

One of the salient points of HIV is that in India, it was concentrated among certain kinds of populations namely

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female sex workers, male sex workers, transgenders and people who inject drugs who are technically referred to as key population. The country took a significant departure from treating the key populations as passive recipients of benefits and instead as community members with equal rights, despite the prevailing national legal framework. The community was regarded as owners of their destiny and had an important role to play in the program including sharing it. Engagement of the affected communities ensured that services and interventions reach out to the ones who most need it. "Nothing for us, without us" became the mantra of community involvement. Focused efforts were made to build capacities of the communities and empower them and make them an integral part of the decision making processes. The government's strategic approach of strengthening community systems is one of the key factors that led to the rapid uptake and scale up of a complex and multi-sectoral program like HIV.

Multi-sectoral approach is the key to addressing the most complex development challenges. This was understood fairly early on, by the National AIDS program and the highest levels of the government. This was not just articulated in the National AIDS Prevention and Control Policy but implemented through careful engagement of nearly twenty two ministries including ministries of rural development, labour and employment, women and child development, human resources development, social justice and empowerment among others. A National Council on AIDS was set up in 2005 with representation from several ministries, to ensure a multi-sectoral response to the epidemic. The fourth phase of the AIDS program also included mainstreaming and partnerships as a strategy to further augment the response. This strategy has helped mainstream HIV within the programs of other sectors, like private sector and other government departments. One example is by leveraging social security schemes provided through various ministries to people who live with HIV. The Ministry of Health has also signed partnership agreements in the form of Memorandums of Understanding with fourteen non- health ministries towards mainstreaming the HIV response.

Sustained political advocacy becomes essential to generate political support and interest in developmental issues. There has been comprehensive and concerted support from political leaders and policy makers at all levels in India for combating HIV. The NACP has seen unprecedented political support cutting across all party lines. Establishment of structures like National Council on AIDS, a Parliamentary Forum to sensitize policy makers on HIV, inclusion in the Five Year Plans unambiguously speaks of the intent of the Government to address HIV/AIDS on priority. Its participation in and endorsement of these calls for action have, in many ways, provided clear directions for an effective response.

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Strategic Information that includes monitoring, evaluations, surveillance and research has always been a priority for the national program as evidence based programming is key. The NACP is known for its HIV Sentinel Surveillance (HSS) system, which is the largest HIV surveillance system in the world. HSS helps the national programme to track the levels and trends of the HIV epidemic in different geographical regions and population groups. Behaviour Sentinel Surveillance (BSS) and Integrated Biological and Behavioural Surveillance are other attempts towards strengthening evidence based programming.

National AIDS Control Organisation strongly believes in developing pilot models and learning from the success and failures. Towards this end, their focus on knowledge management and learning has paid dividends in important program and policy design. The organisation set up learning sites and good practice centres across the country and along with platforms like conferences, workshops, e-forums, seminars etc knowledge was regularly shared and acknowledged. Hence, systematic efforts at bringing together learnings from the ground have well contributed towards improving the design and quality of the interventions.

The HIV response has gone through extraordinary measures of maintaining transparency and accountability including joint reviews with technical partners and donors, national coordinating mechanisms and technical working group which are multi-sectoral in nature and consisted of different constituencies like technical experts, research and academic institutes, civil society including faith based groups. This has propelled the programme towards better performance. The international interest in India's response to HIV can be seen by the diversity of the funding source.

The response has witnessed tremendous contribution from major donors from Global Fund, Gates Foundation, World Bank, UN,DFiD and USAID to name a few.

AIDS is an extraordinary epidemic and requires an extraordinary response. The lessons from the HIV are relevant for many development sectors. As much as there have been successes, still many areas where work needs to be done, especially in the field of legal forms and many a gap needs to be filled. India must continue to innovate and explore if it has to meet the target of 90-90-90 by the end of 2020. ❑

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Adolescent Health: Challenges of a Transitional Stage

Sushma Dureja

The health situation of this age group is a key determinant of India's overall health, mortality, morbidity and population growth scenario. Therefore, investments in adolescent reproductive and sexual health will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, meeting unmet contraception need, reducing the maternal mortality, reducing STI incidence and reducing HIV prevalence .It will also help India realize its demographic dividends, as healthy adolescents are an important resource for the economy

According to 2011 Census data, there are 253 million adolescents in the age group 10-19 years, which comprise little more than one-fifth of India's total population. This age group comprises of individuals in a transient phase of life requiring nutrition, education, counselling and guidance to ensure their development into healthy adults. Considering demographic potential of this group for high economic growth, it's critical to invest in their education, health, and development.

Government of India has recognized the importance of influencing health-seeking behaviour of adolescents. The health situation of this age group is a key determinant of India's overall health, mortality, morbidity and population growth scenario. Therefore, investments in adolescent reproductive and sexual health will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, meeting unmet contraception need, reducing the maternal mortality, reducing STI incidence and reducing HIV prevalence .It will also help India realize its demographic dividends, as healthy adolescents are an important resource for the economy.

Rashtriya Kishor Swasthya Karyakram (RKSK)

In order to ensure holistic development of adolescent population, the Ministry of Health and Family Welfare launched Rashtriya Kishor Swasthya Karyakram (RKSK) on 7th January 2014 to reach out to 253 million adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and underserved groups . The programme expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. The strength of the program is its health promotion approach. It is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities. Key drivers of the program are community based interventions like, outreach by counsellors; facility based counselling; Social and Behavior Change Communication; and strengthening of Adolescent Friendly Health Clinics across levels of care.

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Adolescents often do not have the autonomy or the agency to make their own decisions. RKSK takes cognizance of this and involves parents and community.

Focus is on reorganizing the existing public health system in order to meet the service needs of adolescents. Under this, a core package of services includes preventive, promotive, curative and counselling services, routine check-ups at primary, secondary and tertiary levels of care is provided regularly to adolescents, married and unmarried, girls and boys during the clinic sessions.

The interventions undertaken in this programme, RKSK are as follows

Community-based Interventions:

- Peer Education;
- Adolescent Health Day;
- Weekly Iron and Folic Acid Supplementation Programme (WIFS);
- Menstrual Hygiene Scheme (MHS);

Peer Education

It is a major component of the RKSK. As per the operational framework of RKSK, in every village four peer educators i.e. two male and two female peer educators will be selected per village/1000 population. Of these, one male and female PE will be chosen from school going adolescents and the other pair will be from the out-of-school adolescents in the village (where possible).

Each male and female peer educator will be expected to:

- Form a group of 15-20 boys and girls respectively from their community and conduct weekly one to two hour participatory sessions, using a PE kit detailing a curriculum and games.
- Participate in Adolescent Health Day to inform and educate adolescents/ young people and involve parents.
- Refer adolescents to: 1) Adolescent Friendly Health Centres (AFHCs) and/or Adolescent Helpline; and 2) the Adolescent Health Day for health check-ups.

Adolescent Health Day

It's a quarterly activity to be organized in every village to apprise adolescent, their parents and other caregivers about the adolescent Health issues, their importance and the need to address them. It also orients them on available Adolescent Friendly Health Services.

Weekly Iron Folic Acid Supplementation Programme Rationale:

Adolescence is a period of transition from childhood to adulthood. It is characterised by rapid physical, biological and hormonal changes resulting in psycho-social, behavioural and sexual maturity in an individual.

During this period in life, there is a significant increase in nutritional requirements, especially for iron.

Anaemia, a manifestation of under-nutrition and poor dietary intake of iron is a public health problem, not only among pregnant women, infants and young children, but also among adolescents. Anaemia in India primarily occurs due to iron deficiency and is the most widespread nutritional deficiency disorders in the country today. The prevalence of anaemia in girls (Hb <12 g per cent) and in boys (Hb < 13g per cent) is high as per the reports of NFHS 3 and the National Nutrition Monitoring Bureau Survey. Adolescent girls in particular are more vulnerable to anaemia due to rapid growth of the body and loss of blood during menstruation. According to NFHS-3, almost 56 per cent of adolescent girls aged 15-19 years and 30 per cent of adolescent boys suffer from some form of anaemia. According to NFHS-3, more than 39 per cent adolescent girls (15-19 years) are mildly anaemic while 15 per cent and 2 per cent suffer from moderate and severe anaemia respectively while during NFHS-2, the prevalence was 41 per cent, 18 per cent and 2 per cent for mild, moderate and severe anaemia among 15-19 years old women, indicating that there has not been much change in the trends. In India, the highest prevalence of anaemia is reported between the ages 12-13 years, which also coincides with the average age of menarche.

Implications of Iron Deficiency Anaemia

Iron deficiency anaemia adversely affects transport of oxygen to tissues and results in diminished work capacity and physical performance.

During adolescence, iron deficiency anaemia can result in impaired physical growth, poor cognitive development, reduced physical fitness and work performance and lower concentration on daily tasks.

Iron deficiency in adolescent girls influences the entire life cycle. Anaemic girls have lower pre-pregnancy stores of iron and pregnancy is too short a period to build iron stores to meet the requirements of the growing foetus.

Iron deficient adolescent girls have a higher risk of preterm delivery and having babies with low birth weight. Regular consumption of iron-folic acid supplement is therefore considered essential for prevention of iron deficiency anaemia.

Findings across various studies reveal that weekly supplementation of 100mg Iron and 500µg Folic acid is effective in decreasing prevalence of anaemia in adolescent age group.

As adolescent anaemia is a critical public health problem in the country, the Ministry of Health and Family Welfare, Government of India, based on the empirical evidence generated by these scientific studies, has developed programmatic guidelines for Weekly Iron and Folic Acid Supplementation (WIFS) of adolescent.

Objective

The Ministry of Health and Family Welfare, Government of India

has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme in 2012 to reduce the prevalence and severity of nutritional anaemia in adolescent population (10-19 years).

Target groups

Weekly Iron folic Acid supplementation programme is being implemented for the following two target groups in both rural and urban areas across the country aiming to cover 11.2 crore adolescents:

A. Adolescent girls and boys who are school going and are in government/ municipal schools from 6th-12th classes.

B. Adolescent Girls who are out of school.

WIFS programme also covers married non-pregnant adolescent girls in order to increase their pre-pregnancy iron stores and decrease prevalence of anaemia among pregnant adolescent girls. Pregnant and lactating adolescents girls will be given IFA supplements or treated for anaemia, according to current guidelines for antenatal and postnatal care through the existing system.

Strategy for Reducing Anaemia in Adolescents

Interventions include:

- Administration of supervised Weekly Iron-folic Acid Supplements of 100mg elemental iron and 500ug Folic acid using a fixed day approach.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthic infestation.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.

Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

Menstrual Hygiene among Adolescent Girls in Rural India

The Ministry of Health and Family Welfare has launched Scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas, with specific reference to ensuring health for adolescent girls.

The major objectives of the scheme are:

- To increase awareness among adolescent girls on Menstrual Hygiene;
- To increase access to and use of high quality sanitary products to adolescent girls in rural areas;
- To ensure safe disposal of Sanitary products in an environmentally friendly manner;

(B) Facility based interventions :

- Strengthening of existing Adolescent Friendly Health Clinics (AFHCs)
- Setting up of new AFHCs
- Continued training of the service providers working at these AFHCs

Through Adolescent Friendly Health Clinics, counselling and curative services are provided by the trained service providers maintaining privacy and confidentiality at primary, secondary and tertiary levels of care on fixed days and fixed time with due referral linkages . Commodities such as Iron & Folic Acid tablets and non-clinical contraceptives are also made available in the clinics for the adolescents.

Counselling services for adolescent on important health areas such as nutrition, puberty, RTI/STI prevention and contraception and delaying marriage and child bearing are being provided through these dedicated counsellors.

As on Sept. 2015, 7,174 AFHCs are functional across the country and linkages have also been established with Integrated Counselling and Testing Centres (ICTC) for management of HIV/AIDS and treatment of RTI/STI cases.

To conclude, it may be reiterated that the above mentioned interventions under Rashtriya Kishor Swasthya Karyakram (RKSK) are of utmost importance to ensure transition of these adolescent as health and productive adults contributing to country's economic growth. ❑

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Health Care in North East: 2020 and Beyond

Bamin Tada

The prospect of sustainable Healthcare in the year 2020 and beyond will largely depend on a strong political will, creating conducive and enabling environment, encouraging more private health care players under PPP mode and increase budget allocation on health and safeguarding, security and safety by improving law and order situation in NER. Lastly I can say together we can do

The dynamic of health care has moved very fast over the years. The North East India still lags behind the rest of India as far as health care facilities are concerned. It could be due to geographical isolation, unprecedented geo-political situations making it not conducive for outsider investment in health infrastructure sector. Exploring the prospect of Health Care in North East India by the year 2020 and beyond remains a major challenge. The question of creating sustainable health care system is the major issue among the health planners.

The Government of India has been making endeavours to reach out health care to the people since inception through various health schemes. The Primary Health Care concept came into being in 1948 as per Bhore committee recommendation. Under Indian Public Health standard, National Rural Health Mission (now National Health Mission) came into being in 2005. Both preventive and curative services have been targeted to deliver right at grassroots with ASHA being the key players as first contact in the community level. There has been tremendous impact of NHM.

With United Nation Millennium Development Goal (MDG) which has just ended in 2015, India had embarked to reduce child mortality, nutritional deficiency, strengthen immunization and improve water and sanitation etc with host of other agenda. MDG had not been able to make much headway in achieving its goals. The MDGs are being replaced by a new set of goals- the Sustainable Development Goals (SDG) which run from 2015 to 2030. When it comes to health, the five major issues are responsible for not fulfilling MDG within stipulated time. These are:-

1. Requirement of more resources.
2. Utilizing the available resources as effectively as possible.
3. Acute shortage of manpower and infrastructure.
4. Lack of strong political will.
5. Widening demand and supply gap.

Where India Stands:

India's public health spending is 1.1 per cent of its GDP, compared to 2.9 per cent and 4.1 per cent in China and Brazil respectively. It is not possible to maintain an adequate public health system with inadequate financing. Moreover, there is no existing health system model that can be applied to India.

The health goals for the country demand the need for an alternative system, which encourages the private

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and non-state players to engage in partnerships with the state run public healthcare delivery institution. The current Health care system of India also needs to be flexible and should be able to adapt to the changing health needs as well as respond to the risks and opportunities that may come in the future.

A new mechanism in the form of public private partnerships (PPs) in the health care delivery is being encouraged by the Government. The SAP-LAP analysis of the Indian healthcare system shows that such PPPs can be successful if sustainable models are promoted. There is also a need for a clear guideline or policy in formulating PPPs as these models tend to be quite varied in nature, scope and delivery.

In the last two decades, there has been a growing concern over the performance of the healthcare delivery system in India, with mere allocation of hardly 1.1 per cent GDP to Public Health which is too meagre an amount to meet up growing demand of health care facilities. According to Govt. of India document (2005), only 10 per cent of Indians have some form of health insurance. 40 per cent of Indians have to borrow money or sell their assets to meet their health care expenses. Nearly 25 per cent of Indians slips below the poverty line because of hospitalizations due to a single kind of illness. The public health delivery system in its present state is unable to deliver or meet the health goals of India.

Where N E India Stands:

The North East States with poor health care infrastructure, shortage of manpower coupled with difficult hilly and tribal areas is far behind from advanced States in India. As per vision of the North East by 2020, the goal for health sector is 100 per cent coverage of primary health services facilities in all rural and urban areas, which means to attain health for all by 2020, by communatization of primary health care system, integrating programmes for water, sanitation and health education, creating more health infrastructure such as Medical College, Paramedical and Nursing Institutions and also a Regional Medical University and also to launch special programmes for treatment of cancer and prevention of HIV/AIDS. It is stated for increase of health sector budget to 6 per cent of GDP.

Recommendation of the working group on Medical Health Sector for the 12th plan envisaged that all SC, PHC, CHC, DH and state Hospitals in the region to be strengthened as per Indian Public Health Standard. Each state must have medical colleges and nursing colleges so that manpower requirement can be developed and tertiary care facilities can be made available.

Overall strengthening of health infrastructures in NER remains per below national average. PHCs, CHCs and District Hospitals are under staffed owing to which, First Referral Unit and Secondary care facilities are not properly developed. In whole of North East, there is no fully equipped tertiary care centre worth calling.

Lack of private investments and weak market economy due to low per capita income except Sikkim, health care facilities in NE Region are far behind from the rest of India. No government in NE region has ever taken health agenda at the forefront of the developmental plans. The hospitals in NE region are yet to be equipped with adequate resources i.e. man, machines and money. Average hospitals in the region are in very pathetic conditions. Recent reports of Assam Assembly Committee pointed out that the majority of private hospitals have not renewed their licences and there are no separate beds for BPL patients. They do not display doctors name or fees, no incinerators, no generator, narrow approach road and entrance, inadequate parking and laboratory and nursing services are manned by unqualified people. The situation is the same in almost all the North Eastern states.

The quality of health care delivery system has been heavily compromised. The standard of the ethical value have been degraded. The cost of health care is reaching newer heights with each passing day. With back drop of above factors, the challenges for an affordable, accessible and efficient health care we dream to deliver by 2020 and beyond remain elusive.

Where are the Constraints?

Recent study shows that there are acute shortages of healthcare professionals in hospitals in India. 99 per cent of Indian Hospitals

Fig-1

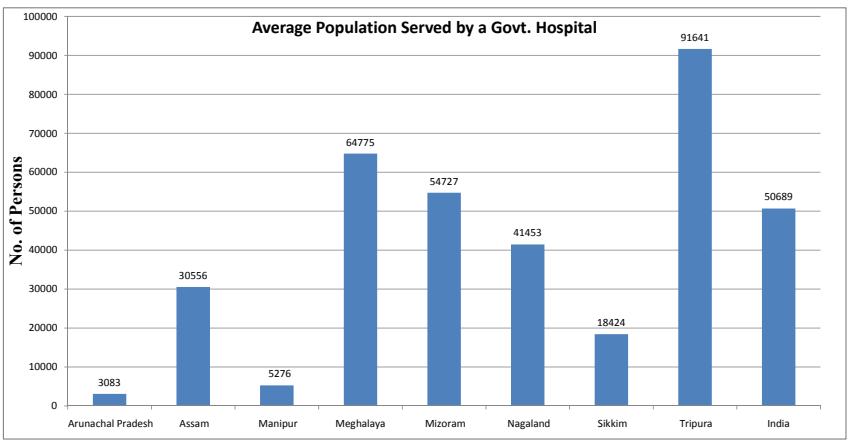

Table -1: Shortfall in Health Infrastructure as per 2011 Population (Provisional) in NER as on March 2012

States	Total Population in Rural Areas	Estimated Tribal / Hilly /Desert area Population in Rural Areas	Sub Centres				Primary Health Centres				Community Health Centres			
			Requirement	In-Position	Shortfall	per cent Shortfall	Requirement	In-Position	Shortfall	per cent Shortfall	Requirement	In-Position	Shortfall	per cent Shortfall
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Arunachal Pradesh#	10,69,165	10,69,165	356	286	70	20	53	97	*	*	13	48	*	*
Assam$	2,67,80,516	36,38,841	5841	4604	1237	21	953	975	*	*	238	109	129	54
Manipur#	18,99,624	18,99,624	633	420	213	34	94	80	14	15	23	16	7	30
Meghalaya#	23,68,971	23,68,971	789	397	392	50	118	109	9	8	29	29	0	0
Mizoram#	5,29,037	5,29,037	176	370	*	*	26	57	*	*	6	9	*	*
Nagaland#	14,06,861	14,06,861	468	396	72	15	70	126	*	*	17	21	*	*
Sikkim#	4,55,962	4,55,962	151	147	4	3	22	24	*	*	5	2	3	60
Tripura#	27,10,051	27,10,051	903	719	184	20	135	79	56	41	33	12	21	64
All India	83,30,87,662	16,87,36,000	189094	148366	43,776	23	30,565	24,049	7,954	26	7,631	4833	3044	40

Table-2: Estimated Birth Rate, Death Rate, Natural Growth Rate and Infant Mortality Rate by Residence in NER-2012

States	Birth Rate			Death Rate			Natural Growth Rate			Infant Mortality Rate		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
1	2	3	4	5	6	7	8	9	10	11	12	13
Arunachal Pradesh	22.5	23.7	15.6	7.9	8.3	5.6	14.6	15.4	10	55	58	33
Assam	19.4	21	13.9	5.8	6.7	2.7	13.6	14.3	11.3	33	37	13
Manipur	14.6	14.4	15.2	4	4	4.2	10.6	10.4	11	10	10	11
Meghalaya	24.1	26.2	14.4	7.6	8.1	5.4	16.5	18.1	9	49	50	40
Mizoram	16.3	20.2	12.2	4.4	5.5	3.1	11.9	14.7	9.1	35	44	19
Nagaland	15.6	15.7	15.1	3.2	3.3	2.8	12.4	12.5	12.3	18	18	18
Sikkim	17.2	17.3	16.7	5.4	5.7	3.3	11.9	11.7	13.4	24	25	16
Tripura	13.9	14.6	10.7	4.8	4.7	5.1	9.2	10	5.6	28	29	19
All India	21.6	23.1	17.4	7	7.6	5.6	14.5	15.5	11.8	42	46	28

Source: SRS Bulletin, Vol. 48, No 2, September, 2013, Registrar General India.

are dealing with acute shortage of healthcare professionals. 70 per cent of Hospitals surveyed- the positions of doctors' remained vacant for at least 2-6 months. 88 per cent hospitals in India take 2-8 months to fill senior positions at the least.

As per WHO 2013 statistics, there are less than 6 doctors per 10,000 populations in India against global average 15 doctors per 10,000 populations. Unless a sound yet flexible compensation system to balance the financial impact is developed, the doctor –patient ratio will remain as low as ever in India as many Indian doctors prefer to go abroad or remain confined to the big cities for their practices. Most parts of North East being hilly, tribal areas compounded with communications and infrastructure bottleneck. For want of basic facilities doctors and nurses are reluctant to serve in PHC, CHC and even in district Hospital, making doctor-patients ratio extremely low.

WHO Report 2000 (WHO2000) identifies six vital functions which can affect the outcome of a health system. These are stewardship (governance), financing, human and physical resources and organisation and management of service delivery. To perform these functions, the health system should have the ability to respond to the changing requirements

and adapt effectively to fulfil the needs.

Public Private Partnership: Viable Alternative:

To meet the current challenges of health care delivery in India especially in North East Region, using the available resources, anticipating the future needs, opportunities and threats, strategic planning is required. One of the frameworks, called the SAP-LAP framework proposed by Sushil (2001) looks at flexible systems and is useful in such strategic planning.

[The SAP-LAP framework analyses the relationship between situational analyses(S), the stakeholders or the actors (A) and the processes (P) that lead to key learning issues (L) followed by suggested actions (A) and depending upon the effectiveness of the actions, there can be enhanced expected performance (P)]

According to Sushil, the more the freedom the actors have, the more adaptive and flexible the processes can be and the better the change. This is because the actors need to perform within the given situation by fooling certain processes.

This synthesis and interaction between the different components of **Situation-Actor-Process (SAP)** and **Learning-Action-Performance (LAP)** helps in dealing with the changing situations and brings about a more positive outcome. This improved performance can, in-turn, affect the situation, actors and processes at different levels (Sushil, 2001).

SAP-LAP Analysis is an essential tool, in the fast moving healthcare system to apply in strategic healthcare management for which there is an absolute role of private public partnership (PPP) for effective healthcare delivery in 2020 and beyond.

The SAP-LAP analysis shows that the current healthcare infrastructure is incapable of meeting health goals and is largely dominated by disjointed and unconnected strategies, and lack of resources. There is limited reach and scope of public health services with players working in isolation. There is an urgent need to develop an alternate system for healthcare delivery in the form of PPPs, which the GoI is also encouraging.

Hence, PPPs should be considered as innovative joint alliances, functioning on joint parameters of risks and rewards. Balance should be maintained between the healthcare needs of the public and the interests of the private players.

A holistic approach through PPPs will help to develop health care delivery mechanism that have inclusive strategies to improve the quality and teach of healthcare as well as ensure the sustainability of these partnerships.

Conclusion:

As far as the role of PPP model for North Eastern Region is concerned, it is essential to attract the private players and investors and they may be encouraged in very special way. To make PPP mode workable in NER, there must be a strong political will to create a conducive atmosphere and an enabling environment by improving law and order situation.

The conducive atmosphere and enabling environment also refers that the people of the Region should be friendly and avoid undue harassment to the investors in the form of extortion and donations. The poor regional connectivity, insurgency and violence will not be so welcoming for outside investors.

A workable mechanism has to be developed among the like minded people to come together and take new ventures jointly with government and private players. Hence, PPP mode of approach will be the best alternative to develop sustainable healthcare system in the region. This kind of gathering must explore avenues for joint alliance and to function on joint parameters of both risk and rewards as cited in SAP-LAP analysis.

The prospect of sustainable Healthcare in the year 2020 and beyond will largely depend on a strong political will, creating a conducive and enabling environment, encouraging more private health care players under PPP mode and increase budget allocation on health and safeguarding, security and safety by improving law and order situation in NER. Lastly, I can say that together we can do. ❑

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Development Roadmap

Pulse Polio Programme for 2016 launched by the President

Pulse Polio programme for 2016 was launched by the President of India administering polio drops to children less than five years old, at the Rahstrapati Bhawan on 17th January which was the National Immunization Day. Around 17.4 crore children of less than five years across the country would have been given polio drops as part of the drive of Government of India to sustain polio eradication from the country. It is noteworthy that India has been now validated for Maternal and Neonatal Tetanus elimination in May 2015, well before the global target date of December 2015. This is a monumental achievement in the country's efforts to achieve universal health care and address health inequities. In order to mitigate the risk of importation, the immunity against polio infection is maintained through National and Sub National Polio rounds along with sustained high quality polio surveillance.. A travel advisory has also been issued as per WHO guidelines to vaccinate all travellers who are travelling between India and eight other countries namely Pakistan, Afghanistan, Nigeria, Cameroon, Syria, Ethiopia, Somalia & Kenya. Also, an Emergency Preparedness and Response Plan (EPRP) is in place under which Rapid Response Teams (RRT) have been formed in all States/UTs to respond urgently to any importations of poliovirus.

In order to provide double protection to children and securing gains of polio eradication, Government of India has introduced the injectable Inactivated Polio Vaccine (IPV) into its routine immunization program along with oral polio vaccine from 30 November 2015. In the first phase IPV has been introduced in six States, viz Assam, Gujarat, Punjab, Bihar, Madhya Pradesh, and Uttar Pradesh. The planning is also to switch from trivalent OPV to bivalent OPV in some months in a globally synchronized manner.

PM launches Start-up India movement, unveils action plan for encouraging Start-ups

The Prime Minister, launched the Start-up India initiative on January 17, 2016. Unveiling the highlights of the Start-up Action Plan, he said, a dedicated Start-up fund worth Rs. 10,000 crore will be created for funding of Start-ups. Start-ups would be exempted from paying income tax on their profit for the first three years. An eighty per cent exemption in patent fee for Start-up businesses was announced and a self-certification based compliance system for Start-ups is to be introduced for 9 labour and environment laws.

Four new IT-based initiatives on Citizen Centric Health Services Announced

The first of the initiatives, called 'Kilkari', is an audio-based mobile service that delivers weekly audio messages to families about pregnancy, child birth and child care. Each pregnant woman and infant's mother, registered in Mother and Child Tracking System (MCTS), a web- enabled name-based system to monitor and ensure delivery of full spectrum of services to all pregnant women and children, would receive weekly voice messages relevant to the stage of pregnancy or age of the infant. The 72 messages would reach the targeted beneficiaries from the 4th month of pregnancy until the child is one year old. On an average, the duration of each message is two minutes. Such messages will empower and educate women and parents to help create a better environment in maternal and child health. This service will be provided free to the beneficiaries. In the first phase of implementation, such messages would be sent to the pregnant women and infants' mothers in six States in Jharkhand, Odisha, Uttar Pradesh, Uttarakhand, and HPDs of Madhya Pradesh and Rajasthan. They are being developed in Hindi, English and Odiya languages in the first phase, to be later expanded to other languages to cover the entire country and would benefit over 2 crore pregnant women and 2 crore infants, annually.

A new mobile-based application, Mobile Academy, has also been developed through which, a large number of ASHAs will be trained using mobile services. This will aid in enhancing their inter-personal skills. Once registered, ASHAs can access the 240-minute course via their mobile phones. They can then complete the standardized course at their convenience. Digital bookmarking technology enables ASHAs to complete the course at their own pace. The course is divided into eleven chapters each containing four lessons. There is a quiz at the end of each chapter. ASHAs successfully completing the course by securing more than minimum prescribed marks will receive a Certificate of Completion from the Government.

The Revised National TB Control Programme (RNTCP) is also to be made more patient-centric. A dedicated toll free number, 1800-11– 6666, with a call centre is being started to provide round the clock support for patient counselling and treatment support services. This call centre will have trained personnel to provide feedback to patients and also link or refer chest symptomatic persons to RNTCP services. Under this initiative, callers can give a missed call or call to get complete support for diagnosis, treatment and support for the completion of treatment on the national toll free number. This initiative is being started in the States of Punjab, Haryana, Chandigarh and Delhi.

'M-Cessation', an IT-enabled tool to help tobacco users to quit tobacco was also announced. Built on a helpline concept, it will register beneficiaries on the basis of a missed call. The counselling would be done through a two-way SMS process.

DO YOU KNOW?

SOUTH ASIAN GAMES, 2016

The South Asian Games are multinational and multi-sport games that are held every two years amongst the athletes from South Asia. They are the regional games of the Olympic Council of Asia and are governed by South Asia Olympic Council (SAOC), formed in 1983.These Games are often considered as the South Asian version of the Olympic Games and give opportunity to athletes to participate and represent their country or region in top-level competition and promote sport and a healthy lifestyle. The first South Asian Games was hosted by Kathmandu, Nepal in 1984. In 2004, in the 32nd meeting of South Asia Olympic Council , their name was changed from South Asian Federation Games to South Asian Games.

Presently SAG have eight member countries namely Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan & Sri Lanka. The 12th South Asian Games will be held in Guwahati, Assam and Shillong, Meghalaya, India from 6th February to 16 February 2016. The Theme Song of 12th South Asian Games is "Ei Prithibi Ek Krirangan" meaning "The world is a playground" which was written by Late Dr. Bhupen Hazarika , an Indian lyricist, musician, singer, poet and film-maker from Assam. The name of the Mascot for the Games is TIKHOR (meaning, someone who is sharp, naughty, sporty and modern) and it will be the the Brand Ambassador for these games. The logo has eight petals representing the countries participating in the 12th South Asian Games. The petals are seen to be moving in a clockwise direction showing the positive spirit of the games.

The Govt. of India in consultation with the Indian Olympic Association has formed the Organising Committee and Executive Committee for the planning, management and execution of the Games. The Organizing Committee will be the apex committee for the management of the Games headed by Honourable Sports Minister, Govt. of India. Officials and 4500 sport persons8 countries are expected to participate in 23 events. ❑

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YOJANA WEB- EXCLUSIVES

Yojana publishes articles on various topics in its 'Web-Exclusives' column for the benefit of its readers on the website of Yojana : www.yojana.gov.in. Announcements about the articles under the Web-Exclusives section are carried in the Yojana magazine of the month.

We are carrying the following articles under the Web-Exclusives section of Yojana for February 2016

1. The Trouble with Being Smart by Amit Mukherjee
2. Oral Health Status in India by Varun Kumar & Ruchi Juneja

Please send in your comments and suggestions to us on ***yojanace@gmail.com***

FROM OUR READERS ...

The special edition of Dec 2015 of Yojana is worth reading about climate change. It gives all valuable knowledge in its 75 pages. There is one more suggestion also - that diverse topics about different aspects can be added in the issues of Yojana. *Utkarsha Utpal, Bihar*

Please use more easy word of English to understand perfectly for students like me having less knowledge of English ... I am grateful to you for your quality work which you put for Yojana. I am regular reader of Yojana from June 2014. I want to suggest you that there is need of awareness column like swachata, woman empowerment, child labour, et al like small stories in one page every month. *Ameet Kumar, J&K*

I am a new reader of Yojana magazine. I am just a teenager studying in class 11th and I have to prepare myself for future competitive exams and I read this magazine on my father's suggestion...I find it very informative and I wait for every month for it. *Meghna Pushpam, Lucknow UP.*

I am a regular reader of Yojana and it gives us a wide and competitive knowledge on each and every sector of life like skill development; transport; economic growth ; natural medicines; health sectors etc. It is a humble request to you to please publish an issue on Indian Economy and stock market. *Wani luqman, Begam Kulgam J&K*

I am an ardent reader of your superb magazine. ..The content in December 2015 issue on Climate Change and Sustainable Development is really applausible and appreciable. Of course Sustainable Development and problem of climate change are so complex that we we need to adopt the BAT (Best Available Technology) and Clean Technology, Clean Development Mechanism (CDM), Sustainable Lifestyle and a flexible adaptable problem solving strategy. It needs Global Action to achieve the common goal i,e, Green Earth. Give Earth a Chance. *Shyamal Prasad Choudhury*

I read Yojana. I find it very sensible and informative, giving detailed analysis on various Government policies and initiatives. Articles by intellectuals on topics like public health, Climate change, Transport makes it very beneficial for the readers. Please publish an issue on maoist and insurgency problems in India. My best wishes to Yojana Team. *Manjul Samal*

Response from Yojana Team

Yojana team is overwhelmed by the appreciation that we have recieved from you, our valued readers. We do try to bring out issues on the economy - Our March issue will be on Union Budget, where we will be covering all sectors of the economy. We will try to include updated information on child labour, women's empowerment, etc in our Do You Know column. Thanks once again!

Your feedback is valuable to us in planning our issues.

Make in India

Sandip Das

India is the only country in the world which offers the unique combination of democracy, demography, and demand from a rising middle class. Besides, the campaign would ensure closer centre and states relations for promoting India as a global manufacturing hub

The global investors have been often critical about complex rules and bureaucratic redtapism that delays investment decisions. In fact, India was ranked 134 out of 189 countries in the World Bank's Ease of Doing Business Index in 2014. The Government of India's flagship initiative - Make in India, was conceived in 2014 in response to slowdown witnessed in the economic growth and global investors questioning the country's ability to emerge as global manufacturing hub.

The programme 'Make In India' was launched by the Prime Minister in September, 2014 which aimed at not only attracting overseas companies to set up shop, but also support and encourage domestic companies to increase production in the country. The ambitious programme focused on increasing the GDP and tax revenues, by producing products that meet high quality standards, and minimising the impact on the environment.

The focus of 'Make In India 'programme is on creating jobs and skill enhancement in 25 sectors including automobiles, aviation, chemicals, pharmaceuticals, construction, defense manufacturing, electrical machinery, food processing, textiles and garments, ports, leather, media and entertainment, tourism and hospitality, railways, renewable energy, mining, bio-technology, space, thermal power, roads and highways and electronics systems.

"It is important for the purchasing power of the common man to increase, as this would further boost demand, and hence spur development, in addition to benefiting investors. The faster people are pulled out of poverty and brought into the middle class, the more opportunity will there be for global business," the Prime Minister had said after launching this mega programme in September, 2014.

While launching the programme, the Prime Minister acknowledged that India being ranked low on the 'ease of doing business' ranking by World Bank and added that he had started to sensitize the Government officials in this regard. On his meeting with World Bank President Jim Yong Kim, the Prime Minister said "World Bank President was also expressing this worry. Probably we were 135th in the world at that time. If we have to come to 50 from 135 then Government alone cannot do this. If Government brings transparency in its decisions and rules and pushes works with simplicity, we can occupy number 50 from 135 in ease of doing business,".

Key Areas

The programme put thrust on four key areas such as improving the ease of doing business through speed and transparency, relaxing rules relating for

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attracting Foreign Direct Investment (FDI), protection of the intellectual property rights of innovators or manufacturers and promotion of domestic manufacturing.

On the critical issue of ease of doing business through simpler procedural norms for setting up manufacturing base, the Make in India policy implemented through Department of Industrial Policy and Promotion (DIPP) has launched an online application for environmental clearance, filing of income tax return using web, validity of industrial licence extended to three years, creation of electronic registers instead of existing paper registers by businessmen and mandatory approval of head of the department for undertaking inspection.

For attracting FDI, the government has allowed 100 per cent FDI in all the sectors except Space (74 per cent), Defence (49 per cent) and News Media (26 per cent). The FDI restrictions in tea plantation has been removed, while the FDI limit in Defence sector has been raised from the earlier 26 per cent to 49 per cent currently.

The DIPP has also decided to improve and protect the Intellectual Property Rights (IPR) of innovators and creators by upgrading infrastructure, and using state-of-the-art technology. IPR protection would cover issues such as patent, design, trade mark, Geographical Indications, copyright, plant variety protection etc.

For the promotion of domestic manufacturing, the Make in India initiative has set a few targets which include increasing manufacturing sector growth to 12-14 per cent per annum over the medium term and increasing the share of manufacturing in the country's Gross Domestic Product from 16 per cent to 25 per cent by 2022, creation of 100 million additional jobs by 2022 in manufacturing sector.

Besides the above, the other targets are creating appropriate skill sets among rural migrants and the urban poor for inclusive growth, increasing the domestic value addition and technological depth in manufacturing, enhancing the global competitiveness of the Indian manufacturing sector and ensuring environmentally sustainable economic growth.

Progress So Far

Since its formal launch, many big domestic and global corporates have announced setting up manufacturing facilities in the country. In the automobile sector, Italian auto major Fiat Chrysler Automobiles has come up with a plan to manufacture a range of Jeep brand premium sports utility vehicles in India and export these vehicles to countries such as Australia, South Africa, and the United Kingdom. This decision is expected to bring in an investment of about Rs 2,500 crore. Swedish companies such as Tetrapak, Scania, Ericsson, and Volvo India have committed to participate in Make in India. Airbus Group aims to increase its sourcing of aerospace parts from Indian companies to $2 billion in the next five years. Defence sector equipments manufacturers from Japan, Germany, France, Russia and Spain have initiated steps to take set up manufacturing facilities in the country under the Make In India initiative. Besides Indian corporates like Reliance and Mahindra, Tata groups has already announced setting up of its new investments as part of the Make in India campaign.

Challenges Ahead

Economists and experts have noted that with the globalization becoming a reality, Indian manufacturers will have to compete with the best and cheapest the rest of the world has to offer even in the domestic market. They urged for providing tax concessions to any industry which would set up manufacturing facility in the country. Besides a critical aspect is the country's huge small and medium-sized industries which could play a big role in making the country take the next big leap in manufacturing.

"India should be more focused towards novelty and innovation for the sectors indentified and integration with the country's premier institute for carrying out research and development would be critical to the success of the Make In India programme," a leading industrialist said.

An Economist said the big challenge for 'Make in India' campaign would be to face the constant comparison with China's 'Made in China' campaign. The China launched the campaign at the same day as India seeking to retain its manufacturing prowess. "India should constantly keep up its strength so as to outpace China's supremacy in the manufacturing sector," he noted.

However, Amitabh Kant, former Secretary, DIPP also the architect of Make in India campaign, had recently talked about giving few years time before assessing the impact of the campaign. "You are talking about structural changes. You are talking about scrapping processes, procedures. It is going to take years. I am telling you, you would not get benefits (soon)...," he had stated.

Notwithstanding the challenges faced in making India a manufacturing hub, the country is poised to reap rich dividend for being one of the youngest nations in the world. According to reports by 2020, India is set to become the world's youngest country with 64 per cent of its population in the working age group.With the Western countries, Japan and even China aging, this demographic potential offers India and its growing economy an edge that economists believe could add a significant 2 per cent to the GDP growth rate annually.

Prime Minister also had said that India is the only country in the world which offers the unique combination of democracy, demography, and demand from a rising middle class. Besides, the campaign would ensure closer centre and states relations for promoting India as a global manufacturing hub. "If investment comes in the States, it comes in India also. States and Centre should work collectively, shoulder to shoulder as a team. they should find solution together and things move forward," he had commented.

Although a sound beginning has been made for the Make in India campaign, now the ball is in the government's court to ensure its success. ❑

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