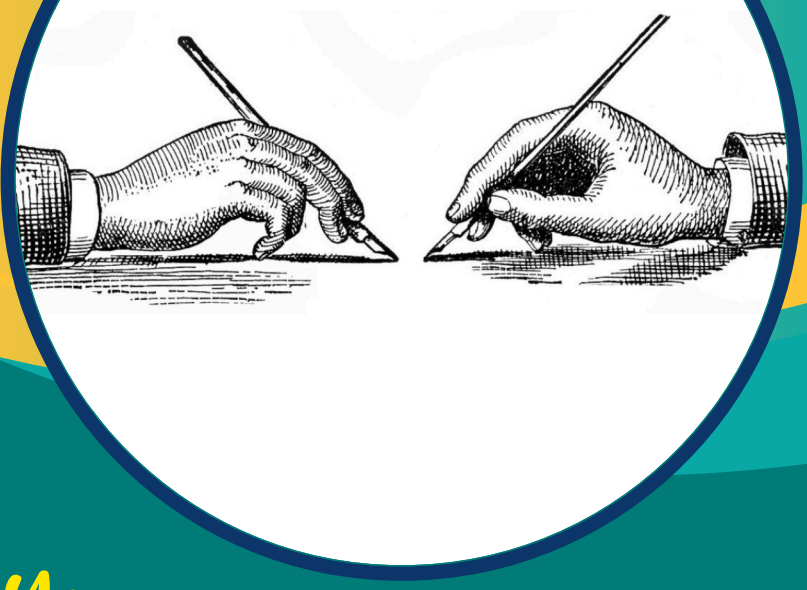
AJMAL INSTITUTIONS
Empowering Young Minds

AJMAL IAS ACADEMY, HOJAI

Run by: AJMAL FOUNDATION, HOJAI
AJMAL FOR EDUCATION, EDUCATION FOR ALL.

A TRUSTED PLATFORM FOR UPSC / APSC PREPARATION



Weekly EDITORIAL ANALYSIS

By- Rais Sir

DECEMBER - WEEK-I

BISHNUPALLY, HOJAI, ASSAM - 782435 CONTACT: 6003341075 / 9565808218 WWW.AJMALIASACADEMY.IN

INDEX

Page No.

SCHOOLING IN INDIA IN TIMES OF POOR AIR QUALITY

The Hindu: 28 November 2024

Source: https://www.thehindu.com/opinion/lead/schooling-in-india-in-times-of-poor-air-quality/article68918906.ece

Schooling in India in times of poor air quality

Dr. Chandrakant Lahariya

a medical doctor who specialises in early childhood development, lifestyle diseases and preventive medicine. He has over 16 years of work experience with the World Health Organization and UNICEF

Dr. Randeep Guleria

a former Director of the All India Institute of Medical Sciences (AIIMS), New Delhi and a specialist in respiratory medicine

Considering scientific rationale and the benefits and risks, the functioning of schools needs to be delinked from Graded Response Action Plan measures

In a stark reminder of the COVID-19 pandemic period, schools in Delhi State, in mid-November 2024 – as a part of the Graded Response Action Plan (GRAP) to tackle air pollution, which is triggered when the Air Quality Index (AQI) is "poor" – had been asked to switch from physical to online mode. While other restrictions imposed as a part of GRAP might have an impact on air quality, the decision to switch schools to online mode needs to be examined for its scientific rationale, practicability, and benefits and risks.

Poor air quality in many north Indian States is harmful for any age group and not just children. The harmful health effects of poor air quality are on a continuum from the moment the AQI crosses normal range. Children (and everyone in any age group) should be protected from poor air quality the moment the AQI crosses 50, which is considered 'good' air quality by Indian norms. However, there are only a few days in a year when the AQI is within acceptable limits. In 2024, till now, there has not been even a single day with 'good' air quality in Delhi; there was just one such 'good' air quality day in 2023. Alongside, it is naive to believe that an AQI that is more than 400 (classified as 'severe' or 'severe plus') is harmful and anything below this is not. This arbitrary and high cut off does not help except inadvertently normalising the harmful health effects of air quality that is in the range of AQI 51 to 399.

More importantly, most children in Delhi or other parts of the country are likely to have the same air quality inside their homes or in their schools. For some underprivileged children, air quality in the classroom might be better than at home as many schools have air purifiers. The idea of having online classes due to poor AQI puts all children at an additional disadvantage of learning loss and nutritional loss (as many children get mid-day meals in schools), while there is no respite from the health impact.

It is widely known that online classes are not a replacement for school-based learning and the only beneficiaries here are EdTech platforms and Apps. Then, the younger children are not supposed to have exposure to screen time. Therefore, when they are forced to attend online classes, they are being exposed to more harmful behaviour than receiving any possible or perceived benefit. In the three years of the COVID-19 pandemic, all of us have learnt that schools are not the places where children read only books; there is life learning. Therefore, the focus has to be on keeping schools functional and ensuring learning continuity. There was an article related to this, in this daily, by one of the writers: "The pathology of school closure in India", February 16, 2022.

The oversold idea of face masks

Poor air quality nearly always brings up the issue of face masks. Even before GRAP stages III and IV recommended the suspension of physical classes, a few schools sent out advisories to parents that children should wear face masks in order to attend schools. Though it was argued that these advisories were to provide guidance, what was forgotten was that such advisories from schools became an 'informal mandate' for children and parents. Such a uniform advisory for all children to wear a face mask is not fully backed by science. As far as children are concerned, even during the COVID-19 pandemic, masks were not recommended for children who were younger than five years for various scientific reasons and utilising empirical data. For those between six to 11 years, masks were advised (and not mandated). There is no rationale for anyone to wear face masks if the set-up has air purifiers. In short, the face mask wearing guidance for children has to have a nuanced and personalised approach. Therefore, schools should refrain from issuing such advisories, which should come only after guidance from medical experts.

Adopt a science-based approach

First, schools should not be made to switch to online classes, no matter what the level of AQI is. The focus should be on keeping the school functional and ensuring learning continuity. This could be done with some mitigants such as completely halting all outdoor activities in schools when the AQI is poor. Everyone should take appropriate personal protective measures, such as the use of purifiers and face masks, taking into account recommendations by age, and pre-existing health issues. Those who have any pre-existing respiratory health issue are likely to benefit more from mask wearing, specifically in a polluted and open space.

Second, to attend school, there is no need for a uniform directive for mask wearing. Schools are not the source of pollution. Arguably, air quality in schools is similar to the homes of children. Therefore, it does not make any sense to do anything differently in school than what is done at home. So, if children and parents wear a face mask at home, they can wear it at school as well. Else, no additional mandatory mask wearing measure is needed. There is a need to remember that face masks can also have negative effects such as causing a skin allergy and other discomforts. So, one should keep in mind the benefits and the associated risks. Also, except for medical recommendations, children younger than 12 years should not be made to wear N95 masks. During periods of severe or above AQI, children who have pre-existing health issues or any other parents who wish to keep their children at home, should be given an 'opt-out' option from physical classes, and the rest of the children should have the opportunity for learning continuity.

Third, in schools or other settings which have functional air purifiers, mask wearing is not going to provide any additional advantage. For such settings, i.e., schools, ensuring that the classroom doors and windows are closed properly and switching on air purifiers at least an hour before children arrive would ensure 'good' quality air.

Fourth, 'online schooling' is an oxymoron – it is not school if teaching is online. The option of hybrid classes should not be interpreted conveniently by schools. Also, other than air quality, there are other reasons such as foggy or cold winter days, which many schools exercise as a reason for switching to online or hybrid classes. These should be actively discouraged and teaching should be in physical mode for all parents, who are willing. In fact, it is problematic that school classes are often referred to as 'offline' or 'online', placing electronic devices at the centre of teaching and learning. We need to break this mode of thinking. Therefore, in future, if and when the government or any authority fails children by passing an order to switch to online classes, the management in every school needs to come up with innovative approaches to ensure that learning is not in front of a mobile or computer screen.

Fifth, poor air quality is a reminder that anyone who has pre-existing health or respiratory conditions should take better care of their health. This means having a routine checkup and a regular follow-up visit with health-care providers. Preventive interventions such as annual influenza vaccination or age-appropriate recommended vaccines like pneumococcal, measles, *Haemophilus influenzae* Type b (Hib) are administered to those who need it.

Policy must be people-centric

From a larger social angle, most of the actions recommended as a part of GRAP, adversely and disproportionately, impact the poor and the vulnerable in terms of wages (for the poor and the marginalised) as well as learning and nutrition (for children) losses. This is a reminder that whatever is done in the name of the policy should have a people-centric and pro-poor focus. Air quality and school functioning need a nuanced approach. India had one of the longest closures of schools during the COVID-19 period and we need to learn from those mistakes. There was another article on this, in this daily, by one of the writers: "Building back to avert a learning catastrophe", April 28, 2022.

Schools are not the source of air pollution. Rather, there is far greater loss than benefit from school closure. While there are valid reasons for implementing other measures under GRAP to improve the AQI, closing schools for physical classes makes the least sense. It has happened for the last eight years, but now is the time that school functioning is delinked from GRAP measures. Nelson Mandela had said, "There can be no keener revelation of a society's soul than the way in which it treats its children." When it comes to handling air quality and the functioning of schools, Indian States and society seem to be failing in their responsibility and their duties.

Delhi's Air Quality Challenges

- **Health Risks Beyond AQI 400**:
  - Air quality begins to adversely impact health at an AQI of 50 (classified as "good" under Indian norms).
  - Levels between 51 and 399 are also harmful, yet GRAP primarily focuses on AQI > 400 ("severe" or "severe plus").
- **Consistent Poor Air Quality**:
  - **2024**: No recorded "good" air quality days so far.
  - **2023**: Only one day was classified as "good."
  - This persistent exposure to harmful air highlights the need for sustainable, structural solutions rather than temporary measures like school closures.

Impact of School Closures

1. **Learning and Development**:
   - **Academic Setbacks**:
     - Online education cannot fully replicate in-person teaching, especially for fostering interaction and critical thinking.
     - Younger children face greater challenges with screen-based learning, risking long-term developmental delays.
   - **Social and Emotional Well-being**:
     - Schools are vital for social interaction, emotional support, and skill-building.
     - Prolonged isolation disrupts these processes, as seen during the COVID-19 pandemic.
2. **Nutritional Concerns**:
   - **Mid-Day Meals**:
     - Many underprivileged children rely on schools for their most nutritious daily meal.
     - Closures exacerbate malnutrition and deepen inequality.
3. **Equity Issues**:
   - **Digital Divide**:
     - Families lacking access to stable internet and digital devices face educational setbacks.
     - Urban-rural disparities in digital infrastructure further marginalize large sections of the population.

Alternative Science-Based Strategies

1. **Keep Schools Functional**:
   - Suspend outdoor activities like sports and assemblies during poor AQI days.
   - Install air purifiers in classrooms and ensure proper ventilation while minimizing exposure to external pollutants.
2. **Decouple Schools from GRAP Policies**:
   - Schools should not bear the disproportionate burden of GRAP measures.
   - Adopt a more balanced, science-based approach to policy implementation.
3. **Tailored Mask Usage**:
   - Avoid blanket mandates for mask usage; recommend them for:
     - Students with respiratory conditions.
     - Scenarios where air purification is unavailable.
   - Use N95 masks selectively, especially for those over 12, under medical supervision.
4. **Hybrid Learning Options**:
   - Allow flexibility for parents to opt out of in-person classes while keeping schools open for the majority.

5. **Enhanced Monitoring**:
    - Regularly track indoor air quality in schools to ensure compliance with safety standards.

Long-Term Measures

1. **Improved Healthcare Protocols**:
    - Encourage annual health check-ups for children.
    - Promote vaccinations for pollution-exacerbated diseases, such as:
        - Influenza
        - Pneumococcal infections
        - Haemophilus influenzae Type b (Hib).
2. **Infrastructure Investments**:
    - Provide subsidies for air purifiers and green barriers in schools.
3. **Community Awareness**:
    - Educate families on air quality, preventive measures, and health practices.

International Best Practices

- **Beijing, China**:
    - Schools receive real-time alerts to adjust activities based on air quality. Outdoor activities are suspended during severe pollution, but indoor learning continues.
- **South Korea**:
    - Mandates high-efficiency air purifiers in classrooms, with subsidies for installation and maintenance in polluted areas.
- **Germany**:
    - Encourages planting vegetation barriers and locates schools away from major pollution sources like highways and industrial zones.
- **California, USA**:
    - Allows parents to opt out of sending children to school on poor air quality days, while schools remain operational.
- **Japan**:
    - Conducts regular health check-ups in schools to monitor respiratory health and provide early interventions.

Conclusion

Nelson Mandela once remarked, “There can be no keener revelation of a society’s soul than the way in which it treats its children.” In addressing the dual challenges of environmental degradation and child welfare, it is crucial to prioritize sustainable solutions that safeguard both health and education.

Practice Question:

Q. Urban areas face persistent health risks due to poor air quality, with measures like school closures offering only temporary relief. Critically examine these limitations and propose long-term, science-backed solutions to mitigate air pollution’s impact on children’s health and education. (250 words)

HEALTHCARE CHALLENGES IN INDIA

Assam Tribune: 30 November 2024

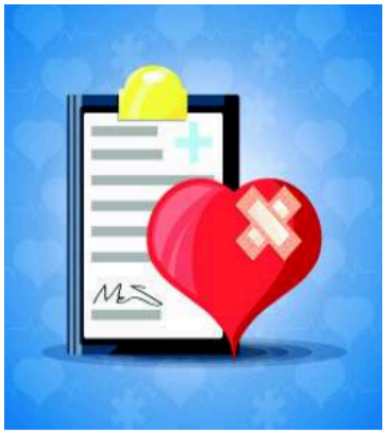
Healthcare challenges in India

DR HARSHA BHATTACHARJEE

India's healthcare system faces significant challenges. Addressing these issues requires systemic reforms and a focus on preventive care.

India's healthcare landscape is experiencing a complex evolution, marked by significant advancements alongside persistent challenges. Although strides have been made, progress often seems haphazard rather than deliberate. Government-run primary healthcare centres are struggling to meet their objectives, while secondary and tertiary care facilities fail to fully address patient needs, a situation highlighted by several recent reports. The growing private healthcare sector offers quality services but often at prohibitive costs, especially for middle-class families. Despite widespread coverage in the media, little has changed in addressing these systemic problems.

With India now the most populous nation globally, the demands on its healthcare system are immense. The rising elderly population and the surge in non-communicable diseases (NCDs) like diabetes, cardiovascular diseases, and chronic respiratory conditions present a daunting challenge. Many elderly Indians face unhealthy ageing, where the last years of life are burdened by illness, straining families and healthcare systems alike. Unfortunately, India lacks robust geriatric care services, and government healthcare spending remains low compared to international standards. True prosperity is measured not just by life expectancy but by healthy life expectancy – a goal still far from being realised in India.



India's healthcare market is growing, driven by increased NCD prevalence, technological advancements, and government initiatives like the Pradhan Mantri Jan Arogya Yojana (PMJAY). Launched in 2018, PMJAY aims to provide healthcare coverage to the bottom 40% of the population, yet its implementation still needs refinement. However, the government has recently increased the PMJAY health coverage to include senior citizens aged 70 and above. It is expected to give further relief to the common people. The scheme must standardise service protocols, ensure timely payments, and upgrade government healthcare facilities to avoid overwhelming private centres of excellence and risking the quality of care.

Rural healthcare remains severely underdeveloped, despite growing healthcare demand. The establishment of new medical colleges is a positive step, but the shortage of qualified teachers threatens the quality of medical education and patient safety. The uneven distribution of healthcare services between urban and rural areas continues to exacerbate inequality, further widening the gap between those who can afford quality care and those who cannot.

India's rising NCD burden, influenced by urbanisation, changing food habits, poor nutrition, unhygienic living conditions, and lack of access to clean drinking water, has far-reaching implications. Health literacy and behavioural changes are pivotal in reducing the incidence, prevalence, morbidity, and mortality of NCDs. Achieving meaningful control over this challenge requires a mission-mode approach to enhancing information, education, and communication efforts. According to studies, NCDs not only account for over half of the deaths in the country but also substantially reduce workforce productivity. It has been estimated that every 10% increase in NCD-related mortality can decrease economic growth by 0.5 per cent. If unaddressed, India could lose $4.58 trillion by 2030 due to NCDs alone. Public awareness about risk factors like unhealthy diets and lack of sanitation must improve to address this growing crisis.

Private healthcare providers, too, must rethink their approach. While efficiency and profit have been key business objectives, healthcare providers should also focus on equity and ethics, ensuring that care remains affordable and accessible to all, not just the affluent. On the other hand, public healthcare systems must become more responsible, stepping up to meet the healthcare needs of the nation, particularly in underserved areas. A fair balance between profit-driven efficiency and patient-centred ethics is crucial.

Achieving universal healthcare coverage requires reform across the entire system – from public and private hospitals to insurance companies and government policies. Only through collective responsibility and a focus on healthy life expectancy, not just survival, can India hope to bridge its healthcare gaps and ensure that the benefits of its rapidly growing economy are shared by all its citizens, regardless of where they live or how much they earn. Quality food, clean water, hygiene, and sanitation, along with a better understanding of healthcare policies and preventive measures, must also be prioritized to create a healthier future for all.

India's healthcare system faces significant challenges, demanding systemic reforms and a stronger focus on preventive care.

1. **Underdeveloped Healthcare Infrastructure**: Government healthcare centers struggle, and private healthcare remains costly for many, widening inequality in access to care.
2. **Aging Population & NCDs**: The growing elderly population and the rise of non-communicable diseases (NCDs) like diabetes and cardiovascular issues put pressure on the system. Lack of geriatric care and low government spending complicate the situation.
3. **Government Initiatives**: Programs like PMJAY provide health coverage to the poor but require better implementation and improved infrastructure to be truly effective.
4. **Rural Healthcare Deficits**: Despite efforts like new medical colleges, rural healthcare remains underdeveloped, with a shortage of qualified professionals.
5. **Economic Impact of NCDs**: NCDs reduce productivity and are projected to cost India $4.58 trillion by 2030, highlighting the need for better prevention and health awareness.

Path Forward:

- **Focus on Preventive Care**: Promote health literacy and behavior change to reduce NCDs.
- **Strengthen Public and Private Healthcare**: Ensure both sectors focus on equity and accessibility.
- **Reform Healthcare Policies**: Prioritize health outcomes over life expectancy alone to achieve universal healthcare coverage.

India's healthcare system needs comprehensive reforms to ensure quality care for all citizens, particularly in underserved areas.

Practice Question:
Q. Discuss the major challenges faced by India's healthcare system and suggest reforms to address them, with an emphasis on preventive care and rural healthcare. (150 words)

INDIANS NEED TO SHARE CONTRACEPTIVE RESPONSIBILITY

The Hindu: 30 November 2024

General Studies Paper II: Governance, Constitution, Polity, Social Justice + Sociology Optional

Indians need to share contraceptive responsibility

Samira Rizvi
a public health student at the Tata Institute of Social Sciences (TISS), Mumbai

Thanooja N.
a public health student at the Tata Institute of Social Sciences (TISS), Mumbai

M. Sivakami
a professor at the Tata Institute of Social Sciences (TISS)

In 1952, India pioneered a national programme for family planning, whose focus has since changed – from improving maternal and child health to stabilising the population. As this programme evolved, so too did permanent methods of contraception.

During 1966-70, about 80.5% of all sterilisation procedures in India were vasectomies. This percentage declined every year due to changing policies that, together with other factors, placed less and less of an emphasis on vasectomies. The five rounds of the National Family Health Survey (NHFS) also show the use of male sterilisation, especially in the last three decades, to be steadily decreasing in all States. In fact, the vasectomies percentage remained constant at around 0.3% in NFHS-4 (2015-16) and NFHS-5.

Gender and the disparity

This trend goes against Section 4.8 of the National Health Policy 2017, which aimed to increase the fraction of male sterilisations to at least 30%. Even today, India is far from meeting this target. Official data also show a large disparity between the rates of female and male sterilisation – 37.9% and 0.3%, respectively. Such huge differences indicate that women continue to bear virtually all of the burden of sterilisation, which in turn poses a challenge for India to achieve Sustainable Development Goal 5 – 'gender equality and empowerment of all women and girls by 2030' – among others.

In one attempt to bridge this gap, the world observes Vasectomy Day on the third Friday of November (it was on November 15 this year). In 2017, India observed a 'vasectomy fortnight' as well.

The initiative is to revitalise the procedure by increasing awareness, generating demand among men, and debunking misconceptions. In the end, the goal is for people already looking for contraceptives as well as those who would if they knew about safe options to consider vasectomies more favourably.

But for these concerted efforts, policies still overlook multiple issues on the ground, keeping them ineffective and allowing the gap between male and female sterilisation rates to persist.

The ground reality, solutions

For example, two of the three writers of this article surveyed a village in Chhatrapati Sambhaji Nagar, Maharashtra, in March 2024 as part of a field exercise. The women said sterilisation was their responsibility and that the men do not believe they need to have vasectomies. Most of them also expressed a belief that men should not be "burdened" by it because they already work hard to make ends meet, and that undergoing the procedure could rob the men of their day's wages, worsening their hardship.

These women were also unaware of the Indian government's cash incentives to those who undergo vasectomies to offset the loss of wages. In fact, many studies in India have suggested that illiteracy, male egos, misconceptions about its impact on libido, and family opposition have led to the poor acceptance of vasectomies. Many men are not aware of their role in ensuring the safe passage of reproductive years in the lives of their female partners.

The unavailability of skilled providers has aggravated the situation, especially in rural areas. To make matters worse, many trained community health workers themselves know little about no-scalpel vasectomies.

As things stand, with increasing awareness of gender equality and rights, it is certainly possible to build a society in which male sterilisation is accepted as normative through proper and timely course correction.

As a first step, sensitisation should begin during early adolescence in schools, where awareness programmes and monitored peer-group discussions can lay the foundation for accepting sterilisation as a shared responsibility. Sustained social and behaviour change communication initiatives will be instrumental in debunking myths around and destigmatising vasectomies. Vasectomy is a safe and simple procedure compared to tubectomy, the corresponding surgical procedure for women involving their fallopian tubes.

Second, these information, education and communication activities should be supplemented with greater conditional cash incentives for vasectomies with the goal to improve male participation.

A study in Maharashtra in 2019 showed that more men in rural tribal areas opted for vasectomies after being offered a conditional cash incentive. Madhya Pradesh's move in 2022 to increase this incentive by 50% is appreciable in this light.

An international comparison

Third, India should draw from the lessons from other countries that have increased vasectomy uptake. South Korea has the highest prevalence of the procedure worldwide, and has reported that men are more likely to shoulder contraceptive responsibilities as a result of progressive societal norms and greater gender equality. Similarly, Bhutan has popularised vasectomy among its men by making the procedure socially acceptable, availing good-quality services, and organising government-run vasectomy camps. Brazil increased vasectomy uptake by running awareness campaigns on mass media. The prevalence rate has risen, from 0.8% in the 1980s to 5% in the last decade.

Greater public awareness of vasectomies allows both partners in a union to make informed family planning decisions. In tandem, the government must strengthen the national health system to align with policy objectives, invest in training more health professionals to perform the procedure, and promote technical advancements to increase the use of non-scalpel vasectomies.

The resulting policy should not have only intention. It should also lay out concrete steps to achieve its targets. The need of the hour is demand- and service-focused efforts rather than mere formulation.

With more awareness of gender equality and rights, it is possible to build a society in which male sterilisation is accepted as normative

1. Historical Context of Family Planning in India:

- **National Family Planning Programme (1952)**: Initially focused on **maternal and child health**, evolving towards **population stabilization**.
- **Vasectomy**: In the 1960s, it was a major form of contraception, but the emphasis shifted away from **male sterilization** over time.

2. Declining Male Sterilization Rates:

- **Vasectomy rates** have significantly declined, with the ratio of **female sterilizations (37.9%)** to **male sterilizations (0.3%)** being disproportionate.
- This trend contradicts the **National Health Policy 2017** target of increasing **male sterilizations** to **30%**.

3. Gender Disparity and Impact on Gender Equality:

- The gender disparity in sterilization highlights the burden on women, undermining **gender equality** and obstructing progress toward **Sustainable Development Goal 5** (empower women).

- **Social attitudes**, **misconceptions** around **masculinity**, and **male ego** contribute to the imbalance.

4. Ground Reality and Societal Perceptions:

- In rural areas, **women** perceive sterilization as their responsibility, while **men** feel it is not their duty.
- **Lack of awareness** about government **incentives for vasectomy**, **cultural myths**, and **family opposition** limit male participation.

5. Inadequate Infrastructure and Awareness:

- The **shortage of trained healthcare providers** in rural areas and the **lack of knowledge** among **community health workers** exacerbate the issue.
- **Stigma** around **vasectomy** still exists, and it is not widely accepted as a mainstream choice for men.

6. Policy Recommendations for Change:

- **Early Education and Awareness**: Sensitize young people in **schools** about **gender equality** and **shared responsibility** in family planning.
- **Social and Behavioral Change**: Use **social campaigns** to address **myths** about vasectomy and its safety compared to **female sterilization**.
- **Incentivizing Male Participation**: Offer **cash incentives** for vasectomy, as seen in states like **Madhya Pradesh**.

7. International Best Practices:

- **South Korea** and **Bhutan** have increased vasectomy uptake through **societal norm changes**, **quality services**, and **government-run camps**.
- **Brazil**'s **media campaigns** have proven effective in raising awareness and increasing male participation in sterilization.

8. Systemic Strengthening:

- Investment in strengthening **healthcare systems**, ensuring availability of **trained professionals** for **vasectomy**, especially in **rural areas**.
- Policies must include **concrete actions** and clear steps to meet the **targets for male sterilization**.

9. Conclusion:

- A **demand- and service-focused approach** is crucial to make vasectomy a mainstream choice for men.
- Achieving **gender equality** in family planning requires **changing societal attitudes**, improving **healthcare infrastructure**, and offering **incentives** to encourage **male participation** in family planning.

Practice Question:
Q. Analyze the reasons behind the declining rate of male sterilization in India and suggest policy measures to promote shared contraceptive responsibility between men and women. (150 words)

INDIA'S CITIES AND NON-COMMUNICABLE DISEASE (NCD) BURDEN

The Hindu: 02 December 2024

Source: https://www.thehindu.com/opinion/op-ed/indias-cities-their-non-communicable-disease-burden/article68935631.ece

India's cities, their non-communicable disease burden

The recent case where a Bengaluru Metropolitan Transport Corporation (BMTC) bus driver passed away after cardiac arrest while on duty, has set off discussions on rising poor health outcomes in our cities.

Our cities are spread over pockets and layers. These pockets house the most marginalised and vulnerable urban citizens such as informal workers and migrant workers. Our cities run, literally and figuratively, because of bike-borne gig workers, cab and auto drivers, bus drivers and conductors. Our cities shine and are clean because of sanitation workers who are awake before the city does to clean the roads, clear the garbage bins and transport the garbage to sorting stations, waste lands, or landfills, all while staying deprived of hygiene and nutrition while at work. Most of them are not on contract and without health insurance.

Poor implementation of policies

As we discuss this, India has a national non-communicable diseases (NCD) surveillance policy, with screening for NCD risks at the community level, aimed at preventive and promotive pathways for NCD care and treatment pathways. Though these policies are often subscribed from global bodies, they are poorly implemented. Health systems in urban areas are overburdened, fragmented and broken, which is a function of poor urban design and rapid urbanisation.

With over half of the world's population living in urban areas, this figure is projected to reach 70% by 2050. India's workforce is characterised by significant inter-State migration, with approximately 41 million people moving between States (Census 2011). This dynamic process, constituting nearly 29% of the total migration rate (Periodic Labour Force Survey 2020-21), highlights the fluidity of labour markets. Notably, a substantial portion of the urban population, estimated at 49% (UN-Habitat/World Bank, 2022), lives in slums, further underscoring the complex socio-economic landscape of India's cities.

Aruna Bhattacharya

leads the urban health domain at the School of Human Development, Indian Institute for Human Settlements. She is also the current Fellow of WomenLift Health's SouthEast Asia 2024 cohort

There is a need to create healthy cities; marginalised communities and urban neighbourhoods must have access to primary health care

The health burden in urban India

Poor urban communities face a triple health burden: hazardous work environments, limited health-care access, and financial vulnerability during health crises, that are exacerbated by social and economic marginalisation. As for national data on health indicators, NFHS data showed a decline in tobacco and alcohol consumption from 2005-06 to 2019-21 (NFHS 3 and 5), which is alarmingly juxtaposed with a rise in hypertension, diabetes, and obesity rates (NFHS 4 and 5).

Symptomatically, NCDs are silent, necessitating regular screening which needs to sit within a robust health promotion and referral system. The lack of understanding of the need for screening, early detection and preventive pathways for NCDs create catastrophic out-of-pocket (OOP) expenditure, in turn jeopardising financial stability and impacting the overall livelihood and life trajectory of the entire family.

This writer's experience of working with marginalised communities aligns with the fundamentals of social determinants of health (SDoH) which tie workplace, work, housing, community, family connections to health outcomes. Health in marginalised communities stems from social identities, work and employment, language, migration status, and accessing primary health systems.

In a country whose foundation of health systems sits on strong primary health care, it is problematic that the availability and access to publicly-run primary health care are abysmally poor among urban marginals. Public health systems are, by design, supposed to cater to all, and, most specifically, to the lowest 40% of the population. The idea of universal health coverage fails. Preventing OOP expenditure fails. And our urban marginals are laden with poor health outcomes, which, for many, runs across generations. This necessitates having an active dialogue between employers, municipalities, traffic systems, schools, as well as health systems. As interconnected systems, there is a need to co-create solutions with the community, and for the community.

Tapping technology

In this age of digital technology and ease of tech-based monitoring, we could bring real-time monitoring of parameters on the lines of 'health in our hands' for those who have hypertension and diabetes. Screening, as a methodology, has a two-fold advantage. It gives us evidence from the population level which could be used for epidemiological modelling and public health planning.

On the other hand, this creates awareness at the individual- and community-level for health risks. It makes room for the implementation of community based, co-created health promotion, and health education activities which are sustainable and in turn un-burden health systems. This also creates an awareness for pathways for health care, referral and knowledge on social protection schemes to limit OOP expenditure.

This is the time for State-level action plans for NCD health care, which lay an emphasis on access to primary health care for marginalised communities and poor urban neighbourhoods – migrants, informal workforce, people living in informal settlements. We need to join hands with urban local bodies, the city administration, health departments and community-based organisations, experts and think tanks and discuss ideas to create healthy cities for all. This should also lead to a scaling up of ideas for community-led, community-based NCD surveillance systems for marginalised urban settlements.

1. Rising Health Concerns in Urban Areas:

- **Gig economy workers** and **sanitation staff** lack **health coverage**, **nutrition**, and **hygiene** despite their crucial contributions to city operations.

2. Implementation of NCD Policies:

- **National NCD policies** are **poorly implemented**.
- **Urban health systems** are **fragmented** and **overburdened** due to **rapid urbanization** and **inadequate infrastructure**.

3. Urbanization and Migration:

- Nearly **50% of the urban population** lives in **slums**, facing complex **socio-economic issues**.
- **41 million inter-state migrants** face **health risks** due to limited access to **healthcare**.

4. Triple Health Burden in Poor Urban Communities:

- **Hazardous work environments**, limited **healthcare access**, and **financial vulnerability** during health crises.

- **Rising rates of hypertension**, **diabetes**, and **obesity**, while **tobacco** and **alcohol** use has decreased.

5. Silent Nature of NCDs and Preventive Measures:

- NCDs like **hypertension** and **diabetes** often go **undiagnosed** without **regular screening**.
- Lack of **preventive care** leads to high **out-of-pocket expenditures**, deepening **financial instability**.

6. Challenges in Primary Healthcare:

- **Public health systems** fail to meet the needs of **marginalized urban communities**.
- **Poor access** to healthcare undermines **universal health coverage** and worsens **health inequalities**.

7. Social Determinants of Health (SDoH):

Employment, **migration status**, and access to **housing** and **healthcare** significantly impact health outcomes in **urban poor communities**.

8. Technological Solutions for Health Monitoring:

- **Digital health monitoring** and **real-time tracking** of health parameters like **blood pressure** and **glucose** can improve **health outcomes** and raise awareness of risks.

9. Community-Based Solutions and State-Level Action:

- **State action plans** are needed for **accessible healthcare**, focusing on **marginalized urban populations**.
- **Collaboration** among local bodies, **health departments**, and **community organizations** is essential for **sustainable health solutions**.
- **Community-led NCD surveillance systems** can help **identify risks early** and improve **healthcare access**.

10. Wayforward for Urban Health:

- Address **healthcare access gaps** and broader **social determinants of health** to build **healthier cities**.
- **Technology**, **community involvement**, and coordinated **policies** are essential for effective, **inclusive urban health systems**.
- Ensuring **access to primary healthcare** and scaling up **NCD surveillance** can help mitigate the rising **NCD burden**.

Practice Question:

1. How does rapid urbanization and migration contribute to the rising health concerns in India's cities? Evaluate the socio-economic factors that influence health outcomes among migrant populations. (150 words)

2. Examine the 'triple health burden' faced by poor urban communities. How do hazardous work environments, limited healthcare access, and financial vulnerability compound health issues in these populations? (250 words)

SIU-KA-PHA'S LEGACY AND MOIDAM HERITAGE

The Assam tribune: 02 December 2024

Siu-ka-pha's legacy and *moidam* heritage

DR SIKHAMONI KONWAR

Siu-ka-pha fostered cultural assimilation, political unity, and economic transformation, laying the foundation for a harmonious Assamese society.

The arrival of Siu-ka-pha in the Brahmaputra valley in 1228 CE was a historically significant event. It was the new year's day 796 years ago, the first day of Din Ching (16 *Aghun*, December 2). That day marked the foundation of Mong Dun Sun Kham (present-day Assam). It had a far-reaching impact on Northeast India's political, geographical, cultural and social landscape.

There were 9,000 people accompanying him, including officials, ministers, royal priests, soldiers, and families. They brought with them their distinctive religion, the royal tutelary deity Chum-Pha-Rung-Seng-Mong or Chumdeo, the *moidam* burial system, the *chaklang* marriage system, a social system, culture, agricultural system, mannerisms, and so on. All these cultural elements were new to the Brahmaputra valley.

Siu-ka-pha brought the tradition of writing history. At the beginning of the 13th century, when Siu-ka-pha started his journey from Mong Mao of southeastern Yunnan, China, to the Brahmaputra valley, he had with him Chiring scholars (pundits), Bailung scholars, and *lik-rai* (royal scripture). Siu-ka-pha ordered these scholars to record whatever they saw and everything that happened on the way. Initially, these historical records were written in the Tai language. However, over time, the Tai people adopted the Assamese language, and their history was also written in Assamese, which became the lingua franca of the region. Besides, they also brought other writings, divination, astrology, a calendar for counting years, religious scripts, the *chaklang* marriage system, and the *moidam* culture, all of which were new to the Brahmaputra valley.

Siu-ka-pha's emergence into the Brahmaputra valley was never a military invasion or aggression, in stark contrast to the imperialistic aggression of the Mughals. He believed in ethnic and cultural assimilation. He had a liberal social outlook and a great assimilative ability. Siu-ka-pha never imposed his own language, culture and religion on the local people. Instead, he adopted their language, culture and religion while keeping his own intact. He had profound faith in the natives and respected and adored their personal qualities. The people of Borahi, Moran, Chutia and Kachari communities, and even those of Naga origin, were freely admitted into his confidence. He gave official titles and positions to deserving people belonging to other religions and communities. Local people were never discriminated against on the grounds of caste, race, religion, language or culture.

Siu-ka-pha gave unity to the politically fragmented Brahmaputra valley of that period. During his time, there was no central political rule encompassing the entire land. Meanwhile, the rules of the mighty dynasties of the Pragjyotish Kamrupa kingdom, like the Barman, Salstambha, and Pal dynasties, which ruled between the 4th and 11th centuries, had come to an end. Small States arose in their place. The Brahmaputra valley was politically fragmented into many parts ruled by different kings. During this period, Siu-ka-pha laid the foundation of Bor Asam (Greater Assam) by uniting various rulers, Bhuyan landlords, Kacharis, Chutias, Morans, and Borahis under one political governance of the Ahoms. This ensured greater political stability in the region. At Charaideo in 1253 CE, Siu-ka-pha planted the seeds of a united Assamese society. The diverse and divided peoples and lands of the Brahmaputra valley were unified by him, creating a legacy of commonality and unity. The integrated Assamese people and culture we have today are a result of his ideology, cultivated in the 13th century.

When Siu-ka-pha died in 1268 CE, he was given a *moidam* at Charaideo. Charaideo was then called Che Tam Doi Che Lung Che Kham Run in the Tai language. Since then, Charaideo has been the royal necropolis for 600 years of Ahom rule, though the capital was shifted to other places in later periods. Siu-ka-pha established Charaideo as a religious and cultural epicentre of the Ahom, which his descendants carried forward. This is why Charaideo has always been a sacred place or sanctum sanctorum for the Ahoms.

The most significant cultural legacy Siu-ka-pha left behind is the grand royal *moidam*s of Charaideo, which continue to showcase a timeless heritage. Due to their unique universal value, Charaideo's *moidam*s were recognized as a World Heritage Site by UNESCO in 2024 as 'Moidam – The Mound Burial System of the Ahom Dynasty.'

Siu-ka-pha ushered in an economic revolution primarily based on wet-rice cultivation, which brought a new era in agricultural production. Plenty of rice grains like *sali* and *bora* were produced by clearing unused and abandoned lands. Large paddy fields were developed in and around Charaideo. The abundant rice production strengthened the economic condition of the kingdom and brought the local people closer to him and his nascent kingdom. They placed their faith and confidence in him and his kingship.

The concept of State-owned and State-managed farms was introduced by Siu-ka-pha. He established three such farms – Angera Khat, Gosikola Khat, and Borakhowa Khat – which still exist at Charaideo.

The road used by Siu-ka-pha about 800 years ago to enter Northeast India, now known as Stilwell Road, can aid in strengthening trade, business relations, and cultural exchange with Southeast Asian countries. His arrival in this land facilitated the exchange of innovative ideas and cultural practices until the end of the Ahom rule (1826 CE) and even beyond. This historical backdrop can play a crucial role in the execution of the Government of India's Act East Policy.

Siu-ka-pha also brought ancestor worship traditions, where deceased ancestors are invoked and worshipped as a mark of gratitude and reverence for their noble deeds. This legacy continues today. Because of its sociological significance, the people and the Government of Assam observe Me-Dam-Me-Phi every year on January 31.

Although he came 796 years ago on December 2, 1228, to the politically and socially fragmented Brahmaputra valley, his relevance is sustained even today. Every year, Assam Divas is observed on December 2 by the Government of Assam to commemorate his advent to the valley and pay respect to the rich legacy he left for the State. It shows his ideologies and philosophy remain significant for the greater good of society.

We must remember his ideology of unity, equality, mutual trust and cooperation, which laid the foundation of greater Assamese society. Siu-ka-pha will always remain an example of integration and cultural unification. Despite having his own language, culture and religion, he respected, fostered and embraced the customs and cultures of other tribes and communities. This is his greatest legacy, whose relevance will inspire generations to come.

02 December: Asom Divas, to honor the legacy of **Swargadeo Chaolung Sukapha (Siu-ka-pha)**, the founder of the Ahom kingdom in Assam.

1. **Historical Significance of Siu-ka-pha's Arrival (1228 CE)**:
   - Foundation of Mong Dun Sun Kham (Assam) with 9,000 followers.
   - Brought new cultural, social, and agricultural practices.
   - **Initiated written history** with scholars documenting events.
2. **Cultural Assimilation and Social Integration**:
   - Promoted **cultural assimilation** without imposing his own culture.
   - Integrated communities like **Borahi, Moran, Chutia, Kachari, and Naga** under Ahom rule.
   - Emphasized unity and equality, with no discrimination.
3. **Political Unification of Brahmaputra Valley**:
   - Unified politically fragmented Brahmaputra valley post-Pragjyotish Kamrupa kingdom.

- Created **Greater Assam** through integration of small states and communities.
- Established political stability under Ahom governance.

4. **Legacy of Moidam and Charaideo**:
   - Established **Charaideo** as a royal necropolis and sacred site.
   - **Moidam burial system** recognized as a UNESCO World Heritage Site in 2024.
   - Charaideo became a cultural and religious epicenter.
5. **Economic Transformation and Agricultural Revolution**:
   - Introduced **wet-rice cultivation**, boosting agricultural production.
   - Developed large paddy fields around **Charaideo**.
   - Established **State-managed farms**, including Angera Khat, Gosikola Khat, and Borakhowa Khat.
6. **Legacy of Ancestor Worship and Cultural Practices**:
   - Introduced **ancestor worship**, leading to **Me-Dam-Me-Phi** festival.
   - Fostered respect for noble deeds of ancestors.
7. **Continuing Relevance and Cultural Integration**:
   - **Assam Divas** celebrated annually to commemorate his arrival.
   - His philosophy of unity and mutual respect continues to inspire Assamese society.

Practice Question:

1. Siu-ka-pha's approach to cultural assimilation was based on respect and integration rather than imposition. How does this principle contrast with other historical instances of imperial expansion? Analyze its long-term impact on Assamese society. (250 words)
2. The integration of diverse communities and cultures by Siu-ka-pha laid the foundation for a unified Assamese society. Discuss how this concept of 'unity in diversity' can be applied to contemporary socio-political challenges in India. (250 words)

OIL AND GAS: CHALLENGES AND OPPORTUNITIES FOR NORTHEAST INDIA

The Assam tribune: 02 December 2024

Oil and gas: Challenges and opportunities for Northeast India

MB DOJA

Oil is to the economy what water is to life. With policymakers consistently emphasising the importance of oil and gas to India's economic and social well-being, the Northeast region plays a key role in the country's energy security. Contributing 13% of India's crude oil and 16% of its natural gas output, Northeast is critical to the nation's energy supply and its goal of becoming a $5 trillion economy.

During a Parliament address in December 2023, Union Petroleum Minister Hardeep Singh Puri emphasized the region's importance, outlining the government's commitment to boosting production with a Rs 61,000 crore capital expenditure infusion over the next few years.

Though the oldest hydrocarbon discovery in the Northeast dates back to 1825, the region still harbours an untapped potential of 6 billion barrels of oil equivalent (boe) in the prolific basins of Assam.

However, oil and gas exploration in the Northeast region faces significant challenges. The rugged terrain and limited infrastructure have slowed progress, hindering economic development. Oil and gas exploration is high-cost and high-risk, and the region's unique geographical conditions require careful planning and adequate time for exploration activities.

To address these issues, the government introduced the "Hydrocarbon Vision 2030 for Northeast India" in 2016. This policy recognized the region's challenges and proposed flexible exploration timelines and streamlined

clearances to improve investor confidence. It also suggested a zero-phase exploration period to build trust with local communities before full-scale operations begin. By 2030, the policy aims to double the region's oil and gas production.

Policy reforms driving private investment

The history of oil exploration in India dates back to 1866, with the first commercial discovery in Digboi in 1881. Post-independence, the government took control of the sector by establishing the Oil and Natural Gas Corporation (ONGC) in 1959.

By the 1990s, India opened the Exploration & Production (E&P) sector to foreign companies. However, most of these early efforts were unsuccessful, with blocks relinquished after no discoveries were made.

Later, the introduction of the New Exploration & Licensing Policy (NELP) in 1999 and the Hydrocarbon Exploration and Licensing Policy (HELP) subsequently streamlined the process, offering a single license for all hydrocarbons and switching to a revenue-sharing model.

A path forward

For India to reach its full hydrocarbon potential, policymakers must balance ambition with practicality. The COVID-19 pandemic highlighted the need for flexibility, which remains critical in oil and gas exploration.

In conclusion, the government's Hydrocarbon Vision 2030 for Northeast India provides a solid framework to develop the Northeast into a hydrocarbon hub. With a collaborative approach and investment in infrastructure, not only the region will benefit but it can also accelerate India's journey towards a more secure and sustainable energy future.

Oil and Gas: Challenges and Opportunities for Northeast India

1. **Economic Significance:**
   - Northeast India contributes **13% of crude oil** and **16% of natural gas** to India's energy security.
   - Key to India's goal of becoming a **$5 trillion economy** by boosting energy production.
2. **Government Initiatives:**
   - **Rs 61,000 crore** investment planned to boost production and infrastructure.
   - **Hydrocarbon Vision 2030** aims to double production by 2030, addressing challenges like **rugged terrain** and **limited infrastructure**.
3. **Exploration Challenges:**
   - **High cost, high risk**, and **difficult terrain** slow progress.
   - **Exploration timelines** and clearances are streamlined under the Hydrocarbon Vision 2030 policy.
4. **Policy Reforms and Investment:**
   - **NELP (1999)** and **HELP (2016)** reforms attract **private and foreign investments** by simplifying licensing and switching to a **revenue-sharing model**.
   - **Private investment** remains slow due to challenges like **land acquisition** and **local opposition**.
5. **Environmental and Social Concerns:**
   - **Ecological impact** due to exploration activities and the need for **sustainable**

- **Community involvement** and **cultural sensitivity** are vital to avoid conflicts and ensure equitable benefits.

6. **Path Forward:**
   - **Infrastructure development**, **technological advancements**, and **public-private partnerships (PPPs)** are key to unlocking the region's full hydrocarbon potential.
   - **Collaboration** across stakeholders will drive the region's transformation into a **hydrocarbon hub**.
7. **Conclusion:**
   - **Hydrocarbon Vision 2030** provides a framework for Northeast India to become a key player in India's **energy future** and **economic growth**.

Hydrocarbon Vision 2030 for Northeast India: Key Features

- **Objective:**
  - Leverage **hydrocarbon resources** to enhance **petroleum product availability**, **clean fuel access**, and **economic development** in the Northeast.
  - Cover all aspects of the **hydrocarbon value chain**: **upstream**, **midstream**, and **downstream**.
- **Five Pillars (5Ps):**
  - **People**: Ensure access to clean fuel, promote **skill development**, and foster **community involvement**.
  - **Policy**: Address terrain/weather challenges, ensure **fund planning** for sustainable projects.
  - **Partnership**: Involve **state governments**, promote **regional trade** with **Bangladesh**, **Myanmar**, **Nepal**, and **Bhutan**.
  - **Projects**: Develop **pipelines**, **refineries**, **CNG highways**, and **gas distribution networks**.
  - **Production**: **Technology deployment**, **production enhancement**, and **fast-track clearance**.
- **Goals:**
  - **Double oil and gas production** by 2030.
  - **Create job opportunities** in the hydrocarbon sector.
  - **Enhance regional cooperation** with neighboring countries for energy security.
- **International Linkages:**
  - Explore **hydrocarbon trade** with **Bangladesh**, **Myanmar**, **Nepal**, and **Bhutan**.

Conclusion:

The Vision aims to establish the Northeast as a key contributor to **India's energy security** and **economic growth** through **infrastructure development**, **regional collaboration**, and **sustainable practices**.

Practice Question:

Northeast India plays a crucial role in India's energy security. With the Hydrocarbon Vision 2030 as a guiding framework, analyze the potential of the region's oil and gas sector to contribute to India's economic growth. What are the key hurdles that need to be addressed? (250 words)

FRONTLINE NUTRITION WORKERS FOSTER DISABILITY INCLUSION

The Hindu: 03 December 2024

Source: Frontline nutrition workers foster disability inclusion - The Hindu

Frontline nutrition workers foster disability inclusion

December 3 is International Day of Persons with Disabilities. It is a day dedicated to advocating the rights of people with disabilities by creating awareness and highlighting the inclusion and the needs of persons with disabilities who are among one of the most marginalised and under-represented communities in the world.

In recent years, there has been growing recognition, globally and nationally, of the significant connection between nutrition and disability. Various studies are increasingly underscoring this relationship. There are reports that illuminate the profound impact of nutritional status on overall health and well-being.

Nutrition, health and disability

Research indicates that countries with high levels of malnutrition tend to exhibit not only poorer health outcomes but also higher rates of disability among their populations. This correlation has far-reaching implications, suggesting that inadequate nutritional intake can lead to a range of health issues that contribute to disability. For instance, malnutrition may weaken the immune system, hinder physical development, and exacerbate chronic health conditions – all of which can significantly impair an individual's ability to function effectively in daily life.

As governments and health organisations strive to improve public health, addressing malnutrition becomes increasingly critical. This is not only for enhancing individual quality of life but also for reducing disability rates on a broader scale. The link between nutrition and disability underscores the need for integrated health policies to improve dietary practices and ensure access to nutritious food for vulnerable populations.

Maternal malnutrition can lead to prenatal disability, malnutrition can contribute to developmental delays and disabilities at different points in the life cycle – for example, vitamin A deficiency can cause blindness), and some disabilities, such as cerebral palsy and Down syndrome, can put persons at risk of nutritional deficiency. There is a real need to make nutrition services, benefits, and information more accessible to persons with disabilities.

Elisabeth Faure
Country Director for the United Nations World Food Programme (WFP)

Amneet P. Kumar
an IAS officer, is Commissioner and Secretary, Government of Haryana

Anganwadi workers have a vital role in the early identification of children with disabilities and also serving as a referral for children and adults with disabilities

In 2023, the Ministry of Women and Child Development introduced the 'Anganwadi Protocol for Divyang Children', a national guideline for frontline community nutrition workers in India regarding disability inclusion. Anganwadi workers are crucial as community nutrition providers, executing and manifesting India's most ambitious development programmes. They engage deeply with the communities, offering vital nutrition services and driving social and behavioural changes related to gender equality, social inclusion, nutrition, and early childhood development. The Protocol for Divyang Children equips them with comprehensive instructions for the early identification of disabilities, monitoring developmental milestones using the POSHAN Tracker, and ensuring referrals in partnership with Accredited Social Health Activist (ASHA) workers.

For an inclusive future

The experience in Haryana

The Haryana government's Department of Women and Child Development is committed to promoting disability inclusion using Mission Vatsalya and the Integrated Child Development Scheme. It has introduced the Divyang Protocol and a unique podcast initiative, 'Nanhe Farishtey', to educate communities about disabilities and enhance awareness at Anganwadi centres for the early detection and inclusion of children with disabilities

The World Food Programme (WFP) has also partnered with the Department of Women and Child Development for a three-year intervention to transform norms around gender equality and social inclusion, including disability inclusion, by developing the capacity of Haryana's network of 25,000 'Anganwadi' workers.

As part of the collaborative programme, in a recent Needs Assessment Study for its intervention in Haryana, the WFP asked 'Anganwadi workers' across four districts about persons and children with disabilities in the local communities they serve. The study found that Anganwadi workers played an essential role in the early identification of children and referral for children and adults with disabilities. Nearly all the respondents had helped connect persons with disabilities to some form of medical and educational support, register for disability certificates, and help them avail themselves of government-provided benefits, including the National Disability Pension.

Early intervention, accessible medical therapy, and supportive services are crucial for aiding children with disabilities. Anganwadi workers play a vital role in this effort. Alongside building the capacity of Anganwadi workers on the Divyang Protocol, development actors must unite to create supportive services and infrastructure for these children. This includes establishing a group of trained specialist therapists for various disabilities, creating accessible schools and transportation, providing affordable assistive devices, and implementing information-communication systems to promote tailored nutritional well-being practices for individuals with disabilities. Community members and frontline workers can contribute by dispelling the disability stigma.

We all share the responsibility of ensuring that the nutrition and food security of persons with disabilities, particularly children, are at the centre of their rights, equal opportunity and well-being.

Context:

The editorial highlights the significance of **International Day of Persons with Disabilities** (December 3) and the growing recognition of the interlinkages between **nutrition and disability**. It sheds light on India's proactive steps to integrate disability inclusion into its nutrition and development frameworks, particularly through the role of Anganwadi workers.

1. Link Between Nutrition and Disability

- Malnutrition directly contributes to higher disability rates by:
  - Weakening the immune system.
  - Hindering physical and cognitive development.
  - Exacerbating chronic conditions.
- **Examples:**
  - Maternal malnutrition: Increases risks of prenatal disabilities.
  - Vitamin A deficiency: Leads to blindness.
  - Conditions like cerebral palsy and Down syndrome: Heighten vulnerability to nutritional deficiencies.

2. Government Initiatives for Disability Inclusion

- **Anganwadi Protocol for Divyang Children (2023):**
  - Issued by the Ministry of Women and Child Development.
  - Focuses on:
    - Early identification of disabilities.
    - Monitoring developmental milestones via **POSHAN Tracker**.
    - Facilitating referrals in collaboration with ASHA workers.
- **Mission Vatsalya and Integrated Child Development Scheme (ICDS):**
  - Haryana's Department of Women and Child Development introduced the **Divyang Protocol**.
  - Educates communities on disabilities via initiatives like the **'Nanhe Farishtey' podcast**.

3. Role of Frontline Nutrition Workers

- Anganwadi workers:
  - **Provide nutrition services** and advocate for inclusion.
  - Identify children with disabilities early and connect them to healthcare and education services.
  - Help beneficiaries access schemes such as the **National Disability Pension**.
- Collaborative Programs:
  - **World Food Programme (WFP)** partnered with Haryana's Women and Child Development Department to enhance the capacity of 25,000 Anganwadi workers.
  - Focus: Transform social norms around disability and ensure inclusion in health and nutrition services.

4. Challenges in Disability Inclusion

- Limited early intervention services and trained therapists.
- Lack of accessible infrastructure (schools, transport, assistive devices).
- Social stigma around disabilities.

5. Way Forward

- Strengthen the implementation of the **Anganwadi Protocol for Divyang Children**.
- Build a pool of **trained therapists specializing in disabilities.**
- Develop **inclusive infrastructure and community-based rehabilitation systems**.
- Enhance awareness campaigns to reduce stigma.

Practice Question:

Q: *Frontline workers like Anganwadi workers are crucial for fostering inclusion and addressing the nutritional needs of persons with disabilities. Discuss the challenges they face and suggest measures to enhance their effectiveness in disability-inclusive development.(250 words)*

ENHANCING ACCESSIBILITY FOR PWDS

The Assam tribune: 03 December 2024

Enhancing accessibility for PwDs

AMVALIKA SENAPATI

True inclusion requires making accessibility a non-negotiable legal obligation, enabling persons with disabilities to fully participate in society.

The International Day of Persons with Disabilities (IDPD), observed on December 3, is a global event to celebrate the accomplishments of people with disabilities and reflect on the progress needed to achieve true inclusion. This year's theme, 'Amplifying the leadership of persons with disabilities for an inclusive and sustainable future,' highlights the essential role that people with disabilities play as leaders and changemakers in shaping just and equitable societies.

True sustainability and inclusion can only be realized when individuals with disabilities are actively involved in decision-making processes that directly impact their lives. However, their leadership and participation become meaningless if their fundamental rights, particularly the right to accessibility, remain unfulfilled. Accessibility is not merely a right in isolation; it is the foundation upon which all other rights rest. Without meaningful access to infrastructure, services, and information, persons with disabilities are systematically excluded from opportunities to lead and participate fully in society. As we celebrate IDPD 2024, it is imperative to focus on how accessible environments and systems enable leadership and pave the way for a future where inclusion is more than an aspiration – it is a reality.

Accessibility is not a privilege but a basic human right enshrined in the Rights of Persons with Disabilities Act (RPwD)-2016, which aligns with the UN Convention on the Rights of Persons with Disabilities (CRPD). It is a cornerstone for exercising other rights such as education, employment, healthcare, and public participation. Yet, the implementation of accessibility standards in India remains inconsistent and often discretionary, reducing this critical right to little more than rhetoric.

In a recent landmark judgement on November 8, 2024, the Supreme Court of India addressed these shortcomings in the case of 'Rajive Raturi vs Union of India.' The Court emphasized the need for mandatory, non-negotiable accessibility standards across all domains. It pointed out the inconsistencies between the RPwD Act and current accessibility rules in various sectors, which are often treated as optional guidelines rather than enforceable regulations. The judgement also drew from the findings of the report, 'Finding Sizes for All,' prepared by the Centre for Disability Studies at NALSAR University, in consultation with Union and State governments, union territories, court administrations, and prison establishments, as well as persons with disabilities, accessibility experts, and NGOs across the country. The report highlighted the significant gaps in the legal framework and the lack of enforcement that have allowed barriers in education, healthcare, transport, and public infrastructure to persist.

The NALSAR report paints a stark picture of India's accessibility landscape, revealing critical issues. Many government schools remain far from inclusive, with classrooms, restrooms, and learning materials failing to meet the needs of students with disabilities. Hospitals often lack essential features such as ramps, accessible toilets, and trained staff, making it difficult for persons with disabilities to access healthcare. Public transport systems and government buildings are frequently inaccessible, limiting mobility and independence. Additionally, many government websites fail to adhere to web accessibility standards, preventing visually and hearing-impaired individuals from accessing vital information. The report also critiques Rule 15 of the RPD Rules, which treats accessibility standards as flexible guidelines rather than mandatory rules. The absence of non-negotiable rules and an overreliance on guidelines, which are couched in discretionary terms, such as "recommend," "may," and "it is desirable for…," undermines the RPwD Act and compromises the effective realization of accessibility rights and an inclusive India.

The Supreme Court's directives based on this report provide a clear roadmap for change. It emphasizes that accessibility requires a two-pronged approach: one focuses on ensuring accessibility in existing institutions and activities, often through retrofitting, while the other focuses on transforming new infrastructure and future initiatives. All new construction and service delivery systems must comply with strict accessibility standards, while retrofitting existing infrastructure should be prioritized. Tailored measures must address the specific needs of diverse disabilities, including intellectual and psychosocial disabilities. It also cautions against "one size fits all" approaches and advocates for recognizing sectoral and population diversity in accessibility measures. Robust accountability mechanisms are essential to ensure compliance, with penalties for non-adherence. Sensitization programmes for architects, policymakers, and service providers are also critical for fostering an inclusive mindset.

In its landmark judgement, the apex court observed that while it is true that accessibility is a right that requires "progressive realization," this cannot mean that there is no base level of non-negotiable rules that must be adhered to. It clearly underscored that accessibility cannot rely on voluntary compliance and must be treated as a binding legal obligation. The court also directed the Union government to delineate mandatory rules, as required by Section 40, within three months from the date of this judgement and observed that this exercise may involve segregating the non-negotiable rules from the expansive guidelines already prescribed in Rule 15. Once these mandatory rules are prescribed, the Union of India, States, and Union Territories are directed to ensure that the consequences prescribed in Sections 44, 45, 46, and 89 of the RPwD Act, including the holding back of completion certificates and imposition of fines, are enforced in cases of non-compliance with Rule 15.

The judgement reinforces a renewed commitment to transforming access to rights into a tangible reality. Instead of being a ceremonial commemoration, the International Day of Persons with Disabilities ought to serve as a call to action. Policies and laws alone are not enough; their implementation is what drives real change. Every inaccessible structure, unreadable website, or inadequate service is an affront to the dignity and rights of persons with disabilities. As we honour this day, we must commit to going beyond token actions. It is time for society, businesses, and governments to work towards removing obstacles and making accessibility a reality for everyone. Only then can we truly celebrate the spirit of inclusion and honour the resilience and boundless potential of persons with disabilities.

1. Accessibility as a Right:

- Accessibility is **fundamental** and forms the **foundation** for other rights such as **education**, **employment**, **healthcare**, and **public participation**.
- Enshrined in the **Rights of Persons with Disabilities Act (RPwD)-2016**, it aligns with the **UN Convention on the Rights of Persons with Disabilities (CRPD)**.
- However, **implementation** remains **inconsistent** across various sectors.

2. Challenges to Accessibility:

- **Government schools** and **hospitals** lack basic accessibility features such as **ramps**, **accessible restrooms**, and **trained staff**.
- **Public transport** systems and **government buildings** often remain **inaccessible**.
- **Government websites** fail to meet web accessibility standards, making it hard for **hearing and visually impaired** individuals to access vital information.
- **Rule 15** of the RPwD Rules treats accessibility as a **flexible guideline** rather than a **mandatory requirement**, undermining the effectiveness of the law.

3. Supreme Court Ruling (November 2024):

- The **Supreme Court** directed the **Union Government** to establish **mandatory accessibility rules** for both **existing infrastructure** (through **retrofitting**) and **new constructions**.
- The Court emphasized that accessibility is not just a **progressive goal** but a **non-negotiable legal right** that requires **enforceable regulations**, not **optional guidelines**.

4. Key Recommendations:

- Enforce **mandatory accessibility standards** that are clear and non-negotiable, making them **legally binding**.
- Implement **retrofitting measures** in existing structures while ensuring **new infrastructure** complies with strict accessibility standards.
- **Tailored accessibility measures** must address the diverse needs of individuals with various types of disabilities, including **intellectual**, **psychosocial**, and **physical disabilities**.
- The **NALSAR report** highlighted critical gaps in the accessibility landscape, such as inadequate infrastructure in **education** and **healthcare**, which must be addressed through stricter enforcement of rules.

5. Conclusion:

- The **implementation** of **accessibility standards** is the key to ensuring **true inclusion** for persons with disabilities.
- **Policymaking** and **laws** alone are insufficient—**action and enforcement** are necessary to remove barriers and provide meaningful access for persons with disabilities.

Practice Question:

How can India ensure the effective implementation of accessibility standards to foster true inclusion for persons with disabilities? (150 words)

RIGHT TO DIE WITH DIGNITY

The Assam tribune: 04 December 2024

Right to die with dignity

JAYANTA KRISHNA SARMAH,
PURNA KANTA TAYE

The debate over euthanasia highlights the tension between respecting individual autonomy and upholding cultural, religious and ethical values.

Euthanasia – 'the right to die with dignity' – is a complex and crucial policy issue in India. It is the administration of a lethal agent by another person to a patient to relieve the patient's intolerable and incurable suffering, which can be both active and passive. Active euthanasia refers to a physician deliberately acting to end a patient's life. Passive euthanasia, on the other hand, refers to the withholding of treatment with informed consent. Recently, a nationwide debate was sparked following the draft guidelines of September 2024 on passive euthanasia issued by the Ministry of Health and Family Welfare, Government of India. These guidelines aim to minimize patient suffering, respect patients' autonomy, reduce financial burdens, reduce emotional stress, and optimize resource allocation for terminally ill patients in India.

In the case of Aruna Ramchandra Shanbaug vs Union of India (2011), the Supreme Court permitted passive euthanasia for terminally ill patients in certain circumstances. Subsequently, in the Common Cause vs Union of India (2018), the apex court declared the right to die with dignity as a fundamental right and an integral part of the right to live with dignity under Article 21 of the Constitution. On the legislative front, before the draft guideline of 2024 – which aims to legislate the apex court's verdict into law – two other parliamentary bills, namely the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, and the Euthanasia Regulation Bill, 2019, were presented in Parliament. However, these bills have not yet been passed.

For many years, there has been intense debate in different cultures and traditions with diverse worldviews on this issue. Even though the Supreme Court has declared the right to die with dignity as a fundamental right, there is an ongoing debate on the legal acceptance of euthanasia policy reforms. The supporters of the legalization of euthanasia are often proponents of the Quality-of-Life (QOL) doctrine, which is concerned not only with assessing the worthwhileness of the treatment but also the patient's life. In short, the advocates of the QOL doctrine are in favour of the legalization of euthanasia to ensure a dignified end-of-life. This viewpoint supports the legalization and asserts that the patient should not be forced to suffer a prolonged and painful death. It justifies euthanasia when the QOL of the patient falls below a minimum quality threshold, where death becomes the only justifiable means to relieve suffering. Respecting the patient's autonomy to determine what treatments are accepted or refused is one of their basic arguments. They criticize the bright-line delineation drawn by the court and religious organizations between active and passive euthanasia as hindering the right to make autonomous choices at the end of life.

On the other hand, there are counterarguments against the legalization of euthanasia across the globe. Cultural and religious sensitivities are key influencing factors. In a culturally diverse society like India, with a dominant belief in the sanctity of human life, the move to legalize passive euthanasia may face resistance. Many religious communities may view passive euthanasia as morally deplorable. They are mostly proponents of the absolutist Sanctity of Life (SOL) doctrine, which views human life as a 'sacred' and supreme God-given value. In this case, the artificial destruction of human life is perceived as a serious sinful act and a crime against the laws of the supreme creator. This view holds that God alone has the right to take anyone's life. It argues that if we cannot give life, then we do not have the right to take anyone's life by any means. Therefore, this view advocates for preserving the life of terminally ill patients at any cost, till life takes its natural course.

In many countries, euthanasia is strongly opposed by mainstream religions, especially the Catholic Church. According to this perspective, "Euthanasia violates the sanctity of human life and the sovereignty of God." In Hinduism, suicide is prohibited. Islam also holds that no one has the right to die before the time determined by God. Killing a terminally ill person, whether through active euthanasia or passive euthanasia, is considered an act of disobedience against God and a violation of Allah's divine sovereignty.

The opponents of euthanasia argue that economically disadvantaged sections of society may be 'coerced,' either directly or indirectly, into requesting euthanasia as a means to relieve their suffering. In this regard, the opponents recommend further development of palliative care, along with psychiatric care and spiritual guidance, instead of euthanasia. Research shows that only 1 percent of dying patients receive adequate palliative care in India. When patients receive adequate and good palliative care, they often refuse euthanasia. Thus, the rhetorical debates among SOL, QOL, mainstream religious worldviews, and different socio-economic dimensions have a significant influence on end-of-life decision-making. In this situation, the human rights and autonomy of terminally ill patients become critical issues, particularly when viewed through the philosophical lens of the SOL doctrine.

Ironically, this debate is not free from apprehension in the eyes of different stakeholders. The potential abuse of law reforms is the prime apprehension surrounding this matter. Passive euthanasia can only be legalized with comprehensive regulation to prevent the potential slippery slope of abuse. Otherwise, there may be a rise in cases of law misuse. Significantly, this draft guideline aims to protect doctors, as some fear they could face legal complications if family disputes arise over the withdrawal of life support. In this regard, the Indian Medical Association highlights the need for additional legal safeguards.

Similarly, if a bedridden patient possesses considerable property, family members may try to intentionally end the patient's life to grab the same. In addition, there exists a gap in communication between family members and doctors, where important decisions are made without consulting the patient. Ensuring informed consent is of utmost necessity, alongside specific guidelines. The guidelines must be accompanied by initiatives to enhance awareness and understanding of end-of-life options, especially in rural areas. Otherwise, relatives may hasten the death of a patient to serve their own interests. Furthermore, the inadequate medical infrastructure in rural areas for treating terminally ill patients in a dignified manner needs to be reversed urgently.

Though passive euthanasia has been legalized by the apex court, active euthanasia is still an illegal medical practice under Indian law. Under Section 244 – attempting to commit suicide – and Section 108 – abetment of suicide—under the Bharatiya Nyaya Sanhita-2023, both practices are still punishable offences. This legal ambiguity needs to be resolved if the Government of India intends to introduce a parliamentary bill on this issue. It is observed that the Indian context is vastly different from that of developed Western countries, making it impractical to replicate Western policies in India. Therefore, framing a new law requires balancing ethical, cultural values, and legal considerations to provide a comprehensive end-of-life choice policy in India.

1. **Definition of Euthanasia**:
   - **Active euthanasia**: Deliberate action by a physician to end a patient's life.
   - **Passive euthanasia**: Withholding treatment to allow a patient to die, often requiring **informed consent**.
2. **Legal Milestones in India**:
   - **Aruna Shanbaug Case (2011)**: Passive euthanasia permitted under specific conditions.
   - **Common Cause Case (2018)**: Declared the **right to die with dignity** as part of the **fundamental right to life (Article 21)**.
   - **Draft Guidelines (2024)**: Aim to legislate court rulings and address issues like minimizing suffering, optimizing resource use, and ensuring patient autonomy.
3. **Philosophical Doctrines**:

- **Quality-of-Life (QOL)** Doctrine: Advocates euthanasia when life quality falls below a certain threshold, emphasizing **autonomy**.
- **Sanctity-of-Life (SOL)** Doctrine: Opposes euthanasia, viewing life as sacred and God-given.

4. **Cultural and Religious Perspectives**:
   - **Hinduism**: Suicide and euthanasia often prohibited.
   - **Islam**: Human life belongs to God, and euthanasia is considered a disobedience.
   - **Catholic Church**: Views euthanasia as a violation of God's sovereignty and the sanctity of life.
5. **Concerns and Ethical Issues**:
   - **Potential misuse**: Fear of coercion or financial exploitation, especially among economically disadvantaged groups.
   - **Family disputes**: Relatives may misuse euthanasia laws to grab property.
   - **Doctor liability**: Legal safeguards needed to protect physicians.
   - **Informed consent**: Essential but often missing due to communication gaps.
   - **Rural healthcare**: Lack of adequate **palliative care** and medical infrastructure in rural areas hampers dignified end-of-life care.
6. **Current Legal Framework**:
   - **Active euthanasia**: Illegal under **Sections 244** (attempted suicide) and **Section 108** (abetment of suicide) of the Bharatiya Nyaya Sanhita-2023.
   - **Passive euthanasia**: Permitted but requires robust regulation to prevent misuse.
7. **Policy Recommendations**:
   - Develop comprehensive palliative care systems to reduce the demand for euthanasia.
   - Promote **awareness campaigns** about end-of-life options, focusing on rural areas.
   - Enact legal safeguards to ensure **transparency** and **prevent abuse**.
   - Frame India-specific laws that balance ethical, cultural, and legal considerations, avoiding direct replication of Western models.

Practice Questions:

GS-4

Q. Balancing the right to die with dignity and societal moral values requires nuanced governance. Critically analyze. (250 words)

RTPS ACT: A REVOLUTIONARY STEP

The Assam tribune: 05 December 2024

RTPS Act: A revolutionary step

BHASKAR J MAHANTA

Collaboration between conscientious officials and an informed public can foster a more equitable governance system.

"A Deputy Commissioner cannot sit in his airconditioned room while the public, who pay his salary, sweat it out in a queue outside his office to access public services." These were the inspiring words with which the Chief Minister of Assam, Dr Himanta Biswa Sarma, launched the portal for citizens to appeal and assert their right to public service. The portal will be a one-stop shop for the public to access 441 public services. The Chief Minister also launched the Assam State Commission for Right to Public Services, which will be headed by Dr Sujoy Lal Thaosen, IPS (Retd), 1988 batch, Madhya Pradesh cadre.

The Commission will have a three-tier structure with graded levels of authority vested in each tier to hold public servants accountable in the course of discharging their solemn duty of delivering citizen services in a time-bound and transparent manner. Each tier will have the power to take punitive action against non-compliant public servants, and the Commissioner will be the final arbitrating authority, safeguarding the rights of citizens to access public services. If a citizen does not receive a particular service listed in the portal within the specified time, he or she will be entitled to approach the first appellate authority to redress the grievance. The authority concerned, on being satisfied that the citizen has been deprived of the service promised in the specified timeframe, will take punitive action against the public servant concerned, like imposition of fines to be deducted from his or her salary. Similar powers would be vested in the second appellate authority and the Commission that wield greater power over the quantum of fines and other punitive measures.

The Commission is the product of the Assam Right to Public Service Act, 2012, as amended in 2019. The genesis of the Sewa Setu project lies in the World Bank Group's programme to bring in GovTech to democratize access to public services. The granular underpinning of the Sewa Setu project lies in a 2017 World Bank report, which provides a practical tool to develop a human rights-based approach to citizen service delivery.

This is a monumental step in establishing constitutionalism in governance. The Preamble of the Constitution starts with "We, the people of India..." This authoritative assertion of the framers of the Indian Constitution demonstrates their intent to establish the primacy of the citizenry and shift from the traditional hierarchical supremacy of the ruler over the ruled to making the citizen the power centre of Indian life. The framers envisioned the will of the people to provide directional guidance to all branches of governance in their strategic, operational, and tactical functioning. While some may categorize this as romantic idealism, one would argue that such idealism was the cornerstone of the Indian freedom movement, culminating in the much-celebrated 'Freedom at midnight.'

However, in our journey as a nation-state, such lofty ideals have been eroded over time, both unconsciously and by design. Gradually, the erstwhile rulers were replaced by a new elite class – the public servants. The notion of power corrupting ideals has been pretty much evident when it comes to this class. As more and more power was bestowed upon them to execute policies framed by the people's representatives, a large number of public servants used their power to transform themselves into the new rulers of the masses. During my over three decades in civil service, I have personally witnessed this across every stratum of governance. I will not shy away here from acknowledging that I have also been the undue beneficiary of some of it, given the entrenched power structures; so much so that when I would make way for an elderly citizen to get ahead of me in a queue, I would be deemed either naïve or excessively down to earth. Quite a number of public servants have actively colluded to ensure that this power structure remains intact to further their stranglehold on society.

It's not that all public servants fail to perform their duties with devotion. Most public servants spend precious hours and energy ensuring that the public receives the appropriate attention and services the government commits to deliver. But, the bad apples are not limited in number as well. Public servants will now need to pay special attention to addressing individual citizens' issues, such as verification reports, land records, certificates of various kinds, and the services listed in the portal, ensuring timely delivery. The shirkers will not be happy with this. There will be attempts to put roadblocks in the smooth functioning of this revolutionary system.

Much now depends on the Commissioner to actualize the vision and ensure that the rebalancing of power, as envisioned, materializes. There is little doubt that he will make more than a few people uncomfortable in his efforts, as I know from my own experience as the Chief Information Commissioner of Assam. Some might even try to use political influence to undercut his efforts. However, if I know anything about Sujoy, he will brush these aside with the grace he has displayed throughout his glorious career in the IPS. Also, he can feel assured that the government, especially the Chief Minister, will support him as long as he follows the mandate in letter and spirit.

Finally, the public should also be aware of not just their rights but also their duties as citizens and not take an antagonistic approach towards all public servants. While some look at public service as a means to consolidate resources and power, many others genuinely use their position to bring a positive change in society. The public must collaborate with them in building a better nation and realizing the vision of the framers of the Indian Constitution.

(The author is a former DGP of Assam)

1. **Right to Public Services Act (RTPS)**:
   - Enacted in **Assam in 2012**, amended in **2019**.
   - Focuses on delivering **time-bound, transparent, and accountable** citizen services.
   - Establishes mechanisms for **appeals** and **punitive actions** against non-compliant public servants.
2. **New Initiatives**:
   - **RTPS Portal**: Provides access to **441 public services**, ensuring ease of governance.
   - **Assam State Commission for Right to Public Services**:
     - Led by Dr. Sujoy Lal Thaosen, IPS (Retd).
     - Three-tier structure for grievance redressal with powers to impose fines on errant officials.
   - **World Bank's GovTech Inspiration**: The **Sewa Setu project**, based on a 2017 World Bank report, aims to integrate a **human rights-based approach** to service delivery.
3. **Constitutional Perspective**:

- The Preamble emphasizes **"We, the people of India,"** establishing the primacy of citizens over hierarchical governance structures.
- RTPS Act reaffirms **constitutionalism**, making **citizens the focal point** of governance.

4. **Challenges in Governance**:
   - **Elite Capture of Power**: Public servants often misuse their authority, creating a new ruling class.
   - **Resistance to Change**: Attempts to sabotage transparent systems by officials reluctant to lose their power.
   - **Public Perception**: Negative attitudes toward public servants may hinder collaboration in governance.
5. **Role of Public Servants**:
   - **Devotion to Duty**: Many work tirelessly to deliver services, but "bad apples" tarnish the system.
   - **Accountability Mechanisms**: RTPS ensures officials are held accountable for failing in service delivery.
6. **Collaborative Governance**:
   - **Citizen Awareness**: Citizens must be informed about both their rights and duties.
   - **Synergy between Public and Officials**: Building trust and cooperation can help foster a **more equitable governance system**.

Practice Questions:

Q. Evaluate the significance of the Right to Public Services Act in promoting citizen-centric governance in India. (250 words)

Essay:

Q. Public service is not about power, but about empowering citizens.