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UNIVERSAL HEALTH WOMEN EMPOWERMENT

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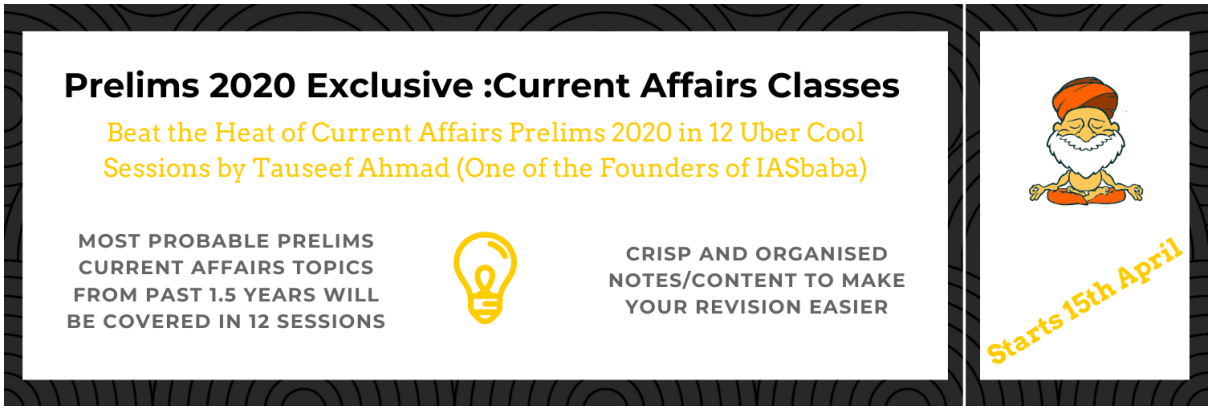
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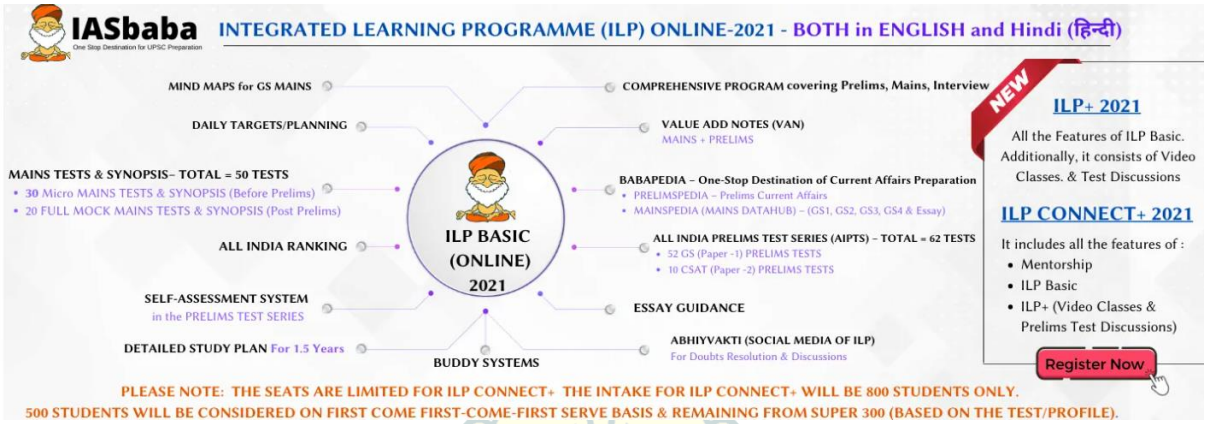
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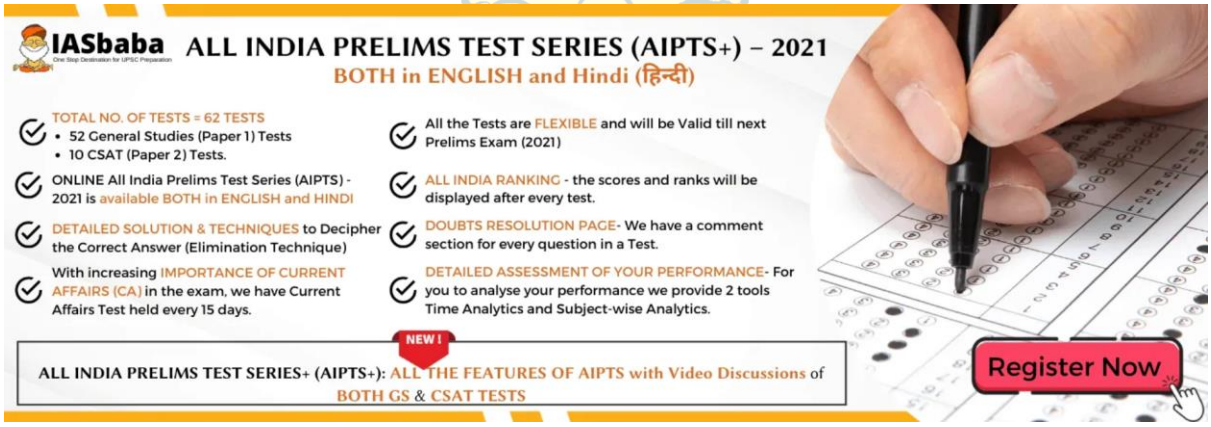
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Preface

This is our 62nd edition of Yojana Gist and 53rd edition of Kurukshetra Gist, released for the month of May 2020. It is increasingly finding a place in the questions of both UPSC Prelims and Mains and therefore, we've come up with this initiative to equip you with knowledge that'll help you in your preparation for the CSE.

Every issue deals with a single topic comprehensively sharing views from a wide spectrum ranging from academicians to policy makers to scholars. The magazine is essential to build an in-depth understanding of various socio-economic issues.

From the exam point of view, however, not all articles are important. Some go into scholarly depths and others discuss agendas that are not relevant for your preparation. Added to this is the difficulty of going through a large volume of information, facts and analysis to finally extract their essence that may be useful for the exam.

We are not discouraging from reading the magazine itself. So, do not take this as a document which you take read, remember and reproduce in the examination. Its only purpose is to equip you with the right understanding. But, if you do not have enough time to go through the magazines, you can rely on the content provided here for it sums up the most essential points from all the articles.

You need not put hours and hours in reading and making its notes in pages. We believe, a smart study, rather than hard study, can improve your preparation levels.

Think, learn, practice and keep improving!

You know that's your success mantra ☺

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Universal Health

Women Empowerment

UNIVERSAL HEALTH

1. Right to Health Act

Health is the core of human development.

- A key indicator in calculation of Human Development Index
- Placed as Goal 3 in the sustainable development goals
- Economic progress– Healthy people live more, are more productive and save more, resulting in increased investments and thus economic progress.
- Education– Healthy population can be more learned and also look for higher educational opportunities.
- Economic freedom– Due to savings on health expenditure, healthy population has more disposable income, giving them better choices economically.
- Nutrition– A healthy person can absorb nutrition better, which in turn increases his/her productivity in other spheres of life.
- Fertility– Healthier populations tend to achieve optimum fertility rates due to lesser child mortality ratio and higher economic development, for example Scandinavian countries.
- Productivity– A healthy individual can produce better outcomes and is less likely to be absent from work.
- Social benefits– A healthy person can have better access to social services as well as help improving the social capital of a nation.
- Learning and innovation– A healthy body includes a healthy mind and with a sound mental health free from depression, anxiety, stress etc. can the learning outcomes be improved along with excelling in innovation.

Health Index

The NITI Aayog has established the Health Index as an annual systematic tool to leverage cooperative and competitive federalism to accelerate the pace of achieving health outcomes and encourage cross-learning among states.

The Health Index is a weighted-composite Index based on select indicators in three domains:

1. Health Outcomes
2. Governance and Information
3. Key Inputs and Processes, with the health outcomes carrying the most weight across the different category of States/UTs.

How can it help?

1. Help States in focusing attention on better targeting of interventions and improving the delivery of health services and also an opportunity of sharing best practices.
2. It not only fosters competition among states by comparing similar states to each other but also nudges them to better their own performance in the previous year.
3. Tracking progress on incremental performance will also help shake complacency among "Healthiest Large States" such as Kerala, Punjab, and Tamil Nadu that have historically done well.

In 2019-20, MoHFW has taken a decision to link 70% of the NHM incentives to the incremental performance of the states and UTs on the Health Index.

2. Enhancing the Health Infrastructure of the Country

"Sarvebhavantusukhinah, sarvesantuniramaya"

Pradhan Mantri Jan Arogya Yojana (PMJAY) Scheme

Aim: To make path-breaking interventions to address health holistically, in primary, secondary and tertiary care systems
Objective: Prevention + Promotion (Health & Wellness)
Two major initiatives:

- **Health and Wellness Centre:** Foundation of India's health system
  - 1.5 lakh centres will provide – comprehensive health care, including for non-communicable diseases and maternal and child health services, provide free essential drugs and diagnostic services
  - The budget has allocated Rs.1200 crore for this flagship programme
  - Contribution of the private sector through CSR and philanthropic institutions in adopting these centres is also envisaged.
- **National Health Protection Scheme:**
  - Will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries)
  - Coverage of up to ₹5 lakh a family a year will be provided for secondary- and tertiary-care hospitalization (50 crore beneficiaries)

The Concern: The National Sample Survey's (NSS) health data of 2014 shows that in an estimated total 24.85 crore families in India, there were 5.72 crore cases of hospitalisation. By that calculation, out of the 10-crore families, there would be roughly 2.3 crore hospitalisations in a year. This means that from the Rs 6,556 crore government funds, health insurance agencies on average have only Rs 2,850 to pay per hospitalisation (assuming there are no administrative costs or insurance overheads).
The average out-of-pocket expenditure (OOPE) per hospitalisation is much higher — around Rs 15,244 as per NSS 2014 data, which amounts to Rs 19,500 in 2019-20 assuming a 5 per cent annual inflation. The PMJAY's budgetary provisions for insurance agencies will barely cover 15 per cent of this expenditure.

Ayushmaan Bharat can be a Game Changer only if

Challenges in mainstreaming health-care innovations – OR challenges in implementing a state sponsored healthcare scheme having universal coverage

1. **Non-uniform regulatory and validation standards.**
   - As a result, hospitals often rely on foreign regulatory certifications such as FDA and CE, especially for riskier devices and instruments.
   - In addition, it is difficult for a start-up to understand the minimum necessary validation requirements in order to qualify for procurement by hospitals
2. **Operational liquidity crunch**
   - Due to a long gestation period, health-care start-ups spend long periods of time in the early development of their product, especially where potential clinical risks are concerned.
   - The process of testing the idea and working prototype, receiving certifications, performing clinical and commercial validations, and raising funds, in a low-trust and unstructured environment makes the gestational period unusually long thereby limiting the operational liquidity of the start-up.
3. **Participation of Insurance companies:**
   - There are concerns about fair play and efficiency. Government insurance companies do not perform effectively and private insurance companies do not provide holistic coverage of diseases.
   - Indian health insurance covers only hospitalization costs and other expenditures like clinical visits, diagnostics and medication are not covered.
4. **Lack of incentives and adequate frameworks to grade and adopt innovations.**
   - Health-care providers and clinicians, given limited bandwidth, often lack the incentives, operational capacity, and frameworks necessary to consider and adopt innovations.
   - This leads to limited traction for start-ups promoting innovative solutions.
5. **Procurement challenges**
   - Start-ups also face procurement challenges in both public and private procurement. They lack the financial capacity to deal with lengthy tenders and the roundabout process of price discovery.
   - Private procurement is complicated by the presence of a fragmented customer base and limited systematic channels for distribution.
6. **Changing pattern of Diseases:** There is an epidemiological transition from communicable towards non-communicable diseases such as hypertension, diabetes and mental illnesses.
7. **Private participation:**
   - Currently almost 70 per cent of our healthcare needs are met by the private sector.
   - Feasibility of empanelling private healthcare in UHC is a major task to be done as private sector feel that the prices fixed by the government are far below market rate and it would be unsustainable to operate at such costs while providing high-quality outcomes.

Time for "More Health for Money"

Health budget during 2020-21 has increased by 4.1% from 2019-20. Till now, the health sector had been focusing on "more money for health and more health for money" but in the current year, the health sector needs to focus on "more health for money" turning towards innovative financing by striving to do more with less. The health sector has tremendous potential to use digital technology using application of machine learning, artificial intelligence, internet of things and virtual reality in making quality healthcare accessible and affordable to the people.

India cannot realize its demographic dividend without its citizens being healthy. UHC is expected to reduce social inequities and is also must for achieving the 17 UN Sustainable Development Goals (SDG's) by 2030.

The new Digital Information Security in HealthCare Act (DISHA)

- *It makes any breach punishable with up to five years' imprisonment and a fine of Rs. 5 lakhs.*
- *It redefines personal information of the patients. It adds, "use of narcotic or psychotropic substances, consumption of alcohol, human immunodeficiency virus status, sexually transmitted infections treatment, and abortion" related information of the patient to the list of sensitive information.*
- *DISHA also defines a 'clinical establishment' as well as the term 'entity' clearly and unambiguously to include individuals, trusts, private and public establishments, hospitals, diagnostic centres, pathological laboratories, radiology laboratories, etc.*
- *It also accords great significance to "informed consent" of individuals and emphasises on obtaining explicit consent before transfer and use of digital health data.*

3. Private Healthcare

Instances of suspected medical negligence and exorbitant bills are not unusual. Some make it to the headlines, others don't.

Basic tenets of regulating private healthcare:

- No payment at the point of service
- Governments as the primary spenders in healthcare
- Robust primary care system
- Regulation of prices of drugs and diagnostics
- Some health cover for every citizen

In India, this is probably the highest barrier currently — public spending on health is less than 1% of GDP, and per capita public health spend is about $15, less than in Bhutan, Indonesia, Thailand and the Philippines.

Need to understand the dynamics of the game

A. Address Information Asymmetry:

- Citizens need to be empowered so that they understand their rights and the recourse available to them should something go wrong. It is important to appreciate that healthcare is in any case plagued by tremendous information asymmetry.
- Patients as buyers of healthcare services and doctors as providers are definitely not equal players. Patients and their families often have little choice but to assume that their doctor knows best. It is, therefore, imperative that citizens are educated about diseases, possible complications and approximate treatment costs.

B. Self-regulation: Best way forward - While we can put in place external checks and balances, the need for the medical profession to self-regulate and adhere to the highest ethical standards cannot be underscored enough.

C. States need to Step Up: While the Central government needs to relook at the Clinical Establishments Act of 2010, (that though adopted by 14 states stands unimplemented) state governments must seize the moment and bring in regulations along the lines of, or bettering upon, what West Bengal and Karnataka have recently done. Karnataka legislated the constitution of empowered grievance redressal mechanisms at district levels; mandated hospitals to display prices for procedures; and ensure observance of a patient's charter. Such patient-centric laws are urgently required.

There is an equal urgency to building the institutional capacity to enforce them –

- Setting of protocols
- Computerisation of every patient interaction
- Supervision on real time basis
- An uncompromising approach to non-adherence of conditions need to go along with legal frameworks

Such an environment protects both doctors — of whom a majority want to do good — and patients, from the greed of hospital investors and managers.

We need to focus on building a strong public health system. It is not an either/or but given India's dual disease burden and the fact that 50 per cent of deaths are now due to non-communicable diseases, we need to do more to keep people healthy and reduce the need for costly hospital treatment.

4. The Public Health Disasters

Towards a resilient public health system - In an increasingly globalised and rapidly urbanising world, the risk of such outbreaks spreading quickly to all parts of the world is only becoming higher. The need of the hour is to build a resilient public health system that can prevent diseases, promote good health, and respond quickly to minimise loss of life when faced with an outbreak of this magnitude.

Increase spending on public health:

- The government needs to enhance funding for health to at least 2.5% of GDP as stated in the National Health Policy (NHP), 2017.
- States, too, have a critical role to play in meeting the NHP target of increasing health expenditure to more than 8% of their budget by 2020.
- We need to ensure that a large share of the funds goes towards preventative care.

A focal point for public health at the central level, with state counterparts:

- Such an agency would be responsible for performing the functions of disease surveillance and response, monitoring health status, informing and educating the public, as well as of providing evidence for public health action.
- In order to be effective, the agency would also need to be legally empowered to enforce compliance from other public authorities, as well as citizens. This is crucial because several factors require inter-sectoral action to achieve a measurable impact on population health.
- The legislation, possibly in the form of a Public Health Act, would clearly confer specific powers on the agency for taking action to promote public health, especially in situations of "public health nuisances".

Essential to institute a public health cadre in states, with officials trained in disciplines such as epidemiology, biostatistics, demography, and social and behavioural sciences:

- NITI Aayog has consulted a wide range of stakeholders on developing a model public health cadre that draws upon various best practices.
- The 13th Conference of the Central Council of Health and Family Welfare (CCHFW) has resolved to establish a public health and management cadre in states by 2022. CCHFW is an apex advisory body that recommends broad lines of policy action in health-related areas.

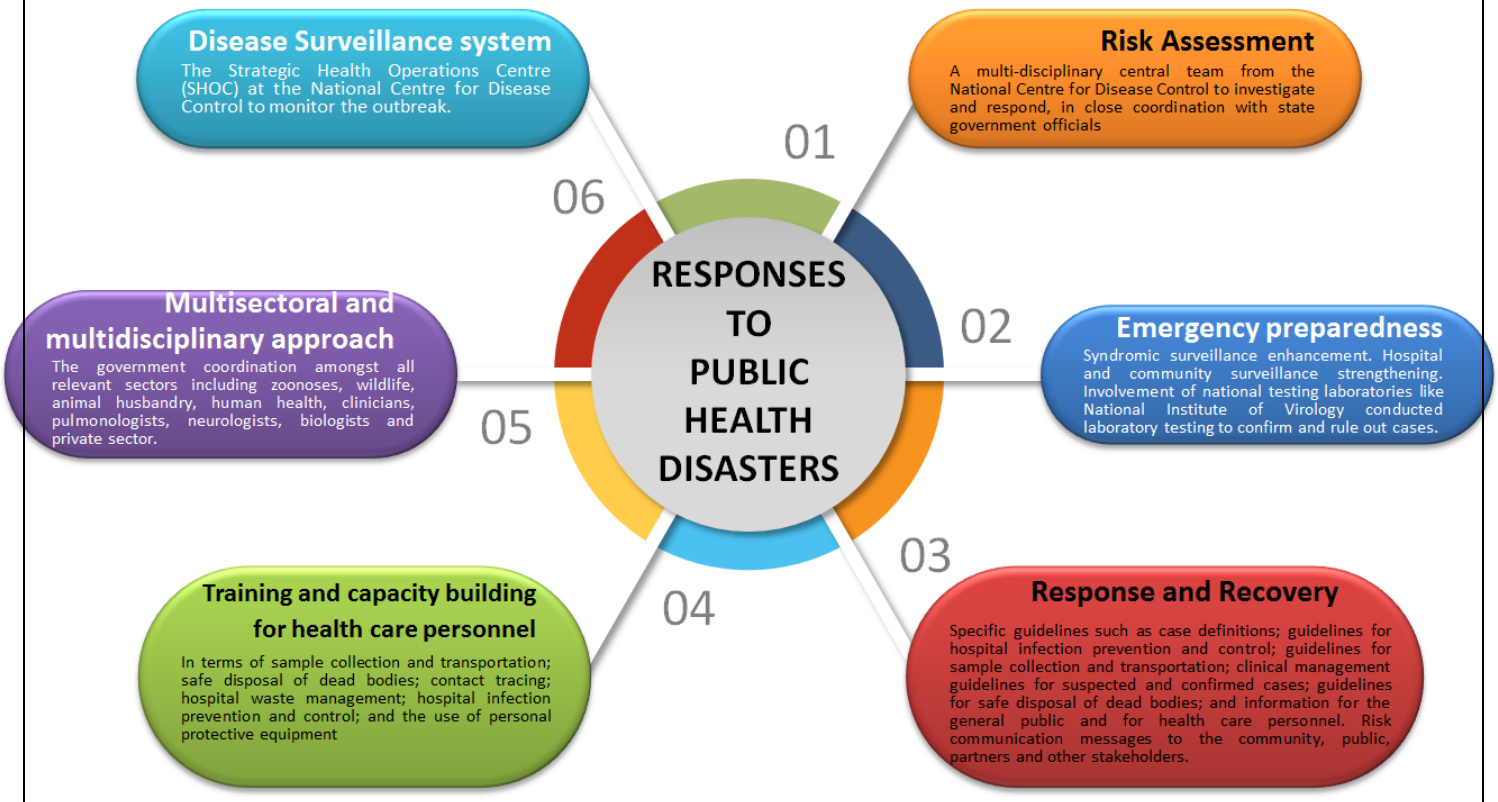
Train front-line workers—like Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Multi-Purpose Workers (MPWs)—

- To promote healthy behaviours among people, and identify early signs of a disease outbreak in communities.
- Given the inherent information asymmetry in health, and the fact that we live in world where misinformation can spread rapidly, appropriate channels are necessary for ensuring that people are aware of diseases, their symptoms, as well as mechanisms for prevention and treatment.
- The National Medical Commission Act, 2019 includes enabling provisions for creating a cadre of mid-level service providers who can also play a vital role in screening people for early signs of illness in rural areas.

Efforts must be made to reinforce disease surveillance, and response:

- This requires the list of notifiable diseases to be expanded, along with steps for integrating health facilities in the private sector in disease reporting as part of regular surveillance systems.
- Infrastructure for surveillance, including adequate numbers of suitably equipped laboratories for testing samples, also needs to be strengthened.

The need of the hour is to build a resilient public health system that can prevent diseases, promote good health and respond quickly to minimise loss of life when faced with an outbreak of this magnitude.

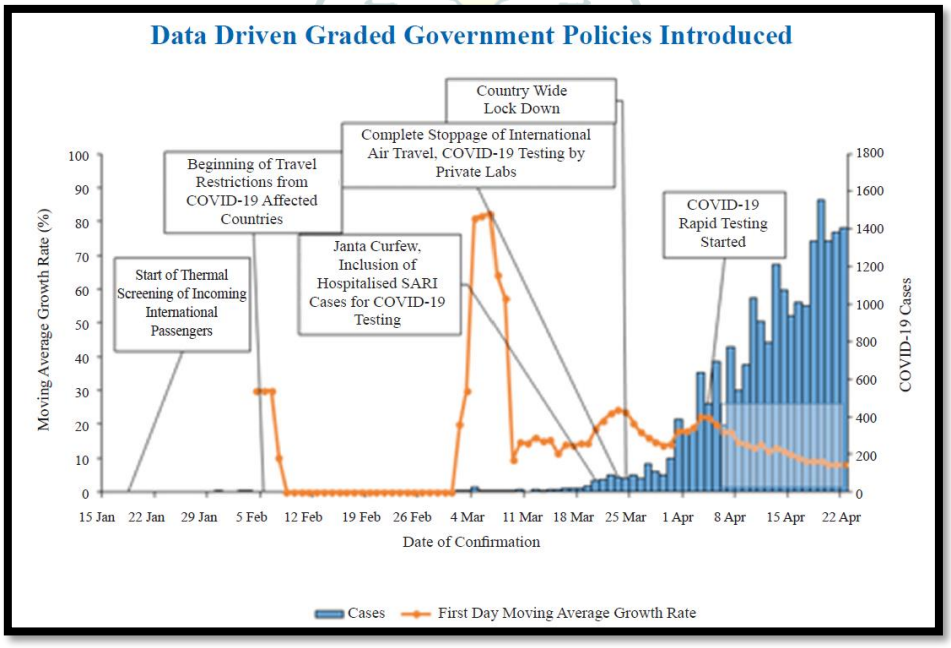


COVID-19

The World is experiencing one of the greatest pandemic in history.

Corona Viruses: All Coronaviruses are large (120-160 nm) enveloped RNA viruses which have single stranded genome. The name "coronavirus" is derived from Latin corona, meaning "crown" or "wreath". The virus possesses a club shaped or crown like peplomer spikes giving appearance of solar corona. High rates of genetic mutations are shown by the corona viruses. Most of these infect animals and birds. Human infection is caused by only those which can adapt to human conditions. There are already known six corona viruses involved in human infections.

- **In 2003** there was an outbreak of SARS-CoV (Severe Acute Respiratory Syndrome coronavirus). It originated from China and spread to around 29 countries causing 8098 cases and 774 deaths. The source was believed to be monkeys, raccoon dogs, cats and rodents.
- **Another member** of corona viruses, MERS-CoV (Middle East Respiratory Syndrome coronavirus) emerged in 2012. First reported from Saudi Arabia, MERS-CoV has affected more than 2143 cases and 750 deaths from 27 different countries. Here, the source was thought to be camels and bats.
- **Latest is CO**rona **VI**rus **D**isease originated in 2019; also known as SARS-CoV-2, 2019-nCoV acute respiratory disease, Novel coronavirus pneumonia and Wuhan pneumonia.
    - It primarily targets the lower respiratory tract, with dry cough, fever, fatigue as the major symptoms, others being; headache, fatigue, joint pains, breathing difficulty and diarrhoea.
    - The clinical features from chest CT of patients with COVID-19 include: pneumonia, acute respiratory distress syndrome, acute cardiac injury and ground glass opacities. People with co-morbidities such as diabetes, hypertension and other cardio-vascular disorders appear to be more susceptible than the rest.



Violence against health-care workers made punishable offence

The Union Cabinet has approved promulgation (put into effect) of Ordinance to amend the Epidemic Diseases Act, 1897 in the light of COVID-19 pandemic situation.

Key takeaways:

- The ordinance makes acts of violence against the healthcare workers as cognizable and non-bailable offences.

- Under it , there is also a provision to provide compensation for injury to healthcare service personnel or for causing damage or loss to the property.
- The investigation into the cases of attack will be completed within 30 days and judgment will be pronounced within one year.
- Accused of the attack can attract a punishment ranging from 3 months to 5 years and a fine from 50 thousand rupees to 2 lakh rupees.
- A compensation amounting to twice the market value of the damaged property will be taken from the accused if damage is done to the vehicles or clinics.

Epidemic Diseases Act, 1897

- This law enables states to ban public gatherings, ask schools and large institutions to stop functioning, and issue advisories to companies to explore work-from-home models.
- It also gives the state a right to penalise media organisations spreading misinformation.
- For background and features, click here.

5. An opportunity for Biomedical Industry

As the COVID-19 pandemic wreaks economy, there is enhanced focus on health & biomedical sector, where every country is trying to strengthen its indigenous capacity.

Scope for Biomedical Industry to expand

- **Potential for Testing industry:** If one only targets urban workers in India, there will be a testing pool of approximately 200 million people.
- **Decentralisation**: In India, the number of labs that can test for the virus needs to be increased to at least 2,000 with each lab having the capacity to test 5,000 samples a day. Also, labs need to be spread across country to ensure timely results.
- **Scope for Biomedical R&D:** India needs to incentivise its universities, research laboratories and biomedical supply chains to develop cheaper and faster testing methods
- **Employment benefits:** Massive testing requires hiring of testers, transporters and contact tracers thus increasing labour demand leading to job opportunities
- **Export Potential**: Massive testing will likely be a worldwide phenomenon over the next year or two. Consequently, world demand for testing kits will explode.
- **MSME boost**: Personal Protective Equipment (PPEs) can be manufactured by MSMEs at a much cheaper cost provided they are provided adequate governmental support
- **Complements India's pharmaceutical Sector**: India is already a leading player in global pharmaceutical market. Enhanced strength in biomedical field will make India a strong player in overall Health Sector

6. Artificial Intelligence in Healthcare

AI in Assistance to Physicians: To relieve highly-skilled medical professionals from routine activities, freeing up doctors to concentrate on the higher-value cognitive application of medical practice, truly connect with patients and positively impact cases of medical errors and misdiagnosis. AI-based technologies can offer improvements with speedy diagnosis and therapy selection, reducing medical errors, improving productivity, assessing and modelling risk and stratifying disease (He et al., 2019).

AI in Diagnostics: One of the key healthcare challenges in India is acute shortage of radiologists. AI based diagnosis can be especially helpful for radiology, pathology, skin diseases, and ophthalmology. While CT scan, MRI and X-ray facilities have proliferated in India, there are only about 10,000 radiologists available. This is where AI can be of great assistance.

AI for Optimising Treatment Plans: AI can also be used for assisting doctors and patients to choose an optimal treatment protocol. ML can be used to mine not only doctor's notes and patient's lab reports, but also link to the extant medical literature to provide optimal treatment options.

AI for Monitoring/Ensuring Compliance: The potential for AI application in remote monitoring has enhanced manifolds via the use of wearables. These can be used for monitoring various aspects such as movements, physiological parameters, temperature and alerts that can be communicated to healthcare professionals.

AI in the COVID-19 Epidemic: There is a need for an AI based epidemic monitoring system that can model and predict outbreaks and help optimise scarce resources. Over 38 million lives could be saved if countries across the globe implement high levels of testing, enforced isolation and wider social distancing. AI can help fight the virus via Machine Learning-based applications including population screening, notifications of when to seek medical help and tracking how infection spreads across swathes of the population.

Some challenges

Healthcare Industry Issues: The challenges of migrating to an AI-technology-based healthcare infrastructure are numerous as medical professionals attempt to transition to new ways of working and adopt new systems and processes. Traditional healthcare personnel may resist new innovations, doctors may not trust AI systems, patients may question AI-based decision-making and medical staff could view the changes as disenfranchising them from their key roles and decision-making powers.

Technology-related Issues: AI systems and the underlying algorithms are reliant on the quality of data to enable the ML elements to perform the necessary processing and decision-making. The challenge within India is the disparate nature of healthcare related data. Each state has its own system and working process.

Socio-cultural Issues in Technology Implementation: Although India is seeing significant development and positive societal change, the country has a long road ahead in the context of nationwide technological development and adoption. Although, policy makers have tended to view successful ideas from other countries and naturally assume these can be transplanted to India, researchers have warned of the inefficiency, even danger of such an approach. Studies have advocated that decisions should take account of cultural context and existing social conditions. While the penetration of mobile phones would at face value seem to be a positive factor for the adoption of AI, it could inadvertently amplify the gender disadvantage. Research highlights that women in South Asia are 38% less likely to own a mobile phone than men and when overlaid with patriarchal and misogynistic social factors, the real access figure could be less.

Regulatory and Ethical issues: Data security and privacy is especially important with the increasing use of wearables which can potentially cause identity theft through hacking of devices and data. AI is set to alter the traditional relationship between the doctor and the patient as technology plays the role of a third substantial actor. Under these circumstances, the regulators need to provide clear and concise user agreement and privacy policies to enhance widespread and safe adoption of these devices.

The Way Forward

The current COVID-19 pandemic and the forced migration of workers back to their rural villages due to the shutdown of major cities, illustrates the challenges faced within India and the logistical complexities in managing the current crisis. The changes needed to realise the benefits of AI

technology within healthcare are significant but investment in this area has the potential to greatly benefit the health and wellbeing of the Indian people.

- To enhance the adoption of technology by healthcare providers, AI and its applications should be incorporated within the curriculum for medical and paramedical training. The changes required to realise the benefits of AI systems must be centred around clinicians and the problems they face, to enhance, not replace the need for highly-skilled medical practitioners.
- Initiatives are needed at state and national government levels to ensure shared data standards, data security and exchange processes are incorporated within healthcare systems.
- Technology should be recognised as socio-culturally embedded; hence the technology design and implementation should take into account cultural practices and address the gender divide in India. Solutions need to take account of the Indian context where pockets of the population are socially and educationally challenged, culturally marginalised and economically disadvantaged.
- Ethical guidelines regarding security and privacy of data should be protected, especially as more and more the data is available through wearables and IOT. The data should be strictly used for clinical purposes only.
- AI systems when used for healthcare would have to be tested against all 7 DEEP-MAX parameters.
- The AI system must be explainable and auditable. All decisions made in the context of diagnosis or recommendations can impact on human lives. As such the underlying algorithms must be transparent and explainable to ensure ease of audit rather than acting as a black-box based system
- Decision-makers need to ensure that public sector healthcare organisations benefit from AI technology rather than default to the private sector reaping the rewards for investment.
- AI systems should not exhibit bias. The algorithms developed for the AI system must not exhibit any racial, gender or Pincode-based decision-making that disenfranchise or favour any population groups.
- AI healthcare systems must conform to human values and ethics. Regulatory bodies must ensure that human ethical values are an integral element of AI algorithms and resulting decision-making.
- Adoption of AI based healthcare must be benefits-driven. The migration toward greater levels of technology use may not be universally accepted or trusted by the medical staff within healthcare institutions. The impact and change in working practices must not be underestimated by policy makers, who need to ensure that changes are geared to the benefits to patients and the overall healthcare of the Indian people.
- Pilot initiatives should be developed within key states to trial the impact that AI systems could have on existing healthcare systems and infrastructure.

Connecting the Dots:

1. Insurance model vs Public Health care provision model
2. Linkages of Health care with other developmental parameters – Education, Sanitation, governance, civic participation, social empowerment etc.
3. Enacting a Right to Health Act and setting up of an independent regulatory authority to manage and monitor the delivery of health care services are the two most important steps in the direction of universal health coverage. Comment.

WOMEN EMPOWERMENT

"Empowering women is a prerequisite for creating a good nation, when women are empowered, society with stability is assured. Empowerment of women is essential as their value system leads to the development of a good family, society and ultimately a good nation." - ***Dr APJ Abdul Kalam***

In outer space or tilling soil, women have excelled in every field they have stepped into!

A shift is required from women development to women-led development.

A. Agriculture and Female Employment

The central role in all operations of agriculture and even rural household management is played by women. They are involved in all aspects of agriculture, from crop and seed selection to harvest and post-harvest management, marketing, and processing. Women have clear edge in dairying and animal husbandry also. Close to 75 million women are engaged in dairying and 20 million in animal husbandry. But they are

- Marginalised and disadvantaged in wages, land rights and representation in group activities
- Women have very limited access to productive resources which consequently limits their productivity

B. Financial Inclusion and Rural Women

According to NABARD's estimates, close to 60 percent of women members participated in the survey were attending to domestic duties and not engaged in any economic activity.

- Women's participation in wages/salaried activities was dismally low.
- Huge gender difference exists in the engagement and activities for employment in rural areas.
- While over one-fourth of the males were either self-employed including farmers only one-twentieth (4.8 percent) of women respondent were self-employed.
- Women participation in waged/salaried activities was dismally low because about 60 percent of women members reported to be attending to domestic duties only and not engaged in any economic activity. This implies that a huge population in rural India is still not economically utilised for better output.
- The All India Rural Financial Inclusion Survey 2016–17 indicated that women have equal and very strong financial knowledge and have better positive financial attitude than their male counterparts.
- SHGs have been a good effort in mobilising more women. The total rural women mobilised into Self-Help Groups stood at 6.47 crore by December 2019.
    - Under the programme 64.39 lakh SHGs have been promoted with a capitalisation support of Rs. 8334 crore extended to SHGs.
    - The banking system in India also extended open arm support to women SHGs with bank credit accessed at Rs. 2.59 lakh crore by these SHGs.
    - Apart from SHGs, 63 lakh women farmers were also provided support for livelihood interventions.
    - About 1.47 lakh SHG members were supported under value chain interventions.
    - Increase in the incomes of women members in the family has increased the access to food and finance, and benefitted their families as well as communities.
- **Skill Development:** One of the very critical gap that often lowers the employability of women and their efficient and quality output at work place is low skilling commensurate with the job

profiles of a particular company or agency. The Skill India Mission needs to map such requirement and design tailor made hands-on training modules for imparting skills to the willing women workers relevant to the prospective employers. Additionally, these training programmes need to be calibrated in such a way that they are sensitive to the needs of women workforce such as providing safe transport, flexible schedules as well as childcare support.

- **Social and Behavioural Change:** The developmental projects and interventions fall short unless the social and behavioural changes are not affected in the other 50 percent partners of the society. The social researches have established that the women tend to drop out in response to family pressures even after completing the skill programmes and consequently getting jobs. Hence, the developmental efforts need to be suitably complemented by changing the social norms around marriages, work and household duties. The society should own its responsibility to raise males to respect girls and women.

India needs to evolve a social revolution to realise the development potential of women workforce. The trend of women attending only domestic works will have to be reversed to embark on the new success. Globally the societies developed and became prosperous by valuing contributions of girls and women in making societies. The women's economic empowerment is closely connected with poverty reduction as women also tend to invest more of their earnings in their children and communities.

C. Gender Budgeting

What is Gender: Gender is the culturally and socially constructed roles, responsibilities, privileges, relations and expectations of women and men, boys and girls. Because these are socially constructed, they can change over time and differ from one place to another. Sex is the biological make-up of male and female people.

Gender Budgeting should be based on: A policy with a primary goal of re-orienting the allocation of public resources, advocating for an advanced decision-making role for women in important issues, and securing equity in the distribution of resources between men and women.

- Gender budgeting allows the governments to promote equality through fiscal policies by taking analyses of a budget's differing impacts on the sexes as well as setting goals or targets for equality and allocating funds to support those goals.
- Gender budgeting remedies the disadvantages and discrimination against women by incorporating them in the budgetary process and fighting marginalisation and exclusion from economic, political, and constitutional processes.
- It is not a separate budget for women; rather it is a dissection of the government budget to establish its gender-specific impact and to translate gender commitments into budgetary commitments.
- Integrating the gender perspective into macroeconomic policy has dual dimensions: an equality dimension and an efficiency dimension.

A simple 50-50 division may look equal, but it is often not equitable, or fair, because the needs of women and men and girls and boys may be different.

- Identifying the needs of women and reprioritising expenditure to meet these needs;
- Supporting gender mainstreaming in macroeconomics;
- Strengthening civil society participation in economic policymaking;
- Enhancing the linkages between economic and social policy outcomes;
- Tracking public expenditure against gender and development policy commitments
- Contributing to the attainment of the Sustainable Development Goals (SDGs)

Practicing Gender Budgeting through the stages –

At the budget preparation stage:

- Ensure financial appropriations made in budgets enable the implementation of programmes, schemes and activities in a way that will match the needs;
- Assess likely impact of new revenue-raising methods on different groups, compared with their ability to pay;
- Compare Budget Estimates (BE) for the current year with Revised Estimates (RE) and Actual
- Expenditure (AE) of the previous year and ensure corrective steps are taken to ensure proper and full utilisation of the budgets of current year.

When the budget is tabled:

- Analyse sector-wise or ministry/department wise trends and shares of allocations and expenditure as an indicator of government's priorities;
- Analyse the revenue side as in what are the sources of revenue, subsidies, etc., and how will they impact men and women.

At the budget implementation stage:

- Is the budget being spent in the way it was intended and to the full extent? What are the delivery costs? Who is receiving subsidies? Is the budget being spent for the purpose and the people for which/whom it was intended?

Figure 1 : Distribution of the Gender Related Budget in the Total Budget[6]

Vivekananda said, "It is not possible for a bird to fly on one wing." Gender budgeting is a powerful tool to give equitable power to both the gender-based wings of the economy. Gender Budgeting not only empowers women but also empowers the economy through efficiency gains to the GDP.

D. Nutrition and health related empowerment of women

Government has accorded top-most priority to tackle malnutrition among women and is making conscientious efforts to address this issue. The broad vision and mission of the Ministry of Women and Child Development (MWCD) is to empower women so that they can live with dignity as well as contribute as equal partners in national development in a non-violent and discrimination-free environment. Thus, efforts a social and economic empowerment through c mainstreaming gender issues, generating institutional/legislative support for enabling them women can contribute towards socioeconomic gr

Some household-level indicators for measuring women empowerment viz. nutrition and health issues:

- Women's involvement in household decision making:
  - economic decisions (finance, expenditure, resource allocation);
  - social and domestic matters (e.g. marriage etc.);
  - children related decisions (like schooling, health & nutrition).
- Women's access/control over household resources (including cash, assets, income, freedom of mobility).
- Power & money relationship (between the spouses); social hierarchy; appreciation and sense of self-worth (self-esteem).

Some important laws enacted prior to Independence for reducing social hostilities towards women:

- Hindu Widow Remarriage Act, 1856
- Female Infanticide Act, 1870
- Married Women Property Act, 1874
- The Child Marriage Restraint Act, 1929
- The Hindu Women's Right to Property Act, 1937

Various acts to ensure special provision/preserve the interest of women from immediate post-independence till date:

- Special Marriage Act, 1954
- The Hindu Marriage Act, 1955
- Immoral Traffic (Prevention) Act, 1956
- Dowry Prohibition Act, 1961
- Maternity Benefit Act, 1961
- Medical Termination of Pregnancy Act, 1971
- Equal Remuneration Act, 1976
- Indecent Representation of Women (Prevention) Act, 1986
- The Commission of Sati (Prevention) Act, 1987
- National Commission for Women Act, 1990
- Prohibition of Child Marriage Act, 2006
- Sexual Harassment of Women at Workplace *(Prevention, Prohibition and Redressal)* Act, 2013
- Muslim Women (Protection of Rights on Marriage) Bill, 2019

As per the National Policy for Women 2016 (draft)–with reference to women's nutrition and health, the priority areas include:

- Lowering the soaring Maternal Mortality (MMR) and Infant Mortality (IMR) rates.
- Increasing the outreach/capacity of ASHAs, ANMs and AWWs and that of the skilled home-birth professionals in backward areas.
- Organising special health camps for the prevention and treatment of diseases affecting pregnant women/nursing mothers (e.g. anaemia, under nutrition, etc.) and launching special drives for imparting nutrition health education.
- Recognising women's reproductive rights by formulation and implementation of gender specific health strategies.
- Apart from maternal health, focusing on other health related problems of women including communicable/non-communicable diseases (CVD, diabetes, cancer, mental health disorders, HIV/AIDS, etc.) with suitable strategies & interventions.
- Under the National Mental Health Policy (2014), systematic approach to facilitate timely screening, care and treatment particularly at primary level for recognising women with greater risk of mental disorders owing to discrimination, violence and abuse, etc.
- Health interventions focusing on physical and psychological well-being of women.
- Initiation of suitable health care interventions for menopausal women to tackle their physical/ emotional health problems like osteoporosis, CVD, depression, etc.
- Strengthening healthcare facilities for elderly women (aged >60 years) including preventive, curative and rehabilitative/palliative healthcare.
- Improving the nutrition/health status of adolescent girls.
- Special emphasis on adolescent girl's sexual & reproductive health needs.
- Healthcare coverage to the surrogates (during pregnancy, post-pregnancy and treatment for preventing the risk of infection due to multiple births).
- Strengthening the interventions and services for addressing the inter-generational cycle of under-nutrition, with special focus on continued nutritional care for the first 1000 days (from conception till 2 years postpartum; 270+365+365 days).
- Devising appropriate strategies for girls and women so as to end intra-household discrimination, particularly with reference to nutrition & health concerns.
- Ensuring availability of nutritious and safe food (through PDS) particularly for the unreached women/children in view of their greater susceptibility.
- Expansion of health insurance schemes including Rashtriya Swasthya Bima Yojana for benefitting the vulnerable and marginalised women in particular.

The Policy enshrines that the women's nutrition be accorded the highest priority since they are at an elevated risk of nutritional deficiencies during all stages of life cycle. Therefore, focussed attention is to be paid at every stage - right from ANC/PNC (for healthy foetal growth) to addressing the needs of girl child, adolescent girls to the post-menopausal/ elderly women.

Ways of empowering women in nutrition and health

1. Dietary diversification or bringing variety in the household diet
2. Adopting nutrient enhancing techniques like mutual supplementation, germination, fermentation, etc. in their day-to-day cooking/ food preparation for the household
3. Promoting the use of nutrient rich local/ seasonal/under-utilized foods or the so called commonly-discarded foods (e.g. radish leaves, pea-peels, cauliflower stalks etc)
4. Homestead-gardening to maximise sustainable gain at the household/community level (increasing availability, access and consumption of wide variety of nutritious foods);
5. In rural settings, promoting mixed cropping and integrated farming systems
6. Using fortified/bio-fortified foods, esp. micronutrient-enriched foods;
7. Inculcating the habit of food and water conservation among family members with due emphasis on avoiding wastage at all levels;
8. Nutrition education to encourage the consumption of nutritious, safe and healthy diets.

E. Schemes for Rural Women for Inclusive Development

Janani Suraksha Yojana (JSY): A safe motherhood intervention under the National Health Mission (NHM) for curbing maternal and neonatal mortality by promoting institutional deliveries especially among the pregnant women belonging to weaker socio-economic strata (SC, ST, BPL households).

National Health Mission (NHM): A flagship programme of the Ministry of Health and Family Welfare, it addresses malnutrition among women. Its components include:

- Anaemia Mukt Bharat;
- Organization of Village Health and Nutrition Daysas well as Sanitation and Nutrition days (for providing maternal &child health services along with awareness generation on maternal and child care);
- Iron and Folic Acid (IFA) supplementation
- Calcium supplementation
- Promotion of iodized salt consumption

Umbrella scheme of ICDS

- **Anganwadi Services Scheme** which aims to improve the nutrition/ health status of pregnant women and nursing mothers, thereby, lowering the incidence of mortality, morbidity and malnutrition among them. The beneficiaries are provided supplementary nutrition, nutrition and health education, immunisation, health check-up and referral services—all of which collectively help in uplifting their nutrition and health status.
- **Pradhan Mantri Matru Vandana Yojana (PMMVY)/ Maternity Benefit Programme** (launched in January, 2017) under which pregnant women and nursing mothers receive a cash benefit of Rs. 5,000/- in three instalments, on fulfilling the respective conditionalities: early registration of pregnancy, ante-natal check-up, child-birth registration and completion of first cycle of vaccination (applicable only for the 1st living child). The eligible beneficiaries also receive cash incentive under the Janani Suraksha Yojana (JSY). Hence, on an average, a woman gets Rs. 6,000/- for her first living child-birth.
- **Scheme for Adolescent Girls (SAG)** provides services to out-of-school adolescent girls (11–14 years) for their self-development and empowerment; improving nutritional &health status; promoting awareness regarding health, hygiene and nutrition; giving support to out-of-school

adolescent girls for successfully transiting back to formal schooling or bridge learning/skill training and upgrading their home-based life skills.

- **POSHAN Abhiyaan** was launched in December, 2017 to improve nutritional status of adolescent girls, pregnant women and nursing mothers in a time bound manner.

Pradhan Mantri Matru Vandana Yojana (PMMVY): PMMVY is a maternity benefit programme that has been made a pan-India phenomenon since December 31, 2016. The beneficiaries would receive cash incentive of Rs. 6000 during pregnancy and after institutional delivery. The scheme implementation guidelines, the software for its roll out i.e. PMMVY – CAS and its user manual were launched on September 1, 2017.

Pradhan Mantri Ujjwala Yojana: To make cooking gas (LPG) available to women from families that are financially backward. It is estimated that the Ujjwala Yojana will assist approximately 1 crore 50 lakh households that presently live below the poverty line. The programme is also expected to cover five crore such households in all.

- Enhance the status of women and caring for their health
- Help to decrease air pollution due to use of fossil fuel.
- Lessening the serious health risks related with cooking based on fossil fuels.
- Reducing the number of deaths due to unclean cooking fuels, which is almost 5 lakh every year in India.
- Preventing young children from acute respiratory illness caused due to indoor air pollution by burning the fossil fuels.

Deen Dayal Upadhyaya Antyodaya Yojana (DAY-NRLM): Ajeevika is a major project of Ministry of Rural Development. It focuses on rural women and aims to achieve universal social mobilization by involving rural women. At least one woman member from each identified poor rural household is to be brought under the Self Help Group (SHG) network in a time bound manner.

- **Deen Dayal Upadhyaya Grameen Kaushalya Yojana (DDU-GKY)** aims to skill rural youth who are poor and provide them with jobs having regular monthly wages or above the minimum wages.
- **Mahila Kisan Sashaktikaran Pariyojana (MKSP)** is another component that aims to improve the present status of women in agriculture and enhance the opportunities for empowerment.

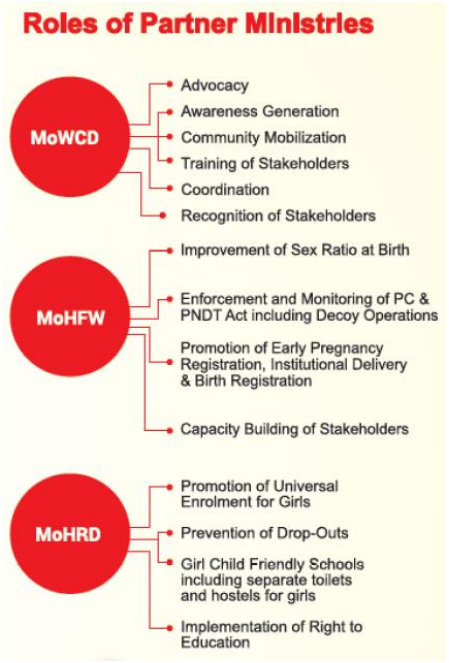
Rastriya Mahila Kosh (RMK): Rastriya Mahila Kosh (RMK), of Ministry of Women and Child Development, extends micro-credit to the women in the informal sector through a client-friendly, collateral-free and a hassle-free manner for income generation activities. RMK has taken a number of promotional measures to popularise the concept of micro-financing, enterprise development, thrift and credit, formation and strengthening of women SHGs through intermediary organisations. Education of credit management has been integrated with the provision of credit, along with literary and skill training for individual women and leadership training among groups for self-management.

Mahila Shakti Kendra (MSK) is envisaged to provide an interface for rural women to approach the government for availing their entitled benefits and for empowering them through training and capacity building. Convergent support is being proposed for equal access to healthcare, quality education, career and vocational guidance, employment, health and safety, social security and digital literacy at Gram Panchayats level in selected districts/blocks across the country with a view to create an environment in which women realise their full potential.

National Repository of Information for Women (NARI): Will provide citizen easy access to information on government schemes and initiative for women. The Portal also provides information to women on issues affecting their lives, for example, there are tips on good nutrition, suggestions for health check-ups, information on major diseases, tips for job search and interviews, investment and savings advice, information on crimes against women and reporting procedures, contacts of legal aid cells and much more.

National Nutrition Mission (NNM): To deal with the problem of malnutrition, government has set-up the National Nutrition Mission (NNM) with a budget of Rs. 9046 crore. The aim is to achieve an improvement in the nutritional status of children of 0–6 years and pregnant and lactating women in a time bound manner, during the three years beginning from 2017–18, with defined targets.

Beti Bachao Beti Padhao (BBBP): BBBP, the flagship scheme, was launched initially to address the declining Child Sex Ratio but as it graduated, it broadened and took under its ambit other concerns such as strict enforcement of PC-PNDT Act [Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act], provisions to motivate higher education for girls and related issues of disempowerment of women on a lifecycle continuum.



Universal Health Coverage (UHC)

UHC "means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation and palliative care."

United Nations Sustainable Development Goals (SDGs) has also set a target that all countries must achieve UHC by 2030.

Solutions

- Public financing is the lifeline of UHC. Important to raise public spending on health to at least 2.5 per cent by 2022 and 3 per cent by 2024.
- Primary health care has to be recognised as the foundational basis of an efficient and equitable healthcare system. Primary care needs to be the fulcrum of UHC.
- Emergency health services are also a high priority, to provide the link between these services and also lifesaving care on location and during transport. All such services have to be provided free of cost.
- Right from start, UHC has to cover several services like commonly needed surgeries and treatments that can protect life.
- Government funded programmes should ensure that financial barriers should not stop access to needed advanced care.
- As UHC evolves, the poor and near-poor must get full cost coverage while others may seek protection through employer funded schemes or privately purchased insurance. Even for them, OOPE must remain low.
- The health work force has to be expanded to make available multi-layered, multi-skilled teams which can deliver the needed services.
- Basic and specialist doctors, nurses, nurse practitioners, physician assistants, pharmacists and an array of allied health professionals need to be developed in large numbers and deployed across the country. This needs reforms in health professional education, cadre planning and incentives for rural postings.
- UHC has to be cashless at the point of care and health benefits under the programme have to be available for access anywhere in the country.

India & UHC: Challenges

- **Funds:** Cost of Providing UHC is far greater than government estimates. India's public health expenditure is amongst the lowest in the world, India currently spends a little over 1% of GDP on health. Considering public and private expenditure on health, the feasibility of UHC seems to be concerning in tandem with the current economic reality of India.
- **State Cooperation:** Health is a state subject. State cooperation is a must for UHC.With states and UTs like West Bengal & Delhi keeping themselves out of Ayushman Bharat Scheme, creates a challenge for UHC.
- **Infrastructure:** Lack of adequate infrastructure is a concern which includes proper hospital infrastructure, number of beds and diagnostic centres.
- **Participation of Insurance companies:** There are concerns about fair play and efficiency. Government insurance companies do not perform effectively and private insurance companies do not provide holistic coverage of diseases. Indian health insurance covers only hospitalization costs and other expenditures like clinical visits, diagnostics and medication are not covered.
- **Changing pattern of Diseases:** There is an epidemiological transition from communicable towards non-communicable diseases such as hypertension, diabetes and mental illnesses.
- **Private participation:** Currently almost 70 per cent of our healthcare needs are met by the private sector. Feasibility of empanelling private healthcare in UHC is a major task to be done as private sector feel that the prices fixed by the government are far below market rate and it would be unsustainable to operate at such costs while providing high-quality outcomes.
- **Awareness and Behavior:** Most of the time people are not aware of government initiatives and schemes. Moreover, people take symptoms for granted and does not consult the doctor at the earliest and prefer taking medicine from the medical shop without prescription. Illiteracy plays a major role in it.
- **Resistance Development:** People are rapidly developing Multi-Drug Resistance in cases of Tuberculosis.

Right to Health - Fundamental Right

- **Introduction**
  - A bill moving to make Right to Health a fundamental right in India has been introduced
- **The Bill**
  - People should be entitled to avail health protection services free of cost
  - Should be in place on the lines of the right to education
  - Amendment in the Constitution by introducing a new article 21 B for making right to health a fundamental right
  - Prevention, treatment and control of diseases and access to essential medicines
  - All citizens should also have access to basic health services, emergency medical treatment and mental healthcare
- **Need**
  - Draft National Health Policy, 2015 - 63 million people are faced with poverty every year due to healthcare costs alone
  - Current public expenditure on health, however, stands at only 1.4 percent of the GDP
  - National Health Policy 2017 in an effort to increase health spending, gradually and timely, to 2.5% of the GDP
    - Strengthening the public health system
    - Leveraging strategic public-private partnerships in the health space
- **Importance**
  - Right to Health is an internationally recognised fundamental human right
  - If Article 21B is introduced - failure to provide health care will have legal consequences
  - It is included in
    - Universal Declaration of Human Rights
    - International Covenant on Economic, Social and Cultural Rights
- **Different healthcare models**
  - **Beveridge model**
    - Government uses its revenue to finance universal coverage
    - Benefits from low per-capita costs - Allows the government to regulate and negotiate prices of drugs and medical services
    - Most of the hospitals and clinics are government-owned
    - Private doctors collect their fee from the government
    - Eg. Cuba, UK, Spain, and New Zealand
  - **Bismarck model**
    - Insurance-based healthcare system
    - Jointly funded by employers and employees via payroll deduction
    - Eg. Germany, France, Belgium, Switzerland, the Netherlands, and Japan
  - **National Health Insurance (NHI) model**
    - Using private-sector providers but financing through a government-run insurance program
    - Every citizen pays into the corpus and there is no profit or financial motive
    - Cost control is exercised by limiting the government-covered medical services

All the best
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