

Policy WATCH

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RAJIV GANDHI INSTITUTE FOR CONTEMPORARY STUDIES

GOVERNANCE AND DEVELOPMENT

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the Health System in
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**Samarth Bastar
and Preservation of
Indigenous Culture**



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Editorial

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Dear Reader,

Through Policy Watch, we explore issues of contemporary importance. Each month, we produce Policy Watch based on one theme that the Rajiv Gandhi Institute for Contemporary Study (RGICS) works on, viz.

1. Constitutional Values and Democratic Institutions
2. Governance and Development
3. Growth with Employment
4. Environment, Natural Resources and Sustainability
5. India's Place in the World

With this January Issue on Governance and Development theme, Policy Watch enters its ninth volume.

Health system in India is characterised by shifting disease burden and a low public spending, limited institutional capability, inadequate manpower, geographical disparities and rural urban dichotomy. The first article is "A Critical Overview of the Health System in India" by Yuvraj Kalia. He highlights key issues in the system, from policy, access and financing, surveillance and awareness, human resources, and health research in the country with a focus on public sector. In addition, there is an article by Dr Amir Ullah Khan and Saleema Razvi on "How India must tackle China's killer bug". It gives a practical strategy to avoid threats from potential pandemics emanating from coronavirus and the like.

It has been more than a decade since education became a justiciable right in India. Within rights based approach to social policy, the third article by Arnab Bose assesses the difference that this legislation has made with a focus on what the bottlenecks are and what can be done to remove them. The article "RTE after a Decade: An Assessment of Bottlenecks" is part of the larger effort to understand the impact the rights based legislations have made in India. It is followed with a factsheet on financing of school education in India.

Within Samarth Zilla framework developed by RGICS, the progress of implementation in Bastar and a perspective on culture of the region is provided in the fourth article "Samarth Bastar and preservation of Indigenous Culture" by Vijay Nadkarni. It is an earnest attempt at understanding what indigenous culture of Bastar is and what can be done to nurture it for the benefit of people there and for human civilization.

We hope you enjoy this issue, and look forward to your feedback. Please write to us at info@rgics.org.

A Critical Overview of the Health System in India

Yuvraj Kalia[^]

Introduction

Millions in India have benefitted from remarkable progress in public health in the past few decades. India has achieved many milestones such as controlling HIV proliferation, eradicating Polio virus, significantly bringing down population indicators such as infant mortality rate (IMR), maternal mortality rate (MMR), and hunger levels. Life expectancy at birth has increased to 68.3 years in 2015, up from 58 years in 1992-93 and IMR has decreased from 78.5 to 41 per 1000 live births from 1992-93 to 2014-15. The MMR has decreased to 130 per 100,000 live births from 437 in the same period. World Health Organisation has declared India free from polio and maternal and neonatal tetanus in 2014 and 2015 respectively (Patel, et al. 2015) (Yasmeen 2019) (Indian Institute for Population Sciences 1993).

This progress, although encouraging, is far from desirable. On IMR, India, with a figure of 33 per 100 live births in 2017, fares below global average (29) and also its neighbours including Myanmar (30), Nepal (28), Bangladesh (27), Bhutan (26), Sri Lanka (8) and China (8). The incidents of infants killed in hospitals in past year alone, whether in Uttar Pradesh, Rajasthan, Gujarat or elsewhere in India, are a grim reminder of the state of health system in India, especially in the public sector (The Wire 2020). Latest report from NITI Aayog points to deep seated inequality in health status between states, with Overall Performance Index (OPI) scores varying from 33.69 in Uttar Pradesh to 80 for Kerala in 2015-16 (NITI Aayog 2018). Globally, Indian health system is among the worst performers. According to Global Healthcare Access and Quality Index published in 2017, India was ranked at 154 among 195 countries studied for 1990-2015 period. The Healthcare Access and Quality Index is based on death rates for 32 diseases that can be avoided or effectively treated with proper medical care, also tracked progress in each nation compared to the benchmark year of 1990 (GBD 2015 Healthcare Access and Quality Collaborators 2017).

In last few decades, non communicable diseases (NCDs) such as cardiovascular diseases, diabetes, chronic obstructive pulmonary disease, cancer, etc. and injuries have shown increased proportion in terms of disease burden and causes of mortality. While disease

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burden due to communicable disease, such as infectious and parasitic diseases, decreased marginally, that from NCDs has significantly increased (Yadav and Arokiasamy 2014). As early as 2004, deaths due to NCDs was twice that of communicable diseases. NCDs caused 50.1% of the deaths in the country that year. In the same year, Indians spent USD 9.1 billion or 3.3% of India's GDP to manage their NCDs (Taylor 2010). Latest studies point to characteristics peculiar to India. While NCDs typically affect population above the age of 55 years in developed countries, their onset can be seen in India a decade earlier (>45 years) and effects younger population too (Arokiasamy 2018).

The National Health Policy of 2017, has fallen short of expectations in even defining an ambitious desirable outcome, with mediocre targets to be achieved in extended periods of time. For example, the commitment to increase public spending on health to 2.5% of GDP has been put off to 2025, as is the commitment to the target to increase life expectancy at birth to 70 years. For comparison, our apparently poorer neighbours, including Nepal, Sri Lanka, Maldives, and Bangladesh have already achieved this target. Similar story for other key indicators such as U5MR, neonatal MR, etc. As per the document, the NHP "advocates a progressively incremental assurance based approach, with assured funding to create an enabling environment for realising healthcare as a right in the future" (Sengupta 2017).

To begin looking for solutions required to improve performance of Indian health system, a deep understanding of the complex structural issues is required. A comprehensive assessment of the health system, although warranted, is beyond the scope of this article. The aim of this article is to simply highlight a few issues within the complex health system in India, with more focus on the public sector. A health system including both preventive and curative services, largely comprises of Surveillance and Awareness; Research; Access; and Law & Policy. Here surveillance and awareness are more concerned with preventive part, Access mainly with curative part, and Research and Law & Policy with both. Each of these components are described and some key issues of national concern pertinent to Indian context in each are highlighted in following sections.

Health Policy, Law and Regulation

National Health Policy

The National Health Policy (NHP), 2017 was needed for four reasons. First, since 2002 when last national policy was adopted, India has undergone significant transition in terms of disease burden and health levels. Second, healthcare industry has shown tremendous growth after 2002 policy was put in place, recording a double digit growth every year. Third, the increasing cost of healthcare and extraordinarily high out-of-pocket expenditure on health pushing millions into poverty every year. And fourth, due to robust economic growth, the fiscal situation of the government is expected to have improved to revise targets and strategies to achieve the targets (IBEF 2019) (Arokiasamy 2018) (Ministry of Health and Family Welfare 2017) (S. Rao 2017).

The NHP 2017 clearly outlines position of the government on three significant areas. First, the goal as to ensure universal access to comprehensive healthcare through "public health sector with focus on quality" in the long run. Second, greater role for private sector "to fill the gap" in provision of a detailed set of services in short term. These include "training, skill development, community training for mental health, disaster management, purchase of services to fill gaps and preferentially for Central Government Health Scheme members, and primary healthcare in urban areas. There will also be collaboration with the private sector for infectious disease control, immunisation services,

disease surveillance and health information and manufacture of medical devices. The policy also seeks to take steps to improve, upgrade and incentivise the quality of services being provided by the private sector in rural and remote areas and among underserved populations and provisioning of diagnostic laboratory support” (Ministry of Health and Family Welfare 2017) (S. Rao 2017).

Third, the acceptance of a differential financing model – per capita basis for primary care; performance based reimbursements for operational costs of the facilities; and fiscal allocations based on “financial ability, developmental needs and high priority districts.” And fourth, institutional reforms required and proposed institutions in a number of areas. The NHP proposes to establish “National Institute for Chronic Diseases, National Health Standards Organization, National Allied Professional Council, medical tribunals, National Digital Authority, a system for health technology assessment and at the Centre and in states a multi-stakeholder institutional mechanisms in the form of autonomous societies or government-owned trusts to purchase services from the providers – government, not-for-profit and for profit, in that order – and a Common Sector Innovation Council as a platform for a more effective collaboration with the departments engaged in medical research and discovery.” (Ministry of Health and Family Welfare 2017) (S. Rao 2017)

There are number of concerns with the NHP 2017. First, the ambitious goals of universal health coverage are not matched with commensurate funding. The policy largely reiterated the spending targets set by the High Level Expert Group on Health in 2012 for 12th five-year plan, and as stated earlier, sets a target of 2.5% of GDP for 2025. This is grossly inadequate. For example, in primary care, where the NHP envisages public sector provision as per Indian Public Health Standards, estimates of MoHFW show investment requirement of INR 1.4 lakh cores. This does not seem feasible with the current or the envisaged rate of public spending on healthcare (Ministry of Health and Family Welfare 2017) (Ministry of Health and Family Welfare 2017).

Secondly, the NHP puts little effort to address the limited agency capability of the public sector and institutions which led some of the earlier targets from 1983 and 2002 policies not being met. The NHP aims to “strategically” utilise capacity in private sector to address the “gaps in public sector” in the “short term”. There is no clarity on how public sector will be strengthened. In addition, the private sector already caters to 80% of the out patient demand and more than 60% of the inpatient care. In such a scenario, gap filling by private sector is a misnomer and lack of clarity on the short term and incentivising the dominant private sector raises a red flag about the capacity of public sector in the future. Third, while the NHP strongly pushes for a larger role for private sector, it is rather weak on its commitment to regulations for the health system. Be it establishment of an autonomous drug regulator; strengthening of Clinical Establishments Act; inspection, monitoring and maintenance of public facilities; the NHP is silent on key areas of regulation (Ministry of Health and Family Welfare 2017) (Ministry of Health and Family Welfare 2017) (S. Rao 2017) (Mohan 2017).

Drug Pricing

As to drug pricing policy in India, the National Pharmaceutical Pricing Authority (NPPA) is authorised to make the pharmaceutical pricing policy and also implement Drug (Prices Control) Order under Essential Commodities Act to regulate price and availability of all drugs listed in National List of Essential Medicines (NLEM) (Department of Pharmaceuticals 2015). First, the NPPA falls under Ministry of Chemicals and Fertilisers, while it's function

is largely related to health. Ministry of Health and Family Welfare, which already prepares the NLEM, may be better suited for carrying out these functions more effectively. In Jan 2019, a standing committee on affordable medicines and health products (SCAMHP) in NITI Aayog has been created to recommend drugs and prices to NPPA (Thacker 2019). Acting on SCAMHP recommendation, in December 2019, NPPA increased prices of 21 formulations by 50% invoking special powers under DPCO 2013 (Business Standard 2019).

Since, NLEM is a limited list, to make drugs (which constitute largest share of the OOP expenses) more affordable, efforts are required in addition to capping prices. There are a few models in Indian states, such as Tamil Nadu worth looking at to provide drugs at lower prices by bulk buying, reducing inefficiencies in distribution, etc. Such state level policies may be a benchmark and replicated in other states.

Regulation

One of the most sensitive issues in health governance has been the regulation of healthcare sector. A number of practitioners have pointed out widespread corruption and malpractice in medical profession (Jain, Nundy and Abbassi 2014) (Sachan 2013). Peters and Muraleedharan (2008) have argued that in Indian healthcare sector, bureaucratic approach has largely failed to ensure protection of vulnerable groups; ensure ways of health financing meets the public interest; and generate trust between providers and public (Peters and Muraleedharan 2008). The Clinical Establishments Act (CEA) was enacted by the Union govt. in 2010, and it has been adopted in 11 states. However, the problem of bureaucratic approach in India of low enforcement is bound to impact implementation of CEA.

India also adopted a consumer based approach, wherein, aggrieved patients approach Consumer Forums set up under Consumer Protection Act 1983. There are studies that point to limited number medical cases in Consumer Forums, high transaction costs, and majority cases being ruled in favour of the defendants (Peters and Muraleedharan 2008) (Misra 2003). As for self or the market regulation, the professional associations such as the Indian Medical Association have always opposed regulatory attempts in the health sector.

At the same time large hospitals have vouched for accreditation through NABH or other international accreditation agencies. This approach to regulation may not be suited for all kinds of healthcare providers, especially small hospitals, clinics, etc. One approach that has not been fostered, however, is an institutional collaboration between non-government healthcare providers, civil society organisations to ensure quality services at affordable price. There are a few examples such as Janani in Bihar and Uttar Pradesh in mother and childcare (National Health Mission 2019).

Surveillance and Awareness

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. It includes assessing and maintaining record of health status of the community through periodic monitoring to identify risks, determinants, needs, groups at higher risk, and community resources. It also includes regular epidemiologic investigations through public health infrastructure like collection centres, laboratories with rapid screening and large volume testing capabilities.

On disease surveillance front, National Centre for Disease Control (NCDC) which runs Integrated Disease Surveillance Program (IDSP) addresses this component to some extent. As per IDSP website, the program, started in 2010, has had a consistent budget of 60-65 Cr, which has never been completely spent. The network of laboratories seems inadequate at 114 in whole of the country (Directorate General of Health Services n.d.). There is a number of national disease programs with surveillance components, and some with screening component as well. In absence of consistent monitoring and maintenance of population health registries, it is impossible to assess effectiveness of NCDC and other institutions engaged in this component. Major national programs like for Malaria, TB, AIDS, and Polio have specific surveillance component.

Recent outbreak of a new coronavirus (CoV) strain in China has travelled to Thailand, Korea, Malaysia, Sri Lanka, Nepal, Japan, Germany, France and even the U.S. and Canada. This has once again, after swine flu of 2009, and SARS, MERS, Ebola and Nipah of 2010s highlighted the global risks when it comes to tackling infectious diseases (World Health Organisation 2020) (Reuters 2020) (Devnani 2020). India (#57) is ranked behind Thailand (#6) and Indonesia (#30) on global health security Index (GHSI). Based on 140 parameters, GHSI represents ability of 195 countries to prevent, detect, and respond to public health emergencies (Nuclear Threat Initiative 2019). The International Health Regulations (IHR) of WHO is a global agreement to control epidemics and pandemics and improve health security signed by 196 countries, including India, in 2005. However, India is one of the very few countries which have not published a joint external evaluation (JEE), which is an external assessment of national capabilities to achieve IHR objectives (WHO 2019). It is desirable for India to go for such assessment in order to create the level of preparedness required to address global health risks.

The issue of antimicrobial resistance (AMR) is of grave concern in India with global effects, the extent of which is unknown, but estimated to be high owing to high burden of infectious diseases. (Harris 2014) (Pitout 2010). A 2013 study estimated that more than 58,000 babies die in India due to 'superbugs' (Laxminarayan, et al. 2013). A few



national programs carry guidelines for appropriate use of antimicrobials but not all. There is no national database on AMR in different pathogens, and it varies throughout the country. Revised National Tuberculosis Control Program generated some useful data on drug resistance in Tuberculosis, but such cases are limited (Kumar, et al. 2013). AMR has increased due to indiscriminate use of antimicrobials driven by unqualified and unlicensed medical practitioners, easy access to drugs, and non-therapeutic use on animals to increase productivity. AMR is a serious threat to population health as it leads to longer periods of sickness and treatment, increasing cost and at times morbidity and mortality, also longer reservoir of infections putting others in the community at higher risk (Willis and Chandler 2019) (Kumar, et al. 2013).

In 2017, Union Government came up with National Action Plan for AMR and there was an inter ministerial consensus on AMR highlighted in Delhi Declaration on AMR. The NAP recognises the need for a robust surveillance system. “Aside from the absence of a One Health¹ approach to surveillance, another weakness of the existing surveillance systems for AMR in India is that it does not account for antibiotic use. The existence of a surveillance system that can establish the relationship between the antibiotic consumption patterns and emergence of AMR is vital to producing evidence that may help in the designing and evaluation of effective interventions.” (Ministry of Health and Family Welfare 2017)

The issue of escalating disease burden and mortality due to NCDs needs attention. The cardiovascular diseases, chronic obstructive pulmonary disease (COPD) and asthma, and diabetes have emerged as the top three NCDs in India. “In absolute terms, cardiovascular diseases, respiratory diseases, and diabetes kill around 4 million Indians annually (as in 2016), and most of these deaths are premature, occurring among Indians aged 30–70 years”. The fact is that, to date, India does not have a reliable data on prevalence on NCDs, as large proportion of those suffering go undiagnosed due to lack of awareness and access to adequate healthcare facilities (Arokiasamy 2018).

In addition, there are significant variations in prevalence of and mortality due to NCDs among different income groups and across states. Share of mortality due to NCDs is highest among high income group at 77%, and high in middle income group at 50%. Lower income groups, with highest years of life lost per 1000 population (at 234) show 69% of mortality due to communicable diseases (Taylor 2010). The Global Burden of Disease study categorised Indian states based on the epidemiological transition levels (ETL). In general, there is higher prevalence of NCDs among high and higher middle ETL states such as Andhra Pradesh, Goa, Himachal Pradesh, Kerala, Maharashtra, Punjab, Tamil Nadu, and West Bengal. But a finer data shows that cardiovascular diseases with 28.1% burden of mortality in India in 2016 were highest in high and higher middle ETL states. The respiratory diseases with second highest mortality burden a 10.9% were higher in a mix of a mix of lower- middle, higher-middle, and high ETL states Jammu and Kashmir, Himachal Pradesh, Uttarakhand, and Haryana. In 2016, diabetes was especially prevalent in southern states (India State-Level Disease Burden Initiative Collaborators 2017).

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke launched in India in 2010, recognising the need has a component on screening to diagnose NCDs (Yadav and Arokiasamy 2014). It requires expansive efforts to create awareness about NCDs, reduce risk factors, and generate reliable real time data

¹ One Health is “the collaborative efforts of multiple disciplines working locally, nationally, and globally, to attain optimal health for people, animals and our environment” promoted by World Health Organisation

and information about patterns of morbidity and mortality to identify and treat population groups at higher risk.

There is a large number of studies pointing to lack of awareness among Indian population regarding their own health. This characteristic is spread across lifespan, and across disease burden. “Adequate knowledge regarding breastfeeding practice was found in only one-third of the antenatal mothers in two studies. Moving ahead in the lifecycle, a study in urban Haryana found that only 11.3% of the adolescent girls studied knew correctly about key reproductive health issues. A review article on geriatric morbidity found that 20.3% of participants were aware of common causes of prevalent illness and their prevention” (Kasthuri 2018)

The impact of awareness on reducing disease burden can be gauged from the evident success of anti-dengue campaign in Delhi. An intensive online and offline campaign helped create awareness about how the disease spreads, and how an individual can prevent the such vector borne diseases. At the same time, the participation of celebrities seems to have resulted in larger participation. The number of dengue cases in Delhi has reduced considerably at around 1700 from more than 4000 in 2016, 2017 and above 2500 in 2018. In 2015, the number was unusually high at around 16,000 cases reported (TNN 2018) (Outlook 2019).

Access and Financing

The debates delve deep into issues in access to healthcare. In India, it seems principles laid by the Bhore Committee and Alma Ata declaration which defined Health as a Right, turned into a limited understanding of the WHO’s Universal Health Coverage (UHC), which is now perceived to be access to healthcare and not all the public health services. In absence of adequate financial resources, low capacity of the institutions and lack of legal and policy framework; the effect is that universal has remained targeted, health has remained healthcare and coverage has been limited to some variant of a public funded insurance scheme.

The hospital centric view of healthcare, got impetus in 2000 when 100% FDI was allowed in hospital sector through automatic route. Subsequently, in 2003, Hospital sector got the status of ‘industry’ facilitating cheaper loans, reduction in custom duties and so on (Hooda 2015). Today, on one side India has some of the largest corporate hospital chains that are able to reduce costs owing to economies of scale and not only make smaller providers fight for survival in domestic healthcare industry, but also attract patients from abroad (Altstedter 2019). On the other, we have deep inequalities in terms of health status across the country, inter- and intra-state. Some of the communities, such as indigenous peoples in remote areas are the worst victims of this disparity (K. S. Rao 2017).

Financing

Prime among barriers in access to healthcare is financing. The budgetary allocation in the latest Union budget at 2.25% of total expenditure is the highest ever. Combined with expenditure of the States, the total on public expenditure stands at 1.4% of the GDP. This figure falls short of even the 2% target outlined by Gol in 2010 (Yadavar 2019). As a result, the out-of-pocket (OOP) expenses in India are very high at 67% of total health expenditure (Ministry of Health and Family Welfare 2017), which push millions into poverty every year, and force 6% of the population to not seek healthcare at all (National Sample Survey Organisation 2006). The State has attempted to address this with publicly funded

insurance schemes like Rashtriya Swasthya Bima Yojana (RSBY). Merits and demerits of the scheme aside, the fact to note here is that the state has decided to forego its role as provider of an essential public good, and has decided market forces to address the needs. Since similar logic has been extended into latest initiative (Ayushman Bharat) of the Union Government towards UHC, let's examine what schemes like RSBY have been able to achieve.



RSBY targeted 65 million families, with around 41 million enrolled into the scheme by 2016. Under this, poor families getting annual coverage of INR 30,000. As per a 2017 study, RSBY was able to cover only half of the Below Poverty Line (BPL) households. The hospitalisation rate among RSBY insured individuals remained low at around 1%. On average for general population, this figure stood at 2.6% in 2014. The variation across states, from 0.1% in Rajasthan to 4.8% in Kerala goes on to show just how important looking at all the components of public health together is, for any intervention to succeed. Similar status can be seen at state level insurance schemes, for example in Maharashtra where utilisation rate of state sponsored insurance scheme started in 2011 remained less than 0.2% till 2014 (Ghosh 2018).

There is no evidence that insurance schemes have been successful in reducing OOP expenses. There is, however, plenty documentation of failures of such schemes on the front of overtreatment or unwarranted surgeries. The drastic variation in usage and effects of such schemes point to a bigger problem. Such schemes aim to solve only one aspect of only the demand side issues in Healthcare. Issues in linkages, capacity and supply side issue has been conveniently ignored. Since, private hospitals have lion's share of capacity (45% beds and 80% human resource), and private hospitals tend to be concentrated in urban areas; such schemes are bound fail to deliver desired outcomes (Bakshi, Sharma and Kumar 2018). Further, the design flaws in the schemes which seldom do not cover for out-patient service, cost of medicines, etc. aggravate the problems further.

Although, it is seen as an incremental step towards achieving UHC, the Ayushman Bharat (AB) extends the same logic of RSBY hospital based care to a grander scale. AB provides for covering 100 million families or 500 million citizens for INR 5 lakh annually, which does not seem to be plausible with the current budgetary allocations. The conservative estimate of premium payment per family is INR 5,000 annually, that means a total premium payment of INR 50,000 crores. Even with NITI Aayog's estimate, this payment stands at 10,000 crores. Compared with similar RSBY variant announced in 2016 budget with 1 lakh cover had allocation of INR 1500 crores, and it was never launched. AB, with higher target population and higher coverage was rolled out with allocation of just INR 2000 crores in 2017-18, and saw an increase to INR 3200 crores in 2018-19.

Apart from that, AB provides for converting Sub-Centres as Health and Wellness Centres (HWC) with allocation of INR 1,200 crore for 1,50,000 sub centres (INR 80,000 per SC per year) (Press Information Bureau 2018). The reality, however, that services envisaged in a HWC are not even available at Community Health Centres (CHC), and over 25% of SCs require a building to be constructed (Ministry of Health and Family Welfare 2017). More than 80% CHCs reported shortfall of a surgeon, a physician and a paediatrician; and around 75% reported vacant posts of a gynaecologist. Even if the government is able to allocate sufficient funds for well functioning HWCs, it stands to undermine primary health services and not matching it with proper referral setup may be counter productive in the long run (Bakshi, Sharma and Kumar 2018).

Human Resources

The other big barrier in access to healthcare in India is the critical shortage of manpower. As to healthcare personnel in public sector in rural India, as on 31 March 2017, there were 14,350 medical officers, 4156 specialist doctors, and 2129 radiographers at 5,624 CHCs (a shortfall of 2168 CHCs); 27,124 doctors, 22,351 auxiliary nurse midwives (ANMs), 14,267 lady health visitors (LHVs), and 12,288 male health assistants at 25,650 Primary Health Centres or PHCs (a shortfall of 6,409 PHCs); and 198,356 ANMs and 56,263 male health assistants at 156,231 sub-centres (a shortfall of 34,946 from required number). Adding 70,738 nurses, 25,193 pharmacists, and 18,952 lab technicians, we get a total of 466,167 healthcare personnel in rural areas in public sector (Ministry of Health and Family Welfare 2017).

This translates to 5.3 healthcare personnel per 10,000 people. This figure stood at 4.8 for doctors, nurses and midwives as against WHO benchmark of 25.4 per 10,000 people. The deficit of 20.6 doctors, nurses and midwives means that around 80% of rural population does not have access to public healthcare services. At national level, a 2011-12 estimate suggests that density of doctors, nurses and midwives was about 13.4 per 10,000 people. After adjusting for educational qualification, it stood at just 6.4. The health manpower in India is not only inadequate, it's distribution is skewed too. With around 70% of the population, rural areas have only 40% of all health workers. The critical shortage of healthcare personnel in rural areas in public sector leaves the population dependent on private healthcare providers. The cost of private healthcare becomes additional barrier to access for rural population (Saikia 2018).

Within NRHM, a program on Accredited Social Health Activists or ASHAs was launched in 2005. It is aimed at training a cadre of women health activists at village level which work for incentives. It has been one of the major catalysts in improvement of health indicators, largely with creating awareness about health, ensuring rural women access

institutional mechanisms to manage their health requirements. Along with that, they carry essential provisions such as Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. to address last mile access (National Health Mission 2020). As of 2017, there are 8.8 lakhs ASHAs in the country (National Health Mission 2017).

There are multiple issues, prime among them is the low amounts of incentive they receive for wide array tasks that they perform. Before October 2018, ASHAs received an incentive of INR 1,000 per month for routine and recurring activities including line listing of households, maintaining village health register, preparation of various lists of children, mothers and couples eligible and due under various schemes, etc. From October 2018, it has been revised to INR 2,000 per month (Jhalani 2018). Second, time spent by ASHAs on these tasks is high. In a recent study on time use of ASHAs found that they worked at least 3-5 hours a day, meeting requirement guidelines. The guidelines also require them to work 3-5 days a week, however, ASHAs worked for six days, and reported being in call 24X7 in their villages in case of emergency (National Health Mission 2017). In addressing acute shortage of health workers, ASHAs are well primed for upskilling, training in assistance at PHCs or trained into ANMs etc.

The ecosystem of medical education, and public health education and training leaves a lot to be desired. There has been proliferation of medical education institutions post 1990. From 156 (109 govt., 47 private) in 1995 to 381 (176 govt., 205 private) in 2013, medical colleges in India have risen at a rapid pace. With intake of around 50,000 undergraduate (MBBS) and 22,000 post graduate students, the total capacity of these colleges to produce medical professionals is still below requirement. Further, there is a dominant trend of increasing private institutions than govt. institutions. Various studies relate this expansion, especially in the private sector, with flourishing corruption, poor infrastructure, and shortage of competent teaching staff (Solanki and Kashyap 2014). Curriculum reform, defining accreditation standards and faculty development are other issues with medical education in India (Sood 2008) (Supe and Burdick 2006). The public health education that is equally important and very different form medical education requires a different approach and a big effort for meeting required manpower for Indian public health system.

Medical Education and Practice

In India, there is a serious lack of medical professionals, as described in the previous section. Health education and management of institutions in India has been in the news with from a long time. The first decade saw serious corruption scandals brought out in the open, which questioned the governance of Medical Council of India. Subsequently, judicial review of the entrance procedure and the institutional mechanism, etc. kept the governance issue alive (Solanki and Kashyap 2014) (Sood 2008). Recently, corruption-ridden Medical Council of India was replaced with a National Medical Commission with passage of the National Medical Commission Act (NMCA) 2019 in the Parliament in August 2019. The NMCA has been criticised on three major issues. First, the provision that fee for only 50% of the seats in private colleges can be regulated by the state, as against 85% earlier. That means the management quota has now increased from 15% to 50%. This, critics say, is a way to corporatisation of medical education in the country, with higher room for corruption (Rajalakshmi 2019).

Second, the Act provides for Community Health Providers (CHPs), who are persons

“connected with modern scientific medical profession”, to supplement health services at preventive and primary care level. At secondary and tertiary level, CHPs to work under supervision of medical practitioners. Since, there is no qualification exam such as National Exit Test stipulated in the Act for CHPs, there is a lot of ambiguity on who these CHPs are going to be. Third, the provisions regarding ensuring transparency and eligibility of members of the commission are not strong enough. The members can have commercial interests in the health sector and they can be employed by any institution after demitting office which they did not deal with during their term. The Act provides for a two-year moratorium on employment in institutions that the members dealt with during their term. Such provisions open wider room for corruption, or worse policy capture. On the whole, the NMCA is anti-federal, pro-private sector and compromises on standards of health services while not ensuring highest levels of transparency that it set out to do in the first place (Rajalakshmi 2019).

AYUSH

A greater role for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) systems of health and wellbeing has been envisaged within Indian health system with National Rural Health Mission (NRHM) from 2005. Given the state of health system in India, the department of AYUSH was restructured into a Ministry in 2014 with a renewed push to utilising the latent potential of the traditional, complementary and alternative medicine. Within NRHM it meant contractual appointment of AYUSH practitioners in community health centres and primary health centres along with support from existing staff, establishment of specialised centres for therapy, involvement of AYUSH practitioners in national programs, and inclusion of AYUSH drugs in health kits of community health workers (Lakshmi 2012).

On supply side, there have been challenges for AYUSH practice and mainstreaming within the system. Post inclusion in NRHM as a mainstreaming effort, AYUSH practice has suffered from “variability in the basic philosophy of practice; disparities in the approach to specific clinical conditions or in decision-making; the lack of specific guidelines to promote cross-referral; unfilled positions; inequitable compensation; minimal support in terms of logistics and infrastructure; an unexpected rise in cross-practice; ethical issues (such as unfriendly relationships between practitioners of either system); and the absence of public accountability mechanisms at the primary care level” (Shrivastava, Shrivastava and Ramasamy 2015).

As to utilisation of AYUSH services, a recent study based on NSS data from 71st round (2014) shows that “about 6.9% of all patients seeking outpatient care (with reference period of last 15 days) had used AYUSH services (3.5% Indian Systems of Medicine or ISM and 3.0% homeopathy).” It also concluded that “patients with higher educational status are more likely to use AYUSH services. It also emerged that AYUSH use is relatively low among patients in the middle MPCE quintiles.” The study indicated that of total ISM based out-patient care in rural areas, only about one-fifth was provided at PHCs or CHCs. It is also noteworthy that analysis pointed out that “while the overall share of AYUSH medicine in total medicine expenditure was only about 6% but the average AYUSH medicine expenditure per AYUSH treated person (Rs. 270 in rural and Rs. 378 in urban) did not hugely differ from average allopathy medicine expenditures (Rs. 392 in rural and Rs. 454 in urban)” (Rudra, et al. 2017).

The AYUSH systems may be too many systems clubbed together, without adequate standard setting, institutions for certification of practitioners or accreditation of facilities. With better end to end institutional ecosystem and medico-legal definition, the utilisation as well as effectiveness of AYUSH systems stands to improve. The envisioned goal of introducing these systems, that is, to supplement existing formal medical care will be achieved when these systems are also codified and education, practice, manufacture of medicines are recalibrated and formalised.

Research

India established Department of Health Research (DHR) under MoHFW in 2007, for this purpose. Indian Council for Medical Research (ICMR) is only national institution under DHR performing this function. Apart from that, there are institutions like Public Health Foundation of India (PHFI), having significant capacity, and other private institutions engaged in public health research. The budget of DHR in 2015-16 was INR 1144 Cr, of which ICMR received INR 894 Cr or around 80% of total. Over the years, DHR's share out of meagre Health budget has remained around 3%, which is inadequate as research studies indicate.

In a dated study, it was found that, out of total health research output in India in 2002, less than 4.4% pertained to public health. The figure was 3.3% for original research in public health (Dandona, et al. 2004). Another study indicates that in the decade ended in 2010, disproportionate share (~60%) of public health research catered to communicable diseases, maternal and neonatal health, and nutritional disorders, categorised as GBD1 (Global Burden of Disease-1) with 39% share. Non-communicable diseases and mental and behavioural disorders or GBD2 having highest share ~50% had only ~31% of research output. Studies on injuries with 10% share of disease burden was just 7% (Kalita, Shinde and Patel 2015).

Moreover, geographically, the research is skewed, with states like Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Orissa, Uttarakhand and Uttar Pradesh, were location of just 10% of published studies. More than 40% of the research came from institutions in just Delhi, Maharashtra and Tamil Nadu, with only 1.4% located in the North East. Of total, a little more than two-third were funded by foreign donors (Kalita, Shinde and Patel 2015). Comparatively, the proportion in Brazil and China is 2.2%, and 8.8% respectively. In these two countries, more than 70% of total health research funding came from public sector. The reliance on foreign funds for public health research seems to be the reason for indicated disparity of distribution across diseases and geography (Dandona, et al. 2004) (Kalita, Shinde and Patel 2015). It shows how inadequate budgetary allocations for the Department of Health Research are.

Another study conducted in 2016, took stock of medical research in Indian medical colleges. Of 579 medical institutions and colleges, only 25 published more than 100 research papers a year and accounted for 40% of the research output in the country. Almost 60% of colleges did not produce any research paper at all. Globally, places like the Mayo clinic and the Massachusetts General Hospital on an average produce 3700 and 4600 research papers every year. It was found that majority of the 25 top research producing institutions were publicly funded. However, overall level of medical research output from India was considered to be poor (Ray, Shah and Nundy 2016).

From above, the issues in health research, therefore, are very less focus on public health

research and more on medical research. Within limited number of public health research studies, there is disproportionate emphasis on particular disease burden. Also, the research focuses more on few locations and distribution across states is skewed. An unusually high amount of public health research is funded by overseas donors. Medical research is gauged to be too little and too bad. Herein, public institutions are seen as making best use of the resources put in research.

Conclusion

Health system in India is chronically sick, and it requires a long term innovative solutions to get better. The interconnectedness of health system with food, employment, education and other systems is well established and cannot be ignored any further. For example, the fact that cardiovascular diseases are the highest cause of mortality in India is due to tremendous increase in risk factors such as air pollution, high total cholesterol, high fasting plasma glucose levels, high body-mass index (Arokiasamy 2018). All these risk factors emanate from other systems and subsystems. The health system in India has to be placed within larger social policy milieu in the country for better resource utilisation and tackling the social determinants of health. A systems approach is needed in understanding and the policy formulation to address the ever growing challenge with limited resources.

Like any developing country, India's health system is marred with systemic issues of low public spending; limited institutional capability in public sector to address the gaps in surveillance, awareness, access and quality of healthcare services; inadequate manpower; and geographical disparities and rural-urban dichotomy. There are, however, a few peculiarities, be it in dual burden of communicable and non-communicable diseases or availability of incredibly low cost treatments for most difficult of medical procedures. To begin addressing the challenges, it requires investment in public health research, especially implementation research, for generation of credible data and knowledge to guide innovative policy solutions. The challenge at hand is too complex and too large to be handled by either public sector or private sector or non-profits alone. The declared intention of the government to utilise private sector to fill the gaps in public system to meet the aim of universal health coverage may be a step in the right direction. However, as stated earlier, given that private sector is already dominant in both out-patient and in-patient care, the government must do what it is in the best interest of the citizens, and guide the progress of health system through better policies, effective regulation and unrelenting enforcement.

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How India must tackle China's killer bug¹

Amir Ullah Khan* and Saleema Razvi**

As China struggles to curtail the deadly new virus that has killed 81 people and spread to four continents, there are flashing warning lights for India.

The coronavirus epidemic was a major crisis in China even before the news came out on 10 January and alerted the Chinese leadership. The illness by then was no longer localized. In fact, it had even travelled abroad. China's rigid bureaucracy discourages local officials from raising bad news with central bosses.

China's health sector is so heavily compartmentalized that officials in the public health division, the disease control department, in hospital administration and drug procurement seldom speak to each other. This makes it harder to manage, or even see, a crisis in the making. Those systemic flaws appear to have played a role in the pace at which Chinese officials responded to the outbreak, and the country's inability to address the health risks from its so-called wet markets, which are stuffed with livestock living and dead, domesticated and wild.

The real bad news is the coronavirus, which comes from a family of viruses that affect the respiratory tract, seems to be far deadlier than before. In 2002, when the SARS (Severe Acute Respiratory Syndrome) virus hit China, it took more than 90 days to mutate and take its new deadly form. But the coronavirus seems to have achieved the capability of transmitting among humans within the first month.

The World Health Organization (WHO) has clarified that the disease only spreads from animals to humans and is not communicable between human beings. However, now questions are being raised as some among those affected claim not to have been near any animals recently.

That is why the panic within the public health machinery in China is palpable, even as human resources are being mobilized and sent to the epicentre in Wuhan, the capital of central China's Hubei province, by the thousands.

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The fact that this is happening during the Chinese New Year, when massive numbers move across the country to visit relatives, is unprecedented and will have a huge economic impact.

The big question is—how long before the coronavirus reaches India? There are already reports of a couple of suspected cases being quarantined in the country. While there is no confirmation as yet of any live cases in India, is the country battle-ready to identify, isolate and prevent the spread of this new virus? What steps do the public healthcare authorities quickly need to take to tackle this crisis on a war footing?

Truth be told, the steps India needs to take do not require rocket science. Surveillance mechanisms have to be improved—detection has to be strengthened at all major airports and along the border with Nepal. Of course, one also needs to maintain quarantine facilities at key points where adequate stock of medicines and fluids is stocked. Finally, awareness campaigns have to be launched on precautions to be taken; the public has to be made aware of the symptoms; information helplines have to be set up; and travel advisories have to be issued to the afflicted countries.

While the Indian government has already moved on some of these measures, what can on-ground experience with past crises tell us about the ground reality—and the challenges ahead?

Lessons from Nipah

Like the Chinese health bureaucracy, in India too there is remarkable time lag before diseases get identified and before they get notified, if at all. India's medical bureaucracy is often loath to report bad news. We see that happening in case of dengue and chikungunya outbreaks in most Indian cities, where news only emerges after a few people have died and several seriously taken ill.

No wonder India ranks high globally in the burden of communicable diseases, a burden which causes approximately 10% of deaths in the country. The issue is serious considering



the phase of rapid urbanization the country is going through—raising challenges to an already beleaguered and cash-crunched healthcare system.

Human resources and healthcare infrastructure are woefully below the WHO standards. The risk from communicable diseases increases manifold when other factors—environmental, socioeconomic and demographic—are considered.

The Nipah virus outbreak of 2018 in Kerala has several lessons for today's emergency. This epidemic showed how the Indian infectious disease management infrastructure could be severely challenged. After its discovery in a small Malaysian village in 1999, the virus emerged in Kerala in May 2018, claiming 17 lives. The seriousness of the public health threat was underscored by the lack of a vaccine or even targeted treatment. This allowed the virus to spread unchecked initially.

Soon after the National Centre for Disease Control was alerted by the state, the ministry of health and family welfare along with local, state, and national agencies collaborated on a response to contain the virus. A multidisciplinary team was deployed with the main aim of preventing and controlling the infection.

This coordination and data-exchange from multiple stakeholders helped to rapidly detect infected cases, treat the patients, and helped in controlling and containing the spread of the disease. It also helped safeguard the front-line health workers who were most at risk. Also, campaigns for information dissemination and education of the public led to reducing panic and fear among the people.

The Nipah case study highlights the fact that the response worked primarily because of the infrastructure available in the state. The only other state where this is possible is perhaps Tamil Nadu. Across the country, there are major gaps in the public health system. Poor surveillance mechanisms and lack of public awareness are again in the spotlight with the re-emergence of the Nipah virus in Kerala and the persistent outbreaks of acute encephalitis syndrome, seen recently in Bihar.

The situation is compounded by healthcare facilities without equipment, doctors and drugs, not to mention the poor nutritional status and poorer sanitation status of the population. A speedy local response is crucial in infectious disease management.

Importance of diagnostics

While epidemiological research is absolutely critical to understand the manner in which diseases emerge and travel, it is also extremely important to identify and track all neglected and communicable diseases. Here, diagnosis almost always suffers from lack of availability of stock, of pathologists and medical equipment.

Existing diagnostic practices are time-consuming and expensive. Innovations for diagnostics, detection, testing, notification and treatment have always been significant variables that make a difference. Till very recently, tuberculosis (TB) diagnostics were cumbersome. Dengue and Chikungunya are fraught with danger primarily because it costs upwards of \$15 (upwards of Rs. 1,000) to get tests done.

Till recently, most diagnostic tests required large amounts of equipment and stocks of chemicals. The lab needed an electricity connection and the samples had to be carried

long distances within refrigerators or in ice boxes. Remote areas and rural health centres simply could not provide these facilities—in fact they still cannot.

All this has been replaced in various parts of the country with health ATMs— private, walk-in medical kiosks with integrated medical devices for basic vitals, lab testing and emergency facilities, and staffed by a medical attendant. Instead of large machinery and human resource requirements, most diagnostics now only need a pinprick. To detect deadly diseases like TB, for instance, the person needs to give just some sputum.

Technology has helped to some extent. Most diagnostics can now be done using smartphones and simple apps loaded on them. Health workers with very little training can now reach patients in the most remote places. With cheaper diagnostics and quicker procedures in laboratories, it is possible to hugely improve access to healthcare and a timely cure.

It is prevention, however, that is always better than identification, diagnostics and cure. Hygiene and sanitation play a huge role. The huge burden of morbidity that exists in India is related in part to unsanitary conditions and practices, unsafe and unclean drinking water, and lack of awareness and information.

Role of vaccinations

Vaccinations are among the most efficient and effective instruments for preventing diseases, operating primarily by providing acquired immunity and thereby preventing the easy spread of infectious diseases among large populations.

However, developing vaccines, especially for new and mutated strains of diseases, can take a very long time. Coupled with the time and the resources needed for mass production and delivery, vaccines cannot be seen as the only solution during fast-spreading epidemics.

India successfully repeated its success against smallpox when it fought off polio with another massive immunization drive 12 years ago. From being the polio capital of the world in 2009 to one with no new cases in 2011, the Indian public healthcare machinery showed that it can fight well when it wants to.

Still, there's a lot of work to be done. The healthcare sector needs inputs from the public and the private sectors to conduct research on improved drugs and tests to help make it easier to treat people quickly. Front-line health workers need modern supply chains and equipment as they already have the tough job of delivering medicines to the hardest-to-reach regions of the world. And importantly, medicine stocks must be maintained and supplied to all vulnerable areas on time.

In conclusion

In China, there is now a travel ban on 16 cities in the epicentre Wuhan province. Wild animal sales have been banned. Three new 1,000-bed hospitals are being built at breakneck speed in areas where the health infrastructure is rather poor. The sale of face masks has shot up and there are enormous shortages, especially problematic because medical supplies are also falling short as manufacturers rush to meet the new demand.

All overseas group tours from China have been banned by the Chinese tourism ministry and all domestic tour groups have been suspended too. The capital city Beijing has

stopped all buses from entering or exiting the city. The US, Japan, France, etc. are chartering flights to evacuate their nationals from Wuhan. The gravity of the situation can be estimated by traffic managers blocking, and in some cases even destroying, roads to prevent people from travelling to vulnerable spots.

This is thankfully far removed from the situation in India, which for now needs to have a strict surveillance and monitoring mechanism at its airports. The sensitive border this time is the one we share with China and it is important that a new enemy in the form of a deadly virus doesn't come in.

Very few tourists—just about 350,000—come from China every year and double that number visit the country from India. This vulnerable million needs to be treated with care and attention. Travel advisories would need to be issued with immediate effect to contain the spread of the infection.

The Indian diaspora (mostly students) who are stuck in Wuhan due to the travel ban by China need to be evacuated quickly. Remember, the doomsday scenario that accompanies any virus outbreak is never as bleak as it seems initially. Deadly pathogens that could cause a global pandemic have been ping-ponging at humanity's defence at least for a thousand years.

It is important that India—which accounts for approximately 18% of the world's population—steps up to take responsibility, by ensuring that the spread of infectious diseases is contained. This, more than anything else, is the true mark of a superpower in the making.

RTE after a Decade

An Assessment of Bottlenecks

Arnab Bose*

Introduction

The Right of Children to free and Compulsory Education (RTE) Act, was enacted in the parliament of India on 4th August 2009, to fulfill the mandate of Article 21-A of the Constitution. The Act describes the modalities of providing free and compulsory education to all children between 6-14 years. It makes it legally binding on the state to ensure that all children within the age group are admitted to a formal school of a certain standard.

Many consider the RTE a historic step to undo past injustices. It carries with it the hopes and aspirations of millions who were previously excluded due to class, caste and patriarchy (RTE Forum 2018). However, even though the 10 year anniversary of this landmark Act has passed, its implementation still continues to be a huge challenge. According to a recent article in counterview, even after a decade only 12.7% of schools in India are RTE compliant. Considering the dismal state of compliance, this paper seeks to assess the performance of the RTE in order to identify some of the major bottlenecks, both, at the level of the Act, and at the level of implementation. It then aims to provide recommendations to address some of these challenges.

Performance and Bottlenecks

This paper seeks to assess the performance of the Act on the key elements on the demand side, supply side, as well as within governance and funding. The objective is to identify implementation bottlenecks.

Demand Side

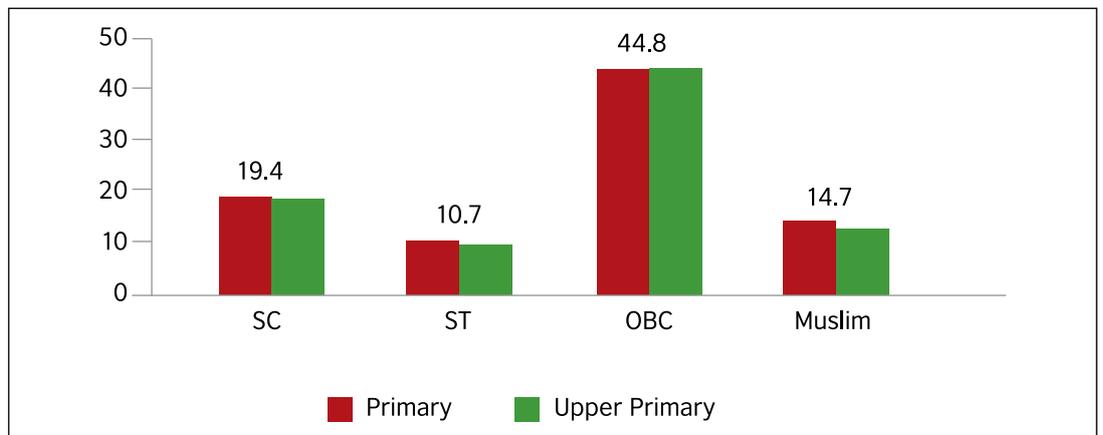
(i) Student Enrolment

The RTE has helped increase the total enrolment in absolute terms especially at the upper primary level. The figure has increased by 23.86%, from 5,33,50,189 in 2008-09 to 6,54,48,222 in 2017-18 (DISE). However, there has been a steady decline since 2015. Table 1 shows the total enrolment at primary and upper primary levels since 2014-15. As per the data, in between 2014-15 and 2017-18 there has been a decrease in primary level enrolment by 6.22% and at upper primary level by 2.56%.

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The enrolment based on different social groups is given in figure 1. As shown, the enrolment of STs and Muslims are particularly low. An important concern is the inclusion of children of migrant labourers and nomadic tribes (RTE Forum 2018).

Figure 1: Social Group wise Enrolment as a Percentage of Total Enrolment 2017-18



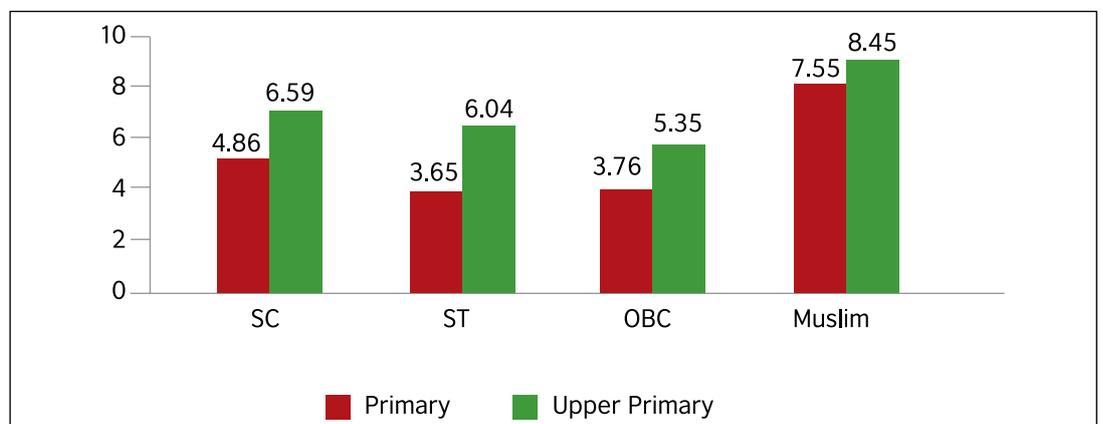
Source: DISE 2017-18

On the question of out of school children, there is lack of availability of updated data. Within the data that is available there are huge discrepancies as highlighted by the RTE Forum (op. cit.). There are contradictions in the data provide by the Census 2011 and MHRD (ibid). Even state level data suffers from variations. For instance, in Karnataka the PAB minutes note a decrease of 1 lakh children, however, as per the data provided by the state the fig. is 21,816 (ibid).

(ii) Student Drop Out and Transition Rates

In between 2016 and 2017 the total drop-out rate at primary level had gone up from 4.13 to 6.35 and at the upper primary level from 4.03 to 5.76 (DISE). As per the latest DISE data shown in figure 2, in 2017-18 it came down to 3.51 and 5.02, respectively. In spite of the slight decline, the overall drop out continues to remain high. The figures also point to a gender divide. The drop out for girls at the upper primary level which is at 5.57 is much higher than boys, which stands at 4.49. This is a matter of concern and needs a gendered focus. There are also large variations in dropouts within the states. As per the data, the dropouts are the highest for Bihar (13.29) at the upper primary level and for Assam (10.08) at the primary level. The figures are particularly high for the north east states.

Figure 2: Average Annual Drop-Out Rates for Different Social Groups 2017-18

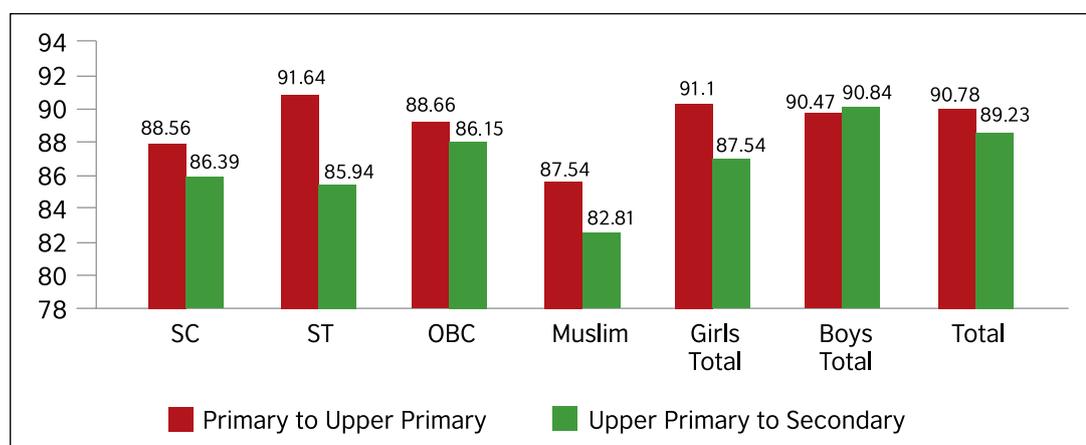


Source: DISE 2017-18

The drop-out rates for different social groups is given in figure 3. As shown, the figures for Muslims are the highest at both levels. Over one year the drop-out rate for STs has fallen from 8.54 to 3.65 at primary level and from 9.58 to 6.04 at upper primary level, which is a positive sign.

The transition rates from upper primary to secondary are much lower than from primary to upper primary, except for boys where it is higher. For girls (91.1) the rate is higher than boys (90.47) for primary to upper primary. However, there is a reduction at the higher level, where it drops to 87.54 as compared to 90.84 for boys. In the context of marginalized social groups the rate for muslims is the lowest at both levels of transition which suggests a concern in retaining muslim children. For STs the figure for 2016-17 (DISE) was 86.65 at the lower level and 83.29 at upper primary to secondary. Thus, there has been an improvement in the transition rate for STs particularly from primary to upper primary.

Figure 3: Transition Rate as a Percentage of Total Enrolment 2017-18



Source: DISE 2017-18

(iii) Student Learning Outcomes

The learning outcomes of students are highlighted in table 1. The data is taken from the ASER (2018) report. As shown, the percentage of children in class 3 who can read class 2 level texts has increased from 25.1% in 2016 to 27.2% in 2018. At class 5 the proportion has increased from 47.9% to 50.3% and at class 8 level the figure has remained constant at 73% between 2016 and 2018. Amongst the states, for students enrolled in government schools, Punjab, UP, Mizoram and Kerala have shown the most improvement (more than 5%) in reading skills across levels.

Table 1: Learning Outcomes at Primary Level

Criteria	2016	2018
Children in Class 3 who were able to read a Class 2 Textbook	25.1%	27.2%
Children in Class 5 who were able to read a Class 2 Textbook	47.9%	50.3%
Children in Class 8 who were able to read a Class 2 Textbook	73%	73%
Children of Class 3 who were able to do subtraction	27.6%	28.1%
Children of Class 5 who were able to do division	26%	27.8%

Source: ASER 2018

In basic arithmetic skills, the students of class 3 who could do basic subtraction has increased marginally from 27.6% to 28.1%, and class 5 students who could do basic division has increased from 26% to 27.8% during the period. While, the figures do reveal a slight improvement, they continue to indicate very poor learning outcomes across levels. This is one of the most important concerns as attending school becomes meaningless if appropriate learning is not happening.

Supply Side

(i) School Compliance with RTE Infrastructure Norms

While most numbers are above 95% and remain consistent with the previous year, the figures for boundary wall, playground, kitchen shed and ramp remain low. However, it is important to note the since the DISE data is self reported by schools the accuracy remains questionable. The CAG (2017) has noticed many inconsistencies in the DISE figures.

(ii) Availability of Trained Teachers

The RTE at the time of implementation allowed 3 years for the recruitment of teachers and 5 years to complete their training. However, the current data highlights a continual shortage under SSA. As per the Lok Sabha Question 2018 (as cited in RTE forum 2018), while the recruitment of 19,33,398 teachers were sanctioned, there is a vacancy of 4,17,057 teachers, which is more than 21%. A large number of para teachers continue to be hired.

The RTE norms prohibit single teacher schools, but as per the DISE data, in 2018 there were still 6.74% schools with single teachers. The PTR at primary level stood at 23 (DISE 2017-18) which is lower than the stipulated 30 and meets the RTE norm. The RTE prohibits the use of teachers for activities other than teaching. A 2008 SC order also prohibits using teachers for non academic duties, however, this practice continues. Another important concern is the lack of grievance redressal options for teachers (RTE Forum 2018).

(iii) 25% Reservation in Private Unaided Schools

Section 12(1)(c) allows for 25% reservation for economically weaker sections (EWS) and disadvantaged groups (DG) in private unaided schools. It has been estimated that around 16 million children should be getting admission under this provision (RTE Forum 2018). However, due to resistance and many implementation hurdles, enrolment remains below the stipulated figure. There are also huge variations across states. A 2017 paper (Sarin, Dongre and Wad 2017) observed that the enrolment rate in 2013 -14 in UP was only 3.62 percent and in AP it was an appalling 0.21 percent of the total stipulated seats under this provision, as compared to MP which had 88.2% filled seats

4. Governance and Financing

(i) Convergence of Schemes

In May 2018 the government launched the Samagra Shiksha programme leading to the convergence of SSA, RMSA and Teacher Education. The rationale was to achieve administrative efficiency by streamlining resource allocation and spending. The unified scheme is supposed to optimize the utilization of both human and physical resources. The goal is also to align elementary and secondary education and give flexibility to states to prioritise either, depending on needs. However, as per a study conducted by CPR in 5 states, at ground level there is lack of clarity. The convergence of finances, administrative structures and monitoring mechanisms remains incomplete. Before this convergence, annual financial plans at each level were prepared separately for elementary and

secondary education. There is a question mark on how collaborative planning under Samagra will be achieved. There is also concern that if in some year secondary education is prioritized this may reduce allocation for elementary education.

(ii) School Consolidation

In order to optimize utilization of resources a new policy tool that is increasingly being used across certain states is the consolidation of schools into one unit. The process involves closure of number of schools and transferring all resources into one integrated school. It was institutionalized in Rajasthan since 2014-15 as part of its “Adarsh Schools” programme, where it was envisioned to develop one such model school in each of its 9895 Gram Panchayats over a period of time (RTE Forum 2018). These model schools were expected to have all the necessary facilities to ensure improved learning. As per the department of education in Rajasthan in between 2014 and 2019 around 22000 schools have been merged (Bordoloi 2019).

The rationale behind school closures, as per the education department in Rajasthan were twofold: (1) Inadequate enrolment in some schools and/or, (2) the existence of more than one primary or upper-primary school within the same revenue village (ibid). However, a study in Rajasthan by CPR (ibid) has found that post consolidation there has been a greater decline in enrolment in these schools (7% in 2014-15) than the decline in all government schools (1.4% in 2014-15) in the state. Further, the study also found that decline in enrolment was the highest amongst CWSN followed by SCs and STs. School consolidation also violates the RTE norm of having primary schools within 1 km from residence.

(iii) Emerging Trend of Privatization

There has been a growing narrative on the poor performance of government schools which has led to a push towards privatization. The NITI Aayog, in its 3 year Action Agenda in August 2017, recommended setting up of expert groups to explore policy options such as vouchers and outsourcing of school services to private players (NITI Aayog 2017). It argued that handing over “non performing” government schools to private entities under the PPP model may help improve performance (ibid). In 2017, the Rajasthan government had pushed the policy for “Public Private Partnership in School Education”. The objective was to privatise 300 government schools which have recorded poor results. However, due to massive protests by the teachers and other community members the government had to eventually roll back the policy.

(iv) Administrative Issues

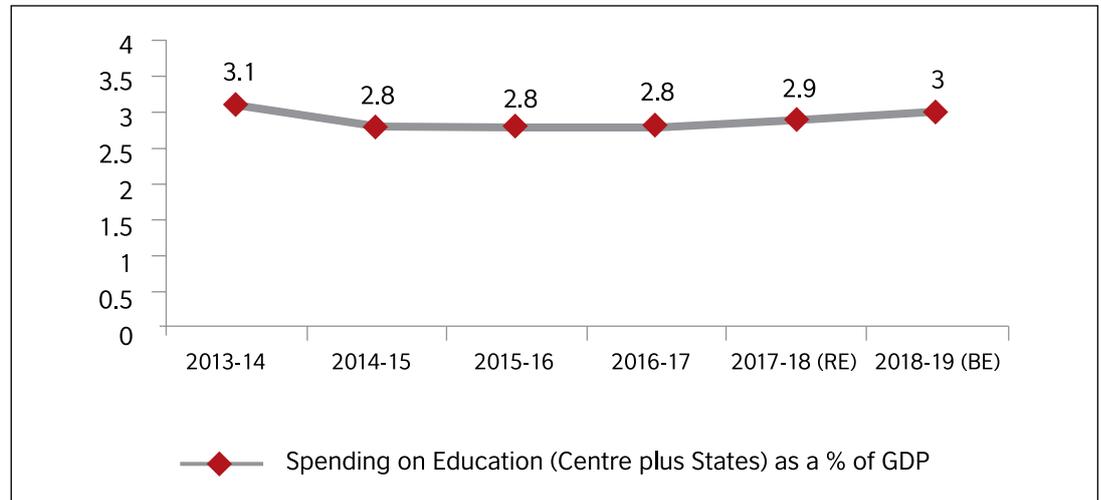
As per the Act the local authorities have several functions which include ensuring availability of schools within neighbourhood limit, preventing discrimination against marginalized communities, maintaining records of children, monitoring admission and attendance, ensuring availability of infrastructure, teaching staff and learning material, making teacher training available, monitoring of school functions, ensuring timely prescribing of curriculum, as well as deciding academic calendar. The extent of roles and responsibilities as well as constant shortage of staff and financial resources has led to huge inefficiencies in administration. There needs to be better linkages between them to enable efficient governance.

(v) Spending on Education

One of the most important factors in implementing the RTE lies in its financing. Since education is in the concurrent list, section 7(1) of the Act states that both the Centre

and the States will have the responsibility of providing funds for its implementation. Over the years activists have been arguing that spending on education is well below what is required. The Kothari Commission in 1964 had recommended spending at least 6% of GNP on education by 1985-86. Further, it also advised allocating two-thirds of total education spending on school education. However, the current data suggests that spending continues to be below par.

Figure 4: Spending on Education as a Percentage of GDP

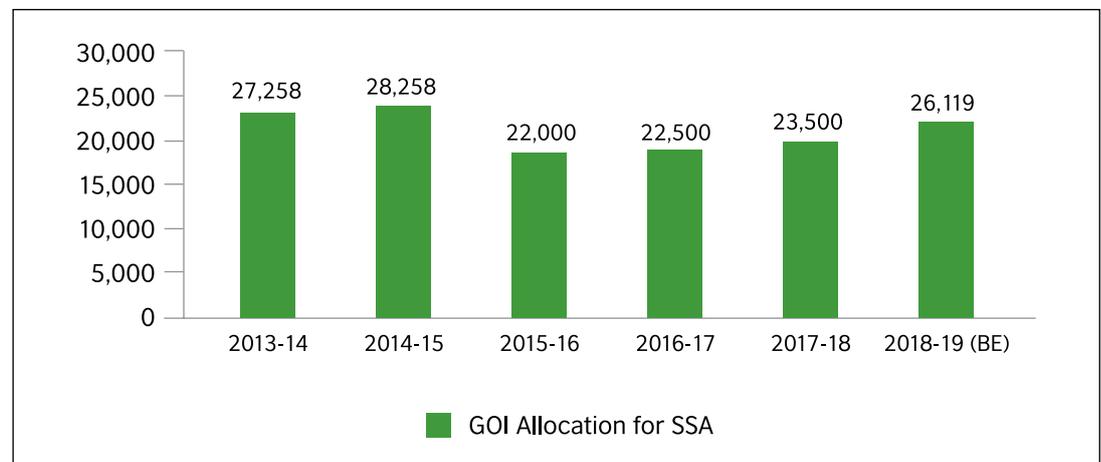


Source: Economic Survey Volume 2, 2018-19

The allocation for SSA, which is the primary instrument of RTE implementation, is depicted in figure 5. As shown, after 2014-15 (28,258 crores), there was a major dip to 22,000 crores (2015-16). Since then there has been a marginal increase over the years, however, as per the 2018-19 budgetary estimates, the figure still stands below 2014-15 numbers at 26,129 crores. This decline is even steeper if inflation is taken into account.

As per 2017-18 budgetary estimates, the figure approved was 55,000 crore but the actual allocation was 26,129 crores, which is 42.7% of the approved amount (CBGA 2017). It is also a matter of grave concern that since 2013-14 there has been a severe and consistent drop in the allocation percentage, which has declined from 87.9% in 2013-14 to 42.7% in 2017-18.

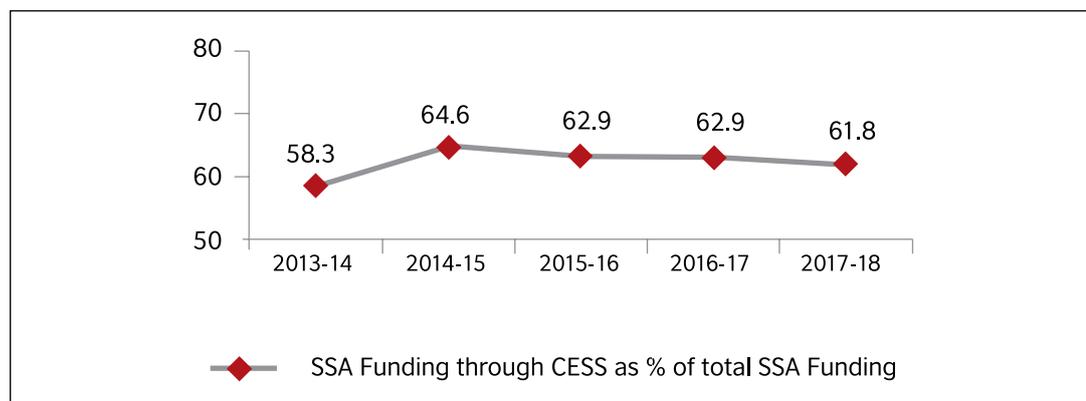
Figure 5: GOI Allocations for SSA



Source: RTE Forum 2018

Another issue with the financing of SSA is that the biggest proportion is coming from the education cess. While the initial purpose of the cess was to supplement the government funding, over the years it has almost replaced government expenditure.

Figure 6: Education Cess % of Total SSA Funding



Source: CBGA 2017

Addressing the Bottlenecks

1. Recommendations for the Government

- i. Addressing Problems in the Act
- ii. Extend the scope of RTE to 3-18 years
- iii. Include a clear definition on which institutions can be considered a minority institution for the purpose of the Act
- iv. Train teachers to effectively implement CCE. Have a clear road map to bring back no detention up to 8th standard, once CCE is properly implemented
- v. Align the RTE to the RPWD Act 2016 from the earlier 1996 law

2. Addressing Demand Side Problems

- i. Mapping of out of school children needs to be done to have up to date data and to understand reasons for non enrolment
- ii. Take measures to track attendance of students through a database, and not just enrolment. Attendance database can help identifying risk of drop out
- iii. Change the Child Labour Act to prevent employment of children even in family run businesses. Also need awareness campaigns targeted to ensure parents don't put children to work and instead send them to school
- iv. Special focus to bring back and retain children from disadvantaged communities especially STs, Muslims, migrant labour and nomadic tribes. Need targeted awareness campaigns and if possible incentives (such as conditional cash transfer like Brazil). Try to provide residential schools for children of migrant labour and nomadic communities
- v. Ensure constant dialogue with representatives of minority institutions to get them under the purview of RTE in the long run
- vi. Need special focus on children from the North East similar to disadvantaged communities
- vii. Girls drop-out rate increases at upper primary level. One possible reason could be that once girls reach puberty, social taboo around menstruation and a lack of menstrual hygiene facilities in school may cause them to drop out. Need to include menstrual hygiene facilities in all schools with female students and having secondary grades. Ensure friendly and supportive environment for girls.

3. Addressing Supply Side Problems

- i. Ensure proper implementation of CCE with a focus on foundational skills. Regular oral assessments for lower grades which focus on basic skills and regular interventions to address weaknesses. Realign curriculum to stress on foundational skills
- ii. Learning outcomes should go beyond standardized tests. The focus of learning should be on understanding. Tests can mostly assess what children know, understanding needs to be assessed by teachers on a continual basis. The overall purpose of education should be intellectual growth of the child and not simply attaining marks in tests
- iii. Medium of instruction in the lower grades as far as possible should only be in the mother tongue. English should be introduced gradually in later grades
- iv. Ensure school availability within mandated 1 km
- v. Ensure availability of all facilities as per RTE norms including safety regulations to ensure child friendly and safe learning environment. Special attention needs to be given to inclusive infrastructure for CWSN as per RPWD 2016 provisions
- vi. Need independent audit of DISE data
- vii. Teacher vacancies need to be filled as soon as possible. Hiring teachers for CWSN also needs attention
- viii. Teacher training needs to be fast tracked. Training should include understanding of CCE as well as sensitization about gender and social inclusion. Need strengthening and adequate funding of teacher training institutions
- ix. Provide autonomy to teachers on teaching activities to enable them to cater to specific needs of children. Non academic duties should be completely stopped
- x. Ensure compliance with 12(1)(c) to enable social integration of rich and poor children. Need regulatory mechanism for private schools
- xi. Application forms for 12(1)(c) needs to be simplified and standardized. Ensure adequate help desks to support filling both offline and online forms
- xii. Strict Action against schools charging non tuition fees from children admitted under 12(1)(c)
- xiii. Mechanism for arriving at per child cost needs to be standardized. Reimbursements should happen on a timely basis

4. Addressing Problems in Monitoring and Grievance Redressal

- i. SMCs in all mandated schools should be constituted on an immediate basis
- ii. Election process of SMCs needs to have clear guidelines and should be made transparent. Encourage parents from disadvantaged communities to participate in elections and ensure they are empowered through proper training
- iii. Increase awareness amongst parents about roles and functions of SMCs and its election process through PTA meetings. Information transparency boards as mandated by SSA, also need to be operationalized within schools to disseminate information about schools such as mid day meals, student teacher attendance etc., as well as information about roles and responsibilities of SMCs
- iv. Ensure adequate funding and training of SMCs to enable them to handle SDPs and other financial and administrative activities. Training funds should be tracked to ensure proper and timely utilization. Training should be interactive and timely and include easy to use handbooks. Strengthen SMC linkages with community and Gram Panchayat as well as ensure platforms for encouraging peer learning between SMCs.

- v. Ensure timely allocation of school grants to enable SMCs to make SDPs in a timely manner. Since SDPs form the basis of decentralized budgetary planning this needs to be a priority
- vi. Ensure monitoring of teacher attendance and teaching practices by SMC. Over a period of time give more responsibilities to SMCs such as monitoring not just inputs, but also academic aspects
- vii. Increase awareness about grievance redressal within communities by engaging CBOs, and in schools through SMCs and PTA meetings. Encourage filing of RTIs by parents to ensure transparency within schools and local authorities
- viii. Form linkages between local authorities and communities to connect local authorities with ground level issues. Ensure role clarity and clear line of ownership of local authorities on grievance redressal. Ensure availability of adequate staff and resources. Increase awareness of local authorities on grievance redressal through proper training
- ix. Provide a complaint tracking system with fixed timelines to enable resolving complaints in a timely manner.
- x. Ensure sufficient child helplines are made available.
- xi. Provide grievance redressal mechanism for teachers
- xii. In the short term strengthen capacity and ensure adequate staff and funding within NCPCR/SCPCR for timely redressal. Since NCPCR is already burdened with other functions, in the long term there needs to be a separate tribunal system for school education with adequate enforcement powers

5. Addressing Problems in Governance and Financing

- i. Provide clarity of administrative and financial functions within Samagra Shiksha post convergence
- ii. Ensure convergence does not lead to lack of focus on SSA which is the primary vehicle for RTE. Ensure separate and adequate funds are available for SSA, RMSA and Teacher Education
- iii. School closure and consolidation needs to stop as it increases dropouts and is in violation of RTE norm of neighbourhood schools within 1km
- iv. Privatization will lead to exclusion of children from disadvantaged communities and needs to be avoided. It needs to be recognized that education is a public good and the responsibility of the government
- v. Local Authorities have too many roles. Community and PRI participation should be encouraged to undertake some of these activities such as mapping of out of school children, mapping of requirements for neighbourhood schools etc. Enable delegation of roles and clear line of ownership within local authorities. Provide adequate staff and funding
- vi. Ensure proper linkages between different departments and ministries involved with education to streamline administration
- vii. Education funding needs to be increased incrementally, with a clear road map with specific timelines of reaching 6% GDP on overall education, and 4% of GDP on school education
- viii. Ensure adequate funds to SSA as approved by MHRD. In 2013-14 allocation had reached 88% of approved amount, but has gone down since and is a serious concern. It needs to be recognized that MHRD approvals are based on AWP&B which forms the basis of decentralized planning. There should be a clear road map of reaching allocation of 100% of the approved amount, and it should be achieved as soon as possible

- ix. Education cess should supplement budgetary allocations. In the short term cess could continue to be used for SSA, however, there needs to be a clear road map with proper time lines to ensure SSA in the long run is funded through budgetary allocation, with cess only providing additional support
- x. SSA allocations need to be tracked with regular reviews to ensure proper and timely utilization of funds

Conclusion

The RTE is one of the most progressive legislations making primary education a legally enforceable right, yet its implementation continues to have many challenges. Even after 10 years many children continue to be out of school, most schools continue to lack basic facilities and many teacher vacancies remain. All these concerns are fundamentally related to the huge resource gap at each level. Education has rightly been recognized as a very important priority by the government (Budget Speech 2016), however, financing of education remains well below par.

Allocations are nowhere near 6% of GDP as recommended by the Kothari Commission and the funding for SSA remains well below the MHRD requirements. Even within the allocations a major chunk is coming from the education cess. Today there is an urgent need for the government to move beyond rhetoric and take concrete steps to showcase its commitment to education. Once adequate resources are provided most ground level concerns can be addressed, and only then can the right to education truly be realized.

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FACTSHEET

STATUS OF SCHOOL EDUCATION FINANCING IN INDIA

India has the highest number of out-of-school children in the world, with over 60 million children lacking access to education.¹ Girls are disproportionately affected:

 **NEARLY 40%**

of adolescent girls aged 15-18 are not attending any educational institution.²

 **30%**

of girls from the poorest families have never set foot inside a classroom.³

The Right to Education (RTE) Act 2009 is a cornerstone of India's education system - setting out norms and standards for access to quality education. Yet more than 10 years on, the Act remains poorly implemented, with rates of compliance as low as 12.7% across India.⁴ Insufficient financing for education is a bottleneck to achieving its ambition to unlock the catalytic benefits of education.



 Centre for Budget and Policy Studies



Purva Bharati Educational Trust
To Seek to Strive and to Yield



THE OPPORTUNITY: BENEFITS OF INVESTING IN SCHOOL EDUCATION

Education is a fundamental right, which states have an obligation to protect, respect and fulfill. It is also one of the best investments to achieve economic growth, a healthier workforce, and peace and prosperity for India.



EMPOWERMENT

Research by the Centre for Budget and Policy Studies shows a strong correlation between public investment in education and child development and empowerment. States that spend more on education score higher on the Education and Empowerment Index.⁵



EMPLOYMENT

Education, particularly secondary education, is the most effective way for children to develop the skills needed for work and life. Quality education also helps counteract social factors that hinder women's labour market participation.

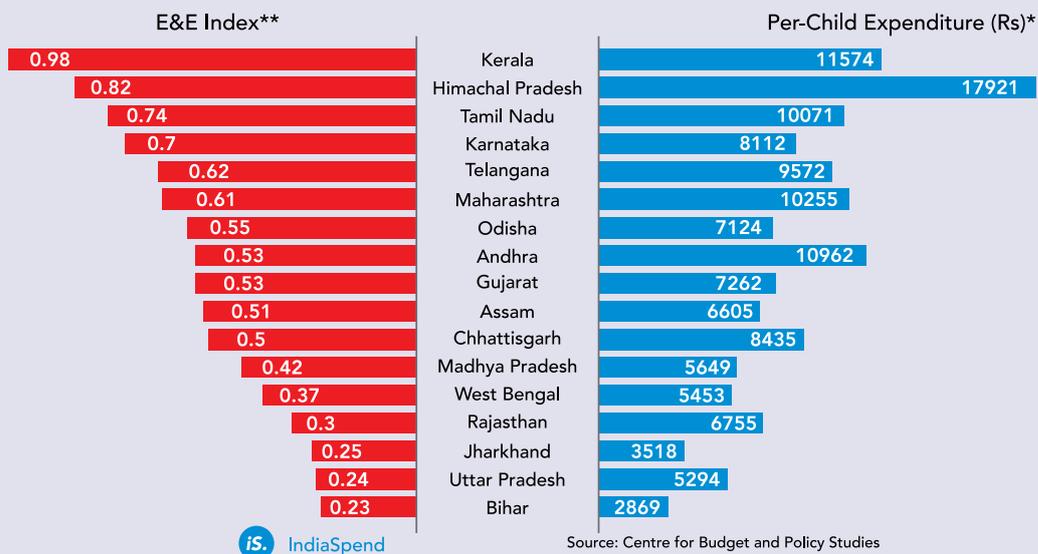


ECONOMIC GROWTH

Each additional year of schooling raises earnings by 8-10 percent% (with larger increases for women)⁶ - meaning that education not only helps to grow the economy but also fights poverty.⁷

Education & Empowerment Index & Per-Child Expenditure of Selected States

States that spent more on education scored higher on the empowerment Index



*Education and Empowerment Index: computed using the indicators from NFHS 4 and NSSO 71st round.

**Per child expenditure: Average expenditure per child on school education for the period 2012-13 to 2018-19 (except the state of AP, Telangana and Uttar Pradesh for which data is for 4 years)

THE CHALLENGE: SCHOOL EDUCATION FINANCING IS TRENDING DOWNWARD

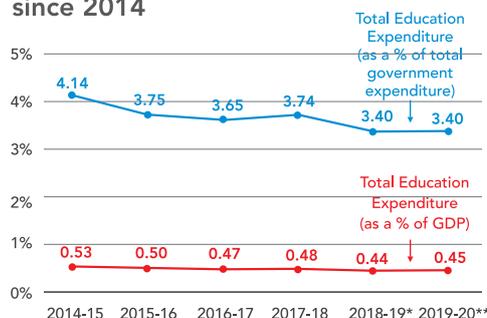
The National Education Policy commits to increasing spending on education from 10% of the government's total expenditure to 20% by 2030. This requires a significant turnaround from the country's historically low level of federal financing and allocation of resources to states.

1. GOVERNMENT SPENDING ON SCHOOL EDUCATION IS DECREASING IN REAL TERMS

The share of the union budget allocated to education fell from 4.14% in 2014-15 to 3.40% in 2019-20.⁸ Government spending on education has also decreased in real terms (adjusting for inflation).

Estimated at 2011-12 prices, the absolute allocations to school education have also decreased in real terms from Rs 38,600 crore in 2014-15 to Rs 37,100 crore in 2018-19, while education for higher education has increased from Rs 19,500 crore in 2014-15 to Rs 24,800 crore in 2018-19.⁹ While school education expenditure should increase, it should increase for both and not at the expense of the other.

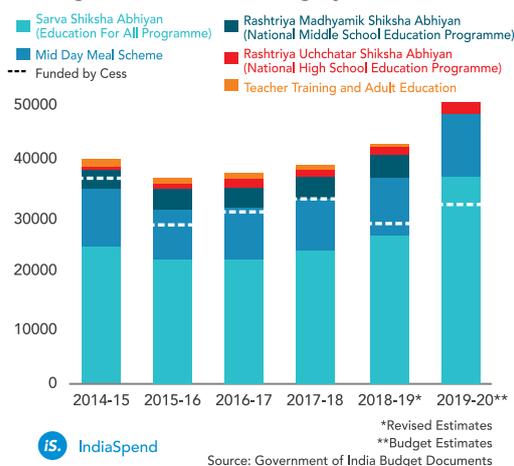
Share of School Education Declining since 2014



iS. IndiaSpend

*Revised Estimates
**Budget Estimates
Source: Government of India Budget Documents

Expenditure on National Education Mission (Samagra Shiksha) & Funding by Cess (Rs Crore)



iS. IndiaSpend

*Revised Estimates
**Budget Estimates
Source: Government of India Budget Documents

2. GOVERNMENT EDUCATION FUNDING IS OVERLY DEPENDENT ON THE EDUCATION CESS

Cess is an emergency and variable source of government funding meant to aid and cushion expenditure sourced from tax revenue/budgetary support.

Since 2015, with the decline of budgetary support for education expenditure, cess has funded 70% of the total education expenditure.¹⁰ This means that the emergency cess has become a regular way of funding education rather than funding it wholly through the government budget.

Cess can also be accessed by the union government alone, locking out state governments from accessing or scrutinising the spending of the fund.

3. STATES SPEND A HIGH PROPORTION OF THEIR BUDGET ON EDUCATION

State spending on education is disproportionately high, against union budget spending: between 75-80% derives from state budgets.¹¹ To expect states to increase their spending to meet the goal of spending 20% of the government budgets on education is unsustainable especially for states already struggling to accommodate needs of higher child populations.

State governments' share of the education budget has declined following the reduction of tied funds through centrally sponsored schemes, as recommended by the 14th Finance Commission. States alone cannot deal with the need for higher public expenditure required to meet the education ambition laid out in the National Education Policy - they need support from the central government.

RECOMMENDATIONS



SPEND MORE

- **Prepare a financial roadmap** for implementation of the RTE Act and the National Education Policy.
- **Front-load investment in the first few years of the National Education Policy** to address the historic downturn in spending. Budgeting in small incremental increases for education spend over 10 years is unlikely to address the immediate crisis in terms of quality and equity in education.
- **Increase the amount of grants given by the central government to centrally funded programmes**, such as Samagra Siksha, especially to poorer states with the lowest capacity to raise resources.



SPEND BETTER

- **Prioritise and increase investment in gender-transformative education methods** to improve girls' access to a free, safe and quality education. This means; ensuring the availability of more public secondary schools in all neighborhoods, increasing allocations to critical interventions like safety and security of girls, recruiting female teachers and providing gender-sensitisation training for teachers.
- **Prioritise investment to educationally lagging states** to fulfill the RTE mandate.
- **Reduce dependency on cess** and explore other sources for financing public education.
- **Allow states greater autonomy to plan and implement programmes** tailored to local needs and conditions without rigid restrictions.



SPEND TRANSPARENTLY

- **Bring tied grants, such as Samgra Shiksha, under greater public scrutiny**, by building internal systems to house progress reports, financial statements and budget documents.

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Samarth Bastar and Preservation of Indigenous Culture

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Introduction to the Samarth Zilla Framework

The Samarth Zilla framework aims to take learnings from earlier regional planning frameworks that were popular for almost three decades after India's independence, apply new techniques and approaches of formulation and implementation to activate holistic development of a district. This framework aims to address spatially lop-sided development of Indian states, wherein, few cities in each state have developed and urbanised rapidly. These cities attract large number of migrants from rural areas of less developed districts from within the state and from other less developed states that fail to provide viable livelihood options.

Samarth Zilla translates as 'Capable District', that is district which is capable of supporting the basic needs of its population - for food, clothing, shelter, livelihoods, health and education. The prevailing duality of rural-urban development programming between rural and urban has not served people in either rural or urban areas of India in achieving development levels comparable to their counterparts in Eastern or South-East Asian countries, which were at similar levels after independence.

The Samarth Zilla framework uses a regional approach to development which recognises the continuum of rural and urban areas. Though the unit of planning could be larger such as a cluster of neighbouring districts, or a river basin, the Samarth Zilla framework makes a district as the unit of development because of data availability at district level as well as the existence of all implementation mechanisms. The framework deals with the whole district, instead of a town or a village, which enables larger, integrated planning and implementation.

This framework, by virtue of its regional approach, carries an opportunity to apply systems thinking perspective to developmental efforts as against isolated interventions conceptualised to address issues in a limited (spatially and in scope) manner. Within a Samarth Zilla, while cities provide a space for enhanced livelihood options for workers from surrounding rural areas and act as growth engines of the district; small towns and

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rural areas act as a resource and production base for meeting rural as well as urban demand.

The major objectives of this framework are to reduce long-term migration and substitute it with day travel to the nearer urban centres by making them capable of providing decent livelihood options through non-farm activities; judicious use of natural resources available within a district; providing uniform standard of amenities and services throughout a district aiding in uniform human development, and finally, building an institutional eco-system to make the district more capable (Samarth) of providing decent livelihoods and a good quality of life to its inhabitants. Beyond that, the framework aims to leverage expertise of local research and educational institutions to identify opportunities in creating local employment. (Please refer to Samarth Zilla study report at www.rgics.org/samarth-zilla-study/),

The Samarth Zilla study began in Bastar district in mid 2019. The idea was to create a document that captures the local community's vision of a Samarth or Capable Bastar with actionable suggestions. It was christened as Samarth Bastar Jan Prerit Yojana at a public meeting at Jagdalpur on June 24, 2019. There began the process of widespread consultations with local experts, intellectuals, thought leaders, entrepreneurs, and people at large within the district. Discussions were held with people from all walks of life such as agriculturists from villages, members of women self-help groups in tribal and other areas, local artisans, businessmen and officials of the chamber of commerce, young entrepreneurs, students, agricultural scientists, lawyers, members from academia and the media, officials of non-profit organisations, social and political leaders and government officials, including the District Collector and the Chief Conservator of Forests. Visits were made to the farms of the horticultural university and to the office of the Coconut Development Board as also to individual farms of progressive farmers.

Samarth Bastar Jan Prerit Yojana

A draft of the outcome of consultations and discussions was compiled and segregated into seven overarching themes under which all the issues and concerns emerged. These were agriculture, forests and forest produce, education, health, entrepreneurship development, community participation in governance, and tourism. The first draft of the Yojana was released on October 2, 2019. Feedback, criticism, and suggestions on the first draft was invited from larger populace of Bastar region.

To push forward, another round of consultations and discussions were held in December-2019 and January 2020, this time in Bastar division, including in Kanker, Kondagaon, Narayanpur, Bastar (new smaller district), Dantewada, Sukma, and Bijapur. During these meetings, the first draft of the Samarth Bastar Jan Prerit Yojana was disseminated and ideas contained thereof were deliberated and discussed. There was more ground covered not only in terms of geography, but also larger number of stakeholders engaged. Subsequently, the Samarth Bastar Jan Prerit Yojana has been enriched, which gives a thematic plan of a capable Bastar while capturing the vision, intention, and expectations of the local community.

The complete Samarth Bastar Jan Prerit Yojana can be accessed at www.rgics.org. Following is the summary of learnings from second round of meetings held across Bastar division in December 2019-January 2020.

Agriculture: Agriculture is a major economic activity, and in Bastar region, it is characterized with lack of irrigation facilities leading to one crop a year which is rain fed; an accelerated shift towards monoculture wherein rice, and only two varieties out of over 200 grown in the region, is the only crop sown in the year; significantly sparse use of chemical fertilisers and pesticides; low labour availability due to changing practices of harvest; and low levels of animal husbandry, poultry, fishery or other allied activities. There are a number of models across the region which have addressed these challenges and utilised strengths for better incomes.



Forests and forest produce: Another important source of livelihoods for a significant proportion of the population is the forest produce. In absence of any value addition, major concern within this is low remuneration levels for people who collect non-timber forest produce like mahua, imli, tendu patta, etc. and sell to local traders or government agencies. The awareness about Forests Rights Act remains low, which reduces scope of indigenous communities' participation in management of forest resources. In absence of forward and backward linkages, attempts by the government agencies to promote plantation of cash crops like cashew, coconut, etc. have not yielded desired results.

Education: Even with growing levels of education in the region, the community believes that it is not translating into non-farm employment. The quality of education services, especially when the context of children from indigenous populations vis-à-vis text books and curriculum are seen, the barriers to learning begin to emerge. The community identified this as a major issue with education which is distancing children with the regional way of life. Apart from this, language of instruction different from that of pupils creates additional barrier along with lack of adequate schools and teachers. There are more than a hundred Ashram Shalas (schools) that have emerged as potential solution, as they provide food, shelter and better student teacher ratio and facilities.

Health: A similar state of affairs is witnessed in health service delivery. The community highlighted extraordinary levels of absenteeism among the staff at public health facilities.

The level of awareness among indigenous communities about common ailments and preventable disease is abysmally low. A high proportion of indigenous people prefer traditional medicine practitioners, which are found in large numbers throughout Bastar region and are even recognised by the state government. Apparently, these traditional medicine practitioners who are from the indigenous communities are more accessible, have contextual understanding of the indigenous lifestyles and common ailments. It might be useful if these were integrated into formal public health system in an appropriate manner.

Entrepreneurship development: The development of entrepreneurship is often considered as a solution to drive community led change. With availability of region specific natural resources, there is plenty of opportunities for local community to create their own enterprises. In order to achieve that, some of the expressed concerns of the community need to be addressed, such as, low levels of exposure of the indigenous people in this region; low availability of sources of finance for new ventures; lack of access to wider market beyond Bastar region for local manufacture; lack of institutions of higher education and vocational training.

Community participation: In order to achieve better governance, the participation of local community is essential. This is something which was largely missing in the area. In absence of awareness about institutional mechanisms such as gram sabha and its powers, there is very little participation in the meetings. Further, very many schemes of the Union and state governments aimed at development of indigenous communities seldom reach them. This has reinforced fear and distrust between indigenous and non-indigenous populations, and between the community and the government.

Tourism: With immense natural resources and beauty and a unique and pristine civilizational culture, Bastar region offers a great potential for tourism. While there are various initiatives, both public and private to promote tourism in the region in terms of religious tours, homestays, organic farming, etc., its impact on indigenous culture and values need to be kept in focus.

In the context of the culture of scheduled tribes, a statement repeated often is that steps need to be taken to preserve their culture. Underlying this assertion is a recognition as well as some assumptions all of which need to be analysed.

Assumptions underlying the call for preservation of culture

First of all, the statement implies a recognition that there are aspects of the “tribal culture” which need to be preserved. It is hoped, and presumed here, that the call for preservation of the culture is not arising out of an interest in the culture from the point of view of a museum goer or that of a tourist in search of novelty or variety, but out of a genuine interest arising out of the recognition of that the culture and way of life of the tribes are valuable in our search for a better future for mankind.

The assertion assumes that the tribal culture is facing the danger of getting submerged in the advancing tide of the cultural norms of the “non-tribal” sections of the society, which could roughly be called the urban-rural sections of the society. The culture of any society is generally not a static phenomenon and, to that extent, cannot be “preserved”. However, the pace of change is generally such that it allows managing continuity with the past and also does not bring in a radical change. The assumption underlying the statement about

the need for preservation is that the culture of the scheduled tribes today faces the risk of getting transformed to such an extent that it is in the danger of losing not just its forms and patterns of expression and interaction as well as customs and mores of day to day living but some of its basic foundational values as well. Moreover, this transformation is assumed to be of a much higher degree than that experienced in the case of the traditional culture of the rest of the sections of society.

The second assumption is that it is possible, through intervention, to stem the tide of transformation a culture faces in these times of rapid change. It is inevitable that all cultures would be undergoing significant changes in the present days of rapid advances in technology with ever evolving means and modes of communication; growing influence of both the market and the state with resultant rise in consumerism, surveillance as well as populism; urbanisation and the dismantling of the traditional social institutions. Hence, when one talks of preservation of culture, it would presumably imply preservation of some of the aspects which form the basic, inalienable foundations of that culture emerging from its fundamental values. It then follows that when one talks of preservation, one has to look for the values, beliefs, norms and practices which form the core of the culture and the modes of outward manifestation of these aspects.

Perceived conflict between inclusion and preservation

In case of the tribal communities, the change in cultural norms and patterns of behaviour are expected to be much more rapid, intense and comprehensive than the rest of the society as their exposure to the rest of the world inevitably increases with improvements in infrastructure and connectivity as well with higher levels of commerce, migration (arising from the degradation of the environment which supported their livelihoods and lives), education, political representation etc. The tribal communities have long been arguably the most deprived sections of the population. It is being increasingly acknowledged that they need to be brought into the mainstream of economic and social life so that these sections too, which have largely been deprived of the fruits of economic and technological progress till now, should be able to benefit from the advances made by the country.

While there is no question about the urgent need for inclusion of the tribal communities in the mainstream and offering them opportunities for a better standard of living, it also needs to be realised that this process would bring about a major transformation in their culture. **The very process of increased participation of the communities, in a more meaningful manner, in the activities of commerce and exchange with the rest of the society would bring a sea-change in their approach to life. Similarly, formal education through our existing system would make them alien to their own culture.** What should then be the choice, if there is a situation of trade-off between economic and social betterment on the one hand and preservation of their culture on the other? Equity demands that we opt for the first option because it would be unjust to keep a section of society deprived just because we believe that their culture should be preserved. One response to this question would be that choice has to be made by the communities and that the rest of the society has no authority to decide on their behalf. While this would unquestionably be the most appropriate response in the case a situation of similar trade-off arises in any other context, it should also be recognised that the choices a society makes would be limited by the extent of its exposure, awareness, knowledge and the opportunities it has been offered hitherto. It would be fair that the decision is made in favour of inclusion and participation.

The most crucial question to be answered in the context of the trade-off between economic and social development of the tribal communities and the preservation of their culture would, therefore, be about the way in which a balance is struck between the two. How could it be seen that the tribal communities enjoy the benefits of economic and social development with opportunities on par with the rest of the society, without losing some of the facets at the core of their culture?

What needs to be preserved, promoted and propagated

There is a need to first identify the various aspects of what is called tribal culture.

Unfortunately, the understanding of tribal culture is grossly inadequate in the urban-rural sections of society. As a result of the depiction of tribal culture in most literary works, the media and arts – especially the popular forms of art including film, the impressions formed of tribes in the minds of the general public is not just inadequate but quite often also incorrect. When one talks of tribal culture, the image which comes to mind is that of their unusual (to the urban eye) headgear, costumes and ornaments, and of their dance and music with traditional instruments. Not just popular works of art and films, even official releases of government machinery or other organisations reinforce these images through the various material released by them including calendars or table diaries, advertisements and events.

No doubt, costume and their music and dance form an important aspect of what is called tribal culture. Dancing to the beat of a drum comes naturally to them and along with dance and drum comes a drink. The drink is generally of mahua, toddy, salpi, made organically (traditionally) from some part of a plant or from grain. However, to consider these to be the be-all and end-all of tribal life would be sacrilegious. It all also needs to be understood that the apparel of most of the people of scheduled tribes today does not differ much from the rest of the population and a tourist who comes to tribal areas looking out for a variety in costumes may be surprised or even disappointed. It may also be mentioned that their music may also get influenced, to some extent, in the near future by the music and catchy tunes of contemporary popular films in the same manner as most folk music in non-tribal India has been influenced.

As mentioned in paragraph 1 above, when one talks of preservation of a culture, one has to look for the values, beliefs, norms and practices which form the core of the culture. What then are the core aspects of the culture of the tribes?

- i) It would be agreed unanimously that **reverence for nature** and practices leading to conservation of nature is one of the most fundamental aspects of tribal life. Their religious beliefs and practices, their lifestyles, their cultural mores – all spring from their reverence and proximity to nature. Their lifestyle is a demonstration of a **sustainable way of living**. Tribal communities practice moderation even when nature gives in an abundant manner. As an activist in Kondagaon mentioned, one would never find elaborate pieces of furniture of teak or any other form of timber in a tribal household, as is found in quite a few urban homes, even if they are placed in the midst of abundant.
- ii) The aspect of moderation brings us to the element of **simplicity in lifestyle**. It could be said that the tribal people are true Gandhians, in their simplicity and austerity in consumption. One could say that their scanty clothing is a result of poverty. However, it should also be viewed in the backdrop of the simplicity of their homes,



their cuisine, their appliances and kitchenware, their instruments – whether for music or for hunting. A tribal is not given to ostentation. Perhaps the only occasion when a slight extravaganza in apparel or ornaments is seen is when they dance for their gods and rituals.

- iii) The simplicity and austerity may make one believe that that their lifestyle is also devoid of **aesthetics**. Nothing can be farther from the truth. The aesthetics of the tribes is subtle, subdued, gentle paced, natural (in the true sense of the word) and devoid of loud and gaudy elements. The simple yet elegant décor of the homes of some of the tribes, the paintings from natural dyes for which many tribes are famous, their ornaments, their music and dance– all hum in unison with the forms, hues and rhythm of nature. Perhaps the tribal people would not have been able to withstand all the drudgeries and hazards of their lives without their innate aesthetic sense.
- iv) **Absence of greed** is another aspect of the tribal culture and lifestyle which especially stands out in the contemporary values of our society characterised by greed and grabbing, competitive and accumulative instincts, ostentatious lifestyles, corrupt practices, profiteering and attitude of extraction whether in dealing with fellow beings or nature. This trait could be on the decline, with increasing contact with the outside world, but there are still many instances and practices which would point toward such behaviour. There are villages after villages in Bastar and other tribal belts, where farming is continued to be done without use of chemical fertilisers and pesticides. This is especially true in villages which are remote from the urbanised settlements. It is not that the farmers are not aware of the increased yield with the use of chemicals but either due to their respect for tradition or due to reverence to mother earth - where it is considered that chemicals would harm the earth – they continue to stick to what we today call organic farming. When a farmer in Killepal was asked why he did not use chemical fertilisers, his response was that he would not like to damage his lands.

The greedless approach is not just restricted to their farming or other occupations. It is a part of their social mores. The instances of thefts in tribal areas were almost unheard of. Instances are galore about visitors and outsiders finding their misplaced or forgotten items lying untouched in many places.

More importantly, there seems to be absence of devious thinking. An average tribal person ordinarily is not found to be of a cheating mentality. As a result, in most dealings with the outside world, it has been found that a tribal person gets cheated. In fact, this quality of greedless behaviour could also be construed as a shortcoming in certain contexts in the current times.

The absence of greed or of a grabbing mentality is in consonance with their respect for nature, concern for conservation and the simplicity of their lifestyles. It also has a spiritual and aesthetic aspect. We thus find that most of the aspects are interwoven. Can it be said that all these qualities spring from a world view of being respectfully contented with what is offered by nature?

- iv) Harmonious communal existence can be mentioned as another noteworthy feature of the tribal lifestyle. This feature too is gradually on the decline. Many tasks of households are shared or were shared in the past by others in the village including farming operations, observance of rituals, celebrating events etc. Many decisions in the community are taken after consultations, though the gaon buda or the village elders hold considerable authority. Many tasks such as hunting used to be community outings and collection of forest produce is even today done in groups. The concept of individual land holding was not relevant in places where zoom cultivation was practiced. Most livelihoods were conducive to communal action and rituals and celebrations are also mostly performed in groups.

It is, of course, true that some tribes in various places were known to be hostile to strangers or people of other tribes. Even in the present times, there are reports of conflicts between different tribes, especially where one tribe is larger and dominant. However, within a tribe or a village, many activities are a shared community event.

- iv) Quality of forbearance and capacity to do hard work under extremely hostile conditions are some of the other aspects of tribal culture. Discussions with various villagers from remote areas indicate the hardships suffered silently by the tribal communities during the days of strife when they had to face accusations from both the government forces and from the left-wing extremists, supporting the other side. Perhaps these traits and the attitude of accepting whatever fate offers in a resigned manner have been the reason why they have only occasionally protested against injustice and unfair dealings.

All the aspects pointed above could be summed up to indicate three principal aspects of tribal life:

- i. Living in harmony with nature
- ii. Living in harmony with each other
- iii. Living happily without much use of energy, matter or technology.

These three aspects form the basis of the philosophy of tribal life. While tribal societies are considered “backward” by many, their lifestyle and approach indicate a much better understanding on their part of what constitutes sustainable living in a harmonious manner. These aspects of tribal life are in fact worth emulating by other societies. Integration of tribal communities with the rest of the society should not lead to their giving up these values but should result in others inculcating these three values

All the aspects mentioned above underline that **tribal culture is less of music, dance, drink and colourful costumes but more of a world view. It is this world view which is in the danger of disappearance and needs to be nurtured.**

What could be done?

There are some facets of tribal culture such as addiction, superstition, belief in black magic, highly unequal distribution of work between men and women etc. which are, of course, not worthy of emulation and need to be discouraged within the tribal society as well. Lack of enterprise can be cited as another shortcoming. However, it would be a tight rope walk to inculcate entrepreneurial ambitions and also retain the characteristic absence of greed.

As we have seen, most aspects of the culture flow from the world view of reverence towards nature and greedless contentment with what is offered by nature. How does one help the tribal communities preserve and nurture this world view? A few suggestions are offered:

- i. *Fostering of self-esteem:* The very first step would be to inculcate self-esteem in the communities for their cultural values. The tribal population faces the risk of developing a feeling of inferiority due to their deprivation. The feeling of being inadequate to successfully operate in the modern world may accelerate the process of abandoning the age-old values of the tribal society. There is a need to convey to them the worth of their culture especially when the lifestyles of the modern times are increasingly proving to be unsustainable. Theatre forms and music could be used to emphasise the value of their lifestyle and culture. Since the worship of their deities forms a major part, rather the basis, of the tribal culture, care has to be taken to ensure that there are no efforts from many quarters to make them give up their traditional forms of worship. It is also important that their forms of worship are not modified under the influence of practices of organised forms of worship. Their simple and natural ways of worship need to be continued in their pristine forms.
- ii. *Innovations in education:* It has been widely accepted that education is unquestionably a key to creating awareness and in inculcating pride in the tribal culture. A leader of the Sarva Adivasi Samaj had opined, in discussions about economic and social development of the tribal communities, that we only need to provide education and the tribal population would be able to take care of the rest of the needs on their own. While this could be true to a great extent, if not fully, it should also be recognised that the current system of education alienates the students from their own culture. The intent of education should be to make the tribal students develop pride in the positive aspects of their culture. The syllabus should contain stories and examples which **highlight the wisdom of their world view**. Instances of initiatives at various places at conservation, regeneration of natural resources and efforts aiding adoption of nature respecting lifestyles should be publicised. Moreover, education should not remain a bookish and theoretical exercise. **Practical training in various livelihoods activities** practised by tribal communities should be mandatorily included in the education system so that the students do not develop a feeling that these occupations are not dignified. In agriculture, the sustainable practices of tribal communities need to be emphasised. In regions where any art form or craft is practised, the syllabus should also include training in these crafts etc. In short, education should not only be used as a tool to develop esteem about their own culture, it should also constructively train students

in activities carried out in their neighbourhood and should help develop a pride in these activities.

- iii. *Incentivise continuation of their practices*: There is a risk that, under the onslaught of forces of modern commerce and “developmental” efforts of the state agencies, farmers from tribal communities may give up farming as practised by them and commence use of fertilisers etc. As we have seen, farming practised by the tribal communities is not akin to just adopting another mode of farming, but is a part of their value system and beliefs. Though most farmers produce mainly for self-consumption, it is important to ensure that their system of farming does not turn into an income depleting operation as compared to farming with chemicals and pesticides. Links would have to be established with urban **markets for organic produce** so that they are not penalised for continuing with the practice.

Similarly, **responsible tourism** with the help of homestay or community arrangements could be promoted with a strict code of conduct for the tourists. Facilities provided and the experience offered should be such that only those tourists who wish to genuinely experience tribal lifestyle and value their culture would be opting for the stay. Such tourists would not just provide income earning opportunities but also serve to make the tribal communities realise the value of their culture. The very thought that a tourist considers it worthwhile to be a part of their cultural existence itself would enhance self-esteem.

- iv. *Promote community activities*: Community action is a central part of tribal culture. There is a risk of this aspect getting lost in the increasing commercialisation of livelihoods and dilution of community bonds. The institutions such as gram sabha or their traditional governance institutions should be strengthened. Besides, **all forms of community action, be it in arts, sports, governance or in livelihoods activities** should be encouraged. Such groups could also serve as vehicles for spreading the feeling of self-esteem in the community.

- v. *Conduct research and document use of herbal medicines and traditional tribal remedies*: Many tribes possess knowledge of the medicinal properties of various herbs and many people are still around who have the knowledge and practice their traditional methods. There is a need to study and document these methods before they get lost and take steps for promotion of those practices and medicines which are found to be effective. This is an important part of tribal culture and could be beneficial for humanity if preserved. Discussions with practitioners in Khandam village in Kondagon indicated that they would be open to such a documentation and study.

- vi. *Promote use and production of natural products over synthetically produced goods*: Production of items of mass consumption which use natural raw materials should be encouraged in tribal communities through community groups taking up the activity. For example, to discourage use of plastic bags and other items, tribal groups could be given orders for producing bags of bio-degradable and naturally available materials or items such as cups and plates of dona pattal. **Making market available** to a product is one of the most effective means of making the production of that item dignified.

Tribal houses are traditionally made of mud and/or bamboo with roofs of tiles or made of various kinds of plant material. There is, no doubt, need for innovation in their housing to lend stability and strength to the houses. However, the alternative is not just building a typical structure of cement and RCC. In the government scheme of Awas Yojana, it is mandatory to have houses of “pucca” structure. As

long as requirements of stability are met, the subsidies should also be available for traditional houses of mud etc. In fact, since the cost of such houses is lesser than the subsidy normally given, a premium over and above the cost of the house should be given to promote building of such houses.

- vii. *Educate non tribal sections of society*: The stereotype which could be existing of a tribal as a backward person needs to be removed from the minds of the urban-rural public and they need to be educated about the world-view of the tribal communities.

Challenges and risks

As mentioned in the earlier paragraphs, any culture is not a static phenomenon and would keep changing and evolving with changing times. It is also observed that cultures of societies or groups which are materially (or militarily in case of nations) weak, also become “weak” cultures in the sense that the risk of getting submerged in the culture of the stronger society is high. The culture of tribal societies is in a similar risk of getting influenced by commercially developed societies. A lot has already changed and it is inevitable that much more of tribal culture would undergo many changes. Mechanical attempts to preserve the outward manifestations of a culture would remain just that and are bound to be ineffective in withstanding the forces of fundamental change. The aim should be to preserve and nurture the values and here, one can be certainly sure that, even if it happens that some of the sections of the tribal societies themselves give up these values, there is certainly a possibility that these values get acceptance over a larger section of population, tribal or non-tribal.

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