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Enhancing Human Resources for Inclusive Growth, Employment and Welfare

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Introduction

The inclusive growth approach takes a longer term perspective. This is necessary because of the emphasis on improving the productive capacity of individuals and creating conducive environment for employment, rather than on income redistribution as a means of increasing incomes for excluded groups. Due to this longer term perspective, there is an explicit focus on structural transformation and internal migration in the inclusive growth analytics framework. The goal is to identify a bundle of binding constraints rather than the binding constraint, and then sequence these constraints to maximizz inclusive growth in a country. Inclusive growth is about raising the pace of growth and enlarging the size of the economy, while leveling the playing field for investment and increasing productive employment opportunities. It focuses on ex-ante analysis of sources, and constraints to sustained, high growth, and not only on one groups the poor. The analysis looks for ways to raise the pace of growth by utilizing more fully parts of the labor force trapped in low-productivity activities or completely excluded from the growth process.

Education and Skill Development

The Prime Minister said that ethical and responsible behavior needs to become the cornerstone of public and corporate behavior, as indeed of our national outlook. He said the Government was totally committed to ensuring that faith of the public is restored in governance and probity of the highest order is restored in public life, and we have already taken action against powerful and entrenched individuals. Systems will be put in place to prevent recurrence of incidences of corruption and malfeasance. He also called upon the corporate sector to work towards improving the ethical standards in corporate governance. The industry leaders reaffirmed their commitment to work in partnership with Government particularly in areas of inclusive growth, skill development and job creation and environmental protection.

The sub-committees of the Council that had worked on the following five thematic areas presented their reports to the Council

- Financial inclusion
- Tribal area development
- Public private partnerships in R&D
- Agricultural production and food security
- Skill development, affirmative action and corporate social responsibility.

Vast research and expert opinions have been sought in the effort to determine the specific soft skills to be implemented and used in higher institutions of learning. Based on the research

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findings obtained, seven soft skills have been identified and chosen to be implemented in all institutions of higher learning here. They are:

- Communicative skills.
- Thinking skills and Problem solving skills.
- Team work force
- Life-long learning and Information Management
- Entrepreneur skill
- Ethics, moral and professionalism
- Leadership skills

Model for implementing soft skills in higher education.

A holistic approach is used to plan and implement the soft skills among students of higher education. This approach is based on the combination of several programs and main activities formal teaching and learning activities include all curricular and co-curricular elements. In general, the development of soft skills among the students via the formal teaching and learning activities takes two models: (i) stand alone and (ii) embedded.

Development of soft skills through support programs

This involves programs and activities that are created, developed and used to support soft skills either directly or indirectly. In general, the program and activity can be divided into two: (i) academic support program and (ii) non-academic support program.

Eradication of illiteracy has been one of the major national concerns of the Government of India since Independence. The need for a literate population and universal education for all children in the age group 6-14 was recognized as a crucial input for nation building and was given due consideration in Constitution as well as in the successive five-year plans. A number of significant programmes have been taken up since Independence to eradicate illiteracy among adults. Some of the important programmes have included:

(i) **Social** consciousness. The programme was implemented in the First Five-Year Plan (1951-56).**Education:** The main elements were literacy, extension, general education, leadership training and social

(ii) **Gram Shikshan Mohim:** Movement for literacy in the rural areas was started in 1959 in Satara district of Maharashtra,The programme, however, suffered from a lack of systematic follow-up which resulted in relapse to illiteracy.

(iii) **Farmers' Functional Literacy Project:** Verdan Started in 1967-68 as an inter-ministerial project for farmers' training and functional literacy, the project aimed at popularization of high-yielding varieties of seeds through the process of adult education.

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(iv) **Non-formal Education:** In the beginning of the Fifth Plan, a programme of non-formal education for 15-25 age-group was launched. Although the scope, content and objective of the non-formal project was clearly spelt out, its understanding in the field was very limited and the programmes actually organized indistinguishable from the conventional literacy programmes.

(v) **Polyvalent Adult Education Centres Workers' Social Education Institutes and Polyvalent Adult Education Centres:** Reviewed by a group in 1977, which recommended adoption of Polyvalent Adult Education Centres in the adult education programmes for workers in urban areas. In pursuance of this decision, Shramik Vidyapeeths wre set up in the states.

(vi) **Education Commission (1964-66)** The appointment of Education Commission (1964-66) was a significant event in the history of education in India. The Education Commission also stated that in the world of science and technology, the main objective should be to relate it to life, needs and aspirations of the people so as to make it an instrument of socio-economic and political change.

(vii) **Functional Literacy for Adult Women (FLAW):** The scheme of Functional Literacy for Adult Women (FLAW) was started in 1975-76 in the experimental ICDS project areas. The aim of FLAW scheme was to enable illiterate adult women to acquire functional skills along with literacy, to promote better awareness of health, hygiene, child-care practices and to bring about attitudinal changes. The target age group was 15-35 age groups.

(viii) **National Adult Education Programme (NAEP):** The first nation-wide attempt at eradication of illiteracy was made through the National Adult Education Programme launched on October 2, 1978. It was a massive programme which aimed at educating 100 million non-literate adults in the age group of 15-35 years within a time frame of five years. The objectives of the National Adult Education Programme were not merely to impart literacy in the conventional sense, but also to provide learners with functional awareness, which were conceived as three integral components of the skills of reading, writing and arithmetic.

(ix) **Rural Functional Literacy Project (RFLP):** This was the flagship programme of NAEP and was started as a centrally sponsored scheme in 1978 for rural areas. The erstwhile 144 Farmers' Functional Literacy Projects and 60 Non-formal Education Projects were merged into it. Further, projects were added and the number of projects throughout the country in 1987 were 513, each having upto a maximum number of 300 adult education centres and each centre having 25-30 learners.

(x) **State Adult Education Programme (SAEP):** The states also similarly took upcentre-based projects under the state plan funds on the lines of RFLPs.

(xi) **Adult Education through Voluntary Agencies:** The Central Scheme of Assistance to Voluntary Agencies was revived in April 1982. Under this scheme, registered societies were sanctioned Centre- based projects for functional literacy and post-literacy, where they were allowed tIntended to be a mass programme, the National Adult Education Programme (NAEP),

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however, remained a traditional centre-based programme, which was also honorarium based, hierarchical and government-funded and government controlled.

Strengths:

1.Women's motivation and participation has been high.

2. Coverage of weaker sections of the society (SCs and STs) was higher than the target.

3. The project approach to management adopted for adult education programme is feasible.

4. The quality of teaching-learning materials prepared by the National Resource Centre and the State Resource Centres was found to be positive.

5. The programme worked well where special recruitment procedures were adopted.

Weaknesses:

- Quality of training of the functionaries was poor.
- The learning environment in the adult education centres was poor.
- Mass media did not provide appreciable support.
- Voluntary agencies did not receive willing cooperation from State Governments.
- The existing procedures for their involvement were discouraging.
- There was no linkage between basic literacy, post-literacy, follow-up and continuing education, resulting in the relapse of large number of neo-literates into illiteracy.
- Achievement levels of literacy were below the desired level.
- Training of adult education functionaries at all levels lacked participatory and communicative techniques.
- Political and administrative support of the state governments and the Panchayati Raj institutions was not forthcoming.

The National Literacy Mission (NLM)

The National Literacy Mission (NLM) was launched on 5th May 1988 by late Prime Minsiter Shri Rajiv Gandhi. The initial experiment of NLM with the campaign mode was first seen in Kottayam city of Kerala. Here the district collector, by mobilizing 200 volunteers from the local university and forging links with 2000 non-literates in the 6-60 age group, succeeded in making them fully literate within three months.

National Literacy Mission (NLM) has been conceptualized and built on an objective assessment of the strengths and weaknesses of the earlier programmes emanating from the evaluation study reports. The creation of a mission for literacy represents a national political commitment on the need to harness social forces and channelise the energies of people towards meeting the ultimate objective of effecting a qualitative change in their own lives. Conceptually, the mission focuses on:

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A new sense of urgency, seriousness and emphasis with fixed goals, clear time-frame and age specific target groups.

Firm belief that adults can be made literate according to certain pre-determined norms within a stipulated time limit (200 hours) and that it not too late to learn.

Emphasis on the close nexus between literacy of adult parents and enrolment of school going children, on the one hand, and literacy and infant mortality; immunization and infant mortality, immunization and child care on the other.

A special mission which believes that literacy is not the concern of the one ministry or department or agency but is the concern of the entire nation and all sectors of society. Emphasis on institutionalization of post-literacy and continuing education in a big way.

A technology mission also in the sense that besides emphasis on improvement of teaching/learning environment, it lays stress on improvement in the content and process of teaching-learning on a continuing basis.

Envisages creation of an effective mission management system to ensure achievement of the mission objectives wi education, resulting in the relapse of large number of neo literates into illiteracy. thin a broad framework of flexibility, delegation, decentralization and accountability.

Emphasis not on mere enrolment of learners but on attainment of certain predetermined norms and parameters of literacy, numeracy, functionality and awareness.

Involvement of NGOs:

The National Literacy Mission (NLM) fully recognizes the vast potential of NGOs in furthering its objectives and has taken measures to strengthen its partnership with NGOs and has assigned them an active promotional role in the literacy movement. Apart from imparting literacy, the NGOs provide academic and technical resource support through experimental and innovative programmes and also conducting evaluation and impact studies; organization of workshops, seminars, etc.

State Resource Centres:

The scheme of establishing State Resource Centres at State level was formulated by the then Ministry of Education in 1976 with the objective of providing technical and resource support to the adult education programme on the recommendation of Standing Committee of the CABE.

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Main functions of State Resource Centres:

1. Development of teaching/learning and training materials for literacy programmes.

2. Production and dissemination (including translation) of literature for adult education.

3. Training literacy functionaries

4. Undertaking motivational and environment building activities for adult education.

5. Multimedia works

6. Running of field programmes

7. Action research, evaluation and monitoring of literacy projects.

8. Undertaking innovative projects to identify future need of literacy programmes.

The target for the XI Plan is to achieve 85% literacy by 2012.The target for male literacy is 90% and for female literacy is 80%.The gender gap in literacy is to be reduced to 10% along with bridging of regional, social and gender disparities.The illiterates in the 35+ age-group are also expected to be covered through a computer based self learning system.New models of continuing education will be developed to reach a much higher level of literacy.The goals as laid down in the Approach Paper of the Planning Commission would mean that a new age-group (35+) would be added to the target.This would mean a target of covering 259.52 million illiterates during the XI Plan.In addition, there are already 124 million neo-literates whose needs for lifelong learning have to be addressed.

Revised strategy for the XI Plan:

The existing schemes of Total Literacy Campaign (TLC), Post Literacy Programme (PLP) and Continuing Education Programme (CEP) have been amalgamated into a single scheme known as 'Adult Education & Skill Development'. The thrust of the programme would be on addressing the learning needs of the illiterates and neo-literates, providing them with opportunities of lifelong learning and skill development, and linking them with issues of rights, governance and livelihoods.The new programme to be launched after amalgamating the TLC, PLP and CE stages is called Lifelong

Education and Awareness Programme (LEAP). The main features of the LEAP are:

1. Different types of learning packages and learning programmes to suit the needs of various categories of beneficiaries.

2. Life Skills Education with focus on communication skills, problem solving skills, entrepreneurial skills etc.

3. Inforamtion window on Health, Rural Development, Environment Conservation etc.

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4. Target Specific Programme particularly Equivalency Programmes to mainstream the neo-literates and others with the formal system.

5. Rural libraries with focus on neo-literates literature.

6. Awareness Programmes to discuss on issues like RTI, REGP, NRHM, HIV/AIDS etc.

Conclusion:

India still needs to improve its educational achievements. It has large deficits on important quantitative education indicators (average years of education and net secondary enrolments) and demand for workers with technical/vocational skills seems to be falling. In addition little is known about qualitative indicators because India does not participate in standardized international examinations, there are no good comparative measures of quality. In comparison, most East Asian and OECD countries have comparative surpluses in the quantitative measures, although some of the Latin American countries are doing just as poorly as India. The comparative shortfall in the number of educated workers in India reflects inadequate investment in education in the past. However, any shortfall in the future flow of educated entrants to the labor market should be minimized. As the previous section showed, demand for educated/skilled workers in India is rising. In order to maintain high levels of productivity and compete effectively with rapidly growing economies, India will need to develop policies to ensure that more people acquire higher quality education and more skills.

Health

Health is the level of functional and (or) metabolic efficiency of a living being. In humans, it is the general condition of a person in mind, body and spirit, usually meaning to being free from illness, injury or pain (as in "*good health*" or "*healthy*").The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health. The maintenance and promotion of health is achieved through different combination of physical, mental, and social well-being, together sometimes referred to as the "health triangle.

Systematic activities to prevent or cure health problems and promote good health in humans are delivered by health care providers. Applications with regard to animal health are covered by the veterinary sciences. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of healthy communities, healthy cities or healthy environments. In addition to health care interventions and a person's surroundings, a number of other factors are known to influence the health status of individuals, including their background, lifestyle, and economic and social conditions; these are referred to as "determinants of health"

Key factors that have been found to influence whether people are healthy or unhealthy include:

- Income and social status
- Social support networks
- Personal health practices and coping skills

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- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Healthy child development
- Biology and genetics
- Health care services
- Gender
- Culture

Rural Health Projects

In developing nations like India, non-profit organizations often join hands with corporate houses to execute rural health projects and bring about improvements in the health levels of rural people.

TeleDoc, a project carried out by Jiva Institute of Faridabad, India, used leading-edge communications technology to bring high-quality healthcare and health related information directly to rural villages. This low-cost, highly effective and broadly applicable networking solution was developed and executed by Partap Chauhan, an Indian Ayurvedic doctor known for his pioneering work in online Ayurvedic medicine, and Steven Rudolph, an American educationist and researcher. In 2003, this project won the World Summit Award in the e-Health category.

Eula Hall founded the Mud Creek Clinic in Grethel, KY to provide free and reduced priced healthcare to the insured and under-insured in the mountains of Appalachia.

Issues in rural health

- Underserviced delivery due to a lack or maldistribution of resources, both in terms of money and labour.
- Lack of specialty services. Medical specialists often do not have enough 'critical mass' of patients to allow them to economically serve a low population area. The hardship on patients can be particularly demanding in some illnesses, say cancer, in which treatment requires regular long distance travel.

Urban Health Projects

In urban areas we have local self governing bodies having three tier administrations.

- Medical officer in charge
- Zonal office in charge
- The chief executive in charge

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Health Care Delivery in India

Among the major public health programmes, the Maternal and Child Health Services constitute an integral part of the family welfare programmes and occupy an important place in the socio economic development planning. It also plays a crucial role in human resource development and in improving the quality of life of the people. The Government has sponsored immunization schemes for infants and children against nutritional anemia among mothers and children and prophylaxis against blindness due to vitamin 'A' deficiency are also in operation. Programme for oral rehydration therapy is another important child survival scheme. Diarrhea disease is a major health problem in India especially among children below five years of age.

To liberate the children from common communicable diseases, the expanded programme of Immunization (EPI) was started by the Governments of India in 1978. The objectives of the programme are to reduce morbidity and mortality due to diphtheria, pertussis and tetanus, poliomyelitis, tuberculosis and typhoid fever by making vaccination services available to all eligible children and pregnant women.

Universal Immunization Programme (UIP) is an important step towards achieving the goal of Health for All by the Year 2000. The programme was dedicated to the memory of the former Prime Minister, Mrs. IndiraGandhi. Under the UIP, it was proposed to cover all eligible infants and pregnant mothers by the end of 1990. A "Technology Mission on Immunization" has been launched covering all aspects commencing from research and development to actual delivery of services to the affected population.

Urban Malaria Scheme was initiated in November 1971. The main objective of the scheme is to control malaria transmission by eliminating aquatic stages of vector mosquitoes by weekly application of larvicides in breeding sources. The scheme has at present been sanctioned for 133 towns distributed over 17 states and two Union Territories.

National Filarial Control programme was taken up in urban areas from 1955 in order to contain the diseases. Anti-larval and antiparasitic measures are being taken in 199 towns distributed in 13 states and four Union Territories.

Tuberculosis is a major public health problem in the country. The National Tuberculosis Programme was launched in 1962. A total of about 46,000 beds are functioning in the country for treatment of seriously sick and emergent TB patients.

Leprosy control programme has been in operation since 1955 but it was only after 1980 that it received a high priority and it was redesigned as National Leprosy Eradication Programme (NLEP) in 1983 with the goal of arresting the disease in all known leprosy patients by the year 2000.

Kala-azar which was almost on the verge of eradication, reappeared in Bihar in 1970s and in West Bengal during 1977. Later it spread to more states. The Kala – azar unit of National

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Malaria Eradication Programme (NMEP) is monitoring the Kala-azar situation along with the incidence of Japanese Encephalitis in the country.

National AIDS Control Programme has emerged as a devastating fatal disease. Up to April 1989, as many as 2, 55,589 risk persons were screened. Of these, 941 have been HIV positive. Amongst these, as many as 29 are the full blown cases of AIDS which include 11 foreigners. The Government of India constituted a task force in the year 1985 under Indian Council of Medical Research and established two surveillance centers, viz., National Institute of Virology, Pune, and Christian Medical College, Vellore to screen high risk people for AIDS. An AIDS cell has been established in the Directorate General of Health Service to coordinate all activities pertaining to AIDS control. At present, 40 surveillance centers and four referral centers are available in the country.

Apart from the above national health programmes, there are programmes like, National Programme for Control of Blindness, National Mental Health Programme, Sexually Transmitted Diseases Programmes and National Goiter Control Programme.

In India, more than nine million people live in slums of which 12,50,000 are in Bombay, 11,00,000 in Calcutta, 9,00,000 in Madras and 7,00,000 are in Delhi. It is no wonder that slum dwellers should be the victims of air—borne and water-borne infections, and should suffer from nutritional deficiencies as also from undiagnosed mental illness. The disorganizations in various aspects of life breed apathy and psychology of defeat which is manifested in fatalism, crime or lack of enthusiasm about preventive aspects of health, although offered free of charge.

Health Insurance

Health insurance in a narrow sense would be ‘an individual or group purchasing health care coverage in advance by paying a fee called *premium*.’ In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individualsand households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

- Voluntary health insurance schemes or private-for-profit schemes
- Employer-based schemes
- Insurance offered by NGOs / community based health insurance, and
- Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer’s

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income. In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes. The Life Insurance Corporation offers *Ashadeep Plan II and Jeevan Asha Plan II*. The General Insurance Corporation offers Personal Accident policy, *Jan Arogya policy*, *Raj Rajeshwari policy*, *Mediclaim policy*, *Overseas Mediclaim policy*, *Cancer Insurance policy*, *Bhavishya Arogya policy* and *Dreaded Disease policy (Srivastava 1999 as quoted in Bhat R & Malvankar D, 2000)*

Insurance offered by NGOs / community-based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits. Some examples of community-based health insurance schemes are discussed herein.

-Employed Women's Association (SEWA), Gujarat: This scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. The enrolment in the year 2002 was 93 000. This scheme operates in collaboration with the National Insurance Company (NIC).

Tribhuvandas Foundation (TF), Anand. This was **e**stablished in 2001, with the membership being restricted to members of the AMUL Dairy Cooperatives. Since then, over 1 00 000 households have been enrolled under this scheme, with the TF functioning as a third party insurer.

The Mallur Milk Cooperative in Karnataka established a CBHI scheme in 1973. It covers 7 000 people in three villages and outpatient and inpatient health care are directly provided.

The Action for Community Organization, Rehabilitation and Development (ACCORD), Nilgiris, Tamil Nadu was established in 1991. Around 13 000 *Adivasis* (tribals) are covered under a group policy purchased from New India Assurance.

Another scheme located in Tamil Nadu is **Kadamalai Kalanjia Vattara Sangam (KKVS),** Madurai. This was established in 2000 and covers members of women's self-help groups and their families. Its enrolment in 2002 was around 5 710, with the KKVS functioning as a third party insurer.

The Voluntary Health Services (VHS), Chennai, Tamil Nadu was established in 1963. It offers sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, with the VHS functioning as both insurer and health care provider. In 1995, its membership was 124 715. However, this scheme suffers from low levels of cost recovery due to problems of adverse selection.

Raigarh Ambikapur Health Association (RAHA), Chhatisgarh was established in 1972, and functions as a third party administrator. Its membership in the year 1993 was 72 000. The terms "public" and "private," although not precise, are often used as descriptors for health-care

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systems. In general, "public" refers to government involvement, while "private" may refer to involvement by businesses, charitable organizations or individuals.

A. Public Financing

In publicly financed systems, there is considerable government involvement in funding health services. There are two types of public financing: (1) tax-based financing; and (2) social security financing.

B. Private Financing

Essentially, there are two categories of private financing: (1) private insurance; and (2) out-of-pocket payments.

1. Private Insurance

When private insurance is used to finance health services, patients pay a premium and are usually required to pay a deductible or co-insurance. The insurer covers the remaining costs. Participation in a private insurance scheme is voluntary and premiums are typically based on the insuree's level of risk.

2. Out-of-pocket Payments

Out-of-pocket payments involve payment, by the patient, of a fee charged for the provision of health services. As noted above, out-of-pocket payments may be required in both private insurance schemes and public health-care insurance plans. The highest out-of-pocket payments are incurred when there is no form of insurance to cover the cost of health services. In these cases, patients pay for the service in its entirety.

C. Public and Private Delivery

Publicly delivered health care is provided by non-profit public-sector practitioners in publicly owned facilities. Funding for these systems typically comes from the public sector. Denmark and Norway are examples of countries that deliver the majority of health services in this way, although a portion of services in all OECD countries are publicly owned and publicly delivered.

The Comparative Approach and Domestic Policy-Making

The comparative analysis of social policies, or "cross-border learning," has grown rapidly in recent years. In the context of health-care systems, Marmor and Okma argue that the growth of comparative analysis is linked to three developments:

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- Funding for health care is a major expenditure in most developed welfare states, and the fiscal strain of the 1980s and 1990s resulted in greater policy scrutiny;
- The maintenance of existing programs has taken priority over bold fiscal expansion; and the post-war consensus on the welfare state is eroding.

Conclusion

The 1960s and 1970s were a period of health-care socialization in OECD countries, while the 1980s and 1990s were a period of health-care privatization. Increased private-sector involvement in health care has been achieved through cost containment strategies, delivery reforms and new methods of allocation. In general, private financing has increased, while access to some services has decreased.

High public debt, the desire for efficiency, and an aging population have all contributed to the increased reliance on private-sector resources for financing and delivering health care. In the future, we will likely see an increased emphasis on promoting healthy lifestyles, preventing illnesses, and maintaining the quality of health-care systems in OECD countries. Addressing these objectives while maintaining costs in the face of increasing demands will likely require even greater private-sector involvement in health-care systems. As a result, we are likely to see further government withdrawal from the health-care sector in most OECD countries, a trend that is consistent with government withdrawal from other sectors.

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