The National Medical Commission Bill, 2017

The National Medical Commission Bill, 2017 was introduced by the Minister of Health and Family Welfare, Mr. J. P. Nadda in Lok Sabha on December 29, 2017. The Bill seeks to repeal the Indian Medical Council Act, 1956 and provide for a medical education system which ensures: (i) availability of adequate and high quality medical professionals, (ii) adoption of the latest medical research by medical professionals, (iii) periodic assessment of medical institutions, and (iv) an effective grievance redressal mechanism. Key features of the Bill include:

**Constitution of the National Medical Commission:** The Bill sets up the National Medical Commission (NMC). Within three years of the passage of the Bill, state governments will establish State Medical Councils at the state level. The NMC will consist of 25 members, appointed by the central government. A Search Committee will recommend names to the central government for the post of Chairperson, and the part time members. These posts will have a maximum term of four years. The Search Committee will consist of seven members including the Cabinet Secretary and three experts nominated by the central government (of which two will have experience in the medical field).

**Members of the NMC will include:** (i) the Chairperson, (ii) the President of the Under-Graduate Medical Education Board, (iii) the President of the Post-Graduate Medical Education Board, (iv) the Director General of Health Services, Directorate General of Health Services, (v) the Director General, Indian Council of Medical Research, and (vi) five members (part-time) to be elected by the registered medical practitioners from amongst themselves from the prescribed regional constituencies under the Bill.

**Functions of the National Medical Commission:** Functions of the NMC include: (i) framing policies for regulating medical institutions and medical professionals, (ii) assessing the requirements of healthcare related human resources and infrastructure, (iii) ensuring compliance by the State Medical Councils of the regulations made under the Bill, (iv) framing guidelines for determination of fees for up to 40% of the seats in the private medical institutions and deemed universities which are regulated as per the Bill.

**Medical Advisory Council:** Under the Bill, the central government will constitute a Medical Advisory Council. The
Council will be the primary platform through which the states/union territories can put forth their views and concerns before the NMC. Further, the Council will advise the NMC on measures to enable equitable access to medical education.

**Autonomous boards:** The Bill sets up certain autonomous boards under the supervision of the NMC. Each autonomous board will consist of a President and two members, appointed by the central government. These boards are: (i) the Under-Graduate Medical Education Board (UGMEB) and the Post-Graduate Medical Education Board (PGMEB): These Boards will be responsible for formulating standards, curriculum, guidelines, and granting recognition to medical qualifications at the undergraduate and post graduate levels respectively, (ii) the Medical Assessment and Rating Board (MARB): The MARB will have the power to levy monetary penalties on medical institutions which fail to maintain the minimum standards as laid down by the UGMEB and the PGMEB. The MARB will also grant permission for establishing a new medical college, and (iii) the Ethics and Medical Registration Board: This Board will maintain a National Register of all licensed medical practitioners, and regulate professional conduct. Only those included in the Register will be allowed to practice medicine.

**Entrance examinations:** There will be a uniform National Eligibility-cum-Entrance Test for admission to under-graduate medical education in all medical institutions regulated by the Bill. The NMC will specify the manner of conducting common counselling for admission in all such medical institutions.

- There will be a National Licentiate Examination for the students graduating from medical institutions to obtain the license for practice. The National Licentiate Examination will also serve as the basis for admission into post-graduate courses at medical institutions.
The decision of the Lok Sabha to send the National Medical Commission Bill to a standing committee for a relook is the right one. First proposed in 2016, the Bill aims to overhaul the corrupt and inefficient Medical Council of India, which regulates medical education and practice. But despite its plus points, the NMC isn’t the game-changing legislation it could have been. One of its goals is to rein in corruption in the MCI through greater distribution of powers. This is sought to be accomplished through an independent Medical Advisory Council to oversee the National Medical Commission, the proposed successor of the MCI. But all members of the NMC are members of the Council, undermining the latter’s independence. This, and other concerns, must be addressed.

Perhaps the most controversial provision of all is for a bridge course allowing alternative-medicine practitioners to prescribe modern drugs. One motivation could be to plug the shortfall of rural doctors by creating a new cadre of practitioners. But if this was the rationale, better solutions exist.

The shortfall of MBBS doctors is partly due to the fact that many of them seek a post-graduate degree to improve career prospects. MCI regulations prevent even experienced MBBS doctors from carrying out procedures like caesarians and ultrasound tests, while nurses are barred from administering anaesthesia. Empowering doctors and nurses to do more is a reform many have called for, and that would have been easier to implement than a bridge course for AYUSH practitioners. Yet, the NMC Bill hasn’t taken it up. Another way to bolster healthcare delivery is a three-year diploma for rural medical-care providers, along the lines of the Licentiate Medical Practitioners who practised in India before 1946. Chhattisgarh tried this experiment in 2001 to tackle the paucity of doctors it faced as it was formed. Graduates from such a three-year programme would only be allowed to provide basic care in under-served pockets. Massive protests by the Indian Medical Association and poor execution derailed the Chhattisgarh experiment, but the idea wasn’t without merit. India has no choice but to innovate with health-care delivery models to tackle the challenges it faces. The trick is to base these innovations on evidence. There is plenty of evidence that MBBS doctors and nurses can do more than they are legally allowed to do. But integrating alternative-medicine practitioners into modern medicine requires a lot more thought. The government will do well to empower existing doctors before attempting more ambitious, and questionable, experiments.

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Revving up infrastructure spending is necessary, but not sufficient

END
The National Medical Commission Bill, 2017 was introduced in Lok Sabha recently and is listed for consideration and passage today.\[1\] The Bill seeks to regulate medical education and practice in India. To meet this objective, the Bill repeals the Indian Medical Council Act, 1956 and dissolves the current Medical Council of India (MCI). The MCI was established under the 1956 Act, to establish uniform standards of higher education qualifications in medicine and regulating its practice.\[2\]

A Committee was set up in 2016, under the NITI Aayog with Dr. Arvind Panagariya as its chair, to review the 1956 Act and recommend changes to improve medical education and the quality of doctors in India.\[3\] The Committee proposed that the Act be replaced by a new law, and also proposed a draft Bill in August 2016.

This post looks at the key provisions of the National Medical Commission Bill, 2017 introduced in Lok Sabha recently, and some issues which have been raised over the years regarding the regulation of medical education and practice in the country.

What are the key issues regarding the regulation of medical education and practice?

Several experts have examined the functioning of the MCI and suggested a different structure and governance system for its regulatory powers.\[4\] Some of the issues raised by them include:

**Separation of regulatory powers**

Over the years, the MCI has been criticised for its slow and unwieldy functioning owing to the concentration and centralisation of all regulatory functions in one single body. This is because the Council regulates medical education as well as medical practice. In this context, there have been recommendations that all professional councils like the MCI, should be divested of their academic functions, which should be subsumed under an apex body for higher education to be called the National Commission for Higher Education and Research.\[5\] This way there would be a separation between the regulation of medical education from regulation of medical practice.

An Expert Committee led by Prof. Ranjit Roy Chaudhury (2015), recommended structurally reconfiguring the MCI’s functions and suggested the formation of a National Medical Commission through a new Act.\[3\] Here, the National Medical Commission would be an umbrella body for supervision of medical education and oversight of medial practice. It will have four segregated verticals under it to look at: (i) under-graduate medical education, (ii) post-graduate medical education, (iii) accreditation of medical institutions, and (iv) the registration of doctors. The 2017 Bill also creates four separate autonomous bodies for similar functions.

**Composition of MCI**

With most members of the MCI being elected, the NITI Aayog Committee (2016) noted the conflict of interest where the regulated elect the regulators, preventing the entry of skilled professionals for the job. The Committee recommended that a framework must be set up under which regulators are appointed through an independent selection process instead.

**Fee Regulation**

The NITI Aayog Committee (2016) recommended that a medical regulatory authority, such as the MCI, should not engage in fee regulation of private colleges. Such regulation of fee by regulatory
authorities may encourage an underground economy for medical education seats with capitation fees (any payment in excess of the regular fee), in regulated private colleges. Further, the Committee stated that having a fee cap may discourage the entry of private colleges limiting the expansion of medical education in the country.

**Professional conduct**

The Standing Committee on Health (2016) observed that the present focus of the MCI is only on licensing of medical colleges. There is no emphasis given to the enforcement of medical ethics in education and on instances of corruption noted within the MCI. In light of this, the Committee recommended that the areas of medical education and medical practice should be separated in terms of enforcement of the appropriate ethics for each of these stages.

What does the National Medical Commission, 2017 Bill seek do to?

The 2017 Bill sets up the National Medical Commission (NMC) as an umbrella regulatory body with certain other bodies under it. The NMC will subsume the MCI and will regulate the medical education and practice in India. Under the Bill, states will establish their respective State Medical Councils within three years. These Councils will have a role similar to the NMC, at the state level.

Functions of the NMC include: (i) laying down policies for regulating medical institutions and medical professionals, (ii) assessing the requirements of human resources and infrastructure in healthcare, (iii) ensuring compliance by the State Medical Councils with the regulations made under the Bill, and (iv) framing guidelines for determination of fee for up to 40% of the seats in the private medical institutions and deemed universities which are governed by the Bill.

Who will be a part of the NMC?

The NMC will consist of 25 members, appointed by the central government. It will include representatives from Indian Council of Medical Research, and Directorate General of Health Services. A search committee will recommend names to the central government for the post of Chairperson, and the part-time members. These posts will have a maximum term of four years, and will not be eligible for extension or reappointment.

What are the regulatory bodies being set up under the NMC?

The Bill sets up four autonomous boards under the supervision of the NMC, as recommended by various experts. Each autonomous board will consist of a President and two members, appointed by the central government (on the recommendation of the search committee). These bodies are:

- **The Under-Graduate Medical Education Board (UGMEB) and the Post-Graduate Medical Education Board (PGMEB):** These two bodies will be responsible for formulating standards, curriculum, guidelines, and granting recognition to medical qualifications at the under-graduate and post-graduate levels respectively;
- **The Medical Assessment and Rating Board:** The Board will have the power to levy monetary penalties on institutions which fail to maintain the minimum standards as laid down by the UGMEB and the PGMEB. It will also grant permissions for establishing new medical colleges; and
- **The Ethics and Medical Registration Board:** The Board will maintain a National Register of all licensed medical practitioners, and regulate professional conduct. Only those included in the Register will be allowed to practice as doctors.

What does the Bill say regarding the conduct of medical entrance examinations?
There will be a uniform National Eligibility-cum-Entrance Test (NEET) for admission to undergraduate medical education in all medical institutions governed by the Bill. The NMC will specify the manner of conducting common counselling for admission in all such medical institutions.

Further, there will be a National Licentiate Examination for the students graduating from medical institutions to obtain the license for practice. This Examination will also serve as the basis for admission into post-graduate courses at medical institutions.


WHO okays Bharat Bio typhoid shot

Shot in the arm:Bharat Biotech CMD Krishna Ella said the first deliveries, after pre-qualification, could begin this year.AFP

Bharat Biotech has received a pre-qualification from the World Health Organisation (WHO) for Typbar Typhoid Conjugate Vaccine.

This paves the way for supplies of the vaccine to UNICEF, Pan-American Health Organization (PAHO) and Gavi supported countries, chairman and managing director Krishna Ella told mediapersons here on Wednesday.

Rs. 150-crore investment

The Hyderabad firm, which had invested Rs. 150 crore in the product and is positioned to supply up to 50 million doses a year, is working to expand the manufacturing capacity to 200 million doses. Mr. Ella said he expected the first deliveries, following the pre-qualification, to begin this year. In India, the product is being marketed for two years now.

Typbar TCV is the first typhoid vaccine clinically proven to be administered to children from 6 months of age to adults, and confers long-term protection against typhoid fever.

A release said the product had been evaluated in human challenge studies at Oxford University and typhoid conjugate vaccines had been recommended by WHO’s Strategic Advisory Group of Experts on Immunization. Bill & Melinda Gates Foundation had supported efforts that helped generate data for the pre-qualification.

With WHO-SAGE recommendation, for use of TCV for use in infants between 6 and 23 months of age and catch up vaccinations for children between 2 and 15 years of age, countries could introduce the vaccine into their immunisation programmes.

“With the recent Gavi Board approval of $85 million funding window to make the typhoid conjugate vaccine available in Gavi-supported countries, we now expect the first introductions to take place as soon as the first half of 2019,” Seth Berkley, CEO of Gavi, the Vaccine Alliance, said.

The company has priced Typbar TCV at $1.50/dose for procurement for GAVI-supported countries. “We announce a further reduction to around $1.0 or below/dose, post procurement of 100 million doses for LIC’s and LMIC’s,” Dr. Ella said.

END
“Gaming disorder” will be recognised as a disease later this year following expert consensus over the addictive risks associated with playing electronic games, the World Health Organization said on Friday.

The disorder will be listed in the 11th edition of the International Classification of Diseases (ICD), to be published in June, WHO spokesperson Tarik Jasarevic told reporters in Geneva.

The current working definition of the disorder is “a pattern of gaming behaviour, that can be digital gaming or video gaming, characterised by impaired control over gaming, increased priority given to gaming over other activities to the extent that gaming takes precedence over other interests,” Mr. Jasarevic said.

The provisional guidelines say that an individual should demonstrate an abnormal fixation on gaming for at least a year before being diagnosed with the disorder, which will be classified as an “addictive behaviour”, he said.

Anecdotal evidence suggests that the condition disproportionately effects younger people more connected to the ever-expanding online gaming world.

But the WHO spokesperson cautioned that it was premature to speculate on the scope of the problem.

“There are people who are asking for help”, he added, noting that formal recognition of the condition will help spur further research and resources committed to combatting the problem.

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Astronauts on extended space travel missions would have significant bone and muscle complications.
India faces an unenviable challenge of tackling the dual burden of diseases and lack of qualified health personnel. The intrusive, non-transparent, infrastructure-obsessed and unpredictable regulatory regime put in place by the Medical Council of India (MCI) has ensured that we can address neither the issue of quantity nor quality of medical professionals being churned out by our medical education system.

The MCI and The Dental Council of India (DCI) have been repeatedly under the scanner as some of its members were accused of taking bribes in order to fast-track accreditation. Experts at NITI Aayog have proposed replacing only the compromised MCI and not the DCI with a new National Medical Commission (NMC), outlined in a draft Bill known as the National Medical Commission Bill, 2016.

Some standout features of the NMC Bill:

* The government, under the National Medical Commission (NMC), can dictate guidelines for fees up to 40% of seats in private medical colleges. This surely will give students relief from the exorbitant fees charged by these colleges, and is a standout feature of the Bill.

* The Bill also has a provision for a common entrance exam and licentiate (exit) exam that medical graduates have to pass before practicing or pursuing PG courses. For MBBS, students have to clear NEET, and before they step into practice, they must pass the exit exam. With a clear roadmap once cleared will ensure a higher standard of care.

* Recognized medical institutions don’t need the regulator’s permission to add more seats or start a PG course. This mechanism will reduce the discretionary powers of the regulator. India does need many more post-graduates passing out to cater to the needs of healthcare.

* Earlier, medical colleges required the MCI’s approval for establishment, recognition, renewal of yearly permission or recognition of degrees, and even an increase in the number of students they admitted. Under the new Bill, the powers of the regulator are reduced to establishment and recognition. This means less red tape, but also less scrutiny of medical colleges.

* Transparent and pro-active disclosure by the medical institution with regard to fees, facilities, faculty and infrastructure. A mandatory assessment and rating of medical colleges on annual basis to be carried out and published in order to enable prospective students to make an informed choice.

But some key concerns remain. The NMC Bill seems to have paved the way for the back door entry of practitioners of traditional medicine into the domain of allopathic doctors via the Bridge Course. This decision merits a deeper and more scientific discussion. The rationale that Allopathic doctors are not available in remote areas, needs to be addressed at the medical education stage, but even that takes time because it takes years before a full-fledged doctor is turned out into the community.

Some traditional practitioners also are unhappy that the Bill that proposes a “bridge course” for their community to practice allopathy. Instead of popularizing traditional medicines, this move encourages many traditional practitioners to gravitate towards allopathy.

But the fact remains how the DCI has been so benevolently let off the hook? Especially when there are surplus dentists passing out in herds from mushrooming dental colleges with meagre job
opportunities, forcing many to work in call centres. Alleging rampant corruption in the DCI, the CBI has named its president, Dr Dibyendu Mazumdar and former secretary Dr S K Ojha, among others in an FIR.

The Niti Aayog, in the current bill, talks about replacing the current Medical Council of India with a primarily nominated team (the Medical Commission) with bureaucrats who will be ruling the roost. This seems like the same old wine in a new bottle. The very preamble of the NMC Bill states that “principle of the “regulated” electing the “regulator” is flawed and creates a conflict of interest, therefore MCI should be discarded”. By this argument however, the Bar council should not regulate advocates, ICAI should not regulate Chartered Accountants and so on and so forth. There must an equal proportion of elected representatives.

**The NMC will frame policies for governance of medical education in India. No specific mention on a clear roadmap to revamp our abysmal public health care systems.** There is an urgent need to beef-up the public health system. For long, the public health system has languished and the space abdicated by the government has been occupied by private players. We need to realize that the quality of care delivered in the public system is far from desirable. The government should increase the budget spent on health care which at the current moment is so sparse, so that fewer people are dependent on private facilities. If public primary care is good, there will be less need for tertiary care centers.

**The structural differences between the proposed NMC and MCI are enormous.**

The NMC will split the selection, advising, and actual accreditation process into three separate boards. By dividing power, the hope is to create a system of checks and balances. However, as per the current Bill, all members of the accreditation board are supposed to be ex-officio members of the advisory board. This defies the logic of good governance. Instead of creating different boards to watch and observe each other, the NMC will instead create a single potentially corrupt body. That’s why all members of the accreditation board must exit from the advisory board.

**Conclusion:**

Clearly, the NMC Bill needs a more open and scientific discussion keeping patient interest at the centre. We have yet to see what further changes are done in the bill before it sees the light of the day. The journey of a thousand miles begins with the first step. The NMC bill purports to be only that – a first step.

END
Total funds allocated/spent under Guru Shishya Parampara Scheme is Rs. 343.61 lakhs and number of beneficiaries is 1290 during the last three years: Dr. Mahesh Sharma

Ministry of Culture

Total funds allocated/spent under Guru Shishya Parampara Scheme is Rs. 343.61 lakhs and number of beneficiaries is 1290 during the last three years: Dr. Mahesh Sharma

Posted On: 03 JAN 2018 4:06PM by PIB Delhi

To protect, preserve & promote various forms of folk art, indigenous art and craft throughout the country, the Government of India has set up seven Zonal Cultural Centres (ZCCs) with headquarters at Patiala, Nagpur, Udaipur, Allahabad, Kolkata, Dimapur and Thanjavur. For this purpose, these ZCCs organize various cultural activities, workshops, exhibitions, craft fairs etc under Shilpgram Scheme.

The number of beneficiaries and the funds allocated/spent under Guru Shishya Parampara Scheme and artists engaged for cultural programmes by ZCCs for these initiatives in past three years is as under:

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Year</th>
<th>Number of beneficiaries</th>
<th>Funds allocated/ spent</th>
</tr>
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<tbody>
<tr>
<td>i.</td>
<td>2014-15</td>
<td>497</td>
<td>98.51 lakh</td>
</tr>
<tr>
<td>ii.</td>
<td>2015-16</td>
<td>425</td>
<td>140.28 lakh</td>
</tr>
<tr>
<td>iii.</td>
<td>2016-17</td>
<td>368</td>
<td>104.82 lakh</td>
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</tbody>
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This information was given by Minister of State (IC) for Culture and Minister of State for Environment, Forest & Climate Change Dr. Mahesh Sharma in a written reply in Rajya Sabha today.

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NB/SK/UD

(Release ID: 1515229) Visitor Counter : 837
Cabinet approves setting up of new AIIMS in Bilaspur

The Union Cabinet chaired by Prime Minister Shri Narendra Modi has given its approval for establishment of new AIIMS in Bilaspur (Himachal Pradesh) under the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The cost of the project is Rs.1351 crore.

Salient features:

- The new AIIMS will be completed in a period of 48 months with a pre-construction phase of 12 months, construction phase of 30 months and stabilization / commissioning phase of 6 months.
- The Institution will consist of a hospital with a capacity of 750 beds and trauma center facilities.
- It will have a Medical college with an intake of 100 MBBS students per year.
- Nursing college with an intake of 60 B.Sc. (Nursing) students per year.
- Residential complexes and allied facilities / services, broadly on the pattern of AIIMS, New Delhi.
- The hospital will have 20 Speciality/Super-Speciality Departments including 15 Operation Theatres.
- It will also have an AYUSH department with 30 beds for providing treatment facilities in traditional system of medicine.

Impact:

The establishment of new AIIMS will serve the dual purpose of providing super speciality health care to the population while also help create a large pool of doctors and other health workers in this region that can be available for primary and secondary level institutions / facilities being created under National Health Mission (NHM).

Background:

Under this scheme, AIIMS have been established in Bhubaneshwar, Bhopal, Raipur, Jodhpur, Rishikesh and Patna while work of AIIMS Rae Bareli is in progress. Also, three AIIMS in Nagpur (Maharashtra), Kalyani (West Bengal) and Mangalagiri in Guntur (Andhra Pradesh) have been sanctioned in 2015, two AIIMS have been sanctioned at Bathinda and Gorakhpur in 2016 and an AIIMS in Kamrup (Assam).

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AKT/VBA/SH

(Release ID: 1515180) Visitor Counter : 1320
The National Medical Commission Bill, aimed at reforming Indian medical education and practice, is in trouble. After countrywide protests by the Indian Medical Association, the Bill was referred by the Lok Sabha to a Parliamentary Standing Committee for a re-look. Whatever be the outcome of this exercise, the altered Bill is unlikely to please everyone.

This is because the questions it seeks to address are knotty, with no straightforward answers. First, how can India produce enough competent doctors to meet its evolving health-care challenges? Second, how can it minimise opportunities for rent-seeking in medical education and practice? So poorly did India’s current medical regulator, the Medical Council of India (MCI), perform on both counts that policymakers believed the only way to redeem the body was to replace it.

The MCI’s failures are well known. For years, it was mired in allegations of bribery and going soft on unethical doctors. Under its stewardship, the medical curriculum grew obsolete, resulting in a cadre of MBBS doctors who frequently couldn’t perform basic procedures. This led to a rush among MBBS doctors to specialise, competing for a small number of post-graduation seats. Today, India neither has enough basic doctors, nor specialists.

Enter the National Medical Commission (NMC), intended by policymakers to be a dynamic regulator responsive to India’s needs, unlike the opaque MCI. In contrast with the MCI, which does everything from advising universities on curriculum to disciplining errant doctors, the NMC distributes powers among four autonomous boards — those for undergraduate education, postgraduate education, medical assessment and rating, and ethics and registration. Also, unlike the MCI, the commission includes non-doctors like patient-rights advocates and ethicists, in line with the medical regulators of the U.K., Australia and Canada. These are all steps in the right direction.

Where the NMC bill trips up is in how it chooses the members of the new regulator. The authors of the NMC bill, a committee headed by ex-vice chairman of Niti Aayog, Arvind Panagariya, argued that the electoral process through which MCI members were picked was fundamentally flawed, because conscientious doctors tended to avoid such elections. Because there was no bar on re-elections, this had created a revolving door through which the same group of members controlled the MCI for years. Sometime around 2008, Gujarati urologist Ketan Desai was elected MCI president, even though he had been prosecuted in the Delhi High Court for abusing power as president in 2001. Further, corruption charges against Dr. Desai and his team led to the MCI being disbanded in 2010.

The NMC Bill’s solution to the pitfalls of the electoral process is for the central government to select most of the commission’s members. But this would tip the scales towards bureaucracy, say experts. “The babudom is now extreme,” says Rama Baru, a health-policy researcher who served on the ethics committee of the MCI between 2012 and 2014. Such political hold on the commission is especially problematic, she adds, given the close ties that private medical colleges in southern India have with politicians. Ms. Baru is in favour of more elected members in the commission, but with limited terms of office, so that corrupt members aren’t re-elected.

Another option to keep the NMC free from political influence is for an independent body like the Union Public Service Commission to select its members, says Sujatha K. Rao, a former Union
Health Secretary. Such a model is followed in the U.K., where the Professional Standards Authority oversees the selection of members to the General Medical Council. Whatever route the NMC takes, it is critical that its members are professionals of high integrity, something that isn’t ensured in the current Bill. “Any law will succeed if it is implemented by good people. The best law, if implemented by corrupt people, can fail,” says Ms. Rao.

The NMC Bill also misses an opportunity to plan for India’s rural health-care needs in the coming decades. While it eases regulations to set up private medical colleges, a move that will hopefully produce more doctors, this measure isn’t enough. As of today, India has one doctor for 1,700 people, compared to the WHO norm of 1:1,000. Most of these doctors are in urban regions, while close to 70% of Indians live in rural provinces. This gap isn’t going to close any time soon. A 2015 Parliamentary Standing Committee report mentioned that even if India were to add 100 medical colleges per year for five years, it would take till 2029 to achieve the WHO prescribed ratio.

Even in States like Tamil Nadu, which has successfully attracted doctors to rural primary health centres (PHCs), tribal regions like Sittilingi are underserved and rely heavily on informal health-care providers, says Meenakshi Gautham, a health policy researcher at the London School of Hygiene and Tropical medicine. This is why India must think of quicker fixes to the doctor shortage instead of waiting for MBBS doctors to fill the gap. “We can’t ask populations here to wait for ten years till we produce enough doctors. Neither can we wait for rural areas to become urbanised,” she reasons.

Several sub-Saharan countries have successfully addressed this problem by training non-doctors in basic medicine and even surgery. Such non-doctors include nurses, or even informal health-care providers, often referred to as quacks. A 2016 study published in Science magazine showed that nine months of training led to a marked improvement in the ability of informal providers in West Bengal to correctly manage chest-pain, respiratory distress and childhood diarrhoea. International organisations like Médecins Sans Frontières and Red Cross have endorsed training programmes for non-doctors to carry out critical surgical procedures like caesarians and intestinal resections. Evidence from countries like Mozambique and Thailand shows that such training can be a safe, effective and cheap way to provide life-saving health care when no doctors are available. This is why even Chhattisgarh attempted to create a cadre of rural doctors in 2001, through a three-year programme. Even though the Indian Medical Association has strongly opposed such ideas, they cannot be off the table, given the evidence backing them. Ms. Gautham says it is time to recognise that MBBS doctors may not be the best means of health-care delivery in isolated parts of rural India. The NMC Bill should, at the very least, include a provision to debate this idea.

The 1956 Indian Medical Council Act, under which the MCI in its current form came to life, set the agenda for nearly 60 years of medical education and practice. The NMC Bill could do the same for the next few decades. If policymakers do not address the many questions that health-care experts have raised over the Bill today, they will miss their chance at truly game-changing reform.

End
Thinking beyond quotas

The Gujjars in Rajasthan, the Jats in Haryana and the Patels in Gujarat have shown that politically powerful communities nurturing a sense of victimhood can mount a powerful challenge to the Indian state. One of India’s foremost political commentators, Rajni Kothari, had once agonised over this, expressing his concern at “our incapacity and our growing powerlessness before vested interests that have acted in concert to take the system in completely different directions”.

With half, and in some instances more, of all educational and job opportunities in the public sector going to candidates coming under the reserved category, there is some resonance to Hardik Patel’s demand made in 2015 to “either free the country from reservations or make everybody the slave of reservations”. This is a widely shared feeling across the country by communities feeling marginalised because of a policy of reservation which was once limited, focussed as well as necessary but is now spiralling out of control.

What the young are looking for today is not more of the same — admissions to courses that lead to nowhere and low-entry jobs in the government. By empowering them with skills the world needs today and tomorrow, the government will be building the country’s human capital far more quickly than any more reservations ever can.

There is a lot of ground to be covered. The vocational training schemes in the country are inadequate and woefully behind the times with many addressing yesterday’s needs. There are some good schemes like those offered by the Nettur Technical Training Foundation (NTTF) in Bengaluru but they are simply too few.

Technical training is also constrained by a small educational base — 70% of India’s workforce is without tertiary education — and a crippling lack of well-qualified trainers. Does it then come as a surprise that India, despite its young workforce, has never been able to challenge China in manufacturing? This needs to be acknowledged upfront as a major national catastrophe and tackled as such.

We have lost more than a decade in not complementing a mass welfare scheme like the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) with a bigger programme to train the young for employment. One outcome of such neglect is that there is a clamour for more reservations that is bringing India to its knees, often with devastating effects. The sooner our politicians acknowledge address this, the better it will be for India.

Uday Balakrishnan is a visiting faculty at Centre for Contemporary Studies, Indian Institute of Science, Bengaluru

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Only an overhaul resembling the industrial liberalisation of 1991 will work

END
Free and compulsory education of children in the 6 to 14 age group in India became a fundamental right when, in 2002, Article 21-A was inserted in the 86th Amendment to the Constitution. This right was to be governed by law, as the state may determine, and the enforcing legislation for this came eight years later, as the Right of Children to Free and Compulsory Education (RTE) Act, 2010, or the RTE Act.

With examples from over a hundred countries having various and similar pieces of legislation or regulations already in place, there were practices drawn from similar experiences. Since its enactment, the RTE Act has been lauded and disparaged. But there has been concern not only over its provisions but also about the lacunae in the school education system. However, there are clauses in the Act which have enormous catalytic potential but that have gone largely untouched and unnoticed. A focus on three of these provisions can result in an immediate and discernible impact.

The RTE Act is a game-changer in that it establishes that the onus to ensure free and compulsory education lies on the state. However, the ‘compulsory’ and ‘state liability’ part needs to be imbibed by the educational bureaucracy, which is now lacking.

Though the Act envisaged that the state, i.e. State governments and panchayats, would aggressively ensure that each child is brought into the schooling system and also “retained” for eight years, it has been business as usual. Unfortunately, tracking dropouts and preparing and mainstreaming them into age-appropriate classes has been subsumed into existing scheme activities. Even seven years after its enactment, there are still children on the streets, in fields and in homes. Therefore, the problem now is more about dropouts than children who were never enrolled. Strategies to ensure retention need to change from the earlier approach of enrolling the un-enrolled. As children out of the fold of schooling are the most hard to reach, such as girls, the disabled, orphans and those from single parent families, the solutions have to be localised and contextualised.

Though criticised as an elitist or input-driven approach, the RTE Act prescribes basic minimum standards for a school such as provision for toilets, drinking water and classrooms.

The most critical requirement, which has also got the least public attention, is the pupil-teacher ratio (PTR). It is impractical to expect quality education without this. According to the Education Department’s data, under the Unified District Information System for Education (U-DISE) database 2015-16, 33% of the schools in the country did not have the requisite number of teachers, as prescribed in the RTE norms, for PTR at the school level. The percentage of schools that were PTR-compliant varied from 100% in Lakshadweep to 16.67% in Bihar. This did not factor in subject-wise teachers at the upper primary level as this is treated differently in each State. All other forward-looking provisions of the Act such as continuous assessment, a child learning at her own pace, and ‘no detention’ policy are contingent on a school with an adequate number of teachers. No meaningful teaching-learning is possible unless trained teachers are physically present at school. Teachers also need to avail of leave or undergo training, so that ‘two teachers per school’ is a basic requirement.

States shy away from recruiting or posting more teachers keeping in mind higher salaries and finances, but PTR at the school level is the most critical of all inputs. Teacher provisioning should be the first option to fund as no educationally developed country has built up a sound schooling foundation without a professionally-motivated teaching cadre in place. In States with an adequate overall number of teachers, their positioning or posting requires rationalisation according to the
number of students. However, this gets more lip service than attention as teacher transfers remain a grey area in most States.

Think decentralisation

The third provision is that the academic calendar will be decided by the local authority, which, for most States and Union Territories, is the panchayat. This provision recognises the vast cultural and regional diversities within the country such as local festivals, sowing and harvesting seasons, and even natural calamities as a result of which schools do not function academically. It is socially acceptable that priority will be given to such a local event and not schooling. Not all festivals and State holidays declared by the State headquarters may be locally relevant. So if panchayats, perhaps at the district level, decide the working days and holidays, this would not only exponentially increase attendance and teaching-learning but also strengthen local panchayats, being closest to the field, to take ownership of their schools. They would be responsible in ensuring the functioning of the prescribed instruction days. For inexplicable reasons, the educational bureaucracy has not allowed the decentralisation of academic schedules even in districts.

A law is as good or as bad as its implementation. It is unfair to blame legislation alone for the sad state of affairs without implementing it in full measure, especially its enabling provisions. Open-minded adoption of these provisions, keeping the child in mind, can go a long way in radically transforming our school education sector.

Maninder Kaur Dwivedi is an IAS officer. The views expressed are personal

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Marriage is a civil contract — adultery or divorce should have only civil consequences
Encourage Youth to be ‘Job-giver ‘and not ‘Job-seeker’: Shri Ram Nath Kovind

Socio-economic Democracy is essential to strengthen Political Democracy

The President of India Shri Ram Nath Kovind gave inaugural address at the ‘Economic Democracy Conclave’ organised by Rambhau Mhalgi Prabodhini, Keshav Srushti, Uttan Village at Thane today. The President emphasised upon self-employment and entrepreneurship, by imparting skills, creating conducive ecosystem and encouraging youth to aspire as ‘job giver’ instead of ‘job-seeker’.

The President at the beginning of his speech at ‘Economic Democracy Conclave’ blessed all the enterprising youth in Marathi. He shared his memories about his association with the Rambhau Mhalgi Prabodhini and praised its values of discipline, dutifulness, commitment and work culture. The President also highlighted that the Mumbai, the financial capital and surrounding region host number of opportunities for all ranging from self-employed vendor to corporate industrialist. He then appealed to all youth that they should play role in development of society and economy by utilising these opportunities. He further congratulated the institute for taking up this initiative and extended his best wishes.

The President acknowledged, as voter awareness is done for building political democracy, similarly, there is also need to inform and inspire people of their socio political rights, policies and opportunities, particularly for the marginalised section of the society. He attributed Dr Bababsaheb Ambedkar as founder of Economic Democracy in Modern India and emphasised that Socio-Economic Disparity must be dispelled and Socio-economic Democracy is essential to strengthen Political Democracy. All citizens must get socio-economic and political justice. Therefore, many programmes like - Jan-Dhan Yojana, Mudra Yojana, Stand-Up India and Start-Up India, have been initiated based on Sabka Sath, Sabka Vikas and ‘Sabka Samman, Sabka Utthan’.

He highlighted that out of 30 Crores Jan-Dhan Accounts opened in banks; about 52% of accounts are of women, making society financially more inclusive. He also noted that domestic saving should not be kept idle but invested. In this context, awareness about financial literacy is critical, which shall inculcate enterprising spirit while strengthening economic democracy. He also noted that financial inclusion through Jan-Dhan Yojana and subsequent Direct Benefit Transfer Scheme
has improved transparency and minimised corruption.

The President called upon to impart skill training to empower and encourage enterprising youth. Such young entrepreneurs are being supported by Prabodhini and DICCI (Dalit Indian Chamber of commerce & Industry) like institutions, also Private sector industrialists like TATA Group have extended opportunities, He added. He expressed confidence that youth shall make best of opportunities created through government programmes and non-government facilities through NGOs, NBFCs, Media and they turn up to self-employment as a matter of choice, becoming ‘job-giver’ than job-seeker’.

Chief Minister of Maharashtra, Shri Devendra Fadnavis expressed confidence that, at this conclave, many of our youth would share their experiences and deliberate by which a future roadmap for a strong global power called ‘India’, will be prepared. He said, our nation achieved political equality with the power of voting to all but our democracy can be strengthened only when financial and social equality too is achieved. This was dreamt by BharatRatna Dr Babasaheb Ambedkar and we are marching forward in that direction. After 70 years of independence, with all such schemes we have opened up the doors of banks for the masses, which were earlier limited to only classes. This is enabling every citizen to stand on his own feet and be independent. This is the true meaning of empowerment, he added.

‘Economic Democracy Conclave’ is a first of its kind initiative organised by Rambhau Mhalgi Prabodhini, at Keshav Srushti, Uttan Village in Thane. Member of Parliament and Vice-Chairman of Rambhau Mhalgi Prabodhini, Shri Vinay Sahasrabuddhe welcomed Chief Guest and dignitaries including First Lady of India Smt Savita Kovind, Governor of Maharashtra C Vidysagar Rao, and Minister of State for Finance Shiv Pratap Shukla. While, Chairman of Rambhau Mhalgi Prabodhini Prof. Aniruddha Deshpande extended vote of thanks to all present at the conclave.

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(Release ID: 1516661) Visitor Counter : 535
Operation Digital Board in the offing

The Central Advisory Board of Education (CABE) on Monday passed a resolution to take steps towards Operation Digital Board on the lines of Operation Blackboard of 1987, which was started with the purpose of providing minimum basic facilities to all primary schools.

“The idea of Operation Digital Board is aimed at providing better digital education in all schools. This will offer new opportunities and new ways of teaching and learning to schools,” Minister of Human Resource Development Prakash Javadekar said after the first day of the two-day 65th CABE meeting here.

The Minister added, “It will be our endeavour to launch Operation Digital Board with the involvement of the Central and State governments, CSIR and community support.”

Would take time

He said that the meeting had resolved to carry out the vision and that it would take time for the details of the scheme to emerge.

Education Ministers of 22 States took part in the CABE meeting. Other States were represented by their officials. Each State informed the policy-making advisory body on education about their educational achievements, initiatives for digital education and teacher training, etc.

Mr. Javadekar said the future vision was to provide quality education, equity, accessibility, accountability and affordability.

Telangana shared its achievement of creating residential schools on the Navodaya Vidyalaya pattern to cater to as many as eight lakh students.

The first-day of the CABE meeting was dedicated to school education. On the concluding day of the meet on Tuesday, higher education will be discussed.

END
The Right to Education Act came into force in 2010. However, the trend towards universal elementary education was well in place before that. For example, for the age group 6 to 14, enrolment levels have been high and rising for quite some time. Even as early as 2005-6, the first Annual Status of Education Report (ASER) and an independent household survey commissioned by the Ministry of Human Resource Development around the same time, confirmed that well over 90 per cent children in this age group were enrolled in school. In fact, tracking ASER data over time, we can see that for children (6 to 14) in rural India, enrolment rates have over 95 per cent for over 10 years now.

What are the implications of almost all children being in school? It is well known that enrolment is high. What is less known is that for the first time in the history of India, we are beginning to see cohorts of children almost all of whom have completed eight years of schooling. Census data suggests that there are roughly about 25 million children in each age group in India. According to government figures (DISE), in 2005-6, a little over 11 million were enrolled in Class 8. In 10 years, this number has almost doubled. In 2014-15, there were close to 22 million children enrolled in Class 8.

This number must be even higher today. Relatively speaking, the overall number for Class 8 enrolment has not increased much in states like Maharashtra or Tamil Nadu. But in young states where provision of primary schooling has expanded a lot in these years, the increase in Class 8 enrolment is massive. In Bihar, half a million children were in Class 8 in 2005-6. By 2013-14 this number had risen to 1.7 million. In UP, the figure had gone from 1.7 million to 3.4 million in the same period.

For young people, age matters. There are distinct differences in activity status by age. By the time children reach Class 8, the bulk of them tend to be in the age range of 13, 14 or 15. But for both boys and girls, the proportion of children not enrolled in school at age 13 is substantially different from that at age 15. ASER data from 2006 indicates that at least in rural India, 10 per cent of 13-year-old girls and 21 per cent of 15-year-old girls were not enrolled in school. By 2016, this number had fallen to 4.2 per cent for 13-year-olds and almost 14 per cent for 15-year-olds. Incidentally, the gender differences among boys and girls had also narrowed considerably in this time.

What do we know about the basic capabilities of those who have completed eight years of schooling? For over a decade, the ASER reports have been pointing out that foundational skills like reading and basic arithmetic even at the point of completion of elementary school are worryingly low. About a quarter of all children in Class 8 struggle with reading simple texts and more than half are still unable to do basic arithmetic operations like division.

ASER data also suggests a declining trend over time. This means that successive cohorts of children reaching Class 8 are doing worse than their previous counterparts. This pattern is also seen in other studies that longitudinally track student achievement. For example, the Young Lives study that has been following children over a long period of time in Andhra Pradesh finds that the percentage of 12-year-olds answering the same maths questions correctly in 2006 is higher than that in 2013. A hint of this decline was also visible in the analyses done on past rounds of the government’s National Achievement Survey data.

What does all this empirical evidence point to? As a country, we need to be ready for a new generation of young people. Every year we will be “graduating” a cohort of close to 25 million young and hopeful boys and girls from elementary school. These cohorts will move past the goal
They cannot enter the work force at least in the organised sector until they are 18. For many families, these children are the first from their families ever to get this far in school. On the one hand, aspirations run high. Parents and children expect that such “graduates” from school will go on to high school and college. Hardly anyone wants to go back to agriculture where their parents may have spent their entire working life. On the other hand, abilities, at least in terms of academic competencies, are far lower than they should be even based on curricular expectations of Class 8. Whether in terms of further education or work, caught between high aspirations and worryingly insufficient levels of learning, this generation is moving ahead into an uncertain future.

There is still time to help. On the side of provision, there are ongoing moves to universalise secondary schooling; there are serious efforts to expand skilling opportunities. But as a country, we need to know not only what we want to prepare this generation for but also what the young people are aspiring to do.

Aligning abilities and achievements with aspirations, forging promising alternative new pathways forward is critical not only for youth but for the country as well. On January 16, a new ASER report will become available. This time, the exercise focusses on the age group 14 to 18. Close to 120 million people are in this age group in India today. We hope that shining a spotlight on this new generation will enable a national discussion to start. If we do that with commitment and urgency, then solutions and possible pathways will follow.
Epidemics or famines, women tough it out better

The report says that newborn girls were able to survive the harsh conditions better than newborn boys. File photo. | Photo Credit: Monica Tiwari

A new study published in scientific journal *PNAS* says that women survive longer than men in adverse conditions such as famines and epidemics. Scientists from Denmark and Germany examined seven populations from different countries that faced extreme conditions and arrived at this conclusion. They figured that other than behavioural and social factors, there must be a strong biological reason behind women becoming “life-expectancy champions.”

Previous research has proved that almost anywhere in the world today women can live longer than men and they also “survive cardiovascular diseases, cancers and disabilities longer than men.”

In this study, scientists wanted to investigate the power of women to survive under extreme circumstances such as famines and epidemics and also during slavery.

The researchers, for instance, found out that 43% of freed slaves who were allowed to return to Liberia from America between 1820 and 1843 died in the first year of their return. Life expectancy at birth was reduced to 1.68 years for men and 2.23 years for women. A similar reduction in life expectancy was seen among the plantation slaves in Trinidad in the early 19th century. Their life expectancy dropped to as low as 15 for men and 20 for women.

They also studied the 1933 famine in Ukraine, the 1772-73 Swedish famine, the Icelandic measles epidemics in 1846 and 1882, and also the Irish famine of 1845-49. In all these case studies, women lived longer than men though women were in bad health during those extra years.

The researchers also found that women survived longer than men during the Dutch famine and famines of Madras and Bombay.

Further, the report says that newborn girls were able to survive the harsh conditions better than newborn boys. The fact that females survive better shows that the survival advantage comes from “fundamental biological roots,” it says.

Some studies have shown that progesterone and testosterone have immunosuppressive effects, while estrogens can enhance immunity. More studies are required to understand the exact mechanisms behind sex hormones and immune response.

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Astronauts on extended space travel missions would have significant bone and muscle complications.

END
WHO revises advice on delamanid drug use in MDR-TB patients

A TB patient in a hospital in Guwahati. | Photo Credit: AP

Delamanid drug, approved for use in multidrug-resistant tuberculosis (MDR-TB) patients by the World Health Organisation in October 2014, did not show any statistically significant difference in successfully curing the disease or reducing the mortality rates compared with a dummy in a Phase III human clinical trial, WHO’s position statement issued on January 15 says. However, the drug was found to be safe unlike many of the other second-line medicines used for MDR-TB treatment.

Though the trial did not confirm the efficacy findings of earlier studies, delamanid should be retained in country guidelines, national essential medicine lists and procurement options, says WHO. But the MDR-TB treatment algorithms “may need adjustment” in view of the Phase III trial results.

The 2014 interim guidance issued by the WHO on the use of the drug for treating MDR-TB patients was based on Phase IIb trial results and subject to review once Phase III trial results become available. A person is said to have MDR-TB when there is drug resistance to at least isoniazid and rifampicin, the two main first-line TB drugs.

In addition to optimised MDR-TB regimen, participants in the trial received either delamanid or a dummy for six months. At the end of 30 months of follow-up, 77.1% of MDR-TB patients who received delamanid drug were cured compared with 77.6% of those who received a placebo (dummy), and mortality was 5.3% in the delamanid group and 4.7% in the placebo group.

As a result, the WHO has advised all national TB programmes to include delamanid to longer MDR-TB regimen only when patients cannot tolerate or show resistance to certain second-line TB drugs. “When an effective and well-tolerated longer MDR-TB regimen can be otherwise composed, the addition of delamanid may not be warranted,” the WHO says.

The conditions for using delamanid drug in patients remain the same — careful selection of patients who are likely to benefit, designing a longer MDR-TB regimen as recommended by the WHO, close monitoring of treatment response, and active TB drug-safety monitoring and management.

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Astronauts on extended space travel missions would have significant bone and muscle complications.
Survival stories: The deaths vary from 43 in rural areas to 25 in urban areas.

India posted its sharpest year-on-year decline in the under-5 infant mortality rate (u5) since 2010, according to figures from the Sample Registration Survey (SRS) made public this week. The u5, at 39 deaths per 1,000 live births, recorded a 5-point decline from the 2015 figure of 43.

According to the Union Health Ministry, this was a “landmark achievement” that translated to nearly 1,20,000 fewer deaths in 2016 as compared to 2015.

At the national level, the u5 varies from 43 in rural areas to 25 in urban areas and ranges from 11 in Kerala to 55 in Madhya Pradesh. Except Chhattisgarh and Madhya Pradesh, all the “bigger States/Union Territories” have higher u-5 mortality rates among girls than boys.

“In Kerala the number of children dying between 1 and 5 years is very low, at just one per 1,000 live births. However, the data shows that the gender divide and the urban-rural gap when it comes to infant deaths continue in Kerala too as in most States. More girls seem to be dying than boys, the death rate of girls being 12 against 10 for boys. Also, the death rate is 12 in rural areas against 10 in urban areas,” Job Zachariah, UNICEF chief for Kerala and Tamil Nadu, told The Hindu, while commenting on the numbers from Kerala.

Though not as good as Kerala, Maharashtra too has recorded a dip. From 23 in 2014 and 24 in 2015, the State has gone down to 21 deaths per 1,000 children in the age group of 1 to 5 years in 2016.

“Our aim is to get as good as Kerala,” Maharashtra’s Health Minister Deepak Sawant said on Tuesday.

Last year in September, the State had recorded a dip in the infant mortality rate (0 to 1 year) and the progress was attributed to the regular screening and immunisation camps, especially in the tribal areas of Jawahar, Mokhada, Melghat, Palghar, etc.

The State’s aggressive troubleshooting, however, started after more than 50 babies died in the Special Newborn Care Unit (SNCU) of the Nashik Civil Hospital last August.

The latest round of data builds on the SRS numbers made public last September that showed India had registered a significant 8% (3 point) decline in infant deaths per 1,000 live births (IMR) over the previous year. The IMR refers to death in infants who were yet to turn one.

The decline from 37 to 34 per 1,000 live births translated to 90,000 fewer infant deaths in 2016 compared to 2015.

In 2016, that edition of the report noted, India also recorded a major drop in birth cohort, which had for the first time come down to below 25 million.

Despite this drop, one in every 29 infants nationally, one in every 26 infants in rural areas and one in every 43 infants in urban areas continues to die within the first year of their lives. Moreover, the sex ratio at birth — the SRS found — continued a steady decline that began in 2013 with only 898 girls for every 1,000 boys in 2016 compared to 909 girls for 1,000 boys in 2013.

(With inputs from Jyoti Shelar and C. Maya)
Left behind: on the right to free, compulsory education

If there is one strong message from the findings of the Annual Status of Education Report (Rural) 2017, it is that the Right of Children to Free and Compulsory Education Act should cover the entire spectrum of 18 years, and not confine itself to those aged 6 to 14. Guaranteed inclusion will empower those in the 14-18 age group who are not enrolled anywhere, and help them acquire finishing education that is so vital to their participation in the workforce. The ASER sample study estimates that 14% of this age group — a total of 125 million young Indians in this category — are not enrolled. It is absolutely essential for all of them to get an education that equips them with the skills, especially job-oriented vocational capabilities, if the expectation of a demographic dividend is to be meaningful. Unfortunately, the state of rural elementary education is far from encouraging. To begin with, only 5% of the respondents in the survey, which was aided by the NGO Pratham, reported doing any kind of vocational course, and even among this small minority a third were enrolled for three months or less. Moreover, learning outcomes for those who had progressed to higher levels of schooling were shockingly low: only 43% of the youth could solve an arithmetic problem involving division of a three-digit number by a single digit; among those who were no longer in school, the percentage was sharply lower.

The insights available from successive studies point to progress being made in raw enrolment of children in school, but miserable failures in achieving learning outcomes. Also, enrolment figures often do not mean high attendance. It is not surprising, therefore, that a significant section of secondary level students find it difficult to read standard texts meant for junior classes or locate their own State on the map. There are also discrete differences among States on the number of youth who are not on the rolls in appropriate levels of schooling, with 29.4% of both boys and girls aged 17-18 not enrolled in a Chhattisgarh district, compared to 4.5% and 3.9%, respectively, in a Kerala district. The ASER data point to a massive digital divide, with 61% of respondents stating they had never used the Internet, and 56% a computer, while mobile telephony was accessible to 73%. Here too, girls were worse off in terms of access to computers and the Internet. Scaling up access to these can be achieved by bringing all children under the umbrella of a school, college or training institution. All expenditure on good education is bound to have a multiplier effect on productivity. What is needed is a vision that will translate the objectives of the RTE Act into a comprehensive guarantee, expanding its scope to cover all levels of education. This will remove the lacuna in policy that awaits remedy seven decades after Independence.

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The draft of Assam’s National Register of Citizens is a first step, but it opens up concerns
Learning gaps

The Annual Status of Education Report (ASER), released on Tuesday, is significant for several reasons. In looking at the age group of 14-18, the survey — to begin with — offers insights into the performance of the Right to Education Act, eight years after it made elementary education a fundamental right. The 14-year olds surveyed in the report, brought out by the NGO Pratham, are amongst the first to have benefited from the Act’s provisions of free and compulsory education for those in the age group of six to 14.

There is heartening news here: Only 5.3 per cent of these teenagers are not in school. The ASER report shows that most continue to stay within the formal education system even when they are out of the Act’s ambit. More than 92 per cent children, aged 15, were in school.

But that’s where the good news end. In fact, with 30.2 per cent children aged 18 not receiving education, the situation gets alarming. As the report notes, “With almost 10 per cent of India’s population in the age group of 14-18, these percentages translate into large numbers of youth who are not in the formal education system”.

The past 11 ASER reports, which focused on 6-14 year olds, indicated parity between girls and boys on school enrollment. Such parity is more or less maintained at age 14. However, by age 18, there are 4.3 per cent more girls than boys who are not enrolled in the formal education system. The gender divide gets even more glaring with the boys outperforming girls in almost every task assigned to them and being privileged in several respects, including access to computers.

The 14-18 age bracket is very close to the incoming earning age. Seen that way, ASER 2017 highlights the challenges that have to be overcome before India can reap the benefits of being the country with the largest young population in the world. It is alarming, for example, that about 25 per cent of the youth in the age group of 14-18 cannot read a basic text fluently in their own language. Learning deficits such as this highlight the need for pedagogic tools that synchronise knowledge with lived realities.

ASER 2017 shows that though the need to increase enrollment remains pressing, the imperatives of reforming curricula and pedagogy can no longer yield second place to it. The report should go some way in addressing the complaint of policymakers that lack of data on learning outcomes prevents tweaking policies, meaningfully. The important takeaway of the report is that education should not only provide young people the skills but also the confidence to deal with the world. India’s education system has some way to go before it fulfills that objective.
Building on India's family planning success

Social reformer Raghunath Dhondo Karve was well ahead of his time when he pioneered family planning in Mumbai in the 1920s. Independent India's first government caught up in 1952 when it started the world's first family planning programme. There have been missteps since, such as Sanjay Gandhi's forced sterilization drive. On the whole, these programmes have done well in tackling India's fertility challenge. The recently released report on the fourth round of the National Family Health Survey (NFHS-4), carried out in 2015-16, shows where it has succeeded—and where shortcomings remain.

The total fertility rate has declined to 2.2, marginally above the replacement rate of 2.1. This is substantial progress from 2005-2006 when NFHS-3 pegged the rate at 2.7. There are a number of takeaways from slicing the numbers in different ways. The first is the geographic variance. The fertility rate in 23 states and Union territories—including all the southern states—is below the replacement rate. It is substantially higher in a number of states in central, east and north-east India. Bihar, for instance, has the highest rate at 3.41, followed by Meghalaya at 3.04 and Uttar Pradesh and Nagaland at 2.74. Plainly, the nature and scope of the fertility-related public health challenge facing state governments varies widely. So must the response. The most effective way of enabling this is a greater role for local bodies in both urban and rural areas—an item on the incomplete devolution agenda.

Second, breaking up the fertility rate by the background characteristics of female respondents produces the central takeaway. Education is a clear differentiator. Women with 12 years or more of schooling have a fertility rate of 1.7, while women with no schooling have an average rate of 3.1. Birth order backs this up. Thirty-one per cent of births to women with no schooling were of birth order four or higher. The corresponding rate for women with 12 years or more of schooling was 2%.

Education levels are strongly correlated with another important aspect of the fertility rate. Higher levels of schooling mean lower levels of teenage pregnancy. In the 15-19 cohort, as many as one-fifth of the women with no schooling have begun childbearing, while only one in 25 women in the same cohort who have had 12 years or more of schooling have done so. Teenage childbearing, in turn, results in greater health risks. The median birth interval in the 15-19 group is 22.6 months. Birth intervals smaller than 24 months “are associated with increased health risks for both mothers and newborns”.

The implication is clear. Lack of education robs women of reproductive control, feeding into India's maternal and child health problem. Combined with younger pregnancies and higher childbearing rates, it also constrains women’s economic choices. This, in turn, reinforces a lack of reproductive control—44% of women who are unemployed use modern contraceptives while 60% of women who are employed for cash do so—perpetuating a vicious cycle.

The skewed pattern of contraceptive usage is the third takeaway. Knowledge of contraceptive methods is now almost universal in India; the government has done well here. Despite this, men have not taken up the responsibility of managing fertility. The most popular contraceptive method by far, at 36%, is female sterilization. Male sterilization—a less invasive and easier method with a much lower chance of medical complications—accounts for a mere 0.3%. Male condom usage is low as well, at 5.6%. The public healthcare system, which accounts for almost 70% of modern contraceptive usage, doesn’t do enough to address this problem caused by societal attitudes. Only 54% of women were informed of other available contraceptive methods while 47% of women were informed of the possible side effects of their chosen method.
The initial decades of India’s family planning efforts were shaped by foreign funds and agencies that were driven by Malthusian economics. That particular logic has long since been debunked. Now, the Centre and state governments must catch up. The National Population Policy (NPP) of 2000 explicitly rejected the numbers game—the targeted approach that had dominated fertility management until then. But the hangover remains with the National Health Policy 2017 again setting a fertility rate target. And it took the Supreme Court, in its 2016 verdict in Devika Biswas vs Union of India & Others, to call for an end to sterilization camps. These corral poorly informed women, largely in rural areas, in order to hit bureaucratic targets, often violating reproductive rights in the process.

Almost a century ago, Karve took the then radical view that women could best confront the fertility challenge via emancipation and gender equality. That continues to hold true today. Successive governments have done well over the decades; NFHS-4 shows improvement in almost all metrics from the 2005-06 NFHS-3. Now, they must focus on enabling educational and economic opportunities for women.

*Has India made sufficient progress in addressing the fertility health challenge? Tell us at views@livemint.com*
Private unaided schools deserve a better bargain

The rot in India’s primary education was bound to affect the quality of our workforce. There is a direct bearing of poor learning outcomes in primary schools on the students’ future, and these concerns have been verified by Pratham’s latest Annual Survey of Education Report (Aser) 2017, “Beyond Basics”, that focuses on students in the 14-18 age group.

The survey finds that while 86% of adolescents are enrolled in schools, they are under-equipped to contribute to the economy in any meaningful way. Twenty-five per cent of the students cannot read a basic text in their own language fluently. Forty per cent of 18-year-olds cannot read a simple sentence in English. And they lack basic arithmetic skills; only 43% of them could perform a simple division. This translates to unacceptable performance in everyday tasks, gauged by proxy tests like measuring length, calculating time, applying the unitary method and comprehending the instructions written on a pack of oral rehydration solution.

India has achieved universal enrolment at the elementary level. This is a great achievement, but getting students to school is only the beginning of human capital formation. Learning requires a lot more than attendance. In order for students to stay in school, the school needs to create a palpable difference in the students’ abilities. The drop in the enrolment rate in secondary education (78.5%), despite the high returns to education, shows that something is wrong in our quality of instruction.

The starting point of the analysis has to be the performance of private unaided schools, vis-a-vis government schools.

Research by Geeta Gandhi Kingdon has demonstrated that private unaided schools have much better learning outcomes per unit of expenditure. Contrary to popular opinion, most private unaided schools are inexpensive; 80% of them charge a fee that is lower than the government’s per-pupil expenditure (PPE). Averaging across states, private school fee is less than 47% of the PPE of government schools (which Kingdon suggests is underestimated.) In terms of learning outcomes, both private and government schools performed poorly, but private schools perform better. In the 2014 Aser report, the difference between the percentage of private and government school students in class V who were able to perform a division and read a class II text was 18.6% and 20.3%, respectively. Controlling for students’ home background, the difference falls but an achievement gap of 0.10 to 0.35 standard deviation remains. Thus, the data shows that private unaided schools are delivering the same, if not better, learning outcomes than government schools at a fraction of the cost, despite resource constraints.

This shows that more inputs do not translate into better outputs. Despite qualified teachers, mid-day meals and free admissions, 13 million students left government schools between 2011 and 2016, while private school enrolment increased by 17 million in that duration.

Clearly, people are choosing private schools for their better service. What implications does this have for India’s education policy?

For starters, the government needs to acknowledge the fact that “unrecognized” private unaided schools play an important role. The Right to Education Act stipulates that private schools cannot be established or continue to function without obtaining a “certificate of recognition” from the state government, i.e. until they meet stipulated norms such as the maximum pupil-teacher-ratio and infrastructure. This has made many schools economically unviable and forced them to shut down.

Given that millions of students have left government schools for private ones, the government...
should support their education by giving school vouchers to all underprivileged students. The students can choose to spend the voucher in their government school, or give it to a private school. This will increase the purchasing power of all parents and allow them to send their child to school for more years, or send them to a better school. Better managed schools will attract more students and expand, while poorly performing schools will shrink. The increasing number of government schools that are emptying-out, but continue to drain resources, will have to improve their performance or they might cease to exist.

The Aser report points to another important problem: more girls than boys drop out of school between ages 14-18. While boys drop out to work, girls usually stay at home and help with domestic chores. The societal conception of gender roles is an important factor, but perceived threat to safety and distant senior secondary schools (especially girls-only schools) might also be a factor. Policies such as free bicycles to girls in Bihar have been successful in increasing enrolment by improving mobility. Building gender-specific toilets in schools is another measure that helps in improving girls’ enrolment.

As a welcome move, the upcoming New Education Policy is likely to focus more on outcomes than inputs. An educated citizenry is vital for a democracy. If our education system does not enable people to comprehend the written word, keep stable jobs and participate in reasonable debates, it is a problem that needs immediate redressal.

While the Aser report does not paint a favourable picture of the quality of the present workforce, education reforms can change the situation for the next generation.

*How should the education system respond to poor learning outcomes? Tell us at views@livemint.com*
A contentious element of the National Medical Commission (NMC) Bill 2017 — an attempt to revamp the medical education system in India to ensure an adequate supply of quality medical professionals — has been Section 49, Subsection 4 that proposes a joint sitting of the Commission, the Central Council of Homoeopathy and the Central Council of Indian Medicine. This sitting, referred to in Subsection 1, may “decide on approving specific bridge course that may be introduced for the practitioners of Homoeopathy and of Indian Systems of Medicine to enable them to prescribe such modern medicines at such level as may be prescribed.”

The debates around this issue have been ranging from writing-off the ability of Ayurveda, yoga and naturopathy, Unani, Siddha and homoeopathy (AYUSH) practitioners to cross-practise to highlighting current restrictions on allopathic practitioners from practising higher levels of caregiving. However, these debates miss the reality: which is a primary health system that is struggling with a below-par national physician-patient ratio (0.76 per 1,000 population, amongst the lowest in the world) due to a paucity of MBBS-trained primary-care physicians and the unwillingness of existing MBBS-trained physicians to serve remote/rural populations. Urban-rural disparities in physician availability in the face of an increasing burden of chronic diseases make health care in India both inequitable and expensive.

Therefore, there is an urgent need for a trained cadre to provide accessible primary-care services that cover minor ailments, health promotion services, risk screening for early disease detection and appropriate referral linkages, and ensure that people receive care at a community level when they need it.

The issue of AYUSH cross-prescription has been a part of public health and policy discourse for over a decade, with the National Health Policy (NHP) 2017 calling for multi-dimensional mainstreaming of AYUSH physicians. There were 7.7 lakh registered AYUSH practitioners in 2016, according to National Health Profile 2017 data. Their current academic training also includes a conventional biomedical syllabus covering anatomy, physiology, pathology and biochemistry. Efforts to gather evidence on the capacity of licensed and bridge-trained AYUSH physicians to function as primary-care physicians have been under way in diverse field settings, and the call for a structured, capacity-building mechanism is merely the next logical step.

The 4th Common Review Mission Report 2010 of the National Health Mission reports the utilisation of AYUSH physicians as medical officers in primary health centres (PHCs) in Assam, Chhattisgarh, Maharashtra, Madhya Pradesh and Uttarakhand as a human resource rationalisation strategy. In some cases, it was noted that while the supply of AYUSH physicians was high, a lack of appropriate training in allopathic drug dispensation was a deterrent to their utilisation in primary-care settings. Similarly, the 2013 Shailaja Chandra report on the status of Indian medicine and folk healing, commissioned by the Ministry of Health and Family Welfare, noted several instances in States where National Rural Health Mission-recruited AYUSH physicians were the sole care providers in PHCs and called for the appropriate skilling of this cadre to meet the demand for acute and emergency care at the primary level.

Our own experience at the IKP Centre for Technologies in Public Health shows that there is hope. Here, the focus has been on deploying a capacity-building strategy using AYUSH physicians upskilled through a bridge-training programme, and the use of evidence-based protocols, supported by technology, to deliver quality, standardised primary health care to rural populations. Protocols cover minor acute ailments such as fever, upper respiratory tract infections, gastrointestinal conditions (diarrhoea, acidity), urological conditions, as well as proactive risk-screening. The Maharashtra government has led the way in implementing bridge training for
Capacity-building of licensed homoeopathy practitioners to cross-prescribe.

Capacity-building of licensed AYUSH practitioners through bridge training to meet India’s primary care needs is only one of the multi-pronged efforts required to meet the objective of achieving universal health coverage set out in NHP 2017. Current capacity-building efforts include other non-MBBS personnel such as nurses, auxiliary nurse midwives and rural medical assistants, thereby creating a cadre of mid-level service providers as anchors for the provision of comprehensive primary-care services at the proposed health and wellness centres. Further, the existing practice of using AYUSH physicians as medical officers in guideline-based national health programmes, a location-specific availability of this cadre to ensure uninterrupted care provision in certain resource-limited settings, as well as their current academic training that has primed them for cross-disciplinary learning hold promise. These provide a sufficient basis to explore the proposal of bridging their training to “enable them to prescribe such modern medicines at such level as may be prescribed”.

Ensuing discussions will be well served to focus on substantive aspects of this solution: design and scope of the programme, implementation, monitoring and audit mechanisms, technology support, and the legal and regulatory framework. In the long run, a pluralistic and integrated medical system for India remains a solution worth exploring for both effective primary-care delivery and prevention of chronic and infectious diseases.

Aparna Manoharan and Rajiv Lochan are involved with the IKP Centre for Technologies in Public Health; Rajiv Lochan is MD and CEO of The Hindu Group

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Marriage is a civil contract — adultery or divorce should have only civil consequences
Having the second largest standing army in the world or possessing nuclear weapons or putting satellites in orbit will not make a country a great power — or even a great people — if our children grow up into adults who are simply not equipped to build a great economy or a great nation.

On March 26, 2017, I had written a column titled ‘Celebrating Gods, Neglecting Children’. I had said “Our idea of human resource development is minus child development, minus child health and minus child nutrition’. My focus was on the state of nutrition of children and the data was based on the National Family Health Survey 2015-16. I should have added “minus child education and minus child skilling”.

There is another acclaimed report published every year. It is the Annual Status of Education Report (ASER). We have a new report (2017) on the status of education in rural India and it was published on January 16, 2018.

Chilling Facts

ASER 2017 recalls a chilling fact that is known to all in the field of school education: ASER studies, over the last 12 years, have ‘consistently pointed out that many children in elementary school need urgent support for acquiring foundational skills like reading and basic arithmetic’. Nothing much has changed except in terms of ‘numbers’. Thanks to the Right to Education Act, the proportion of out-of school children has fallen to 3.1 per cent. Earlier, children were dropping out at Class V; now enrolment beyond Class V has improved dramatically and enrolment in Class VIII has doubled in the past decade, rising from 11 million to 22 million. However, as the numbers increased, the proportion of students with foundational skills has declined:

One-fourth of students enrolled in Class VIII cannot read a Class II-level text.

One-half of students enrolled in Class VIII cannot do simple division.

ASER 2017 shifted its focus to children in the age group 14 to 18 years in rural India. The report explains the reason: ‘More and more students are completing eight years of elementary school at about age 14. Just four years later, these young people will become adults. So what do these youth do during these four years? Are we ensuring that they acquire the skills and abilities they will need to lead productive lives as adults?’

Regrettably, the answer is ‘no’ or, at least, ‘not yet’. In 2008-09, 24 million children were enrolled in Class V, but in 2011-12 only 19 million students were enrolled in Class VIII. That was a loss of 5 million. As these students progressed to Class XII, another 7 million dropped out, and enrolment in Class XII in 2015-16 was only 12 million. On a rough calculation, therefore, nearly 1.7 million children drop out of school every year.

Among the reasons are vacant posts of teachers, teacher-absenteeism, lack of accountability in government schools, absence of regulation of private schools and low government spending on education.

The 14-18 Years

What do the 14-18 year olds do? Most are enrolled in schools, but significant proportions drop out every year, the number increasing with age. At age 18, 30 per cent in that age group have dropped out. One-fourth of the respondents in that age group said they had to discontinue their
studies because of financial reasons. Another 34 per cent said the reason was lack of interest and 16 per cent because they had failed.

Nearly 78 per cent of rural youth in the age group 14-18 — whether enrolled as students or not — do some agricultural work for wages or on their own land. Almost none aspires to join agricultural or veterinary courses, and ‘the percentage of students in agricultural or veterinary courses around India amounts to less than half a per cent of all undergraduate enrolment’.

What are we doing with our 14-18 year olds? The ASER survey has found that ‘there is not much evidence that children are learning vocational skills’. It found that young untrained youth are not flocking to skill development courses, nor is industry chasing the training centres.

So long as agriculture is a major source of employment for rural youth, the ASER report argues, ‘agriculture could use a more educated and trained workforce considering that productivity lags far behind world’s leading nations’. But there are no foundational agricultural courses on offer as alternatives to the usual bachelor’s degree courses that are worth nothing.

A Failed System

Our school education system is a failure. Fifty per cent of all children have dropped out at various ages before reaching the age of 18 and acquiring what can be called a ‘school education’. Many of whom are with no foundational skills, barely literate or numerate, not enrolled in foundational or skill development courses, unemployable except in low-skill jobs, and fated to depend on farm employment and other casual, manual labour.

Place that alongside the state of health of our children. Among children under five years of age, one out of two is anaemic; one out of three is underweight and stunted; and one out of five is wasted. It is well-documented that the first five years will determine a child’s physical and mental development during the rest of the child’s life.

Having the second largest standing army in the world or possessing nuclear weapons or putting satellites in orbit will not make a country a great power — or even a great people — if our children grow up into adults who are simply not equipped to build a great economy or a great nation. Reflect on the words of Nelson Mandela: ‘Education is the most powerful weapon you can use to change the world’. And India.
There is no doubt that the Medical Council of India (MCI) has outlived its utility and should be reformed or replaced. The remit for the proposed new body, the National Medical Commission, should be clear, direct and workable. A regulatory body should be expected only to regulate and not to formulate policy, which is the function of Parliament and requires inputs from a number of sources, preferably with different points of view.

The fundamental flaw in the proposed Medical Commission is the lack of clarity on its function. Unfortunately, in the National Medical Commission Bill, 2017 in the chapter titled “powers and functions of the commission”, the phrase “lay down policy” occurs repeatedly. The Commission is also expected to “assess the requirements in healthcare, including human resources...” Such complex tasks, which require inputs from multiple agencies, will be done poorly, if at all, by the commission. The Commission should only be expected to monitor and regulate the training of health-care personnel and maintain professional standards.

Point of integration

What type of medical practitioners should the country train? This is a matter that the government should decide. It is poor policymaking to smuggle in clauses about interdisciplinary meetings between different medical systems and bridge courses into this Bill, under the omnibus “miscellaneous” section (item number 49). The failure of successive governments to promote scientific medicine and integrate the best of indigenous systems into one unified system has led to unhealthy competition among the various streams of medicine in India. It must be emphasised that modern medicine is wrongly labelled “Western” or “Allopathy”. Modern medicine takes all that is useful in therapy regardless of its source. It subjects every treatment protocol to the impartial tests of science. “Allopathy” is a term coined by Hahnemann, the founder of homoeopathy, and is seldom used in countries other than India. It would be great statesmanship to move to just one scientific system of medicine in India, combining all that is proven from different streams.

Who should the members of the Commission be? The present system of appointing members to the MCI has failed, resulting in rent-seekers repeatedly entering the Council. The present method of election, where potential candidates have to spend quite a large amount of money and time to get elected, has the unfortunate outcome of ensuring that mostly rent-seekers seek election. The election process should be reformed, not replaced. The proposal to have sections of society other than medical professionals in the commission is laudable. Having an almost entirely nominated commission, as the present Bill provides, is unhealthy. It will lead to a collection of ‘yes men and women’ whose chief qualification will be proximity to the existing government.

Medical education

Should private initiative be allowed in medical education? If the government is sincere in its objective of providing universal medical care, it is clear that high-cost private education will further exacerbate the problem of too many specialists in metropolitan areas chasing too few patients. Many ethical problems in India arise from this basic situation of too many doctors chasing too few paying patients. Issues such as unnecessary investigations and procedures, and too little time spent with each patient arise from the need to earn a reasonable amount and the need to do it from the small pool of paying patients. More importantly, such policy decisions should not be left to the Commission.

To start a medical college, State governments first issue a certificate of essentiality. The MCI then decides whether the proposed college has enough facilities to start the first year. Subsequently,
inspections are done every year till the first batch of students has completed the final year. This has led to problems, as somewhere along the way, the Council finds that some colleges are unable to meet the requirements and withdraws recognition. This leaves students in a lurch and they then approach the judiciary to solve their unhappy situation. The proposed Commission has no mechanism to prevent this from happening. Merely shifting this responsibility to a medical assessment and rating board is no solution.

The present Bill is unlikely to provide a dynamic new thrust to medical care in India. It falls between the stools of excessively ambitious objectives and micro-management. On the one hand the Commission is expected to formulate policy, but on the other it is to decide fee structure. The government should exhibit statesmanship and form a parliamentary committee to draft a new Bill altogether with clear and workable objectives. In the end, policy decisions should be decided by policymakers, and not bureaucrats.

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Marriage is a civil contract — adultery or divorce should have only civil consequences
Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) Crosses One Crore Mark!

Safe pregnancy has become a social movement in our country: J P Nadda

Posted On: 19 JAN 2018 10:48AM by PIB Delhi

Shri J P Nadda, Union Minister of Health and Family Welfare expressed heartfelt gratitude to the Hon'ble Prime Minister Shri Narendra Modi for his un-daunting support to the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), as the programme crossed one crore mark in antenatal check-ups. The Union Health Minister stated that Hon'ble Prime Minister of India had envisioned that 9th of every month, symbolizing the 9 months of pregnancy, should be dedicated to pregnant women. The PMSMA programme was launched in 2016 to fulfil his vision and ensure comprehensive and quality antenatal checkups to pregnant women across India. “More than one crore antenatal check-ups have been conducted under the ambitious Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), which has provided quality antenatal checkups to pregnant women on the 9th of every month. Now safe pregnancy has become a social movement in our country,” Shri Nadda added.

Expressing satisfaction, Shri Nadda further stated that that the programme has been successful in reaching out to the difficult and remote areas of India, since out of the 1 crore checkups across the country, more than 25 lakh check-ups were conducted in high priority districts identified by the Health Ministry for focussed attention. “While all States/ UTs have made significant efforts to reach out to pregnant women, Maharashtra has reported the largest number of check-ups among the Non-Empowered Action Group (EAG) States and Rajasthan has reported the largest number of check-ups among the Empowered Action Group States. All pregnant women visiting the PMSMA sites are examined by an obstetrician/ physician and appropriately investigated,” Shri Nadda elaborated.

Shri J.P Nadda also expressed his heartfelt gratitude to all doctors from the public and private sectors, for responding to the call of Hon'ble Prime Minister and making this remarkable milestone possible. He also urged all the doctors to continue their commitment, ‘IPledgefor9’ and boost the chance of further reducing maternal and infant mortality in the country.

It may be noted, that in the 31st July 2016 episode of Mann Ki Baat, Hon'ble Prime Minister had urged private sector doctors to dedicate 12 days in a year to this programme and provide voluntary services under PMSMA on the 9th of every month. There are more than 12,800 government health facilities across States/ UTs where PMSMA sessions are conducted on the 9th of every month and pregnant women receive fixed-day assured, comprehensive and quality antenatal care in their second and third trimesters. More than 4,800 private sector doctors have pledged to provide voluntary service under PMSMA. More than 385 private sector volunteers have provided services in the high priority districts such as Bilaspur in Chhattisgarh. Several of these volunteers have provided free services at nearby government health facilities more than 10 times
in the past months.

There are several instances where private sector doctors have gone beyond the expectations to serve in remote areas. For example, Dr Pooja Upadhyay, a well-known gynecologist of Raipur turned down the travel support offered by the government and, instead, travelled all the way to Narayanpur, a remote left-wing affected district at her own expense to provide services under PMSMA.

Comprehensive and quality ANC, and identification and follow-up of high risk pregnancies are critical components of the Abhiyan. In order to enable early detection of high risk pregnancies, 84 lakh haemoglobin tests, 55 lakh HIV tests, 41 lakh tests for gestational diabetes, 33 lakh tests for syphilis and more than 15 lakh ultrasounds have been conducted under the programme based on the individual requirements of pregnant women. Based on the clinical conditions and investigations, over 5.50 lakh pregnant women were identified as high risk pregnancies and referred to a specialist or a higher health facility for appropriate care. Identifying high risk pregnancies is the first step towards saving mothers and infants from preventable deaths.

“India is committed to reducing preventable maternal deaths through concerted efforts and public–private partnership. The PMSMA has reached one crore mark with the commitment from doctors in the government sector across States/ UTs and with the help of the large number of private sector doctors who have voluntarily pledged for this initiative,” Shri Nadda stated.

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MV/SK

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ASER survey: We must focus on the three ‘R’s

Another Annual Status of Education Report (ASER) has been released, and the results don’t look good: 40% of the students between the ages of 14 and 18 surveyed in rural schools across 24 states could not tell the time from the image of a clock and 46% couldn’t read and understand three out of four instructions. Many (57%) couldn’t do basic math, even read fluently in their own language (25%).

ASER’s study included an assessment of the ability of these students to perform daily tasks (such as telling the time and counting money); common calculations (measuring length); and read and understand instructions (such as those on the sides of packs).

The gaps in learning mirror those among children in elementary school, but are far more critical. Young adults such as those surveyed are just a step away from entering the economic mainstream and their learning deficit could translate into a shortage of skilled manpower that could hurt the economy.

It isn’t all bad, 53% of all 14-year olds surveyed and close to 60% of 18-year olds, can read in English, and almost 79% of these get the meaning of what they are reading. And 76% can count money.

ASER doesn’t look at writing ability, but it is clear that most students in government and private schools in rural India don’t fare well in two of the three `R’s of education (reading and arithmetic).

The reasons for the performance of the students in the ASER tests are known: poor infrastructure; gaps in the quality and quantity of teachers; and antiquated teaching methods that ignore the media-rich environment in which these students live.

While only 30% of the students surveyed had used the Internet in the week before the study was conducted, 86% had watched TV; 72.9% used a mobile phone; and 62.5%, read a newspaper.

The students aren’t lacking in aspiration, though: 60% of those surveyed want to study beyond Class XII.

Together, these ingredients add up to a recipe for frustration, possibly civil unrest.

This should be the focus of the government’s efforts. Rewriting curricula (and history) to push a particular worldview can wait till we can get the basics right. And it doesn’t get any more basic than the 3´R’s.
With 2018 under way, 30% of India’s 4,386 cities and a quarter of the 685 districts have been verified as being free of open defecation by the urban and rural arms of the Swachh Bharat Abhiyan (Clean India Mission), respectively. Over 4 million toilets have been built across cities, and close to 60 million toilets across the rural landscape since the mission’s launch on 2 October 2014. Administrators of another 122 districts and 509 cities are awaiting verification of their status, and others find themselves pressed for time. Many states have set themselves steeper individual targets, challenging their already overworked front-line bureaucracies.

With only two more years left for the mission to achieve its target of an Open Defecation-Free (ODF) India, the high-pressure, target-driven approach towards toilet construction is likely to gain momentum and at the current rate of roughly 2,450 toilets constructed every hour, we may even meet the target.

The challenge, however, will be in ensuring that ODF villages and cities are firstly, truly ODF, but more crucially that they remain so. Habits are difficult to change, and social norms even more so. Yet, in a mission mode programme, the likelihood of continuing efforts towards an objective that has already been (even nominally) met is limited. Visits to ODF-declared panchayats by Accountability Initiative at the Centre for Policy Research between April and June last year found that work towards behaviour change usually stops cold as soon as the declaration is made.

Sustainable, safe sanitation demands unimpeded toilet usage. Breaking habits is only the first step. Usage can also be obstructed by simple choices like the type of toilet one builds. While the Swachh Bharat Mission-Gramin advocates low-cost, twin leach pit model, lack of awareness and a desire to own a “better” toilet coupled with poor construction quality, drive many households towards larger, cemented pits which local masons market as septic tanks. These tanks require much more water, and a means for safe containment and disposal of the waste. Water however is generally scarce and sewerage connections are simply not viable in most villages (and even some urban areas).

The results of this proliferation of septic tanks could be disastrous not only for sustainable sanitation, but also for another mission of the government—that to end manual scavenging. Between 2013 and 2017, the government’s Self Employment Scheme for Rehabilitation of Manual Scavengers was able to identify less than 14,000 manual scavenging households across the country. Activist groups claim that this is a gross underestimation of the actual problem and even the Socio Economic and Caste Census of 2011 listed over 10 times the number of manual scavengers. Meanwhile, seven manual scavenger deaths were reported in septic tank accidents in the first week of 2018 alone, to add to the 323 cases officially recorded till December 2017.

Yet, the debate is centred not on solutions but on the extent and even the existence of the problem. The reason: independent, national data on most of these issues is currently non-existent. In 2015, the Comptroller and Auditor General of India, while commenting on the preceding Nirmal Bharat Abhiyan, had warned that an effective mechanism for independent evaluations would be essential to ensure data integrity and “alone can provide reliable, periodic status check and timely remedial methods”. Despite this, the much-awaited national annual sanitation survey is yet to leave the drawing board. The only non-government monitoring and verification process, Swachh Survekshan, has its limitations.

For instance, we simply do not know what kind of toilets have been created, or even whether they are being used consistently. The mission’s management information system makes no record of toilet types, nor concerns itself with individual choices, beyond recommendatory guidelines. The
Swachh Survekshan urban reports are limited to city rankings and the latest rural report for 2017 is still not available in the public domain.

Even on the ground, the slow pace of verification and the lack of government monitoring post-declaration challenge sustainability. Especially so because of the absence of any form of social audits or community involvement in what is essentially meant to be a community-led movement.

In the coming two years, the mission has to build tens of millions of toilets, counsel and convince millions of often intransigent households of their value, dispel myths, and establish non-exploitative, modern systems for waste and sludge management. All this through an administration that is overburdened and under-equipped. If any of these knots are left untied when the mission ends, thousands of crores of rupees would have been spent to achieve what economist Lant Pritchett would term “mimicry of form without substance”.

Avani Kapur is a fellow at the Centre for Policy Research and director of Accountability Initiative. Devashish Deshpande is senior research associate at Accountability Initiative.
AYUSH Minister lays foundation stone for Homeopathy Research Institute in Jaipur

posted on: 23 JAN 2018 4:16PM BY PIB Delhi

The Minister of State (IC), for AYUSH, Shri Shripad Yesso Naik laid the foundation stone for Central Research Institute (CRI) in Jaipur on 22nd January 2018. This will be the third CRI under the aegis of Central Council for Research in Homoeopathy (CCRH), an autonomous body of Ministry of AYUSH for undertaking scientific research in Homoeopathy, with 23 institutes across the country.

In his address during the stone laying ceremony, Sh. Naik said that Ministry of AYUSH is determined towards a focused infrastructural push to Homoeopathy and other systems of AYUSH. He further said that strengthening of infrastructure of research institutes meant more quality research, and therefore, more evidence-based information on Homoeopathy. With this aim, homoeopathy research institutes at Shimla in Himachal Pradesh, Lucknow in UP and Siligudi in West Bengal are in the pipeline the Minister disclosed. The Minister complimented the state of Rajasthan for being the leading state in the field of Homoeopathic education. He further hoped that Rajasthan will soon be leading in terms of homoeopathy research too.

The institute is also contributing to the Swasthya Rakshan Program at five adopted villages i.e. Chharsa, Kumbhawas, Sakatpura, Khoraladkhani, Hanutpura. Under National Health Mission, 19 villages under Amber block are being catered to for the program “Healthy Teething in Children through Homoeopathy”.

On this occasion, Shri Vaidye Rajesh Kotecha, Secretary, Ministry of AYUSH, also expressed his solidarity towards further development of homoeopathy. Dr. Girendra Pal, Project officer RRI (H), Jaipur and Dr. Raj Kumar Manchanda, Director General CCRH, Dr. S. Bhuvaneswari, Research Officer(H), Scientist - 4, Dr. J.D. Daryani, Chairperson Drug Proving Committee, CCRH, Prof. C.B. Nayak, Vice Chancellor, Homoeopathy University were also present on this occasion.

SK

(Release ID: 1517492) Visitor Counter : 1228

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Not only do vast numbers of young Indians face a dearth of decent jobs, it now turns out that many of them are unemployable too. That’s the stark message from the Annual Status of Education Report (Aser) published last week.

Here are some highlights: after eight years of schooling, only 43% of 14-18-year-olds could do simple division; slightly less than half couldn’t add weights in kilograms; more than 40% couldn’t tell hours and minutes from a clock; 46% didn’t know which city was the capital of India. We’ve been so busy congratulating ourselves for herding these kids into school that we’ve forgotten to teach them anything.

This is not the first time Aser has pointed to the dismal state of the education system in India, nor is it the only survey to have done so. In December 2017, a working paper from Research on Improving Systems of Education (RISE) had this damning assessment of Indian board examination papers: “In India and Pakistan, higher-order skills were almost entirely lacking and the focus was very much on recall of very specific rote-learnt knowledge.” They said our examination systems were worse than those of Nigeria and Uganda.

The World Bank says the same thing. In its latest *World Development Report*, it says the percentage of grade 2 kids who could not read a single word of a short text or perform a 2-digit subtraction is higher in India than in Uganda and Ghana.

In its *Global Economic Prospects*, the World Bank projected potential GDP growth in South Asia over the next 10 years at 6.7% per year, slightly lower than in recent years. It added that investment in education could raise that potential growth rate. Coincidentally, Fitch Ratings puts India’s potential growth rate at 6.7% for the next five years and adds that access to education is one factor holding back growth in productivity. Measuring potential growth is very tricky, but what they’re saying is the dismal state of our education system is going to hobble economic growth.

It’s well known that East Asian countries emphasized education as a cornerstone of their development strategy. More recently, writing in a World Bank blog, Eric Hanushek, a professor at Stanford University, said, “What is driving the East Asia miracle? On the whole, East Asian kids learn more each year they are in school than those in other places, producing a highly skilled labour force.”

But is the outlook really that gloomy for India? It depends on where you stand in the country’s income distribution and whether you reside in rural or urban India. There’s no question that the global economy is changing and the much-heralded Fourth Industrial Revolution calls for higher skills from workers. 18-year-olds who can’t do simple division are unlikely to find employment in this brave new economy, other than in menial drudgery.

But note that the Aser study is about education in rural areas. There’s a vast gap between education in rural and urban India. The National Sample Survey Office’s Key Indicators of Household Consumer Expenditure showed that in 2011-12, average monthly expenditure on education for those in the 50th-60th percentile of income distribution (the real “middle class”) in rural India was Rs31.47. For those in the same percentile in urban India, the figure was Rs125.49. Such a big difference is likely to be reflected in the quality of education too. Moreover, monthly spending on education for the top 5% of urban Indians was Rs908.12. For the bottom 5% of our rural countrymen, it was Rs7.54. What these figures show and what everybody knows is there is enormous inequality in access to quality education in India, which results in massive inequality of opportunity.
While the sons and daughters of the top 10% are able to get good jobs and compete with the best in the world, the vast majority of poor kids will eke out a precarious living in the informal sector.

True, the concern is that the fourth industrial revolution will change the economic environment, placing a big premium on skills, but there is no reason why the top echelons of the Indian population won’t be able to master those skills. And, given India’s size, the top 10% or 20% adds up to a very big number, bigger than entire nations.

What about the rest? Upward mobility due to increased educational opportunities has improved and a few of the bottom 80% will no doubt better their lot. The rest will fall even further behind. But they have their place in the economy. They will do the backbreaking work in our sweatshops and at our construction sites, so necessary for keeping our costs low. They will provide the army of maids and watchmen and sweepers and other servants so necessary for the comfort of their richer countrymen.

Is education such a low priority for us because we lack resources? Not really—Vietnam, poorer than us, has consistently done better than the OECD average in PISA (Programme for International Student Assessment) scores. And as we’ve seen, India’s educational outcomes are worse than in several poor African countries.

Is it because of lack of ideas? Hardly. There is no dearth of suggestions and prescriptions about what needs to be done. The Aser reports, World Bank studies, Unesco publications, innumerable seminars and no doubt several reports by expert committees all have excellent suggestions, which are gathering dust in mouldy government cupboards.

The real questions we need to ask are: why aren’t these suggestions heeded? Why is the pace of change so glacial? How is it that India, which is a democracy and therefore supposed to be more responsive to the needs of its people, does so badly on education compared to East Asian nations with either no democracy at all or a patchy history of democracy?

Perhaps the most important question, the question we usually prefer not to ask, is: could it be that our ruling classes don’t really care what happens to the poorer half of our children?

Manas Chakravarty looks at trends and issues in the financial markets.

Respond to this column at manas.c@livemint.com
For the first time, a vaccine conceived and developed from scratch in India has been “pre-qualified” by the World Health Organisation.

The Rotavac vaccine, developed by the Hyderabad-based Bharat Biotech Limited last year, was included in India’s national immunisation programme. To be “pre-qualified” means that the vaccine can be sold internationally to several countries in Africa and South America.

While several vaccines from India have been pre-qualified, this is the first that was entirely developed locally and, according to experts, is a sign that there is a credible industrial, scientific and regulatory process in place to develop vaccines in India.

The Rotavac vaccine protects against childhood diarrhoea caused by the rotavirus and was built on strain of the virus isolated at the All India Institute of Medical Sciences here over 30 years ago.

Krishna Ella, chairman and managing director of Bharat Biotech, said that about 9 million children in nine Indian States have been vaccinated.

Some medics have raised concerns that the rotavirus vaccine carried a small chance of causing infants to develop a bowel disorder; but the Rotavac vaccine, having been tested in the field for over a year, have not shown any negative effect, he claimed.
The National Technical Advisory Group on Immunization (NTAGI), an advisory body that recommends vaccines for India’s Universal Immunization Programme (UIP), has given the green signal to the introduction of the Human papillomavirus (HPV) vaccine in the UIP.

However, the decision of who will make the HPV vaccines will depend on the outcome of a 2012 Supreme Court case. This is reported in the minutes from a December 19, 2017 meeting of the NTAGI, published on the website of the Ministry of Health and Family Welfare (MoHFW) on Wednesday.

A spokesperson from the Ministry also told The Hindu that media reports published earlier this month alleging that the Ministry had dropped the vaccine from the UIP after a letter from the Swadeshi Jagaran Manch protested its inclusion, were incorrect.

The Swadeshi Jagaran Manch is an affiliate of the Rashtriya Swayamsewak Sangh which deals with economic issues.

As on today, two HPV vaccines are available in India, developed by Merck Sharp & Dohme (MSD) and GlaxoSmithkline (GSK), while one vaccine developed by an Indian firm is in clinical trials. But a 2012 writ petition in the Supreme Court of India asks for the licences of the MSD and GSK vaccines to be revoked, because they were allegedly approved by the Drug Controller General of India (DCGI) without adequate clinical trials. This is why the inclusion of these vaccines in the UIP will wait till the Supreme Court decides on the case, the Ministry spokesperson said.

HPV vaccines have been at the centre of a controversy in India since 2009, when a clinical trial conducted by the American non-profit PATH, in partnership with the Andhra Pradesh and Gujarat governments, went wrong. Around 24,000 pre-adolescent girls were given MSD and GSK vaccines in the trial, overseen by the Indian Council of Medical Research (ICMR) and DCGI. When eight of these girls died, health activists said PATH and others had violated research-ethics by giving the girls the vaccine without informed consent from their parents.

They also pointed out that trial-researchers had not set up a system to track the vaccine’s side-effects. These allegations led to a 2012 writ petition in the Supreme Court by the activists, demanding action against the DCGI, ICMR, PATH, MSD, GSK and the two State governments. The case is still continuing.

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India has one of the world’s highest burdens of HPV-related cancer. Around 67,000 women die from this disease each year, more than India’s maternal mortality burden of 45,000. But opponents of the HPV vaccine say it is unnecessary, because screening for cervical cancer alone can prevent many deaths.

Proponents say that while screening is important, it is difficult to implement this in Indian healthcare settings. The NTAGI meeting minutes acknowledged this difficulty in mass-screening programmes in Tamil Nadu.

Vaccine opponents have also raised the issue of rare side-effects. Since the introduction of HPV vaccines worldwide, Japan and Denmark have reported some cases of autoimmune illnesses in vaccine recipients. But no study, so far, has demonstrated a link between the vaccines and these illnesses.

As a result, the World Health Organization and Global Advisory Committee, among others, have
declared the vaccine safe.

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Astronauts on extended space travel missions would have significant bone and muscle complications.
3 lakh villages and 300 districts & 10 States/UTs declared ODF 6 crore toilets built under Swachh Bharat

Ministry of Drinking Water & Sanitation

3 lakh villages and 300 districts & 10 States/UTs declared ODF 6 crore toilets built under Swachh Bharat

Posted On: 24 JAN 2018 4:26PM by PIB Delhi

The Swachh Bharat Mission is the largest behaviour change programme in the world. Through mobilization of rural communities, the SBM (Gramin) has truly turned into a jan andolan, a people’s movement. As per a progress update shared in the capital today, over 6 crore toilets have been built across rural India under the Mission. Two independent surveys by the Quality Council of India in 2017, and National Sample Survey Organization in 2016, have pegged the usage of these toilets at 91% and 95% respectively. As an outcome, over 3 lakh villages and 300 districts have been declared Open Defecation Free (ODF), across ten States and Union Territories, namely, Sikkim, Himachal Pradesh, Kerala, Haryana, Uttarakhand, Gujarat, Arunachal Pradesh, Chhattisgarh, Chandigarh and Daman & Diu.

The progress update was shared by the Secretary, Ministry of Drinking Water and Sanitation, Shri Parameswaran Iyer today during a technical briefing given to the media in New Delhi.

Terming this a “Sanitation Revolution in Rural India”, Shri Iyer said that 15 States/UTs are expected to be declared ODF by March 2018, and with this accelerating progress, the Mission is on track to achieve an ODF India by October 2019. He also shared some studies done by international agencies that estimate the health and economic impact of sanitation on a rural family. UNICEF estimates that the lack of sanitation is responsible for the deaths of over 100,000 children in India annually. A Bill and Melinda Gates Foundation study estimates that households in ODF villages in India have significantly better health indicators.

Another UNICEF study estimates that a household in an ODF village in India saves Rs.50,000 every year by way of disease treatment costs averted, saving of livelihood by not falling ill, etc. At the macro level, a 2007 World Bank study estimated that lack of sanitation costs India over 6% of our GDP.

Shri Iyer announced that the Ministry of Drinking Water and Sanitation will be launching a mass media campaign to promote the twin pit toilet soon. A twin pit toilet is a toilet model that is economical, safe, easy to clean, eco-friendly, and is effectively a self-contained waste treatment plant that does not harm the ground water beneath the toilet.

Speaking on the issue of solid and liquid waste, he said that there was a paradigm shift underway in the way the Mission looks at this issue. He said that the Mission is moving from seeing it as a Solid Liquid Waste Management issue to seeing it as Solid and Liquid Resource Management, because waste is a resource that can be tapped and converted to wealth and energy.

Speaking on the issue of drinking water in rural India, he said that there have been a number of initiatives to reform the National Rural Drinking Water Programme. He enumerated several steps to improve the speed and quality of implementation of the Programme, especially targeting arsenic and fluoride-affected habitations.
Shri Iyer also shared some stories of champions of Swachh Bharat from the field, including women, children, differently abled and senior citizens, who have contributed immensely to the sanitation mission through their dedication to cleanliness. These champions have gone beyond their call of duty to make Swachh Bharat a true jan andolan.

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SNC

(Release ID: 1517640) Visitor Counter : 1400
AYUSH Minister lays foundation stone for Homeopathy Research Institute in Jaipur

The Minister of State (IC), for AYUSH, Shri Shripad Yesso Naik laid the foundation stone for Central Research Institute (CRI) in Jaipur on 22\textsuperscript{nd} January 2018. This will be the third CRI under the aegis of Central Council for Research in Homoeopathy (CCRH), an autonomous body of Ministry of AYUSH for undertaking scientific research in Homoeopathy, with 23 institutes across the country.

In his address during the stone laying ceremony, Sh. Naik said that Ministry of AYUSH is determined towards a focused infrastructural push to Homoeopathy and other systems of AYUSH. He further said that strengthening of infrastructure of research institutes meant more quality research, and therefore, more evidence-based information on Homoeopathy. With this aim, homoeopathy research institutes at Shimla in Himachal Pradesh, Lucknow in UP and Siligudi in West Bengal are in the pipeline the Minister disclosed. The Minister complimented the state of Rajasthan for being the leading state in the field of Homoeopathic education. He further hoped that Rajasthan will soon be leading in terms of homoeopathy research too.

The institute is also contributing to the Swasthya Rakshan Program at five adopted villages i.e. Chharsa, Kumbhawas, Sakatpura, Khoraladkhani, Hanutpura. Under National Health Mission, 19 villages under Amber block are being catered to for the program “Healthy Teething in Children through Homoeopathy”.

On this occasion, Shri Vaidye Rajesh Kotecha, Secretary, Ministry of AYUSH, also expressed his solidarity towards further development of homoeopathy. Dr. Girendra Pal, Project officer RRI (H), Jaipur and Dr. Raj Kumar Manchanda, Director General CCRH, Dr. S. Bhuveswari, Research Officer(H), Scientist - 4, Dr. J.D. Daryani, Chairperson Drug Proving Committee, CCRH, Prof. C.B. Nayak, Vice Chancellor, Homoeopathy University were also present on this occasion.

SK

(Release ID: 1517492) Visitor Counter : 1798
The state of education in rural India

An amazing transformation has occurred in the course of a generation. Young men and women in rural India are far surpassing their parents’ levels of education. Two generations ago, people in remote villages were largely unlettered: there were hardly any schools in remote areas. And it is still common to find low educational levels among village residents who are 40 years old and older. But the early-morning image of a rugged but illiterate peasant pulling a plow fades before the newer reality of village children walking to schools in the hundreds. As late as 2001, only a little over 25% of all rural 18-year-olds were attending schools, the rest having dropped out earlier. By 2016, the share of 18-year-olds in schools and colleges had gone up to 70%. There is a rapidly rising trend of education in rural India.

The latest annual report of the Aser Center, released on 16 January, presents these results. Derived from an innovative survey of more than 30,000 youth, in the age group of 14-18, that was conducted in 1,641 villages of 24 states in India, this survey is important because more than 125 million individuals are in this age group, of whom more than two-thirds, roughly 85 million live in rural India, a population the size of Germany or the UK. They are the ones on whom their families’ hopes are vested, the future of the nation.

The fact that larger and larger numbers of individuals in this age group are opting to remain in the educational system is heartening, therefore. There are other optimistic findings. Girls have closed the gap with boys in rural areas: at age 14, 94% of girls and 95% of boys are enrolled in school; by age 18, 68% of girls and 72% of boys are still in school, a wholesale improvement on the proportions of a generation earlier.

That is the good side of the story. It is very welcome. Modern economic growth has little room for people with rudimentary skills and low education levels. The age of assembly-line production has given way to newer technologies, with complex processes, requiring a better trained workforce. And that’s where things don’t look so good.

The quality of education in rural schools is dismal, on average. Among 14-18-year-olds surveyed by the Aser teams, only 43% could solve a class IV mathematics problem. This proportion was roughly the same among 14-year-olds as among 18-year-olds, showing that the problem of low learning outcomes was not resolved by remaining in school. Only 40% of 18-year-olds could take 10% off a given number. More than that percentage could not locate their state on a map of India. Twenty-seven percent of 14-year-olds, and 21% of 18-year-olds could not read a class II textbook in the regional language, and more than 40% in each age group could not read a simple sentence in English (such as “What is the time?”).

When it comes time to look for employment, what are young people trained in this shabby manner going to find? How are they going to cover the learning deficits that have accumulated from years of attending low-quality rural schools?

With the secular decline of the rural economy, the belief has gained ground that education will be the road out of a scrimped and precarious livelihood on the farm. Inspired by this hope, rural children have flocked to schools. Most of them are first-generation learners. It’s a huge social experiment in which rural parents across the land have invested heavily, letting their children study well beyond the age when they had themselves joined the workforce.

Soon, however, this younger generation will be graduating from high schools and colleges—and then they will find that there are very few good jobs. It’s a calamity waiting to happen, a cliff from which many will fall.
A reaction against education is around the corner. “When my first-born was unable to make much of his 16 years of education,” a parent might argue, “why should I waste time and money on the education of my second-born?” With mass disappointment looming on the horizon, the rising trend of education is going to fall.

Raising the quality of education in rural schools is essential, and a nationwide dialogue is necessary for charting the way ahead. Business-as-usual will not fix the problem. Privatizing the government system is not a viable solution, either. The market for education performs poorly in situations where information flows are sparse and competition is limited or non-existent. Rural private schools perform no better than rural public schools in terms of learning outcomes.

The essential problem is one of a broken governance system. There are few rewards for being a good teacher and few punishments for being a careless one. That is because of faulty designs which need to repaired or replaced with more effective and accountable governance systems.

What is currently a highly regimented and top-down system in India needs to give way to another in which teachers are innovative in the classroom and parents are involved as co-decision-makers. Noteworthy smaller-scale innovations developed by state governments and non-government organizations provide indication of the larger potential of societal innovation. These reform efforts should serve as the starting points for a broader and increasingly essential public conversation.

*Anirudh Krishna is the Edgar T Thompson professor of public policy at Duke University.*
Three milestones in education

“Today there is much more data and evidence about the contours of the learning crisis in India than ever before.” School children at the government higher primary school at Doddakallahalli in Malur, Karnataka. Bhagya Prakash K.

Every year in January, when the Annual Status of Education Report (ASER) is released, there is a hue and cry about the status of children’s learning in India. The hand-wringing, debates and discussions die down after some time. But this year’s situation is different. India is in a position right now to think and act differently.

Benefits of RTE

First, this year is historic because the children who are today in Class VIII are the first cohort to benefit from the Right to Education Act, which came into effect in April 2010. With almost all these children not only enrolling in school but completing at least eight years in the education system, we are in an excellent position to think seriously about what eight years of schooling should entail and what it should enable children to do.

36% rural youth can’t name India’s capital, finds survey

Second, there are now two new sources of data available on children’s learning. Last week, ASER 2017 and the district report cards from the National Achievement Survey (NAS) were released. The recently released ASER data is different from the usual survey: it concentrates on the 14-18 age group, which is different from the usual target population. Also, unlike the usual ASER surveys which are carried out in all rural districts of the country, this year the exercise was done only in one or two districts per State. The ASER 2017 “beyond basics” assessment framework explores how youth cope with everyday tasks that involve literacy and numeracy. This is in line with the National Council of Educational Research and Training’s (NCERT) learning outcomes approach where developing connections between mathematical thinking and daily life is stressed. In a departure from usual practice, the NAS reports lay out performance of children by different broad competencies rather than by reference to the syllabus or simply in terms of a score. For example, for Class VIII, the report card gives the proportion of students who can “read textual/non-textual materials with comprehension and identify the details, characters, main idea and sequence of ideas and events while reading” or “solve problems involving large numbers by applying appropriate operations”. Both 2017 exercises, one by the government and the other done by non-governmental organisations, indicate a significant shift in thinking about children’s learning. In their own ways, both point to the importance of considering stage-wise learning outcomes, a move which will contribute towards a much-needed rethinking of class-wise curricular expectations. (In both cases, the information available is of the current school year. Every year ASER releases data in the same school year in which the assessment is conducted. The government has done this with NAS data this year. Again, a laudable move.)

Different methodologies

Both use different methodologies – ASER is a household survey and NAS is a school-based effort. ASER conducts its assessment one-on-one, while NAS is a pen-paper test. ASER is aimed at a representative sample of all children (whether in school and attending or out of school) whereas NAS is a representative sample of children who are enrolled in government or aided schools. Typically, ASER focusses mainly on foundational skills like reading and arithmetic, while NAS looks at a wider variety of skills. In the last 10 years, much has been made of these differences. However, the truth is that they both point to important trends related to children’s learning in India.
They are also the only two sources of data that are repeatedly available (whether periodically in the case of NAS or annually in the case of ASER). Contrary to recent assertions in the media, many researchers have accessed and used ASER data for more detailed analyses than is published in the ASER report. Data being available over time enables analysts to track progress and identify persistent gaps of different kinds.

Third, district-level data are now available. This is significant as within the government’s education system, planning focuses on the district as the unit for planning, allocation and implementation. Information on inputs or infrastructure are available annually at the district level. However, until this year, other than the annual ASER data, estimates on children’s learning were not available at the district level. One of the reasons for ASER collecting data on a representative sample of children at the district level was to contribute to decisions at that level. The timely release of the NAS district report cards is also a welcome move. Now districts in the same State will have the opportunity of making contextually relevant and appropriate plans to address the needs of their children.

More data to mine

Given these three important milestones, India is in a good position to think of effective new ways of moving beyond universal schooling towards learning for all. Each year, as the Finance Ministry prepares the Budget, it carries out consultations with different groups. Recently, in such a discussion, our suggestion was to have a learning improvement fund that districts can apply to for implementing a results-oriented multi-year learning improvement programme. The annual nature of the planning process in education may have been useful for when inputs had to be provided. But when the focus is moving from “providing schooling” towards “ensuring learning”, a multi-year period is needed for implementation.

Also read

Numbers aren’t neutral

Over and above whatever States do, for many years we have seen many instances where the district administration wants to implement serious district-wide learning improvement efforts. But sometimes this energy can be constrained by lack of interest, funds and guidance at the State level. Although there is a provision for innovation funds in the annual work plan guidelines, these are usually not effectively spent. In the upcoming Budget, an amount could be set aside specifically for a learning improvement fund. Financial mechanisms could be worked out to access this Central or State-level special fund so that interested districts could bid for these funds based on a well worked out plan. The mechanism could include provision of know-how and support, external verification of progress, and room for course correction.

Today there is much more data and evidence about the contours of the learning crisis in India than ever before. The time is ripe for timely and effective decentralised action to improve the quality of children’s learning outcomes.

*Rukmini Banerji is CEO of Pratham Education Foundation*

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Marriage is a civil contract — adultery or divorce should have only civil consequences
Utmost Priority to Social Infrastructure Like Education, Health and Social Protection is Given to Engineer an Inclusive and Sustainable Growth, Says Economic Survey

Ministry of Finance

Utmost Priority to Social Infrastructure Like Education, Health and Social Protection is Given to Engineer an Inclusive and Sustainable Growth, Says Economic Survey

Posted On: 29 JAN 2018 12:43PM by PIB Delhi

Utmost priority to social infrastructure like education, health and social protection is given by the Government to engineer an inclusive and sustainable growth for India. This was stated in the Economic Survey 2017-18, tabled by the Union Minister for Finance and Corporate Affairs, Shri Arun Jaitley, in the Parliament today.

On the subject of “Social Infrastructure, Employment and Human Development”, bridging the gender gaps in education, skill development, employment, earnings and reducing social inequalities prevalent in the society have been the underlying goals of the development strategy to enhance human capabilities. The Survey notes that India is poised to grow as one of the leading knowledge economies where education, skill development and health will remain priorities for the Government.

The Survey adds that the government has been enhancing the expenditure on human capital along with adopting measures to improve the efficiency of expenditure by convergence of schemes. The expenditure on social services by the Centre and States as a proportion of GDP had remained in the range of 6 per cent during 2012-13 to 2014-15. Expenditure on Social services stands at 6.6 per cent in 2017-18 (BE).

As the way forward, the Economic Survey 2017-18 recommends that though macro-economic growth and efficient markets are essential, it is necessary to equally ensure that the benefits of growth are equitably accessible to all citizens to make growth broad-based. The Survey concludes that strengthening the policy and institutional eco-system supporting inclusive growth deserves to be a top policy priority.

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DSM/OK/RM/SBS/KMN/DKP

(Release ID: 1518064) Visitor Counter : 407
The Economic Survey 2017-18 highlights Government of India’s commitment to achieve the Sustainable Development Goal (SDG-4) for education. It mentioned the significant progress made in universalising primary education, with substantial improvement in the enrolment and completion rates of education of children in both primary and elementary school. The Survey takes note of the increased percentage of schools which comply with the Student Classroom Ratio (SCR) and Pupil Teacher Ratio (PTR) at the all India level. This was stated in the Economic Survey 2017-18 tabled in Parliament today by the Union Minister for Finance and Corporate Affairs, Shri Arun Jaitley.

The Survey, however, notes the inter-state variations in the adherence to Student Classroom Ratio (SCR) and Pupil Teacher Ratios (PTR) norms. Taking note of the substantially improved Gender Parity Index (GPI) at the primary and secondary levels of school enrolment with the consistent efforts of the government, the Survey acknowledges the success of programmes like Beti Padhao, Beti Bachao in addressing issues of gender bias in access to education.

Figure 3. State-wise Primary Schools with PTR > 30 (per cent)

Source: Elementary Education in India and Flash Statistics (UDISE)
DSM/OK/RM/SBS/KMN/DKP

(Release ID: 1518062) Visitor Counter : 527
Economic Survey Reiterates India’s Commitment to Achieve the Targets Under SDG-3 and to Strengthen Health Delivery Systems

Posted On: 29 JAN 2018 12:39PM by PIB Delhi

The Economic Survey 2017-18 reiterates India’s commitment to achieve the targets under Sustainable Development Goals-3 (SDG-3) with some of them also aligned with the National Health Policy 2017. This was stated in the Economic Survey 2017-18 tabled in Parliament today by the Union Minister for Finance and Corporate Affairs, Shri Arun Jaitley. The Survey takes note of the shift in the disease burden from Communicable Diseases to Non-Communicable Diseases in the country between 1990 and 2016. The Survey mentions that Child and Maternal Malnutrition continues to be the most challenging risk factor for health loss in India in 2016. The other key risk factors include air pollution, dietary risks, high blood pressure and diabetes etc.

The Survey takes note of the National Health Policy 2017 which recommended increasing State sector health spending to more than 8 per cent of the States’ Government Budget by 2020. It also takes note of the Report ‘India: Health of Nation’s States’ 2017’, which provides the first comprehensive set of findings for the distribution of diseases and risk factors across all States from 1990 to 2016. The concept of Disability Adjusted Life Years (DALYs) has been developed to provide a framework for analysing the disease burden and risk factors. The Survey advocates there is a need to understand the efficiency of public spending with respect to DALYs behaviour across the major States and to assess whether high-spending by States on health results in better health outcomes.

The Survey notes that there has been significant improvement in the health status of individuals in India as life expectancy at birth has increased by 10 years during the period 1990 to 2015. The Survey, however, notes with concern that there are wide differences in the average prices of diagnostic tests across cities which need to be addressed by standardising rates to reduce Out of Pocket Expenses (OPE) on health services.

According to the Survey, the National Health Policy 2017 will help in strengthening health delivery systems and in achieving universal health coverage.

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DSM/OK/RM/SBS/KMN/DKP

(Release ID: 1518056) Visitor Counter : 416
India Needs to be a net producer of Knowledge, says the Economic Survey

India Needs to be a net producer of Knowledge, says the Economic Survey

Posted On: 29 JAN 2018 12:27PM by PIB Delhi

As India emerges as one of the world’s largest economics, it needs to gradually move from being a net consumer of knowledge to becoming a net producer.

This has been emphasized in the Economic Survey 2017-18 tabled in the Parliament today, by the Union Finance & Corporate Affairs, Shri Arun Jaitley.

Given the dizzying pace and expansion of scientific research and knowledge on the one hand and a generally higher importance given to careers in engineering, medicine, management and government jobs amongst India’s youth on the other, India needs to rekindle the excitement and purpose that would attract more young people to scientific enterprise. Doing so would lay the knowledge foundations to address some of India’s most pressing development challenges in addition to maintain a decent, open society. Investing in science is also fundamental to India’s security, the human security of its populations, the resilience needed to address the multiple uncertainties stemming from climate change and the national security challenges stemming from new emerging threats, ranging from cyber warfare to autonomous military systems such as drones.

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DSM/OK/RM/RDS/sk

(Release ID: 1518046) Visitor Counter : 476