Kurukshetra Summary November 2018

AYUSHMAN BHARAT: INDIA'S ROAD TO UNIVERSAL HEALTH CARE COVERAGE

About Ayushman Bharat:

- The Ayushman Bharat scheme marks an unprecedented high-level political commitment to universal Health coverage (UHC).
- It comprises **two pillars** - the first is provision of universal and comprehensive Primary Health Care (CPHC) delivered in formulation of **Health and Wellness Centres (HWCs);** which are the transformed first two tiers of the public health system i.e. the Sub Health Centres (SHC) and the primary Health centres (PHC).
- The **second component** is the **Pradhan Mantri Jan Arogya Abhiyaan** (PMJAY) for provision of health coverage of up to Rs.5, 00,000/ family for nearly 10.34 crore Households to obtain secondary and tertiary in –patient care.
- The implementation of Ayushman Bharat rests on the health systems strengthening achieved through the National Health Mission (NHM).

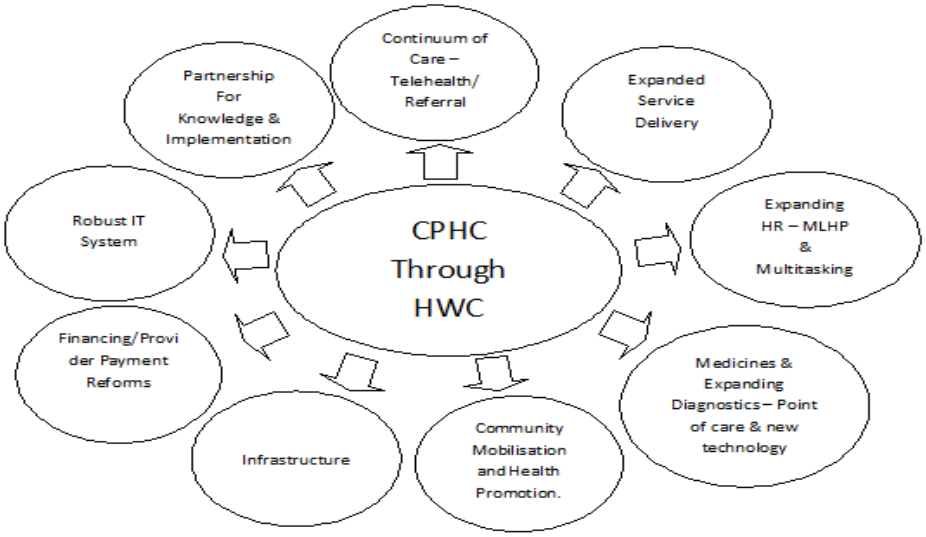
Health Statistics:

- As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS) , MMR of India has shown a decline from 167per 100,000 live births in the period 2011-13 to 130 Per 100,000 live births in the period 2014-16.
- India has thus, achieved the Millennium Development Goal (MDG) for Maternal Mortality Ratio (MMR).
- Infant Mortality Rate (IMR) is 34/1000 live births with rate of decline increasing from 2.5% in 2013 -14 to 8.1% in 2015 -16.
- The under- five Mortality Rate (U5MR) in India is 39/1000 live births with rate of decline increasing from 8.2% in 2013-14 to 9.3% in 2015-16.
- At the current rate of decline, India will achieve the Sustainable Development Goal (SDG) target of U5MR and MMR by 2023 itself.
- The country also achieved the MDG 6, which was to reverse the incidence of Malaria, TB and HIV/AIDS.
- Despite these positive outcomes, **some challenges persist**. These are - *the unfinished MDG Agenda, elimination of TB, eradication of Malaria, Kala Azar, relative lack of services for chronic diseases , inequity in access to services and fragmented and poor quality care that have forced care seeking in the private sector leading to high Out of Pocket Expenses (OOPE).*

Pillar I: HWCs

- The World Bank estimates that just 10% of medical conditions require more complex treatment in hospitals or specialist care. The delivery of CPHC through HWCs therefore becomes a necessity.

- The H&WCs are proposed to provide Comprehensive Primary Health Care (CPHC), covering both Mother and Child Health services, Communicable as well as Non-Communicable Diseases (NCD), including free essential drugs and diagnostic services.
- In addition, they will also be responsible for providing a range of preventive and life style related services such as vaccination screening for early detection of diseases as well as yoga.
- However, the transformation of HWC requires action on many fronts and coordination of multiple work streams, as demonstrated in the following diagram:



Pillar II: PMJAY

- Launched in September 2018, it has subsumed the Rashtriya Swasthya Bima yojana (RSBY) and Senior citizen Health insurance Scheme (SCHIS).
- Poised to be the largest public - funded health insurance scheme in the world, PMJAY will ensure the continuum of care from AB-HWCs and substantial reduction in OOPE on catastrophic healthcare.
- AB-PMJAY leverages on CPHC through HWCs for preventive, Promotive and curative care and will ensure seamless continuum of care.

- This will avoid overcrowding in tertiary facilities and improve quality of care at secondary and tertiary facilities as well as provide UHC, making services equitable, affordable and accessible.
- It is an entitlement based scheme which covers poor and vulnerable families based on deprivation and occupational criteria as per Socio-Economic and Caste Census (SECC) data.
- It will cover over 10 crore poor and vulnerable families (approx. 50 crore beneficiaries) providing coverage up to Rs.5 lakh per family per year for secondary and tertiary hospitalization.
- There is no limit on the family size to ensure that all members of designated families specifically girl child & senior citizen, get coverage. The AB-PMJAY is being **managed by National Health Agency (NHA).**
- There are three modes of implementing the scheme i.e. **Insurance mode, Trust Mode and Mixed Mode.**

Conclusion*:*

- In India's federal structure, the power for effective implementation vests with the states.
- No central scheme, no matter how consultative and participatory the process of design, can hope to address the challenges in implementation.
- Differences between existing health systems in states, funds availability, political, geographical and governance contexts elucidates that there cannot be a one-size-fits-all approach.
- Nevertheless, there are common strategies that can help all states expand and improve access to CPHC.
- The ability to convert vision into practice, learning from multi contextual experiences and evidence and converting them into intervention strategies, will be the true test of Ayushman Bharat.

National Health Agency (NHA):

- For focused approach and effective implementation of PM-JAY, an autonomous entity, the National Health Agency (NHA) was constituted.
- Established as a Society on 11th May 2018. The State Governments are expected to similarly set up state Health Agencies (SHA) to implement PM-JAY.
- The NHA will provide overall vision and stewardship for design, Roll - out, implementation and management of Pradhan Mantri jan Arogya Yojana (PM-JAY) in alliance with state Governments.
- It will play a critical role in fostering linkages as well as convergence of PM-JAY with health and related programs of the Central and State Governments, including but not limited to Ayushman Bharat - comprehensive Primary Health Care, the National Health Mission, RSBY to name a few.

AYUSHMAN BHARAT: SILVER LINING IN HEALTH CARE

Ayushman Bharat:

- Our National Health Policy 2017 aptly articulates healthcare goal as "attaining the highest possible level of health and well - being for all at all ages, through preventive and promotive health care orientation in all development policies, and universal access to good quality health care services without any financial hardship".
- Ayushman Bharat, with its two Components- Health & Wellness Centres (H&WCs) and PM jan Arogya yojana (PMJAY) - is an attempt to move from sectoral and segmented approach of health service delivery to a comprehensive system-based one.

Present Situation:

- Indian Health system exhibits extreme fragmentation on multiple dimensions - financing, organization and regulation. This has a major impact on the quality of care as well as overall outcomes of the Health System.
- For instance, a whopping **67% share of the overall financing** of our health system is in the from **out of pocket expenditure** by the Households, mostly at the point of care.
- If we look at the organization of care providers, 95.3% of our private health facilities are small facilities employing less than five workers. Clearly, in a situation where an overwhelming proportion of health seeking occurs directly by the households from very small private providers on paper based prescriptions, *it is virtually impossible to monitor or regulate the quality of such care provision.*
- The Government facilities face a different set of challenges in ensuring quality of care: **huge patient load, lack of accountability, absenteeism, management gaps and fixed salary based payment incentives.**
- This is further compounded by **inadequate investments** in creating an **appropriate regulatory infrastructure** and framework.
- India's healthcare sector exhibit a striking range of quality in available services - from **globally acknowledged best in class facilities** providing innovative and quality healthcare at comparatively cheaper prices to facilities that are **overburdened and/or delivering an unacceptably low level of care**.
- Recent studies have highlighted low levels of provider knowledge (both public and private sector) and have found evidence of large "**know- do gaps**" between providers' knowledge and the kind of care provided.
- The current legal framework for regulation of medical services is under the Clinical Establishment (Registration and regulation) Act , 2010, Drugs & Cosmetics Act , 1940 and the various Acts governing the profession such as Medicals Council of India (MCI) and other related Professional councils.

- The weaknesses in our regulatory framework are well documented. For instance, the Clinical Establishment Act is yet to be adopted by many of the state Governments. Even where they have been adopted, implementation remains patchy.
- The MCI has been repeatedly hauled up by the Supreme Court as well as the parliamentary standing committee on health and legislation to replace MCI by a National Medical Commission.

Impact of Ayushman Bharat:

- The fear is that by empowering the poor to access hospitalized care by providing them with financial cover, a sudden spurt in demand for health care along with very competitive reimbursement rates for the identified packages, quality may get compromised.
- However, the **potential benefits to the health system far outweighs the risk factors**.
- Besides the equity argument of ensuring access to hospitalized care to those who were so far excluded due to financial reasons , there will be **huge efficiency gains** in organizing citizen into large risk pools and Creating **big centralized players** such as the National Health Agency (NHA)and the state Health Agency (SHA) under the Ayushman Bharat.
- The **asymmetric relation** between the provider and the health Seeking households is set to **undergo a fundamental transformation**.
- From a situation where the provider calls the shot vis-à-vis unorganized households, large payers are in much stronger negotiating position to seek accountability from providers; not only in terms of the prices for services rendered but also in terms of quality.
- The **accountability is further enforced** through insistence upon compliance to empanelment norms in order to be registered as a provider with the respective NHA/SHA.
- NHA is now in the process of developing standard Treatment Guidelines (STGs). As and when the adherence to STGs is enforced, facilities will be obliged to follow the standard operating procedures rather than a free for all approach prevalent now.
- Another level to induce quality improvement by providers is through **payment based incentives**.
- For instance, the NHA has announced that National Accreditation Board for Hospitals (NABH) accredited providers will be paid 15% higher and entry level NABH facilities will be paid 10% higher for the same package than non-accredited ones.
- There is also a stated policy intent to introduce **pay-for-performance** for the health personnel in the H&WCs.
- While the detailed contours of such policy is awaited, it is believe that such payment incentives **could have transformative impact** on the quality of care transacted in these centers improving the overall efficiency of the system.
- It is also quite evident that given the measurement and data challenges that India faces , the ability of the National and the state governments to initiate the desired policy changes and to take appropriate action to improve quality of care is severely constrained .

- Another potential game changing impact of the Ayushman Bharat would be through the **establishment of the Technology platform and a common IT system** to ensure availability of real time data pertaining to health system-of course, subject to privacy constraints.
- Enormous amounts of data would now be instantaneously available for analysis to multiple researchers and enforcement authorities.

Conclusion:

- Improving the quality of health care at the system level requires a focus on governance issues, improving public-sector management, building and augmenting institutional capacities as well as promoting a culture of data- driven approach.
- Ayushman Bharat has initiated a number of these steps in the right direction.

POSHAN ABHIYAN: TOWARDS HOLISTIC NUTRITION

Statistics:

- In the last decade, India has made some improvements in tackling malnutrition. For instance, **stunning** has declined from 48% in 2005 - 06 to 38% in 2015 – 2016.
- Similarly, **underweight prevalence** has reduced by 0.68 percentage points from NFHS - 3 to NFHS -4.However, gaps remain.
- According to the National Family Health Survey 4 (NFHS – 4), over one third of all under - five children are stunned (low height for age), every fifth child has wasted (low weight for height), 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 age of 6 and 23 months are receiving and adequate diet.
- A 2017 **report published by Save the Children** indicates that over to 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.

Why we need to address this situation?

- **A World Bank estimate** indicates reducing stunning in the country can raise to the GDP of India by 4 - 11%. On the other hand, Global Nutrition Report estimates return USD 16 for every USD 1 spent on health and nutrition.
- Additionally, undernutrition is the prime risk sector in over 40% of under-five child deaths.
- Thus, while the India's infant Mortality Rate (IMR) has declined from 37 per 1,000 live births to 34 per 1,000 live births in 2016, tackling malnutrition will be crucial for bringing the IMR down further and accelerating the rate of decline.
- Early onset of malnutrition causes irreversible damage with reduced conservative and physical growth and development, increased susceptibility to diseases, diminished capacity to learn, poor performance in school and a lifetime of lost earning potential.

Determinants of Malnutrition:

- There are several underlying determinants of malnutrition including lack of access to health service, 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 diarrhoea and stunning in children. Similarly, a greater influence of women in household decisions plays a major role in the nutritional choice made by households.

POSHAN

- A comprehensive and coordinated approach is necessary for addressing the multiple and inter-related determinants of malnutrition across the life cycle of an individual.
- Acknowledging malnourishment as a major challenge, ***POSHAN Abhiyaan*** was launched in March 2018 with the aim of improving nutritional outcomes for children, pregnant women and lactating mothers.
- It is an ambitious mission that targets prevention and reduction of undernutrition across the life cycle- as early as possible, especially during the first two years of life.

Pillars of the Abhiyaan:

- One of the most important pillars for the POSHAN *Abhiyaan* is **programmatic convergence** for enabling the development of a shared understanding of roles and responsibilities as well as virtual accountability mechanisms across sectors.
- Another key aspect of the *Abhiyaan* is **focusing on the first 1,000 days of a child's life by providing health and nutrition services in an intensive manner**.
- **Home visits** would be conducted by Frontline health workers, there by shifting the approach from **Centre- based to outreach - based**. Thus, in addition to ensuring the availability of age appropriate complementary food, families about the importance of feeding practices will be a critical element of the *POSHAN Abhiyaan*.
- Further, There will be an emphasis not just on foot but a range of essential Healthcare measures, including birth spacing, delaying age of marriage, exclusive breastfeeding for 6 months and immunization (Rota Virus and Pneumococcal).
- The ***Abhiyaan*** **will also focus on providing joint incentives to motivate the Frontline workers** for improving nutrition outcomes.
- **Incentives will also be provided to state and districts** based on the improvement to the nutritional status of their respective populations in the form of both high absolute levels of achievement as well as positive changes in the indicators.
- Further, **Greater flexibility will be given To States** so that they can focus on health and nutrition interventions that best address their needs.
- Another important pillar of the *POSHAN Abhiyaan* is **enabling the scaling up of innovative and impactful Service Delivery models across the states.** For instance, some States have adopted innovative approaches for home - based counseling and tracking of pregnant and lactating mothers as well as children under three years.

- In Chhattisgarh, ***Suposhan* volunteers** where assigned to look after a group of undernourished children and the community level.
- Similarly, in Bihar, female volunteers take the responsibility of counseling and linking families with ICDS and related Health Services.
- Emphasis has been laid on taking the POSHAN Abhiyaan beyond a routine Government program and making it a ***Jan Andolan***, a people's mass movement.

EDUCATING COMMUNITIES:

- A major Challenge is that **families are often unaware** that the young infant is slipping into malnutrition until it becomes patently visible.
- The success of the nutrition effort in other country including Thailand, Peru, Brazil and Zimbabwe has been attributed at least partially to their **ability to involve local communities**.
- Greater community ownership can enhance awareness of nutrition -related issues, improve practices and expand outreach to the most vulnerable groups.

Steps taken and way forward:

- With the launch of the POSHAN Abhiyaan, we have a historical opportunity to change the statistic and conquer malnutrition.
- The **month of September** was celebrated as the **National Nutrition Month** *(Rashtriya Poshan Maah)* to take the message of nutrition to the last household.
- Platforms such as monthly village health and nutrition day need to be utilised for providing counselling services to mothers and children.
- The active involvement of *Panchayats* has been a key factor in changing societal norms and entrenched behaviour patterns in the successful implementation of campaigns such as Swachh Bharat and Beti Bachao Beti padhao.
- They can play a similar role in encouraging local communities to adopt nutritious feeding practices as well as address gender-related discriminatory behaviors such as allowing the female members of the household to consume food only after all the male members have finished eating.
- While progress has been made, we are still lagging behind other emerging economy is such as Brazil (stunning - 6.1%, wasting - 1.6%), China (stunning - 6.8%, wasting - 2.1%) & Mexico (stunning -13.6%, wasting - 1.6%) which fare far better than us on key nutritional outcomes.

National Dissemination Workshop on Anaemia Mukt Bharat and Home- based young child care:

- The two-day National Dissemination Workshop **on Anaemia Mukt Bharat** and **Home-based young child care (HBYC)** was inaugurated by MoS of MoHFW.
- The objective of this workshop was to orient the state program managers for rolling out these interventions.
- The Anemia Mukt Bharat - **intensified Iron-Plus Initiative** aims to strengthen existing mechanism and foster newer strategies for tackling anemia, focus on six target beneficiary

groups, through six interventions and six institutional mechanisms the envisaged target under the POSHAN Abhiyaan.

HEALTH CARE FOR INDIA'S REMOTE TRIBES

Statistics related to tribe in India:

- India is a home to large variety of indigenous people, represents one of the most economically impoverished and marginalized Groups. With a **population of more than 10.2 corers**, India has the single largest tribal population in the world.
- According to census 2011, the tribes of India constitute **8.6 of its total population** and at present, there are 705 **Scheduled Tribes(ST)** groups and among them 75 are considered as **particularly Vunerable Tribal Groups (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 is in *Madhya Pradesh, Maharashtra, Odisha, Jharkhand, Chhattisgarh, Andhra Pradesh including Telangana, and West Bengal*.
- By proportion, however, the populations of states in the North East have the greatest concentrations of STs, i.e., 31% 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.

Challenges faced by these tribes:

- Most tribal people are poor and they live in remote rural hamlets in hilly, forested or desert area. Illiteracy, tough physical environments, malnutrition, inadequate access to potable water, lack of personal hygiene and sanitation make them more vulnerable to disease. 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 facilities, 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.

Health Status:

- Cultural practices such as **high level of consanguineous marriages** among the tribes may lead to hereditary disease such as sickle cell anaemia, G6PD and thalassemia.
- They have **high fertility rates** (TFR-2.48 as per NFHS - 4) followed by **Low institutional delivery rate** (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- stunning and underweight**- especially among preschool children and anaemia among the women in general.

- The Other widely prevalent health problems in tribal area apart from malnutrition and anaemia include communicable and tropical diseases like malaria, other parasitic diseases and diarrhea.
- Another health concern in this population is the **prevalence of tuberculosis**. Some of the highest rates of tuberculosis in the country have been reported from the Sahariya tribe of Madhya Pradesh.
- **Kyasannur forest disease** (KFD) is also reported to be a looming threat to forest tribe with occasional deaths.
- Other health related problems observed in tribal areas are poor hygiene and sanitation, lack of emphasis on mainstreaming their traditional systems of medicine and Poor health seeking behavior.

Challenges and Need Of the Hour:

A. *Lack of awareness of health issues:*

- Racing awareness of health issues is a first step towards improving health outcomes.
- There is a requirement of local need based ITC strategy which is culturally acceptable to the tribal population concern.
- ICMR- National Institute of Research in tribal health located at Jabalpur demonstrated designing of thread based communication strategy using school students as agent of change to generate awareness and control of malaria in the Baigachak area of Dindori district of Madhya Pradesh.

B. Health facilities in remote tribal areas:

- Difficult terrains, existence of insurgency, Shortage of trained doctors are major challenges.
- Mobile medical camps to improve outreach in remote tribal populations would play a major role.
- Health workers from tribal communities may become the link between the healthcare facilities and tribal communities to guide patients, explain doctor's prescriptions, help patients take advantage of welfare schemes, and counsel them on preventive and promotive health behaviors.

C. Lack of emergency transportation:

- There is a need to improve the road connectivity along with regularity and frequency of the public convenience and telecommunication facilities in the outreach areas.

D. Discriminatory behavior by Healthcare providers:

- Many tribal populations face language barriers while accessing Healthcare since their dialects are not easily understood.
- Tribal people are frequently exploited for informal payments and are often referred to private chemists or medical practitioners with mal-intent.

E. Financial constraints:

- Poor tribal people often have to borrow money, to meet medical expenses, or else let the sick person die. They also cannot sustain the opportunity cost of a doctor's visit.
- Mechanism should be worked out for more fund flow in the tribal areas with proper monitoring and evaluation to track the fund to reach the target population.

Conclusion:

- It is believed that proper awareness generation to improve the preventive and prompt utilization of health services and compliance in one hand and straightening the health System operating in the outreach area will improve the health and quality of life of the tribal in the days to come.

FINANCING RURAL HEALTH CARE

- There is a strong and positive Association between public expenditure on health and the per capita incomes of the people. Enhanced public spending on health increases social welfare of the citizens and develops human capital.
- The delivery of health services in India however, is yet to improve itself, particularly in rural areas, as it lacks quality health facilities and human resources, financial limitations, absence of health awareness.
- The framework of Government of India's fiscal responsibility legislation and that of the states restricts vigorous pressing for public expenditure on health services financed by respective government deficits and public borrowings.
- Thus, efficient and effective Health Services financing within the fiscal responsibility Framework is the need of the Hour.

Rural Health infrastructure:

- India's rural Healthcare delivery is characterized by a three-tier system.
- At the **lowest level** are the sub- centres (SCs) with each covering a population between 3,000 (in hilly/ difficult areas) and 5,000 (in plain areas).
- The **second tier** is Primary Health Centres (PHCs) covering a population of 20,000 to 30,000 and the **third tier** is Community Health centres (CHCs) with a population of 80,000 to 1,20,000.

India's Specific Health Goals to be achieved by 2020

Indicator	**Existing (Year of Estimate)**	**Target 2020**
MMR (per 1 lakh live births)	167 [2013]	120
IMR (Per Thousand live births)	40 [2013]	30
Under 5 Mortality Rate (Per Thousand live births)	48 [2015]	38
Total Fertility Rate (TFR)	2.3 [2013]	2.1
Incidence of TB (Per 1 lakh population)	217 [2015]	130
Out of pocket spending on health Expenditure(% to total Health Expenditure)	62.4 [2014]	50.0

National health policy 2017:

- The union Government announced the revised National health policy, 2017 (NHP 2017) with a view to achieve Universal health coverage and deliver quality healthcare services to all at an affordable cost.
- NHP 2017 looked at problems and solutions holistically with the private sectors as strategic partners and attempted to addresses health security by not only ensuring patient centric and quality healthcare interventions, but also sought to increase investments in the promotive and preventive healthcare in India.
- It wants to achieve Universal access to good quality health care services without anyone having to face financial hardship in the process.
- Further, it made provisions for offering drugs, diagnostic services and emergency care services free of cost in all public hospitals to ensure financial protection at secondary and tertiary Healthcare levels.

NHP 2017 envisaged the following:

- Raising Public Health expenditure to 2.5% of GDP.
- Positive and proactive engagement with the private sector to achieve National goals.
- Financial and other incentives for increasing the encouraging the private sector participation.
- Investment in health, organization and financing of Healthcare services.
- Prevention of diseases and promotion of good health through cross- sectoral action.
- Reorienting and straightening Public Health Institutions across the country, so as to provide universal access to free drugs diagnostic and other essential Healthcare.
- Achieving significant reduction in out of pocket expenditure due to health care costs.
- Ensuring voluntary service in rural and underserved area on Pro- bono basis by recognized healthcare professionals under a 'giving back to society' initiative.

Budget 2018-19 & 'Ayushman Bharat' program:

- Union budget 2018-19 announced *'Ayushman Bharat'* programme for making path breaking interventions to address health holistically, in primary, secondary and tertiary care system covering both prevention and Health Promotion.
- Keeping in view the recommendations of the National Health Policy, 2017, the Budget earmarked fund to finance 1.5 lakh Health and Wellness Centres to revolutionize India's health system.
- The Government decided to launch a flagship National Health Protection Scheme to cover over 10 crore poor and vulnerable families providing coverage up to rupees 5 lakh per family per year for secondary and tertiary Care Hospitalization.
- In addition, listing beneficiaries of Rashtriya Swasthya Bima Yojana and senior citizen Health Insurance Scheme who do not figure in the SECC database are also entitled to avail the benefits under the scheme.

Conclusion:

- A recent estimate indicates that the public expenditure on healthcare in India is only 1.4% of the country's GDP where as the world average is 6%. Government needs to increase the healthcare financing.

- Public Health being a state subject, the primary responsibility is to provide health care services lies in the domain of respective state/UT Governments.
- However, under NHM technical and financial support is being provided by the Union Government for straightening of healthcare systems in States/UTs including support for engagement of human health resources.
- The recent is specific symmetric intervention has the propensity to maximize social welfare of the people and to develop human capital, it is required that such increased allocation and blanket healthcare protection benefits are not concerned by relatively better off/ affluent individuals.

National Health Profile 2018 Released

- The National Health profile covers demographic, socio-economic, health status and health finance indicators, along with comprehensive information on health infrastructure and human resources in health.
- This is the 12th edition.
- CBHI has been publishing National Health profile every year since 2005.
- The data in National Health profile - 2018 is not only important for understanding the health indicators of the country, but it also provides an opportunity to monitor the situation.
- It indicates that significant progress has been made in the country for various health outcomes, which is an encouraging sign.

ADOLESCENT HEALTH

- World Health Organization (WHO) defines an adolescent as any person between the age 10 and 19 years.
- There are many physical and psychological changes that occur during the phase of life.
- Moreover, adolescence is classified further into:
  a. **Early adolescence** - Period between the ages of 10 to 14 years. At this stage, the start of physical changes in the body.
  b. **Late adolescence** – The period between the ages of 15 to 19 years.
- Some authors divide adolescence into three age groups: **Early adolescence**(10 to 13 years); **Middle adolescence** (14 to 16 years); **Late adolescence** (17 to 19 years)
- There are about 253 million (about 21% of Population) adolescents (10 – 19 years) living in our country out of which ,more than sixty per cent lives in rural areas.
- They are a huge opportunity for the nation as they can transform the socio-economic fortunes of India.

Problems in the adolescent age group:

1. ***Teenage pregnancy*** - About 47% of Indian women are married before the age of 18 years. Unmet need for family planning in the 15 to 19 years age group is 27%.

- About one- fifth of the pregnant girls (below 20 years of age) have no antenatal checkups. Perinatal deaths and infant mortality are higher in girls is less than 20 years.
- The incidence of low birth weight babies is higher among adolescent mothers.

2. ***Malnutrition:***
   - Data showed that about 56% of female and 30% of males in the 15 to 19 age group are anemic.
3. ***Violence/ risk taking behavior****:*
   - Four risky behaviors such as sexual activity, substance abuse, risky driving and violence cause nearly half of the morbidity and mortality among adolescents.
4. ***Substance abuse***
5. ***Sexually transmitted infection including HIV/ AIDS***
6. UNICEF (2013) study on "Adolescents in India" reveal that though there is a ample data on adolescents but they are mostly focused on the 15 to 19 years old, where adolescents age 11 to 14 years are under studied and that it is important to acknowledge that their needs are distinct from those age 15 to 19 years.

Government Initiatives for Adolescent Health

- ***School Health Programme*** - To handle the health problems/ requirements of the six to 18 years age groups in the government and government aided schools
- ***Rashtriya Bal Swasthya Karyakram (RBSK)*** – A systematic approach of early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, deficiencies, Diseases, Development delays including disability.
- **Kishori Shakti Yojana** – To improve the nutritional, health and development status of adolescent girls, promote awareness of health, hygiene, nutrition and family care.
- **Balika Samridhi Yojana –** To change negative family and community attitude towards girl child at birth, improve enrolment and retention of girl children in schools and raise the age of marriage of girls.
- **Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) - SABLA**
- **Integrated Child Protection Scheme-** 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 attitude
- **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.

Development of Adolescent Health Programes:

- Programmes and policies for adolescents' health should be designed in a manner to fulfill the requirement of all types of their physical emotional, nutritional and health needs. This will require various principles. This principle are:

1. Life course approach

2. ***Ecological model -*** A need for different levels of two- way interventions acting on both the immediate environment of family and the wider environment created by policies, social determinants.
3. ***Human right based approach -*** This approach supports good public health. It also ensures the implementation of evidence based interventions for adolescent health up to the target.
4. ***Heterogeneity***
5. ***Equity*** - The Principle helps to ensure that the state gives sufficient consideration to vulnerable adolescents.

Rashtriya Kishor Swasthya Karyakram(RKSK)

- RKSK identifies 6 strategies priority area for adolescents:
  - Improve nutrition
  - Improve sexual and reproductive health
  - Enhance mental health
  - Prevent injuries and violence
  - Prevent substance misuse
  - Address NCDs

  Interventions under RKSK:

  - Adolescent friendly health clinic(AFHCs)
  - Weekly iron Folic acid supplementation(WIFS)
  - Menstrual hygiene scheme
  - Peer education(PE) programme

Scheme for adolescent girl:

- 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 district of the country, the Kishori Shakti Yojna has been phased out.

SAATHIYA Resource Kit and 'Saathiya Salah' Mobile app for adolescents:

- It is a part of the Rashtriya Kishor Swasthya karyakram(RKSK) programme.
- The key interventions under the RKSK programme are the introduction of the Peer Educators (Saathiyas). Health ministry has launched the Saathiya Resource Kit (including 'Saathiya Salah' Mobile App).
- This resource kit comprises:
  1. Activity book.
  2. Bhranti Kranti game.
  3. Question - Answer Book.
  4. Peer Educator Diary.

- A mobile app named **'Saathiya Salah'** is launched by the government. This application is ready information source for the adolescents in case they are unable to interact with the Peer educators.
- The mobile app is also linked to toll-free Saathiya helpline (1800-233-1250) which will act as an e-counselor.
- Shy adolescents or those unable to interact with the Peer educators due to family reasons can access the information through the free mobile app as well as the toll free helpline.

Conclusion:

- Though India has 113 million adolescent girls, which is nearby 10% of its population, they are largely invisible groups.
- Policies and programs are largely aimed either at children or 8 women, leaving adolescent girls in the gap.
- Much more needs to be done in terms of innovative strategies involving adoles-cents in all stage of program development to ensure program sustainability.

MOBILE CONNECTIVITY FOR RURAL HEALTH

- Marshall McLuhan, one of the world's foremost communication experts, once said, "**Medium is the message**".
- He insisted the technology platform disseminating information itself has the power to slowly but surely alter the social landscape. Nowhere this theory is more visible than the rural area of India.

Persistent challenge:

- Individuals are easy to convince but it is the **group that act as a nemesis** against any new idea.
- Second challenge is **fear of the unknown**. This reaction is symptomatic of the eternal challenge a communication professional faces while proposing a new idea.
- People may be enthused by the possibility of some benefits but they are always wary of the community's response.
- The third and the biggest challenge till recently was **lack of information**. It started with **lack of basic awareness**. Once the basic awareness was addressed **the challenge was to seek concrete actionable information.**

Mobile, the Great Enabler:

- In such a scenario, the initial messaging of creating awareness remains important but day to day follow up and constant communication plays decisive role in turning the tide in favour of or against a new idea.
- However, during the last five years, rural life has witnessed a dramatic shift through the use of mobile phones.

- The communication access has fundamentally altered the reach, efficacy and effectiveness of ASHAs, Anganwadi workers and ANMs.
- Similarly, the net connectivity available in mobile has made the process of communicating new ideas and getting feedback from the target audience that much easier and focused.

Game changing initiatives:

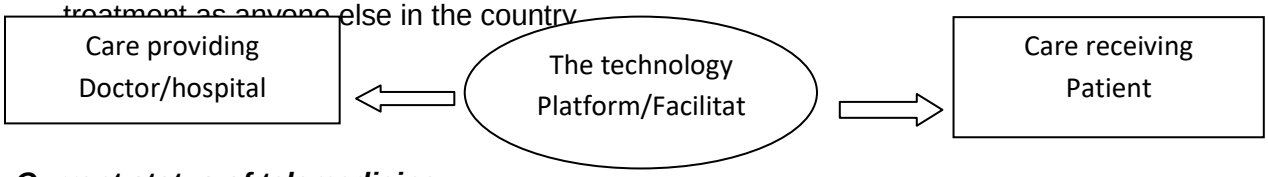
- One such initiative has been extremely successful in the **state of Uttar Pradesh** where ASHA workers were asked to download a mobile app on their smart phones. The app called **mSakhi**, initiated in five districts.
- On nationwide scale, the Government of India launched a **national health portal** in six languages including Hindi, Tamil, Gujarati, Bengali and Punjabi.
- It also has a voice portal and a mobile app. The portal, app and toll free number is meant to create awareness among the citizens about the health issues faced by the society in general and individual in particular.
- **Online registration system** and **MeraAspatal** apps have created completely new paradigm for every citizen.
- The online registration system helps in getting appointment in advance, paying fees bypassing the long waiting lines, accessing their diagnostic reports without taking the pains of coming back again and again and inquiring about availability of blood in blood banks.
- Similarly, the MeraAspatal app seeks patient feedback to create a more responsive and patient driven healthcare service.
- Initiative like **Mission Indradhanush** (launched in 2016) which tracks the immunization of children and helps the parents in carrying out timely and complete immunization programme.
- Similarly, **India fight Dengue**, **NHP Swasth Bharat**, **NHP Directory service**, **Pradhan Mantri Surakshit Matritva Abhiyan** app and other have been able to act as the first port of call for generating awareness.
- Another intervention that used mobile phones extensively is **Kilkari initiative**.
- It is a 72 message series delivered from pregnancy onwards to systematically prepare the woman and her family about the pregnancy issues, childbirth and child care.

Conclusion:

- Communication interventions are needed at stages to turn an initiative into success.
- The **first stage** is creating awareness. The **second stage** is reinforcement through providing actionable information.
- The **third stage** is seeking feedback, tweaking the system, reorienting the focus and Service Delivery mechanism for deeper and effective penetration of service.
- In the case of reproductive health and childcare initiative the effort over the year has borne fruits and due to sustained messaging, effective follow-up and constant upgradation has resulted in registration of 12 crore pregnant women and 11 crore children under mother and child tracking system.

TELE – MEDICINE: A NEW HEALTHCARE OPPORTUNITY

- India has roughly 550 million internet users today out of which 210 million user are rural users.
- That makes telemedicine one of the strongest solutions for India's poor Public Health infrastructure at rural and small city level.
- What tele-medicine does is empower every Indian. With the use of tele-medicine any Indian citizen irrespective of his location can have the access to the best healthcare opinion and treatment as anyone else in the country.



Current status of telemedicine:

- Accredited social health activities (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.
- NEHA and digital India are using e- health means and programs in their campaigns.
- 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 state; &
    - State governments.
- The Apollo hospitals where one of the first to set- up a telemedicine facility in the rural village called Aragonda 16 km from Chittoor in Andhra Pradesh.

Challenges:

- A tele-medicine delivery is a three stakeholder process:
    - **Stakeholder 1**: The hospital or doctors.
    - **Stakeholder 2**: The technology provider or telemedicine facilitator.
    - **Stakeholder 3**: The patients/a small clinic/ primary care centre based in rural areas.
- The biggest challenge and hence also the opportunity lies with the stakeholder 2: Technology platform/ facilitator. Currently there is a lack of “Independent facilitators”. We cannot expect hospitals (stakeholder 1) to act as a facilitor as well.
- It must be the private players, technology start-ups, private inventors and investors. Private players such as Glocal Health, Tattvan E Clinics and a few other are working towards this direction but there are miles to go before this become the national phenomenon as it deserve to be.

Conclusion:

- Today telemedicine is effectively practiced even in under-developed countries of Africa such as Zambia (where it was used during the EBOLA outbreak).
- Therefore, India can also realise its dream to provide best healthcare facilities to all its 600+ districts through the extensive use off telemedicine.