KURUKSHETRA

Introduction:

- In this changing world, with unique challenges that threaten the health and well – being of the population it is imperative that the government and community collectively face these challenges inclusively and sustainably, the future of a healthy India lies in mainstreaming the public health agenda in the framework of sustainable development.
- The **ultimate goal of great nation would be one where the rural and urban divide has reduced to a thin line**, with adequate access to **clean energy and safe water**, where the best of health care is available to all, where the governance is responsive, transparent and corruption free, where poverty and illiteracy have been eradicated – a health nation that is one of the best places to live in.
- No community and society can be successful sans cleanliness. The goals related to education, health, poverty alleviation, human development etc. cannot be achieved in the absence of cleanliness
- Cleanliness also contributes significantly in the economic development of the nation

Health facts:

- Stunting has declined from 48% in 2005-06 to 38.4% in 2015-16, Similarly, underweight prevalence has reduced by 0.68 percentage points from NFHS-3 to NFHS-4.
- According to the National Family Health Survey -4 (NFHS-4), over one – third of all under – five children are stunted (Low health for age), every fifth child is wasted (low height for age), and more than 50% children are anaemic.
- Further, half of women in the reproductive age – group are anaemic and only 10% of children between the ages of 6 and 23 months are receiving an adequate diet.

- A 2017 report published by save the children indicates that over two – third of the world's stunted children live in 10 countries. In this list of 10 countries, India is ranked at number 1 with an estimated 48.2 million stunted children.
- According to National Family Health Survey – 4 (NFHS-4), 31.5 per cent of the currently married women aged 20-24 were married before 18 years of age and 24.4 percent of men aged 25-29 years were married before 21 years of age in rural India.
- National mental Health Survey (2015-16) Report showed a prevalence rate of 0.8% (CI 0.3 – 1.4 for depression among 13-17-year-old adolescents.
- As per national mental Health Survey (2015-16), the prevalence of mental disorders in the age group 13-17 years was 6.9 percent in rural areas.
- As per NFHS-, 9.2 percent of girls (15-19 Years) from rural areas were either pregnant or have already given birth to a child.
- According to Global youth Tobacco Survey14.6 percent of students in class 8th – 10th used any form of tobacco; 4,4 percent smoke cigrettes; 12.5 percent currently used other forms of tobacco.
- According to NFHS-4 data adolescent age group (10-19 years) forms about one fifth (19.5%) of the total population of India. This age group when dived further into early (10-14 yrs) and late adolescence (15-19 yrs) group they form 10.1 percent and 9.4 percent of the total population of the country. The adolescent age group (10-19years) comprises 20.2 percent of the rural population of India.
- Data from NFHS-4 showed that 10.2 percent of adolescent females (10-19yrs) never went to school. Similarly, about 7.5 percent male adolescent had no schooling.

Ayushman Bharat

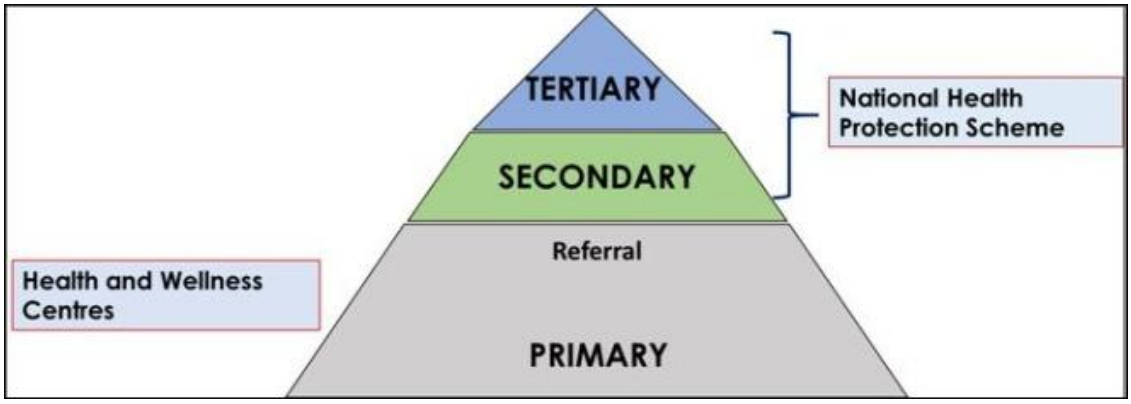
- Under the ambit of Ayushman Bharat, a Pradhan Mantri Jan Arogya Yojana (PM-JAY) to reduce the financial burden **on poor and vulnerable groups** arising

out of catastrophic hospital episodes and **ensure their access to quality health services** was conceived.

- PM-JAY seeks to accelerate India's progress towards achievement of **Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).**
- Pradhan Mantri Jan Arogya Yojana (PM-JAY) will provide financial protection (Swasthya Suraksha) to **10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families** as per the latest Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries). It will have offer a benefit cover of Rs. 500,000 per family per year (on a family floater basis).
- PM-JAY will cover medical and hospitalization **expenses for almost all secondary care** and most of **tertiary care procedures**. PM-JAY has defined 1,350 medical packages covering surgery, medical and day care treatments including medicines, diagnostics and transport.
- To ensure that nobody is left out (especially girl child, women, children and elderly), there will be no cap on family size and age in the Mission. The scheme will be cashless & paperless at public hospitals and empanelled private hospitals.
- The beneficiaries will not be required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. The scheme is an entitlement based; **the beneficiary is decidedon the basis of family being figured in SECC database.**
- When fully implemented**, the PM-JAY will become the world's largest government funded health protection mission**
- Ayushmanbharat comprises of two pillars, the **first is the provision of universal** and **comprehensive primary health care (CPHC**) delivered in formulation of health and wellness centre (HWC) which are the transformed first two tiers of the public health system (sub health Centres and primary health centers)
- Ayushman Bharatwith its two components, Health& Wellness Centres (H & WCs) and PM Jan Arogya Yojana (PMJAY). The success of the

ayushmanbharatrests on the health systems strengthening achieved through the national health mission

- It is an attempt to move **from Sectoral and segment approach of health service delivery to a comprehensive system based one.**
- It undertakes path breaking interventions to holistically address health; adopting a continuum of core approach. Addressing prevention, Promotion, primary and ambulatory care; as well as secondary and territory care requiring hospitalized treatment.



Poshan Abhiyan

- Acknowledging malnourishment as a major challenge POSHAN Abhiyaan was launched by the Prime Minister in March, 2018 with the aim of improving nutritional outcomes for children, pregnant women and locating mothers.
- It is an ambitious Mission that targets prevention and reduction of under nutrition Across the life cycle – as early as possible, especially during the first two years of life. Through a targeted approach, technological interventions and convergence, the program strives to address malnutrition holistically.
- Early onset of malnutrition causes irreversible damagewith reduced cognitive and physical growth and development, increased susceptibility to diseases, diminished capacity to learn, poor performance in school and a lifetime of lost earning potential.

- This, in order to fully realize the potential of our children, capitalize on our demographic dividend and catalyse economic growth, urgent measures are necessary as nutritional deficiencies in childhood have a compound effect in adulthood, both in the short and long term.
- Determinants of Malnutrition: There are several underlying determinants of malnutrition including lack of access to health services, safe drinking water, sanitation and household food security as well as unhealthy behavioural practices.
- As a result, both direct and indirect interventions in areas like agriculture, education, drinking water, sanitation and gender equity, impact outcomes in nutrition for instance, several studies have highlighted the link between inadequate sanitation, diarrhea and stunting in children.
- Similarly, a greater influence of women in household decisions plays a major role in the nutritional choices made by households. This means that implementing programs in a fragmented manner can contribute significantly to the persistence of malnutrition.

Adolescent Health:

Government Initiatives for Adolescent Health:

- **School Health programme:** To handle the health problems/requirements of the 6-18-year age groups in the Government & Government aided schools. Preventive biannual health check – ups and screening for diseases, deficiency, and disability amongst school going adolescents.
- **Rashtriya Bal SwasthyaKaryakram (RBSK):** A systemic approach of early identification and early intervention for children from birth to eighteen years to cover 4 'D's viz. Defects at birth, deficiencies, Diseases, Development delays including disability.
- **Kishori Shakthi Yojana:** To improve the nutritional, health and development status of adolescent girls, promote awareness of health, hygiene, Nutrition, and family care. This scheme is replaced by scheme for adolescent Girls.

- **Balika Samridhi Yojana:** To Change negative family and community attitudes towards the girl child at birth, improve enrolment and retention of girl children in schools and raise the age at marriage of girls.
- **Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-SABLA:** Self Development, improvement in nutritional and health status, promote awareness about health, hygiene, upgrade their home – based skills and tie up with National Skill Development program (NSDP) for vocational skills.
- **Integrated Child protection Scheme (ICPS):** To build a protective environment for children in difficult circumstances through Government – Civil Society Partnership.
- **Adolescence Education Programme:** Aims to empower young people with accurate, age – appropriate and culturally relevant information, promote healthy attitudes.
- **National Programme for Youth and Adolescent Development:** To develop leadership qualities and to channelize their energy towards socio – economic development and growth of the nation.
- The main health issues faced by the adolescents include mental health problems, early pregnancy and childbirth, HIV / STI and other infectious diseases, violence, unintentional injuries, malnutrition and substance abuse. Addressing the challenges during this phase with relevant information on various facets of life can go a long way in easing the transition of young girls to womanhood and promoting a healthy and productive lifestyle amongst young girls and their familes.

Scheme for Adolescent Girls (SAG):

- Objective: To Facilitate, educate and empower Adolescent Girls so as to make them self-reliant and aware citizens.
- To Focus on Out – of – school adolescent girls in the age group of 11-14 years.

- With the expansion of the scheme to all the districts of the country, the kishori Shakti Yojana has been phased out.
- To be implemented using the platform of Anganwadi services of Umbrella ICDS scheme through Anganwadi centers (AWCs).
- Services: Provision of nutrition, Iron and Folic Acide (IFA) supplementation, Health checkup and Referral Services, Nutrition & Heath Education (NHE), Mainstreaming out of school girls to join formal schooling, bridge course / skill training, Life skill Education, home management etc. and counselling on accessing public services

Tribal health problems and solution:

- India is a home to large variety of indigenous people, they represent one of the most economically impoverished and marginalized groups. With a population of more than 10.2 crores, india has the single largest tribal population in the world.
- According to census 2011, the tribes (ST) groups and among them 75 are considered as particularly vulnerable Tribal Group (PVTG) and each group vastly different from the other from ethnic and cultural stand points.
- Geographically they are spread in almost all states and union territories but the greatest numbers are in
- Madhya Pradesh (12.2 million, or 20.3% of the state's population),
    - ✓ Maharashtra (8.58 million or 8.9%),
    - ✓ Odisha (8.15 million or 22.1%),
    - ✓ Jharkhand (7.1 million or 26.35%),
    - ✓ Chhattisgarh (6.16 million or 31.8%),
    - ✓ Andhra Pradesh including Telangana (5.02 million or 6.6%), and
    - ✓ West Bengal (4.4 million or 5.5%)
- By proportion, however, the populations of states in the **North east** have **the greatest concentrations of STs**, i.e., Thirty one per cent of the population of Tripura, 34% of Manipur, 64% of Arunachal Pradesh, 86% of Meghalaya, 88% of

Nagaland, and 95% of Mizoram are scheduled tribes. Other heavy concentrations are in Dadra and Nagar haveli, and Lakshadweep (94%) (Akhter & Akhter, 2018; Guruswamy, 2016; Bisai et al 2014;)

- Most tribal people are poor and they live in remote rural hamlets in hilly, forested or desert areas where illiteracy, tough physical environments, malnutrition, inadequate access to potable water, lack of personal hygiene and sanitation make them more vulnerable to disease and as a result they have worse health indicators than the general population.
- This is compounded by the lack of awareness among these populations about the measures needed to protect their health, their belief system and indigenous practices, their distance from medical facilties, the lack of all-weather roads and affordable transportation, insensitive and discriminatory behavior by staff at medical facilities, financial constraints and so on.
- Further their over dependence and faith on unqualified local traditional health providers adds to their woes. Government programs to rais their health awareness and improve their accessibility to primary health care could not bring about desired impact.
- Not surprisingly, tribal people suffer illness of greater severity and duration, with women and children being the most vulnerable.
- Cultural practices such as high level **of consanguineous marriages** among the tribes may lead to hereditary diseases such as sickle cell anaemia, G6PD and thalassemia.
- They have high feritility rates (TFR-2.48 as per NFHS-4) followed by low institutional delivery rates (68 percent) and higher maternal mortality and infant mortality (IMR-44.4) compared to national average. Immunization status is by and large poor among them. The tribal population has high prevalence of malnutrition- stunting and underweight – especially among preschool children and anaemia among the women in general.

Tele – medicine:

- The problem India's poor public health infrastructure at rural and small city level can be solved by tele medicine. India has roughly 550 million internet users today out of which210 million users are rural areas.
- A 210 million rural population today have access to internet that makes tele medicine one of the strongest solutions for India's poor health infrastructure in rural pockets
- It will be quite ignorant to say that there is nothing happening in Tele – medicine in the country. Biggest steps have been taken by the government itself through programs such as:
- **Accredited social Health activists (ASHAs**) who are part of the Government of India's (GOI) **National Rural Health Mission (NRHM)** are using basic tele – health programs for pregnant women and children.
- Ministry of Health & Family welfare has undertaken various initiatives using information & Communication technologies (ICT) for improving efficiency & effectiveness of the public healthcare system

In India, telemedicine programs find their support in the following:

- Department of Information Technology (DIT);
- Indian Space Research Organization;
- NEC Telemedicine program for North – Eastern states; & state Governments.