

Health class ppt

As of 8 May 2025 MMR of India is 93 death per 1 lakh of women and target according to SDG-3 (Good Health and Well being) is 70 women per 1 lakh women.

Key highlights of the survey (All India level)

Indicator	NFHS 5 (2019-21)	NFHS 4 (2015-16)	Changes from NFHS 4 to NFHS 5
<ul style="list-style-type: none"> Total Fertility Rates (TFR) (an average number of children per women) 	2.0	2.2	
<ul style="list-style-type: none"> Sex ratio of the total population (females per 1,000 males) This is the first time, in any NFHS or Census, that the sex ratio is skewed in favour of women. 	1,020	991	
<ul style="list-style-type: none"> Neonatal mortality rate (NMR) 	24.9	29.5	
<ul style="list-style-type: none"> Infant mortality rate (IMR) 	35.2	40.7	
<ul style="list-style-type: none"> Under-five mortality rate (U-5 MR) 	41.9	49.7	
<ul style="list-style-type: none"> Women age 20-24 years married before age 18 years (%) 	23.3%	26.8%	
<ul style="list-style-type: none"> Institutional births 	88.6%	78.9%	
<ul style="list-style-type: none"> Children under 5 years who are stunted (height-for-age) Children under 5 years who are wasted (weight-for-height) Children under 5 years who are underweight (weight-for-age) 	35.5% 19.3% 32.1%	38.4% 21% 35.8%	

Neonatal Period – The first 28 days after birth.

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- Key trends

Specification	2013-14	2017-18	Changes from 2013-14 to 2017-18
Out-of-pocket expenditure (OOPE) as a share of total health expenditure (THE)	64.2%	48.8%	
Share of Government health expenditure in the total GDP of the country	1.15%	1.35%	
Share of Government Health Expenditure in THE	28.6%	40.8%	
Government health expenditure in per capita terms	₹1,042	₹1,753	
Share of primary healthcare in current Government health expenditure	51.1%	54.7%	
External/ Donor Funding for health as per cent of THE	0.3%	2.3%	
<ul style="list-style-type: none"> Other findings <ul style="list-style-type: none"> Primary and secondary care accounts for more than 80% of the current Government health expenditure. The share of social security expenditure on health, which includes the social health insurance programme, Government financed health insurance schemes, and medical reimbursements made to Government employees, has increased. 			

Issues wst HealthCare System (COVID)

- ↳ Lack of **basic Infrastructure**
(eg: 8.5 beds | 10,000 citizens)
1 doctor | 1456 ps " (WHO: 11/1000)
1.7 Nurses | 1000 " (WHO: 3/1000)
- ↳ **Uneven distribution** (Rural - Urban divide)
- ↳ **Pvtization of HealthCare**
(+) Denial of HC by pvt sector during COVID
- ↳ Gaps in **Urban Health Inf.**
- ↳ **Negative perception** of medical career
- ↳ dysfunctional state of **Integrated Disease Surveillance Prog^{me} (IDSP)**
(lack of manpower, resources, failed to create robust database)
monitor disease trends \downarrow (+) detect (+) Respond
- ↳ Gaps in care of **Non-COVID** patients
- ↳ India's dependence on Imports of API
- ↳ lack of faith in traditional medicinal system
↳ Lack of 'preventive Care' (< 7% spending)

SHORT- TERM	LONG- TERM
<ul style="list-style-type: none"> ① Reduce the chances of hospital-acquired infections ↳ Ensure non-cond patients are not denied services ↳ Disruption of immunization as well as other programme to be addressed ↳ Supply of affordable medicines ↳ Use of tech⁹⁴ (for contact tracing) eg: AROGYA SETU ↳ "Inter-faith Corona Coalition" ↓ to engage religious communities in action against covid-19 	<ul style="list-style-type: none"> ↳ Upgradation of health <u>infrastructure</u> ↳ More focus on <u>PHC</u> ↳ Improve <u>pharma supply chain</u> ↓ diversify source of raw materials & destination for products ↳ <u>Innovation</u> : eg: mobile hospitals etc ↳ Creation of <u>Central Bed Bureau</u> ↳ Promote <u>Preventive + Promotive</u> health ↳ Boost Pvt sector Investment through <u>PPP.</u> ↳ <u>Regulation</u> of pvt sector ↳ Implementation of <u>National health policy</u> ↳ Creation of <u>Centralised HMIS</u>.

Universal Health Coverage

- ① What is UHC :-
 -) Equity in health services
 -) Quality
 -) protection of people against financial risk.
- ② Prospects :-
 -) It is a catalyst for socio-eco dev⁺
 -) ensures social justice, equity, inclusive growth, end to extreme poverty.
 -) Helps in aiding **SDGs** such as
goal 1 (poverty), goal 4 (edu'), goal 10 (inequality),
goal 5 (gender equality), goal 8 (work & eco growth)
goal 9 (infrastructure) etc.
- ③ Barriers :-
 -) low govt. expenditure
 -) narrow interpretation of concept of 'good health'
 -) Lack of adequate infrastructure

- .) Lack of Health workforce both wrt quality & quantity.
- .) Lack of Integrated platform for data.
- .) privatization of Health care
- .) AoP expenditure.
- .) lack of use of generic medicines
- .) lack of Health insurance.
- .) Regional variations (R-v divide etc).

④ Way forward :-

- .) Community participation (all stakeholders)
- .) training, skillin^{Only deepakshar2999863@gmail.com}, retaining of health workers
- .) Prioritizing health promotion & disease prevention
- .) Strengthening legislative, regulatory framework.
- .) Robust Health Information system.
- .) More budgetary allocation
- .) Multi-sectoral approach.

Challenges in achieving Universal Health Coverage

- **Low Health care spending:** As per, the Economic Survey 2022-23, central and state governments' budgeted **expenditure on healthcare increased marginally** from 1.6% in FY21 to 2.1 % of GDP in FY23 and is **among the lowest in the world.**
- **Lack of financial protection:** As per NITI Aayog, at least 30% of the population is devoid of any financial protection for health due to **existing gaps in coverage and overlap between schemes.**
- **High out-of-pocket expenditure (OOPE):** India's OOPE as a per cent of current health spending is 47.1% in 2019-20, significantly **above the global average of 18%.**
- **Inequitable Access:** Rural communities in India suffer from significant access to healthcare such as a **lack of qualified medical professionals, physical limitations** like distance, lack of established healthcare infrastructure and inability to pay for necessary medical treatment.
 - As per the Lancet publication (2023), the provision of **core health services lacks uniformity across state-run district hospitals.** Only 16 per cent of the district hospitals in Tamil Nadu offered all key services. In states like Assam, Punjab, Madhya Pradesh, Mizoram and UP, it was found to be just 1 per cent.
- **Lack of medical manpower:** India faces a shortage of healthcare professionals, including doctors, nurses, and paramedical staff, which impacts the delivery of healthcare services.

Initiatives taken to achieve Universal Health Coverage

- **Ayushman Bharat Yojana:** It aims to undertake interventions to holistically address health at primary, secondary and tertiary level.
- **Ayushman Bharat Digital Mission:** It will improve equitable access to quality healthcare by encouraging use of technologies such as telemedicine and enabling national portability of health services.
- **National Health Policy 2017:** It aims at achieving universal health coverage and delivering quality health care services to all at affordable cost.
- **Intensified Mission Indra Dhanush:** It focusses on reaching **zero-dose children aged between 0 and 5 years** and pregnant women who might have missed any vaccine doses in the national immunisation schedule.

Way forward

- **Recommendations from report**
 - Adopting a **primary healthcare approach** can improve health systems and accelerate progress toward UHC.
 - **Expansion of essential services**, especially for Non-Communicable Diseases.
 - Removing financial barriers e.g., issues of **indirect costs** and **co-payments** in health care.
 - Strong commitments to **International Health Regulations** in acute public health risk.
- **Increase public spending:** Government spending should be increased to around 5.2% i.e., the average health spending of the Lower- and Middle-Income Countries (LMIC).
- **Address Structural Issues:** Structural weaknesses within the healthcare delivery system i.e., lack of medical supplies and healthcare workers; irrational treatments etc. can be addressed by **engaging the private sector, and civil society and expanding medical seats** etc.
- **Centre-State Coordination:** Central government should adopt a **collaborative mechanism allowing for flexible policy-making, and differential financing from the Centre to the state.**
 - This will also allow states to better meet the diverse requirements and develop health plans that are consistent with the needs and requirements of populations.

④ AYUSHMAN BHARAT PM-JAY

- ⇒ About the scheme :- (fully funded by CG, Cost of implementation will be shared b/w CG + SA). ①
-) Centrally Sponsored Scheme
 -) Objective is to health insurance cover of Rs 5 lakh per family / per year for secondary & tertiary care hospitalization to 10 cr poor + vulnerable families
 -) It has subsumed : RSBY SC - Health Insurance Scheme. * Launched in 2018 * Recommended by NHP - 2017
 -) Implementing Agency : National Health Authority
 -) No Cap on family size
 -) Identification of beneficiaries through SECC
 -) provide cashless, paperless access to services
 -) Both at Public & Pvt empanelled hospitals
 -) Covers upto 3 days (pre) + 15 days (post) hospitalization expenses
 -) free to chose basis of implementation (trust / society / mixed) (states are free to chose modalities of imp).

Prospects of PM-JAY

- .) It will help achieving UHC + SDG
- .) Strengthen public Health Care through Infusion of Insurance Revenue
- .) Enable creation of New Health Infrastructure in remote areas.
- .) Ensure improved access + affordability of quality secondary + tertiary care
- .) Reduce DoP expenditure
- .) Improvement in Quality of life
- .) Ensure transformation of HR \Rightarrow MC Capital
- .) Overall economic growth of Nation.

Analysis of PM-JAY :-

- .) **Consolidation** of health insurance schemes
 - (eg: K'taka has merged 7 existing schemes)
 - Kerala has integrated 3 diffⁿ health schemes
- .) **Expansion** of coverage :- (11 states/UT's have expanded coverage to make it universal)
 - (23, 311)
 - 12.6 cr e-cards issued.
- .) **Strong monitoring** of transactions, locating suspicious surges.
 - (341 hospitals have been blacklisted)

- # Ayushman Bharat has **2 components**
- HWC → PM-JAY
- .) Creation of **1,50,000 HWC's**, by transforming existing PHC's, SC's
 - .) to bring health care closer to people
 - .) to provide free **Essential services** + **Diagnostic services**
 - .) It covers both **MCH** + **NCD's**

CONCERN'S

- ↳ Widening Inequities :- Most top performing states are rich states except chhattisgarh.
- ↳ Lack of control over pvt sector :- Lack of implementation of clinical est. Act on pan-Indian basis
- ↳ Lack of Adequate Budgetary allocation :- 6400 Cr
- ↳ Absence of pvt healthcare Infra -
 - (only 30% hospitals are eligible)
 - (approx 1.28 hospitals empanelled for 1 Lakh ppⁿ)
 - Lack of infra to treat patients
- ↳ Lack of Quality accredited + certified hospitals under empanelled criteria (eg: Out have 18019, only 603 quality certification)
- ↳ Lack of credible data
- ↳ Ghost beneficiaries, conversion of OPD into IPD deliberately provider induced demands, hospitals charging fees etc.
- ↳ provider coverage of medicines post discharge upto 15 days only.
 - (doctors perform unnecessary procedures, treatment of diseases for which hospital is not equipped)

Key issues highlighted in the report

- **Inadequate registration:** Only 73% (7.87 crore) of the targeted households of 10.74 crore were registered.
 - The ministry has now increased the beneficiaries to **12 crore families**.
- **Irregularities in identification:**
 - Of the total registered beneficiaries, **less than 30%** (2.08 crore) were identified from the **SECC-2011 database**.
 - ✓ SECC database **does not account for economic development** and employment opportunities since then.
 - Also, there were **errors in the beneficiary database**, like invalid names and dates of birth, duplicate PMJAY IDs, etc.
- **Empanelled Health Care Providers (EHCPs):**
 - Many EHCPs **did not meet the minimum criteria and quality** of support system and infrastructure.
 - **Many beneficiaries were charged** for their treatment.
- **Financial irregularities:**
 - Many states did **not maintain a separate escrow account** for PMJAY.
 - National Health Authority (NHA) and State Health Agencies (SHAs) **did not fully comply** with the direction of **tracking the expenditure** flow through the **Public Financial Management System (PFMS)**.

- Other issues include the **release of grants** by NHA **before the implementation** of the scheme or **without ensuring the release of upfront shares** by the respective States.
- **Claim management:**
 - Inadequate validation checks like admission before pre-authorisation, **delay in payment**, **inadmissible payments** and **payment without penalty** to erring EHCPs, etc.
 - **More than half of the payment** went to **only six States** (Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra and Tamil Nadu).
- **Monitoring and Grievance Redressal:**
 - Many states did **not adopt the Whistle Blower Policy** to receive complaints relating to allegations of corruption, fraud, etc.
 - Absence of **Anti-Fraud Cells, Claim Review Committees**, etc. in several States/UT.
 - **Less than 10%** of grievances **were redressed** within a turnaround time of 15 days.

- **Registration:**
 - Devise appropriate mechanisms to ensure coverage of intended beneficiaries and to avoid delay in the registration. Information, Education, communication
 - Set up a designated IEC cell to maximise the reach of the scheme.
- **Weed out ineligible beneficiaries:**
 - Put a suitable mechanism for the identification and validation of beneficiaries' data to increase the accuracy and reliability of the data.
- **Hospital Empanelment and Management:**
 - Ensure mandatory physical verification for the empanelment of hospitals to prevent the empanelment of a de-empanelled hospital.
 - Invest in public hospitals and devise mechanisms to curb instances of out-of-pocket payments by the beneficiaries.
- **Financial Management:**
 - Ensure SHAs have designated escrow accounts for PMJAY to receive their upfront share without delay.
 - Have a mechanism to map and identify PMJAY beneficiaries to avoid overlap of PMJAY and state-specific schemes.
 - Also, implement PFMS on priority to track the flow of expenditure.

- **Claims Management:**
 - **Timely** payment of the claims **after** ensuring **necessary scrutiny** by SHA.
 - Ensure the **claim amount is utilised for improving the infrastructure**, functioning of the hospital, quality of services, etc.
- **Monitoring and Grievance Redressal:**
 - Initiate **Anti-fraud activities** on an urgent basis and **penalise defaulters** in a timely manner.
 - Ensure that **District Implementing Units** are formed in every District.
 - **Ensured effective redressal of grievances and implementation of corrective measures** for improving the working of the Scheme.

REASONS FOR LIMITED EFFECTIVENESS

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FUNDING & INFRASTRUCTURE

- Underfunded Public Health care system leading to supply (hospitals beds, doctors and nurses).
- Services and Drugs availability in hospitals.



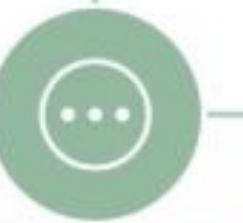
SCHEME ISSUES

- Exclusion errors in beneficiary identification due to issues in SECC and other data used,
- Limited incentives for private hospitals due to specified package rates.
- Limited Hospital Empanelment.



IMPLEMENTATION ISSUES

- Poor Regulation over Private Hospitals.
- Information Asymmetry between beneficiaries and hospitals.
- Electronic data sharing challenge due to digital infrastructure and digital literacy issues.



OTHER ISSUES

- Lack of awareness in rural areas, small towns.
- Information Asymmetry regarding health, diseases, etc. with Lock of hospitalization rate of the bottom 40% of the population (2.45%).
- Corruption, e.g. Provider induced demand.
- Demand for cash by hospitals, limited number of empanelled hospitals

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| Secondary Health Care in India

↳ Premise:) Niti Ayog released a performance assessment report
"Best Practices in the Performance of District Hospitals"

-) 1st ever assessment
-) shift towards data-driven governance for communities
+ people availing health services.
-) Jointly released :- Niti Ayog (+) MHFW (+) WHO India
By

↳ | Secondary Health Care

- 8-) 2nd tier of Health Care
-) patients from primary care are referred to specialist in higher hospitals
-) provided by district / regional hospitals

④ Global Health Security Index:

(measures pandemic preparedness of country)

India's rank (57)

US (1)

Brazil (22)

low govt spending on health care

b/w 1.2% - 1.6%
of GDP

Weak govt & accountability
eg: health tragedies such as Gorakhpur, Chhattisgarh sterilization camps

challenges wet
Secondary Health Care

On/Off

Unmanageable patient load

lack of pandemic handling capacity

Accessibility

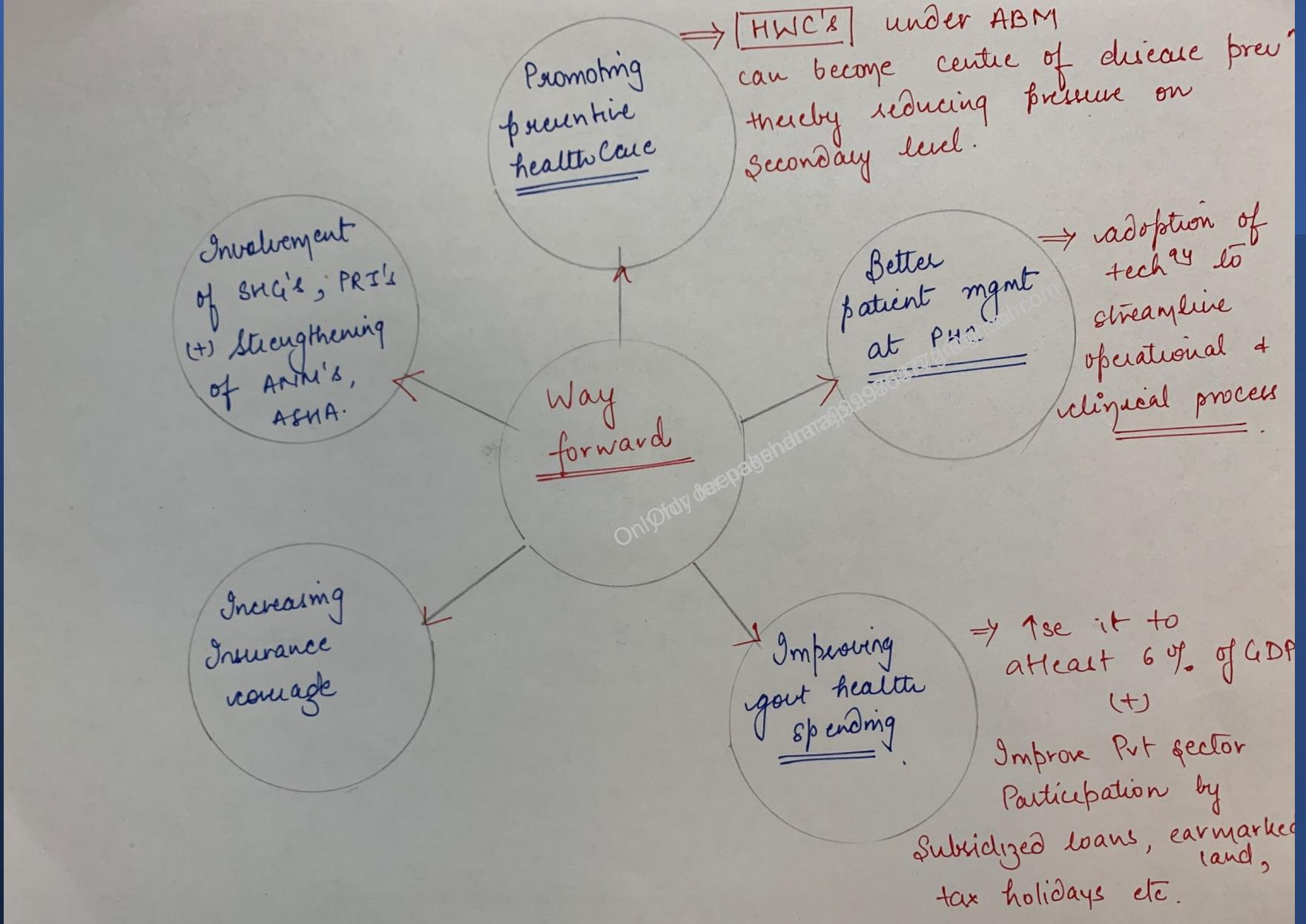
80% (Doctors)
75% (dispensaries)
60% (hospitals)
are in urban

⇒ Major challenge for Rural areas

Non-availability of skilled workforce
(esp in public hospitals)

⇒ patients will go for expensive pvt. healthcare

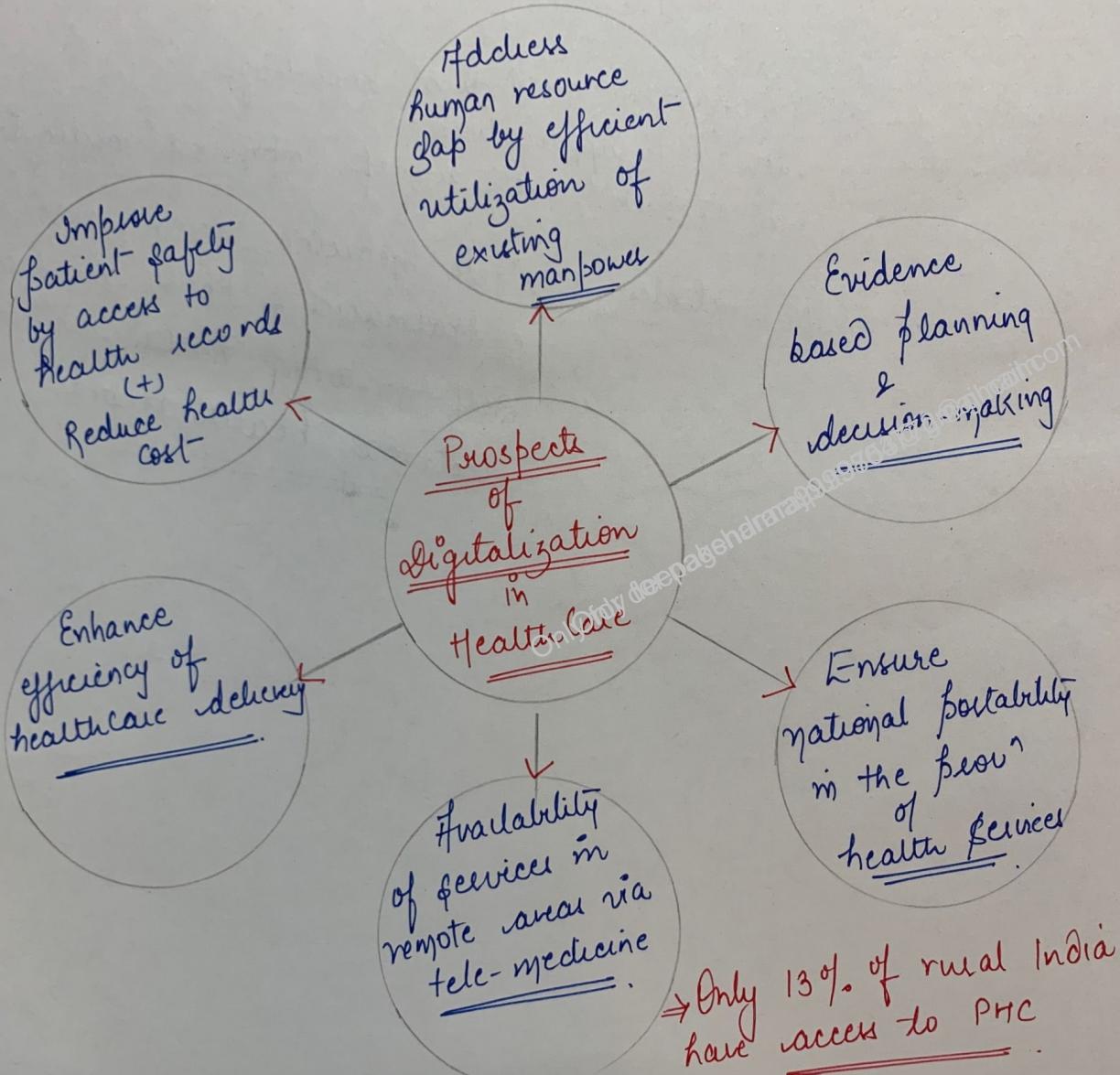
Weak PHC
It impacts filtering of patients
Impact prevention & early detection



④ | Digitalization of Health Infrastructure

↳ What is digitalization
of healthcare?

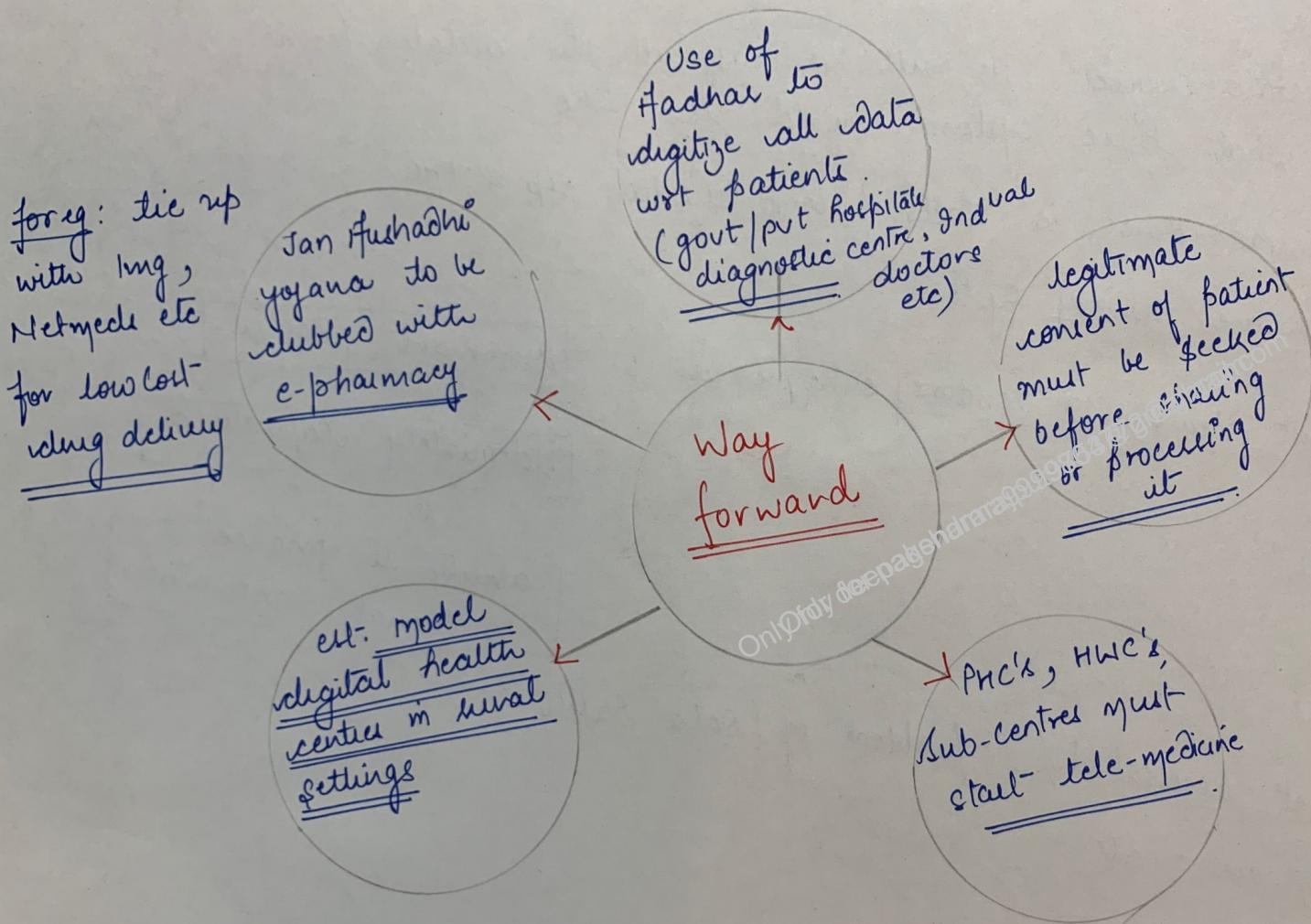
-) Integration of Medical knowledge with IT application (or IT Tech⁴ with aim of improving medical care).
-) It includes
 -) Tele-medicine, e-insurance, e-pharmacies, Robot assisted surgeries, self-monitoring health care devices, electronic health records



④ Challenges :-

- Health is a state subject. It will be difficult to dictate from central level, what these system should look like
- Under developed Infrastructure ie Lack of computerization esp in PHC.
- Fragmented HealthCare delivery system
- Lack of dominant Health IT vendors | enterprise :-
 - Dominant player
 - Inadequately capitalized
 - ability to finance continual innovation

- Lack of Internet accessibility, problem of Data Safety
- Information stds are weak.



Initiative taken to promote digital healthcare

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- ◎ **Ayushman Bharat Yojana (AYB)** to deliver a comprehensive healthcare services
- ◎ **National Digital Health Mission (NDHM)** for developing the backbone for a unified digital health infrastructure.
- ◎ **National Digital Health Blueprint (NDHB)** to transition into integrated digital services in a comprehensive and holistic manner.
- ◎ **States are supported under National Health Mission (NHM)** for services like Telemedicine, Tele-Radiology, Tele-Oncology, Tele-Ophthalmology and Hospital Information System (HIS).
- ◎ **Telemedicine Practice Guidelines, 2020** for regularization and diversification of tele-consultation services across the country.
- ◎ Digital applications like **eRaktkosh, eSanjeevani, CoWIN etc.**

About ABDM

- **Aim:** To develop the backbone necessary to support the integrated digital health infrastructure of the country.
- **Implementing Agency:** NHA under the Ministry of Health and Family Welfare.
- The digital infrastructure under the scheme is being developed by adopting **India Enterprise Architecture Framework (IndEA)** released by the Ministry of Electronics and Information Technology.
 - IndEA is holistic a framework for **streamlining, standardizing, and optimizing the e-Governance efforts across the country for interoperability and integration.**



**national
health
authority**

**National Health Authority
(NHA)**



Genesis: Set up in 2019 as a successor of the **National Health Agency**.

Ministry: **Ministry of Health and Family Welfare**

Governing Board: Chaired by the Union Minister for Health and Family Welfare

Functions: apex body responsible for-

- Implementing **Ayushman Bharat Pradhan Mantri Jan Arogya Yojana**"
- Designing strategy, building technological infrastructure and implementation of "**Ayushman Bharat Digital Mission**"

Components of the mission

Ayushman Bharat Health Account (ABHA) Number	<ul style="list-style-type: none">• A randomly generated 14-digit number generated through self-registration.• Purpose: Identifying individuals, authenticating them, and threading their health records (only with the informed consent of the patient) across multiple systems and stakeholders.
ABHA app	<ul style="list-style-type: none">• A Personal Health Records {PHR} application available on Android and iOS platforms.• Allows the self-uploading/scanning of existing physical health records such as diagnostic reports, prescriptions, etc.
Health Facility Registry	<ul style="list-style-type: none">• A comprehensive repository of all the health facilities of the country across different systems of medicine.• Includes both public and private health facilities including hospitals, clinics, diagnostic laboratories and imaging centers, pharmacies, etc.
Healthcare Professionals Registry	<ul style="list-style-type: none">• A comprehensive repository of all healthcare professionals involved in the delivery of healthcare services across both modern and traditional systems of medicine.

Challenges in the implementation of ABDM

- **Digital divide and illiteracy** make it difficult for certain sections of the population to adopt ABDM.
- **High cost of digitization of medical data.**
- **Poor interoperability between states**, with data migration and inter-state transfer facing multiple errors and shortcomings.

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- **Capacity building and digital skilling of medical professionals** needed to prepare them to use digital tools.
- **Concerns about personal data security and privacy**: For instance, the recent ransomware attack on the All-India Institute of Medical Sciences (AIIMS), Delhi has brought questions of safety and privacy.
- **Limited awareness among citizens** about the app and its use.
- **Health is a state subject**: There are state schemes and initiatives that have the same vision and mission as ABDM leading to a multiplicity of efforts. For instance, the eHealth initiative by Kerala.

Way forward

- **Protecting details of patients through methods like anonymization** and ensuring that the health records of the patients remain entirely confidential and secure.
- **Encourage Research and Development** in digital health technologies, especially in areas such as artificial intelligence, machine learning, and predictive analytics.
- **Streamlining processes and standardizing medical data** to ensure the smooth transfer of data between states.
- **Increase Public Awareness** to ensure that citizens understand how to access and utilize the digital healthcare services available.
- **Introducing the concepts of ABDM and digital health in the curriculum** for medical professionals.
- **Incentivizing private providers** to participate in the process of digitization of medical health records. E.g., the Digital Health Incentive scheme aims to incentivize stakeholders such as hospitals, labs etc. to adopt a digital health ecosystem.

Mental HealthCare

(S)

-) Premise :-
-) Acc. to National Mental Health Survey, approx, 150 mn people in India need care for mental health.
 -) (70-92 %) cases fail to receive treatment
 -) WHO says India has highest no. of teenage suicide rates
 -) It forms part of SDG-3.
-) Issues :-
-) Lack of awareness
 -) Lack of Infrastructure
 -) Stigmatization
 -) Lack of Implementation

Mental Health

- WHO defines **mental health** as state of mental well-being in which
 - people cope well with many stresses of life.
 - can realize their own potential
 - can function productively and fruitfully
 - can contribute to their communities
 - people are able to contribute to their communities
- WHO states mental illness makes 15% of total disease cond'
- Acc. to ICMR, (17) individuals in India suffer from mental health concerns.
- WHO labelled India as world's most depressing country?

.) Gout efforts :-

↳ National Mental Health Prog^{nme} (1982)

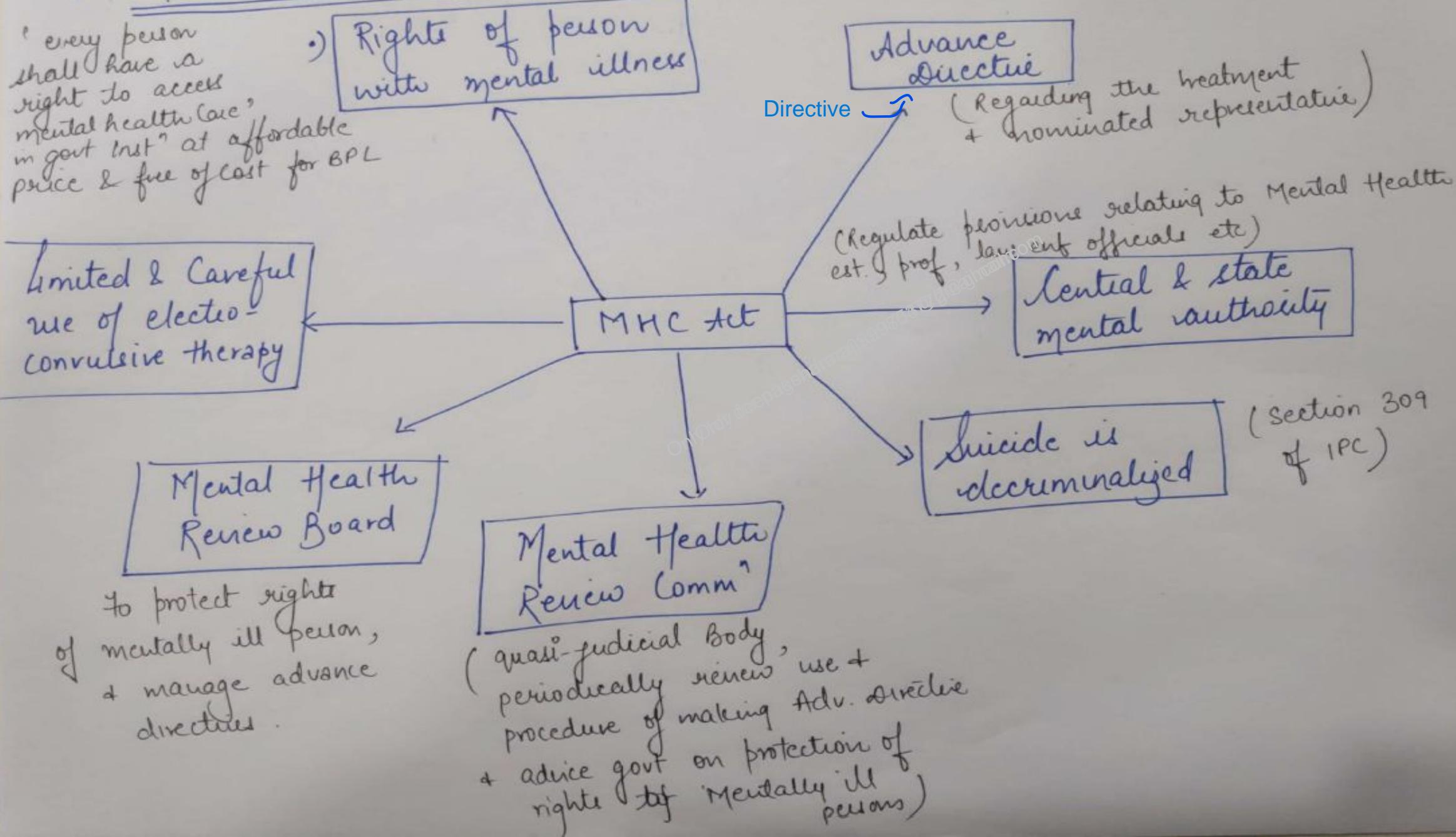
(detection, mngt + treatment)
of mental illness

↳ National Mental Health Policy (2014)

(Universal Access
strengthen L'ship in mental Healthcare
give out role for Central, state govt
local bodies, civil society etc

↳ RAAH app
(By NIMHANS, it is a mobile app which
helps people do search inf w/ wt
psychologist, therapist, psychiatrist working
with NGO's, rehab centre, hospitals etc)

⑥ Mental Healthcare Act '2017



#

CAUSES

- ① Urbanization, Modernization
- ② discrimination
- ③ Relative Deprivation
- ④ Isolation
- ⑤ Imbalance in Means + Goals.
- ⑥ Negative Impact of Social Media (FOMO)
- ⑦ objectification + Commodification
- ⑧ Hormonal factors

#

Way forward

-) Awareness abt Mental Health
-) De-stigmatization
-) Robust Infrastructure
-) Promoting Yoga, Meditation
-) Strengthening role of community
-) Tele-Medicine
-) Integrated Approach :-
 - DETECT
 - TREAT
 - MANAGE

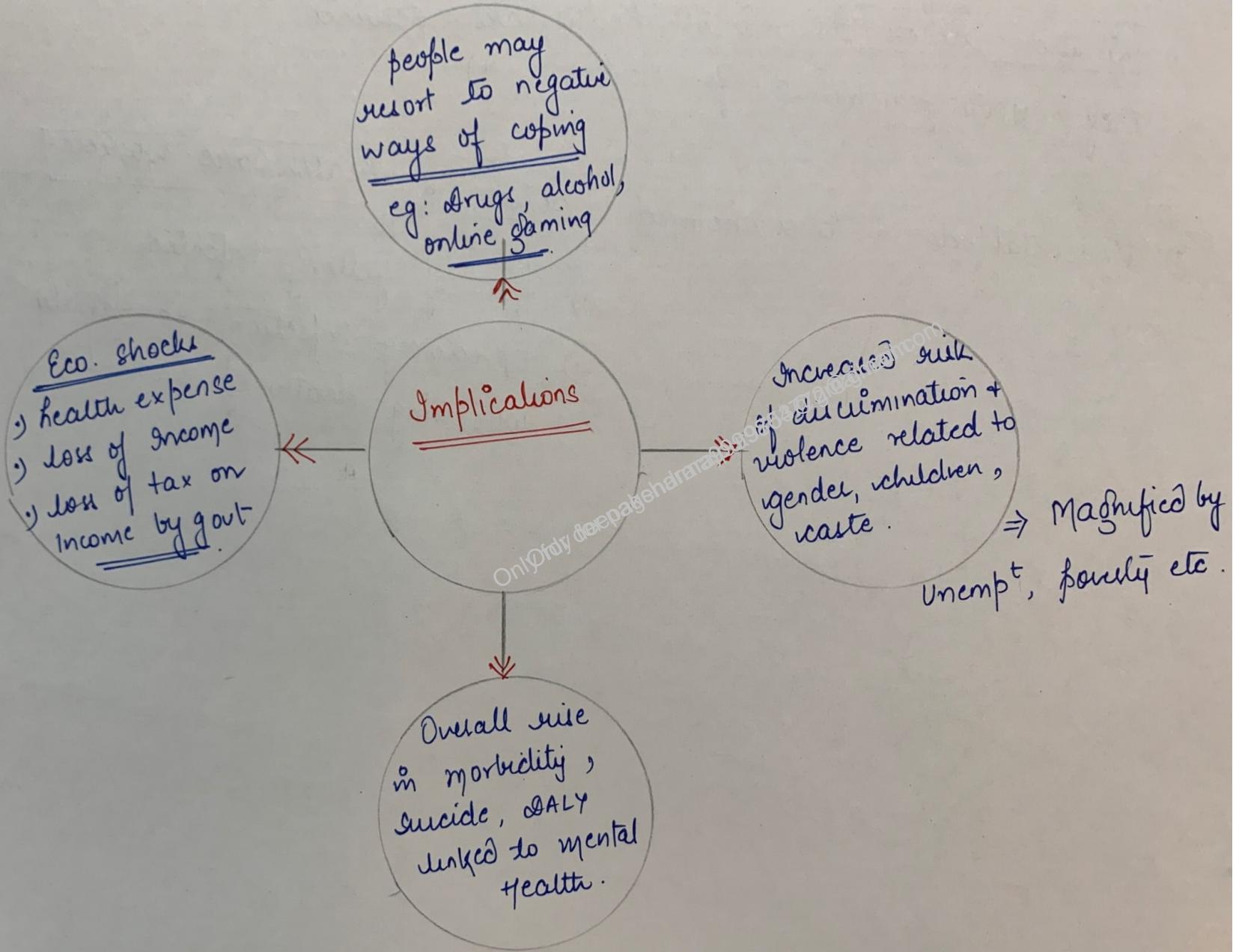
COVID-19 + Mental Health

↳ Reasons why COVID has aggravated problems of mental illness

-) Policies of Govt such as :-
 -) Social distancing
 -) Quarantine
 -) Travel restrictions
 -) Temporary closure of schools
 -) Restrictions on large gatherings
-) Generated fear, panic, anxiety, depression etc.
-) Constant fear of losing jobs / businesses, savings etc.
esp informal sector has spiked anxiety, frustration etc.
-) Stigmatization during pandemic : esp frontline workers, people who tested +ve
elderly & people with co-morbidities.

-) disrupted education, stress abt future, \Rightarrow mental health of children is impacted
victim to increased abuse etc
-) women have come under mental stress due to longer 'double shift'
along with rise in incidences of violence
-) fear of getting infected by virus (+) has aggravated mental illness among old people (+) people with comorbidities
Lack of access to appropriate care
-) lack of responsible journalism: eg:- frequent misinformation about virus
repeated media images of ill people.
dead bodies etc.
 \Downarrow
Spiked stress among people.
fear of not being with family during last time of life etc

-) Limited access to mental health care services
(eg: 9000 psychiatrists for 1.3 bn pp")
-) Understaffed + Overwhelmed Police & Health Care workers
 -) fear of getting infected
 -) spreading infection to family
 -) witnessing death of patients



- i) Sustaining & Strengthening of mental health care service should be prioritized.
- ii) Community based interventions such as SCARF's mental health mobile vans (TN) VISHRAM (Vidarbha)
- iii) Digital mediated therapy & telepsychiatry should be scaled up.