News Analysis (15 Sep, 2018)

HDI Ranking by UNDP

India is ranked 130 out of 189 countries in the latest human development Index (HDI) released recently by the United Nations Development Programme (UNDP).

What is HDI?

- The Human Development Index (HDI) is a tool developed by the United Nations and was **introduced in the first Human Development Report in 1990** to measure and rank countries' levels of social and economic development.
- The HDI is the composite measure of every country's attainment in three basic dimensions:
  - **standard of living** measured by the gross national income (GNI) per capita;
  - **health** measured by the life expectancy at birth;
  - **education** levels calculated by mean years of education among the adult population and the expected years of schooling for children.
- This index makes it possible to follow changes in development levels over time and to compare the development levels of different countries.

Key Points

- **Global Scenario**
    - Norway at 0.95 has been ranked the highest on the HDI scale while Niger is the bottom at 0.35. The greatest increase in HDI rank over the last five years is by Ireland followed by Turkey while the **worst decline** was seen in **conflict-hit countries of Syria, Libya, and Yemen**.
    - **Norway, Switzerland**, Australia, Ireland and Germany lead the ranking, while **Niger, the Central African Republic, South Sudan,** Chad and Burundi have the lowest scores in the HDI's measurement of national achievements in health, education and income.
    - Within South Asia, **India's HDI** value is above the average of 0.638 for the region, with Bangladesh and Pakistan, countries with similar population size, being ranked 136 and 150 respectively.
    - The overall trend globally is toward continued human development improvements, with many countries moving up through the human development categories: out of the 189 countries for which the HDI is calculated, 59 countries are today in the very high human development group and only 38 countries fall in the low HDI group.
    - **Inequality manifests in the massive differences across the world in people's well-being** with a child born in a low HDI country expected to live just over 60 years as compared to a very high HDI country where a child could live up to 80 years. Likewise, children in low HDI countries are expected to be in school seven years fewer than children in very high HDI countries.

- **Indian Scenario**
    - India climbed one spot to 130 out of 189 countries in the latest HDI ranking as compared to 131st out of 188 countries in the 2017 Human Development Index (HDI).
    - India's Human Development Index (HDI) value for 2017 is 0.640, which puts the country in the **medium human development category**. Between 1990 and 2017, India's HDI value rose from 0.427 to 0.640, an increase of nearly 50%, indicating rapid progress in poverty eradication.
    - People are living longer, are more educated, and have greater income today as seen in the rise in average HDI levels since 1990 at 22 per cent globally. The least developed countries registered a 51 per cent increase. In keeping with the global trend, in the last 17 years since 1990, India registered a 50 per cent increase.
    - Life expectancy at birth in the country has increased by 11 years and children have been predicted to stay in school for 4.7 years longer than in 1990. Further, the highest leap has been in GNI per capita which registered more than 200 percent increase between 1990 and 2017.
    - At the same time the value of **India's Inequality-adjusted HDI (IHDI) falls by more than 25%** to 0.468, far worse than the global average decrease in the global HDI value due to to the stark inequality in access to education, health, and income.
    - India ranks 127 out of 160 countries on the Gender Inequality Index which reflects gender-based inequalities in reproductive health, empowerment (political and educational), and economic activity.
    - The report notes that in **India women hold only about 11 per cent of parliamentary seats** which implies that women hardly have a role in policy making, while only about 40 percent of adult women have reached at least a secondary level of education as compared to more than 60 percent men .
    - India's worst performance on the gender scale is with regards to its **female participation in the labour market** which is about 30 per cent compared to 80 per cent for men even as globally about 50 per cent women are part of the labour force as compared to 75 per cent men.

Limitations of HDI

- It provides a limited evaluation of human development which is much beyond the parameters considered for its measurement.
- It does not specifically reflect quality of life factors, such as empowerment movements or overall feelings of security.
- In recognition of these facts, the Human Development Report Office (HDRO) provides additional composite indices to evaluate other life aspects, including inequality issues such as gender disparity or racial inequality.

- So, examination and evaluation of a country's HDI is best done in coordination with examining other factors, such as the country's rate of economic growth, expansion of employment opportunities, success of initiatives etc undertaken to improve the overall quality of life within a country.

Way Forward

- India's HDI has increased tremendously in the last two and half decades. However, we **need to focus on inequality and the pockets of deprivation** that are dragging the HDI down for achieving development for all and the key principle of the **Sustainable Development Goals** to leave no one behind.
- Gender inequality is another big issue which adversely affects human development. So the development schemes like Beti Bachao Beti Padhao, Sukanya Samridhi Yojana, Stand-up India etc. would be crucial in ensuring the upward trend of human development.
- Deteriorating air quality in major Indian cities and its impacts on human health are also worrying. There should be more **sensitization towards eco-friendly solutions** for mobility like the recent Global Mobility Summit to make transition towards sustainable alternatives for transport.
- **Climate change** is likely to increase migration, displacement and negatively affect livelihoods. As the **solution lies in innovation**, so the government with all the stake holders including community participation should create an ecosystem that fosters creative thinking and innovation to make India climate change resilient.

Report by Expert Committee on Tribal Health

An expert committee has released a comprehensive report on tribal health in India.

Why the Committee?

- Tribal people account for 8.6% of the country's population and their problems like health, education, poverty have largely remained out of the national discourse. The committee focused on the issue of Health and Healthcare of Tribal areas.
- The aim of the committee was to find the present status of health and health care in tribal areas and the roadmap for future to solve the issues.
- The 12-membered committee was chaired by Dr. Abhay Bang.
- The expert committee on Tribal Health was constituted jointly by the Ministry of Health and Family Welfare and Ministry of Tribal Affairs.
- This report is the first comprehensive report on Tribal Health in India.

Key Findings

- **Child Mortality:**
  - There are improvements in parameters but there is certainly a gap between tribals and rest of India.
  - The child mortality among tribals halved in 26 years from 90 in 1988 to 44 in 2014.
  - Under-five mortality rate declined from 135 in 1988 to 57 in 2014.
  - Under-five child mortality for the rest of India was around 39 in 2014.
- **Disease Burden**
  - Tribal population suffers from the triple burden of disease:
  - **Malnutrition**

    The percentage of underweight ST children have reduced from about 54% in 2005-06 to around 40% in 2015-16.
  - **Communicable Diseases like Malaria and tuberculosis and non-communicable diseases like cancer and diabetes**
    - Tribal constitutes 8% of India's total population but they have 30% of all cases of Malaria.
    - Prevalence of TB in rest of India is 256 per 100,000 cases but in tribals, it is 703 cases per 100,000 almost three times.
    - One of every 4 tribal adults suffers from Hypertension.
    - About 70% of tribal men between 15-54 age group uses tobacco as compared to around 55% among non-tribals.
- **Health Care Infrastructure**
  - In nearly five out of the ten states with tribal population, healthcare institutions in tribal areas were less than required.
  - There is a huge vacancy of allopathic doctors and specialists in the Primary health center and community health center in tribal areas.
  - On the other hand, Accredited social health activists (ASHA) have proved to be a potent tool to deal with health care problems in tribal areas.
  - Lack of data at the local level and the lack of community participation in agenda setting is the key challenge in the planning process.

- **Issues ailing Tribal health in India**

  The report notes the ten burdens ailing tribal health. It includes:

  - Communicable diseases and malnutrition
  - Non-communicable diseases including mental illness
  - Animal and snake bites and violent conflicts
  - Worse socio-economic determinants especially in housing, education, and sanitation
  - Difficult natural conditions arising out of geographic terrains
  - Poor quality and inappropriate health care services
  - Constraints in the availability of health human resource at all levels
  - Lack of Funds or allocated funds not utilized properly
  - Lack of data for evaluation and monitoring of schemes and their impact
  - Political dis-empowerment of tribal people from individual to the national level. Lack of participation from tribal people in planning, priority setting and execution.
- **Conclusion**
  - Despite the high dependence of tribals on the public health care system. It continues to be characterized by low quality, low output, and low outcome delivery system, often targeting wrong priorities.
  - It is necessary to restructure and strengthen the public health care system in accordance with the needs and aspirations of the tribal communities, with their full participation.

Recommendations of the Report

- The promise of **Universal Health Assurance** under **National Health Policy(2017)** should begin with tribal areas.
- Primary care in the community should be taken care by **Aarogya Mitra**, trained local tribal youth and ASHA's with support from gram sabha.
- Financial protection through government medical insurance scheme should be provided to tribals for secondary and tertiary care.
- For tribal people living outside scheduled areas committee recommends **ST Health Card** which will help them to avail their benefits at any like insurance at any health care institutions.
- To provide doctors dedicated to working in tribal areas, the committee recommended the **creation of dedicated medical colleges in tribal districts** exclusively for tribal areas.
- The committee recommends the introduction of **Tribal Malaria Action Plan** in tribal-dominated districts under National Health Mission.
- To reduce infant and child mortality committee recommended strengthening **Home Based New Born and Child Care**(HBNCC).

- To reduce malnutrition food security should be ensured and Integrated Child Development Services should be strengthened.
- There should be awareness against addictive substances and provision for de-addiction and mental health services.
- The committee recommended that a state of tribal health report should be published every three years and placed before the nation.
- **Tribal Health Index (THI)** should be created to capture the state of tribal health.
- Various national surveys should aim to estimate various health parameters in tribal areas.
- For responsive and focused governance structure for tribal health, the committee recommends **National Tribal Health Council** as apex body along with **Tribal Health Directorate** and **Tribal Health Research Cell**, both at center and state level. **Prime Minister Tribal Health Fellow (PMTHF)** should be appointed as District Tribal Health Officer.
- The fund allocated for health in tribal areas should be proportional to their population.
- Almost 15% of district allocation of the Ministry of Tribal Affairs should be spent on health.
- It is necessary that all tribals whether living within or outside tribal areas should be covered under the health insurance scheme.

SC Questions Leprosy-Free Tag of India

Supreme Court ordered the government to take measures for the eradication of Leprosy and spread awareness about it to end discrimination.

Key Points of Judgment

- Supreme Court's observations on government actions against Leprosy
    - Supreme Court pointed out that though the country was declared leprosy-free on December 31, 2005, patients and their families continue to suffer from leprosy and its stigma.
    - Patients are denied their fundamental right to food. They are not issued BPL (Below Poverty Line) cards to claim the benefit of various welfare schemes such as the Antyodaya Anna Yojana (AAY). They are deprived of housing, basic civic amenities, adequate sanitary facilities, and rehabilitation programmes.
    - The Supreme Court referred to progress reports of the National Leprosy Eradication Programme (NLEP) to show that only 543 districts of the total 642 districts in the country had achieved the **World Health Organisation-required prevalence rate of less than one case of leprosy for 10,000 persons**.
    - The underestimation of cases of leprosy and the declaration of elimination of leprosy has resulted in the integration of leprosy in general health services. Thus, leading to diversion of funds which would have otherwise been dedicated to eliminating leprosy,
- Supreme Court's directions to Central Government
    - The court has directed the government to be transparent about leprosy and conduct periodic national surveys to gauge its detection rate.
    - Central Government should publish reports of the National Sample Survey on Leprosy conducted in 2010-2011.
    - Both the Centre and States should embark on **"regular and sustainable massive awareness campaigns"** to educate the public.
    - Awareness must be spread about the **Multi-Drug Therapy (MDT),** which is freely available at health centers to completely cure leprosy under **National Leprosy Eradication Programme (NLEP).**
    - The court banned the use of "frightening" images of leprosy patients, instead it called for the use of "positive" photographs of those cured of leprosy in the campaigns.
    - Currently, the persons affected with leprosy live as a marginalized section in society, deprived of even basic human rights. Awareness campaigns should inform that a person affected with leprosy can lead a normal married life, can have children, can take part in social events and go to work or school as normal.
    - Court had asked the Centre to consider framing a law to repeal all laws that discriminate against those suffering from leprosy.

About Leprosy

Leprosy (Hansen's disease) is an infectious disease caused by Mycobacterium leprae that involves the skin and peripheral nerves. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and eyes.

National Leprosy-Eradication Program

- The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India.
- Govt. of India started National Leprosy Control Programme in 1955.
- NLEP was launched in 1983 with the objective to arrest the disease activity in all the known cases of leprosy.
- In 1983 Multidrug therapy (MDT) was introduced in Phases.

Multi-Drug Therapy

- Multidrug therapy (MDT) consisting of Rifampicin, Clofazimine, and Dapsone which are identified as the cure for leprosy. The MDT programme is supported by the World Health Organisation.
- Since 1995, WHO has supplied MDT free of cost to leprosy patients in all endemic countries.

Important Facts for Prelims (15th September 2018)

Great Indian Bustard

- Once the contender for becoming India's national bird, the Great Indian Bustard is now facing extinction.
- It is listed in **Schedule I of the Indian Wildlife (Protection) Act, 1972**, in **Appendix I of CITES**, as **Critically Endangered on the IUCN Red List** and the National Wildlife Action Plan (2002-2016).
- It has been identified as one of the species for the recovery programme under the Integrated Development of Wildlife Habitats of the Ministry of Environment, Forest and Climate Change.
- Historically, the great Indian bustard was distributed throughout Western India, spanning 11 states, as well as parts of Pakistan. Its stronghold was once the Thar desert in the north-west and the Deccan plateau of the peninsula.
- Today, its population is confined mostly to **Rajasthan (where it is the state bird)** and Gujarat. Small population occur in Maharashtra, Karnataka and Andhra Pradesh.
- The Desert National Park (Rajasthan) in Rajasthan is one of the most prominent habitats for the Great Indian Bustard.
- The ***sewan*** grassland landscape is the bustard's natural habitat. The bustard, known locally as ***godawan***, flourished for years in these grasslands, but now most of that land is lost to agriculture and other human activities.

- In 2013, the Rajasthan government launched **Project Great Indian Bustard**, with the aim of constructing breeding enclosures for the species and developing infrastructure to reduce human pressure on its habitats.
- Recently, wildlife officials and experts submitted their recommendations to the standing committee of the **National Board for Wildlife** to save bustard, from extinction.

National Board for Wildlife

- It is a statutory Board constituted under the Wild Life (Protection) Act, 1972.
- It is chaired by the Prime Minister.
- It works as advisory body in framing policies and measures for conservation of wildlife in the country.
