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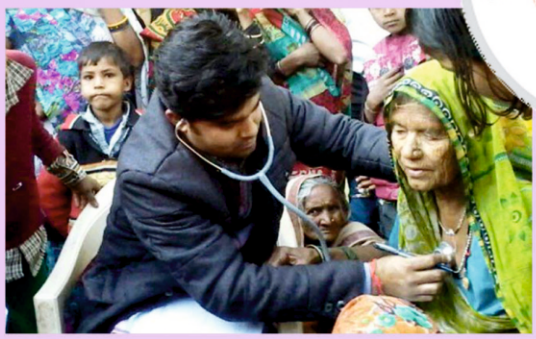
Rural Health

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY



President of India Inaugurates Mahatma Gandhi International Sanitation Convention

The President, Shri Ram Nath Kovind addressing at the inauguration of the Mahatma Gandhi International Sanitation Convention, organised by the Ministry of Drinking Water & Sanitation, in New Delhi on September 29, 2018.

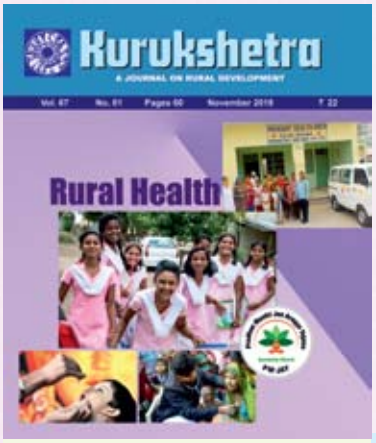
A four –day international convention on sanitation - the Mahatma Gandhi International Sanitation Convention - was organised by the Ministry of Drinking Water and Sanitation in New Delhi to mark the beginning of the 150th birth anniversary celebrations of Mahatma Gandhi, also coinciding with the fourth anniversary of the launch of Swachh Bharat Mission. More than 160 international representatives from 68 countries were amongst the 350 attendees at the convention of whom were fifty-three international Ministers of sanitation.

The Convention was inaugurated by the President, Shri Ram Nath Govind on 29th September, 2018 . In his inaugural address , the President noted that “an open defecation free India is the best 150th birthday gift we could give Mahatma Gandhi”

Following the opening plenaries, a series of parallel technical sessions examined key sanitation-related topics, including strategic partnerships, urban sanitation and fecal sludge management, gender and inclusivity sustainability of ODF communities sanitation as everyone' business and technology and innovation..

On the second day of the Mahatma Gandhi International Sanitation Convention, 116 foreign delegates including sanitation ministers visited select sites related to the life and work of Mahatma Gandhi on the “Gandhi Trail”. The delegation first visited Punsari village, an example of the success of the Swachh Bharat Mission (SBM). For the 5,100 residents, each home has a functional toilet with a water facility. Since it was declared open defecation free, not a single child has dropped out of school. The delegation showed keen interest in the twin pit toilet technology used in India, which is a low-cost, eco-friendly and easy to use toilet technology, suitable for large parts of rural India.

The visitors viewed the local health facility and took note that the infant and maternal mortality rates are zero. They also visited the school, anganwadi and interacted with villagers about the toilets they had built in their homes. They also undertook tree plantation, visited a micro compost pit and drainage as part of SLWM work in the village. The delegation visited Dandi Kutir at the Mahatma Mandir complex and paid homage to Mahatma Gandhi at the Sabarmati Ashram in Ahmedabad.



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Editorial

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 healthy nation that is one of the best places to live in.

The importance of healthcare services in a fast growing economy is globally recognised. This requires addressing the needs of the targeted population by fully utilizing the existing capacities in the most effective and efficient manner, in addition to creating capacities by way of additional infrastructure, human resources, etc. and new programmes. Government has placed considerable emphasis on this with a view to achieving the objective of 'Universal Health Coverage'.

Towards fulfiling this objective, India has taken a giant leap towards providing accessible and affordable healthcare to the common man with the launch of Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) by the Prime Minister, Shri Narendra Modi on 23rd September, 2018 at Ranchi, Jharkhand. Under the vision of Ayushman Bharat, Pradhan Mantri Jan AarogyaYojana (AB-PMJAY) shall be implemented so that each and every citizen receives his due share of health care. With Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana, the government is taking healthcare protection to a new aspirational level. This is the "world's largest government funded healthcare program" targeting more than 50 crore beneficiaries.

Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PMJAY) will provide a cover of up to Rs. 5 lakhs per family per year, for secondary and tertiary care hospitalization. Over 10.74 crore vulnerable entitled families (approximately 50 crore beneficiaries) will be eligible for these benefits. PMJAY will provide cashless and paperless access to services for the beneficiary at the point of service. When fully implemented, PMJAY will become the world's largest fully government-financed health protection scheme. It is indeed a visionary step towards advancing the agenda of Universal Health Coverage (UHC).

Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) is a paradigm shift from sectorial, segmented and fragmented approach of service delivery through various national and State schemes to a bigger, more comprehensive and better converged and need based service delivery of secondary and tertiary care.

National Health Policy and Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PM-JAY) are the main drivers for achieving the goal of Universal Health Coverage (UHC) and with these strong catalysts, Indian healthcare sector has geared up to provide access to affordable quality healthcare. The government's focus on Universal Health Coverage (UHC) is expected to offer several opportunities for diverse stakeholders of healthcare sector and contribute to health & well-being of the Nation as a whole.

The government now needs to play the role of a powerful catalyst by creating an enabling ecosystem which draws investments from both domestic and international players to achieve the goal of Universal Health Coverage. Once investment goes up, the government would be in a better position to push reforms with promotional policies.

BUILDING CLEAN & HEALTHY VILLAGES

Narendra Singh Tomar

For the development of the villages, country's lifeline in true sense, Ministry of Rural Development is making concerted efforts to ensure overall cleanliness in the rural areas. MGNREGA, the country's most ambitious scheme being implemented by the Ministry of Rural Development, has understood its importance and thousands of its success stories have proved that the citizens of our country have become aware of the importance of cleanliness in the village.

Our country lives in her villages and only when the villages are developed, the holistic and inclusive development of the country is possible. Under the leadership of Prime Minister Narendra Modi, the present Government is committed to all round development of rural areas but this dream of development would remain unfulfilled without making rural India clean. The government is making all out efforts to bring about large scale development in the villages and cleanliness is the most important component of it. If the villages are not clean then the development of the villages will remain incomplete. Many innovative efforts are being made which have transformed or they are in the process of transforming the lives of the crores of people living in rural areas. An initiative that has made marked contribution in changing the quality of life of rural people is the Swachh Bharat Mission. The objective of Swachh Bharat Mission, launched by Hon'ble Prime Minister on October 2, 2014, is to make human life cleaner, healthier and dignified. Cleanliness is not only life-force but also the cornerstone of human development. 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. Hon'ble Prime Minister had given a clarion call for building Clean India in his first Independence Day address from the ramparts of Red Fort. He accorded national priority to cleanliness. While launching Swachh Bharat in New Delhi, the Prime Minister had said that it is our social obligation as the citizen of India to fulfil Gandhiji's vision of Clean India in the year 2019 on the occasion of his 150th birth anniversary. Today, the whole nation is in unison with that call. The people of different sections of the society have promoted this peoples' movement of cleanliness and it still continues in full zest. Every day, crores of Indians are joining the India clean-up initiative. Today 22 states, 468 districts and more than 4 lakh 68 thousand villages in the country have become Open Defecation Free (ODF). Since October 2, 2014, more than 8.59 lakh individual household toilets have been constructed. On October 2, 2014, the sanitation coverage was 38.70 per cent and currently it is 93.9 0 per cent. Such a huge progress

has not been seen anywhere in the world in the field of hygiene and cleanliness. This great effort of India has presented a unique example before the world about how the nation can be enthused and inspired on the issue of social concern. Today, inspired from this program of India, many countries of the world are planning on this pattern to improve their sanitation conditions.

Clean Village: Healthy Life

Swachh Bharat has transformed the face and destiny of the village today. Studies have revealed that in every house of Open Defecation Free village, about 50,000 rupees are being saved because the family is saving on the expenditure otherwise being incurred on treatment of various diseases. The rural families are utilizing this savings to acquire new amenities and facilities, to provide better education to the children, and to improve their standard of living. People's health related expenses have come down and they are able to work for more days. According to a study by the World Health Organization, with the implementation of Swachh Bharat Mission, every year we have successfully prevented a large number of children to become victims of the deadly diseases in rural areas and the situation is continuously improving. Swachh Bharat has also led to certain unique initiatives in rural areas that have never been seen before. Women associated with Self Help Groups have made commendable contribution in the cleanliness movement. They have invested their savings in cleanliness related works and thus played an important role in making the environment and surroundings beautiful and clean. Women members of Self Help Groups have extended financial help to many families who were trapped in the financial crisis. Self Help Groups have also helped in strengthening social harmony through many efforts of mutual cooperation. Our Panchayat representatives have also shown commendable interest in Swachh Bharat Mission. They drew up effective schemes to make their Panchayats ODF, implemented them enthusiastically and efficiently and made significant contribution in their sustenance. The Panchayats have made sincere efforts to not only connect the masses with this program and with the cooperation of all made the village panchayats ODF, but they have also promoted environment related cleanliness by undertaking activities related to solid and liquid waste management.

SBM: Mass Movement now

Swachh Bharat Mission has now acquired the form of a mass movement and with the aim to

take it forward, the Rural Development Ministry has taken a number of measures through its ambitious scheme Mahatma Gandhi National Rural Employment Guarantee Act- MGNREGA. This includes awareness promotion among the village panchayats towards cleanliness in the rural areas and encouraging and training villagers to take up activities related to livelihood creation .The Ministry is engaged in construction of individual household toilets and soakage pits, solid waste management (Vermi / NADEP compost pits), works related to solid and liquid waste management (drainage channel, liquid bio-compost, recharge pits, toilets in schools and Aanganwadis, soakage channels, village drains, construction of water stabilization ponds and water conservation works to make used grey water (dirty water) useful. It is being emphasized that every village Panchayat becomes a clean Panchayat. In present time, management of the waste water is a big challenge for the whole world. Whether it is rural area or urban, the lack of planning and infrastructure for waste water management leads to unclean life situations. It causes spread of diseases and infections. In this connection, we are happy

to inform that for waste water management in Telangana state soakage pits are being constructed through MGNREGA at family and community level. In the same way in Nanded district of Maharashtra, MGNREGA funds were utilized for making soakage pits which has helped in the villages to get rid of mosquitoes. The scheme was implemented in about 30 villages. Together they ensured that by constructing soakage pits, breeding of mosquitoes would be controlled so that the people of the villages sleep peacefully and protected from diseases caused by mosquitoes. Construction of Lingpui water tank of Tlenguam R G Block in Aizawl district of Mizoram was started as an innovative experiment under MGNREGA. This water tank is built in the shape of the airplane along the road leading to the airport in Aizawl district. There are also public taps in the tank premises which provide safe drinking water. Toilets have been constructed in tank premises which can be used on payment basis. With these facilities and arrangements in place, this tank has become a multipurpose asset. It is also earning income for Gram Panchayat. Haryana Government has developed a five pond system in rural areas for stabilization of waste water under MGNREGA. The main objective is to ensure proper disposal of waste water in rural areas and to clean the environment of the village by ensuring better living conditions. Ariad Gram Panchayat in Matilakam block of Thrissur district of Kerala has started a project to produce construction material. The cement- concrete blocks fabricated under this project were used for MGNREGA works like construction of individual household toilets. Under MGNREGA scheme, vermicomposting units are also being constructed.

MGNREGA Funds for Rural Cleanliness:

Substantial amount of MGNREGA funds are being spent on the activities related to rural cleanliness and the results have come out as anticipated. During the Financial Year 2014-15, Rs. 92435 lakhs have been spent on the construction of individual household toilets through this scheme. During the last financial year, the expenditure was more than Rs.13, 935 lakhs. On the construction of soakage pits, the expenditure was more than Rs. 15598 lakhs during the last financial year as compared to Rs. 2938 lakhs for the financial year 2014-15. During the financial year 2014-15,1676 lakh rupees were spent on solid waste management by way of constructing vermi/NADEP compost pits while more than 54853 lakh rupees were spent last year on these works. During the financial year 2014-15, 49512 lakh rupees were spent on solid and liquid waste management works like drainage channels, liquid bio fertilizer, recharge pits, school and aanganwadi toilets, soakage channels, village drains and stabilization ponds. As compared to this, in financial year 2017-18 more than 85221 lakh rupees were spent on these works. About 4,71,230 lakh rupees were

spent on water conservation works in financial year 2014-15. However, as compared to this amount 6,92,216 lakh rupees were spent in financial year 2017-18.In all works related to cleanliness, 6,17,792 lakh rupees were spent in financial year 2014-15, 6,98,357 lakh rupees in 2015-16 and 9,87,822 lakh rupees in 2017-18. During the current financial year also about 5,93,070 lakh rupees have been spent till now on all works related to cleanliness. This way, a substantial amount of MGNREGA funds have been spent or being spent in activities related to overall cleanliness of rural areas.

If we look at the physical achievements in the area of rural cleanliness through MGNREGA we find that during the financial year 2014-15, 13.88 lakh individual household toilets have been constructed using MGNREGA fund. About 7 lakh toilets have been constructed during the financial year 2015-16, about 7.5 lakh toilets in financial year 2016-17 and about 9 lakh toilets in financial year 2017-18 by using MGNREGA funds . In financial year 2016-17, rapid construction of soakage pits was witnessed. As compared to construction of 37000 soakage pits in financial year 2015-16, the number has markedly increased to 421553 in financial year 2016-17. In financial year 2017-18 also more than 219000 soakage pits were constructed. Solid waste management through constructing vermi/NADEP compost pits has also shown significant progress. Works related to this has increased from 5000 in 2014-15 to 182000 in 2016-17 and 254000 in 2017-18. Solid and liquid waste management through works like drainage channels, liquid bio fertilizer, recharge pits, school and aanganwadi toilets, soakage channels, village drains and stabilization ponds has also shown significant progress. In financial year 2015-16, 82564 such works were completed. The number of such works increased to 382725 in financial year 2016-17. During financial year 2017-18, also more than 183000 such works have been completed. MGNREGA funds are being utilized efficiently in water conservation works which have also shown good progress. Under infrastructure development related to water conservation about 276000 works were completed during the financial year 2014-15, 277000 in the financial year 2015-16, 600000 in the financial year 2016-17 and about 384000 in the financial year 2017-18.

All these facts and data clearly indicate that the present government is focussed on the development of rural areas and making the villages clean in every respect. For the development of the villages, country's lifeline in true sense, Ministry of Rural Development is making concerted efforts to ensure overall cleanliness in the rural areas. This is an aspect which cannot be ignored. MGNREGA, the country's most ambitious scheme being implemented by the Ministry of Rural Development, has understood its importance and thousands of its success stories have proved that the citizens of our country have become aware of the importance of cleanliness in the village and they are resolving to make rural India clean and maintain cleanliness in the villages.

Role of Panchyats in Cleanliness:

The village panchayats are not only focusing on cleanliness through individual household toilets now but also taking steps to clear waste through vermicomposting pits. Panchayats are playing critical role in the maintenance of clean environment by taking up activities like drainage channels, liquid bio fertilizer, recharge pits, school and aanganwadi toilets, soakage channels, village drains and stabilization ponds under the implementation of MGNREGA. However, considering the diversity of the villages in the country, it should be kept in mind that no one model of sanitation can be adopted for all 238617 Gram Panchayats in India. Yes, we have to focus on developing such measures which are easy to adopt, economical and have minimum technical limitations. MGNREGA's revolutionary initiative to make rural India clean and its effective implementation by the present government has started to show constructive results.

In fact, this innovative initiative of the Rural Development Ministry is improving ecological balance and helping immensely in taking the country's rural population towards a clean and healthy environment. Our Prime Minister has launched the 'Swachhta Hi Sewa ' programme from September 15, 2018 to 02 October 2018. The enthusiasm of people participating in this program is very commendable. In this regard, I would like to request to all the dear villagers of our country that they do not have to limit it to October only but rather make it an integral part of their daily life, make it a habit and work on regular basis to clean their villages, streets, environment and surroundings, thereby contributing to the prosperity of rural life. Indeed, this will be their unique contribution to building of a new India.

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AYUSHMAN BHARAT: INDIA'S ROAD TO UNIVERSAL HEALTH COVERAGE

Manoj Jhalani

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.

The Ayushman Bharat scheme, launched by the Honourable Prime Minister in April this year, marks an unprecedented high-level political commitment to Universal Health Coverage (UHC). Ayushman Bharat stems from the policy articulation[1] and budgetary commitment that are derived from experiences and lessons of the past few decades.

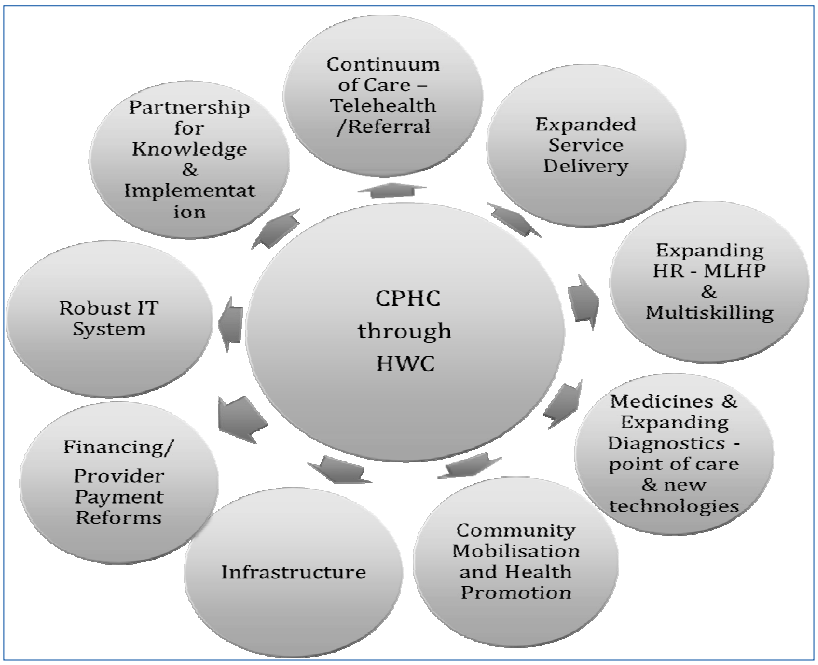
Ayushmaan Bharat comprises two pillars - the first is provision of universal and Comprehensive Primary Health Care (CPHC) delivered in formulation of Health and Wellness Centres (HWCs); which are the transformed first two tiers of the public health system i.e. the Sub Health Centres (SHC) and the Primary Health Centres (PHC). The second component is the Pradhan Mantri Jan Arogya Abhiyaan (PMJAY), for provision of health coverage of upto 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).

In the last decade, the investment in health by both the centre and states has increased. Input related investments in infrastructure and human resources, at most primary and to a limited extent in secondary care, coupled with support for strengthening procurement systems, improving governance, establishing referral and transport systems, incentives for performance have yielded accelerated positive outcomes for mothers and children, and to an extent ,in communicable diseases as well. As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), MMR of India has shown a decline from 167 per 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 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 viz. 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). The World Bank estimates that just 10% of medical conditions require more complex treatment in hospitals or specialist care.[2]

The delivery of CPHC through HWCs therefore becomes a necessity. Without effective primary health care, India is likely to be unable to meet either the goals of the NHP-2017 or its commitments to the SDGs. However, the transformation of HWC requires action on many fronts and coordination of multiple work streams, as demonstrated in Box 1.

The impetus on Ayushman Bharat – HWCs is aimed at a paradigm shift in provisioning CPHC to the people:



i) HWC will enable the expansion of package of services that go beyond Maternal & Child Health (MCH), to include care for non-communicable diseases, palliative and rehabilitative care, oral, eye and Ear-Nose-Throat (ENT) care, mental health and first level care for emergencies and trauma.

ii) In order to provide these services at the Sub Health Centre (SHC)- HWC, a new cadre of worker – the Mid-Level Health Provider (MLHP)- who is either a nurse or an Ayurveda practitioner, trained in competencies of public health and primary health care, clinical management, continuum of care, dispensation of drugs and close follow up for those with chronic illness/patients discharged from health facilities, will lead the team of Multipurpose Workers, and ASHAs.

iii) While the expanded primary health care package will be available at the SHC and Primary Health Centre (PHC), the focus of the SHC-HWC is to promote wellness through social and behavioural change communication for an emphasis on preventive and promotive health, encouraging changes in lifestyle i.e. physical activity, including yoga, healthy diet and avoidance of tobacco and alcohol. In addition, HWC would

provide preventive care for MCH and undertake screening and early detection, dispense drugs and conduct regular follow up for chronic care, including post operative, rehabilitative care.

iv) The HWC would follow a well-defined referral chain to ensure continuum of care. PHC-HWC are linked to their SHC- HWC, with the PHC Medical Officer (MO) serving as the team leader for the HWC cluster. Care for all packages is also available at the PHC level, but of a higher order of complexity. For chronic diseases such as hypertension and diabetes, the PHC MO could initiate the treatment plan. In addition, the MLHP and PHC MO would access specialist care through telemedicine hubs located at the district/ medical college levels.

v) There would be a progressive inclusion of diagnostic tests and medicines available at the HWCs so that more conditions could be managed at those levels and less referral happens to higher facilities.

Besides the above mentioned services, other important elements of the HWCs include: (i) a robust IT system for population enumeration (such that every individual and family is mapped to a particular SHC-HWC and uses it as the first port of call), (ii) use of digital apps for frontline workers for enumeration, recording of services, reporting and payment of team based incentives, serve as clinical decision support system and (iii) regular up-gradation of skills of all providers through distance learning and the use of platforms such as ECHO for clinical support, supervision and mentoring.

The other component of Ayushman Bharat which makes it a programme for ensuring UHC is the Pradhan Mantri Jan Arogya Yojana (PMJAY). Launched on September 23, 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.

PMJAY is an entitlement based scheme. This scheme 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 upto 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 citizens, get coverage. Services are cashless & paperless, at the point of service, in both the public and empanelled private facilities. These will also be portable anywhere in the country.

The AB-PMJAY is being managed by National Health Agency (NHA). The current status of implementation of this schemes is that 33 States/ UTs have signed MoUs or agreed to sign MoU with the Centre (remaining being Odisha, Telangana and Delhi) and out of these, 26 States have started the implementation. There are three modes of implementing the scheme i.e. Insurance Mode,

Trust Mode and Mixed Mode. The NHA has created robust safeguards to prevent misuse/ fraud/ abuse by providers and users, including pre-authorisation being made mandatory for procedures with moral hazard. As on date, one lakh beneficiaries have availed of services under PMJAY, in a period of just about a month.

In conclusion, we must be cognizant that policy articulation alone will not suffice. 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. This programme will succeed or fail depending on our efforts and collective energy focussed on its implementation, advocating with all stakeholders, operationalizing multi-sectoral action, making sufficient financial investment and above all, holding ourselves accountable to people to deliver high quality CPHC as we move towards the aspiration of Universal Health Care.

Footnote

1. National Health Policy, 2017, Ministry of Health and Family Welfare, Government of India.
2. Doherty G and Govender R, 'The cost effectiveness of primary care services in developing countries: A review of international literature', Working Paper No. 37, Disease Control Priorities Project, World Bank, WHO and Fogarty International Centre of the US National institutes of Health, 2004, https://www.researchgate.net/publication/242783643_The_Cost-Effectiveness_of_Primary_Care_Services_in_Developing_Countries_A_Review_of_the_International_Literature

(The Author is Additional Secretary in Ministry of Health and Family Welfare and has been designated as the Mission Director of the Government of India's ambitious health insurance programme, Ayushman Bharat.
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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 National Health Agency is registered under the Society Registration Act, 1860. The State Governments are expected to similarly set up State Health Agencies (SHA) to implement PM-JAY.

The National Health Agency (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. Inter-alia, this will include, formulation of PM-JAY policies, development of operational guidelines, implementation mechanisms, co-ordination with state governments, monitoring and oversight of PM-JAY amongst other.

The National Health Agency 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.The NHA will lead the development of strategic partnerships and collaborations with Central and State Governments, civil society, financial and insurance agencies, academia, think tanks, national and international organizations and other stakeholders to further the objectives of PM-JAY.

The National Health Agency will provide technical advice and operational inputs, as relevant, to states, districts and sub-districts for PM-JAY including formulating standards/ SOPs/guidelines/manuals to guide implementation, identification of capacity gaps and related trainings, development of health information and IT systems, facilitating cross-learnings, documentation of best practices, research and evaluation and undertake associated administrative and regulatory functions as a Society.

(Source : Ayushman Bharat Website (www.abnhpm.gov.in)

AYUSHMAN BHARAT: SILVER LINING IN HEALTH CARE

Alok Kumar

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. It undertakes path breaking interventions to holistically address health; adopting a continuum of care approach- addressing prevention, promotion, primary and ambulatory care; as well as secondary and tertiary care requiring hospitalized treatment.

WHO defines quality of care as "the extent to which heath care services provided to individuals and patient populations improve desired health outcomes". To achieve this, health care must be safe, effective, timely, efficient, equitable and people centred. In a setting, where we are struggling to meet the ever rising demand for access to health services on account of various constraints – financing, availablility of skilled human resources, inadequate and unevenly distributed health care infrastructure, under-developed regulatory infrastructure to name just a few- our health system has a long distance to cover. Amidst all the serious challenges and concerns pointed out, the inititation of *Ayushman Bharat* provides the proverbial silver lining. For the first time in India, we have witnessed health becoming a part of the mainstream politics. Moreover, what is refreshing is the fact that we are taking a more comprehensive health system approach- addressing all the levers affecting it - rather than tinkering at the margins. In this article, we examine the impact of these new initiatives on the quality of health care in India. Before we deleve into this aspect, it would be useful to recapitulate the initatives under this initative.

Ayushman Bharat:

When the Government of India announced ***Ayushman Bharat*** in the Union Budget for 2018-19, it signalled its intent to take health promotion and health care to the centre of the political discourse. However, some critics were sceptical as to whether a programme of such dimensions could be launched within such a short time-span. With the launch of both components: the Health & Wellness Centres (H&WCs) on 14th April and the PM Jan Arogya Yojana (PMJAY) on 23rd September, the Government has amply demonstrated that the

budgetary announcements not only had a strong political backing, but also sent out a clear signal that there is growing consensus in the higher echelons of policy making that investing in a good health system is critical to building a prosperous India.

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.

The Pradhan Mantri Jan Arogya Yojana (PMJAY)- by far the "world's largest fully government funded health insurance program"- is aimed at providing financial protection for those seeking hospitalized care. PMJAY will provide a cover of Rs 5 lakhs per family per year, against 1350 most commonly occurring disease conditions requiring secondary and tertiary care hospitalization. A minimum of 10.74 crore (approximately 50 crore beneficiaries) of the poorest and most vulnerable families will be covered. To ensure that nobody is left out (especially women, children and elderly) there is no cap on family size and age in the scheme as well as no exclusion on ground of pre-existing conditions. The benefits under the scheme are portable across the country and the health care services can be availed of by the beneficiaries in a network of empanelled facilities- both public and private. The transaction is completely cashless and paperless in so far as the beneficiary is concerned.

Interpreted in a literal sense, *Ayushman Bharat* is a promise for long lives to Indians. In other words, it is about mortality avoidance. But increasing life expectancies cannot be the only goal, if we also simultaneously cannot guarantee well being by minimizing morbidity. Our National Health Policy 2017 aptly articulates our 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 developmental 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. It undertakes path breaking interventions to holistically address health; adopting a continuum of care approach- addressing prevention, promotion, primary and ambulatory care; as well as secondary and tertiary care requiring hospitalized treatment.

Present Situation:

In the absence of a strong Government stewardship, the Indian Health System has evolved almost by default. As a consequence, it 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. This has ensured that 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. In addition to this, lack of incentives in the health systems, lack of evidence-based information in the market, combined with a lack of accountability among providers and poorly functioning governance systems in the health system are the main reasons responsible for low quality of care being 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 Medical 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 a legislation to replace MCI by a National Medical Commission.

What is the likely impact of Ayushman Bharat?

The key question is "will the Centre's flagship 'Ayuhsman Bharat' scheme ensure quality healthcare?". 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 competetive reimbursement rates for the identified packages, quality may get compromised. However, although it is early days for the scheme, I am optimitic that 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, I see huge efficiency gains in organizing citizens into large risk pools and creating big centralized payers such as the National Health Agency (NHA) and the State Health Agency (SHA) under the Ayushman Bharat. The asymmetric relation between 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 . This payment based accountability works well in sync with the legislation based enforcement of accountability, since the providers find a payment incentive in complying with the quality norms.

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. Since the payers would be carrying out inspections of the health facilities against standardized checklists both at the empanelment stage and also during the operations stage, it would provide the necessary impetus to the provider to plug the gaps between their existing

infrastructure, procedures and human resources and what is required of them by the payer. 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. But the process of ensuring strict adherence needs to be gradual, so that the compliance burden on the empaneled providers does not become unmanageable.

Another lever 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. Admittedly, there is an increasing awareness of quality on the part of providers with a movement towards voluntary accreditation through NABH, but the proportion of such facilities represents a miniscule fraction of overall number of providers. Such payment incentives will also accelerate this process. 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, I believe that such payment incentives could have transformative impact on the quality of care transacted in these centres 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 initate the desired policy changes and to take appropriate action to improve quality of care is severley constrained . This has a serious deleterious effect upon the overall governance and accountability of the Health System. Another potential gamechanging 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. This would give a serious boost to the quality movement in our health system ,further the use of evidence in making policy decisions and would enable pushing for behavioral change on the part of the providers

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, but they constitute a small sub-set of a large number of steps that need to be taken to drive the quality process in the Indian health care system. This is just the beginning of a long and an arduous journey.

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E-GOVERNANCE INITIATIVES

Ministry of Health & Family Welfare is promoting eHealth or Digital Health i.e. use of Information & Communication Technology initiatives in the direction of "reaching services to citizens" and "citizen empowerment through information dissemination" to bring about significant improvements in the public healthcare delivery. The purpose of such initiatives is to:

• Ensure availability of services on wider scale. • To provide health care services in remote & inaccessible areas through telemedicine. • To address the health human resource gap by efficient and optimum utilization of the existing human resource. • To improve patient safety by access to medical records and helps reduce healthcare cost. • To monitor geographically dispersed tasks and effective MIS for meaningful field level interactions. • To help in evidence based planning and decision making. • To improve efficiency in imparting training and capacity building.

(Source : Annual Report 2017-18, Ministry of Health & Family Welfare)

AYUSHMAN BHARAT-PMJAY: INDIA'S ANSWER TO UNIVERSAL HEALTH CARE

The scheme is cashless & paperless at public hospitals and empanelled private hospitals. The beneficiaries are not required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. The scheme is entitlement based, the beneficiary is decided on the basis of family being figured in SECC database. When fully implemented, the AB-PM-JAY will become the world's largest government funded health protection mission.

India has achieved significant public health gains and improvements in health care access and quality over the last three decades. The health sector is amongst the largest and fastest growing sectors, expected to reach US$ 280 billion by 2020. At the same time, India's health sector faces immense challenges. It continues to be characterized by high out-of-pocket expenditure, low financial protection, low health insurance coverage amongst both rural and urban population. It is a matter of grave concern that we incur a high out-of-pocket expenditure on account of health and medical costs. 62.58% of our population has to pay for its own health and hospitalization expenses and are not covered through any form of health protection. Besides using their income and savings, people borrow money or sell their assets to meet their healthcare needs, thereby pushing 4.6% of the population below the poverty line. The Government is committed to ensure that its population has universal access to good quality health care services without anyone having to face financial hardship as a consequence.

In his Independence day speech on 15 August 2018 PM Modi announced, "the Government of India has decided to launch Pradhan Mantri Jan Arogya Abhiyan so that the poor man, the common man gets free treatment for serious diseases and he can be admitted to big hospitals free of cost. Pradhan Mantri Jan Arogya Abhiyan and Ayushman Bharat Yojana will cover 10 crore families of the country. In the coming days, the people from lower middle class, middle class and upper middle class income groups can also access health care services from these two programs. There is a provision of giving five lakh rupees per annum health assurance for each family. It means about fifty crore citizens belonging to ten crore families will benefit. We are going to give this benefit to our countrymen. This is a technology driven system which is transparent. As such, an ordinary citizen will not face any difficulty as technological tools have been built for this purpose."

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) aims to reduce the financial burden on poor and vulnerable groups arising out of catastrophic hospital episodes and ensure their access to quality health services. It seeks to accelerate India's progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) provides 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 offers a benefit cover of Rs. 500,000 per family per year (on a family floater basis). PM-JAY covers 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 is cashless & paperless at public hospitals

and empanelled private hospitals. The beneficiaries are not required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. The scheme is entitlement based, the beneficiary is decided on the basis of family being figured in SECC database. When fully implemented, the AB-PM-JAY will become the world's largest government funded health protection mission.

Two major initiatives in health sector , as part of Ayushman Bharat programme were announced by the Union Minister for Finance and Corporate Affairs, Shri Arun Jaitely while presenting the General Budget 2018-19 in Parliament on February 01, 2018. He said that this was aimed at making path breaking interventions to address health holistically, in primary, secondary and tertiary care systems, covering both prevention and health promotion.

The initiatives are as follows:-

(i) **Health and Wellness Centre**:- The National Health Policy, 2017 has envisioned Health and Wellness Centres as the foundation of India's health system. Under this, 1.5 lakh centres will bring health care system closer to the homes of people. These centres will provide comprehensive health care, including for non-communicable diseases and maternal and child health services. These centres will also provide free essential drugs and diagnostic services. The Budget has allocated Rs.1200 crore for this flagship programme. Contribution of private sector through CSR and philanthropic institutions in adopting these centres is also envisaged.

(ii) **National Health Protection Scheme**:- The second flagship programme under Ayushman Bharat is National Health Protection Scheme, which will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. This will be the world's largest government funded health care programme. Adequate funds will be provided for its smooth implementation.

The Finance Minister further said, that these two health sector initiatives under Ayushman Bharat Programme will build a New India 2022 and ensure enhanced productivity, well being and avert wage loss and impoverishment. These Schemes will also generate lakhs of jobs, particularly for women.

In order to further enhance accessibility of quality medical education and health care, 24 new

Government Medical Colleges and Hospitals will be set up, by up-grading existing district hospitals in the country. This would ensure that there is at least 1 Medical College for every 3 Parliamentary Constituencies and at least 1 Government Medical College in each State of the country.

Implementation Strategy:

At the national level to manage, an Agency would be put in place. States/ UTs would be advised to implement the scheme by a dedicated entity called State Health Agency (SHA). They can either use an existing Trust/ Society/ Not for Profit Company/ State Nodal Agency (SNA) or set up a new entity to implement the scheme. States/ UTs can decide to implement the scheme through an insurance company or directly through the Trust/ Society or use an integrated model.

Major Impact:

In-patient hospitalization expenditure in India has increased nearly 300% during last ten years. (NSSO 2015). More than 80% of the expenditure are met by out of pocket (OOP). Rural households primarily depended on their 'household income/savings' (68%) and on 'borrowings' (25%), the urban households relied much more on their 'income / saving' (75%) for financing expenditure on hospitalizations, and on '(18%) borrowings. (NSSO 2015). Out of pocket (OOP) expenditure in India is over 60% which leads to nearly 6 million families getting into poverty due to catastrophic health expenditures. AB-PMJAY will have major impact on **reduction of Out Of Pocket (OOP) expenditure** on ground of:

i) Increased benefit cover to nearly 40% of the population, (the poorest & the vulnerable)

ii) Covering almost all secondary and many tertiary hospitalizations, (except a negative list).

iii) Coverage of 5 lakh for each family, (no restriction of family size).

This will lead to **increased access to quality health and medication**. In addition, **the unmet needs** of the population which remained hidden due to lack of financial resources will be catered to. This will lead to **timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency, job creation thus leading to improvement in quality of life.**

Poised to be the largest public funded health insurance scheme in the world, the Union Health Minister Shri J.P. Nadda said that the beneficiaries can avail of the benefits in both public and empanelled private facilities. "All public hospitals in the States implementing Ayushman Bharat-NHPM (now AB-PMJAY, will be deemed empanelled for the scheme. As for private hospitals, they will be empanelled online based on defined criteria.

The Ayushman Bharat-NHPM (now AB-PMJAY) will leverage on Comprehensive Primary Health Care through Health and Wellness Centres for preventive, promotive and curative care and will ensure seamless continuum of care. This will avoid overcrowding and improve quality of care at secondary and tertiary facilities and provide universal health coverage and make services equitable, affordable and accessible.

"Ayushman Bharat-NHPM (now AB-PMJAY) is in synergy with NHM and will strengthen public health infrastructure. Various measures like identity validation through Aadhaar, cost control etc., make the Ayushman Bharat- (now PMJAY) easily accessible and transparent in approach. The Health Minister said that Ayushman Bharat-NHPM-(now PMJAY) will also strengthen spirit of cooperative federalism. "NHPM provides ease to be merged with the ongoing health protection or Insurance schemes in various ministries and governments,".

Shri Nadda further stated that all pre-existing conditions will be covered from day one of the policy.

A defined transport allowance per hospitalisation will also be paid to the beneficiary. He further added that benefits of the scheme are portable across the country and a beneficiary covered under the Mission will be allowed to take cashless benefits from any public/private empanelled hospitals across the country.

With effective implementation, the scheme may have a positive impact on reducing out-of-pocket expenditure. The government argues that the poorest and the vulnerable will have health insurance. The scheme will initially cover nearly 40% of the population. Barring a few procedures, the scheme covers almost all secondary and many tertiary hospitalizations, which in normal circumstances, bankrupt poor people. This can have a cumulative positive effect on increased access to quality health and medication. In addition, the unmet needs of the population, which remained hidden due to lack of financial resources, will be catered to. This may lead to timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency and job creation, leading to improvement in overall quality of life.

Expenditure involved:

The expenditure incurred in premium payment will be shared between Central and State Governments in specified ratio as per Ministry of Finance guidelines in vogue. The total expenditure will depend on actual market determined premium paid in States/UTs where AB-NHPM-(now PMJAY) will be implemented through insurance companies. In States/UTs where the scheme will be implemented in Trust/ Society mode, the central share of funds will be provided based on actual expenditure or premium ceiling (whichever is lower) in the pre-determined ratio.

Number of Beneficiaries:

AB-PMJAY will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data covering both rural and urban. The scheme is designed to be dynamic and aspirational and it would take into account any future changes in the exclusion/ inclusion/ deprivation/ occupational criteria in the SECC data.

States/Districts covered:

AB **-PMJAY** will be rolled out across all States/ UTs in all districts with an objective to cover all the targeted beneficiaries.

Impact:

According to international rating agency Moody's, Ayushman Bharat is credit positive for insurance companies as it will aide in higher premium growth. "The launch of universal health coverage is credit positive for the country's insurers because it will help grow health premiums and provide insurers with cross-selling and servicing opportunities," Moody's said in a report.

British medical journal Lancet has praised Prime Minister Narendra Modi for prioritising universal healthcare with his Ayushman Bharat initiative. An article by the journal's editor-in-chief Richard Horton appreciated the Modi government for recognising the 'perils of public discontent about health' after years of neglect. Modi is the first Indian Prime Minister to prioritise universal health coverage as part of his political platform, Horton wrote in his article.

How to get covered under Ayushman Bharat Yojana? It's simple….Just memorize the helpline number of the Ayushman Bharat Yojana, 14555. PM Modi says this number must be memorized by every citizen of India. Ayushman Bharat Yojana helpline: 14555.

Conclusion:

The scheme is innovative and path-breaking in the history of public health in India, which may have a transformative impact if implemented in an effective and coordinated manner. The scheme will also help in enriching the database of hospitals registered with the Registry of Hospitals in Network of Insurance (ROHINI) System and the human capital captured under the National Health Resource Repository (NHRR) project. This can later be used innovatively for improvement of access to and quality of healthcare services in the country. The scheme will have a multiplier impact on the healthcare and allied sectors like pharmaceutical, diagnostics and medical devices and the overall Indian economy by way of employment generation. In the long run, AB- PMJAY should envision strengthening of primary care, inclusion of out-patient treatment and a public healthcare delivery system, and expanding the scope of coverage to the entire population in order to make the government's transition from provider to payer a successful one and achieve Universal Health Coverage in the true sense.

Team Kurukshetra

POSHAN ABHIYAN : TOWARDS HOLISTIC NUTRITION

Urvashi Prasad, Vedeika Shekhar

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 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. Through a targeted approach, technological interventions and convergence, the program strives to address malnutrition holistically.

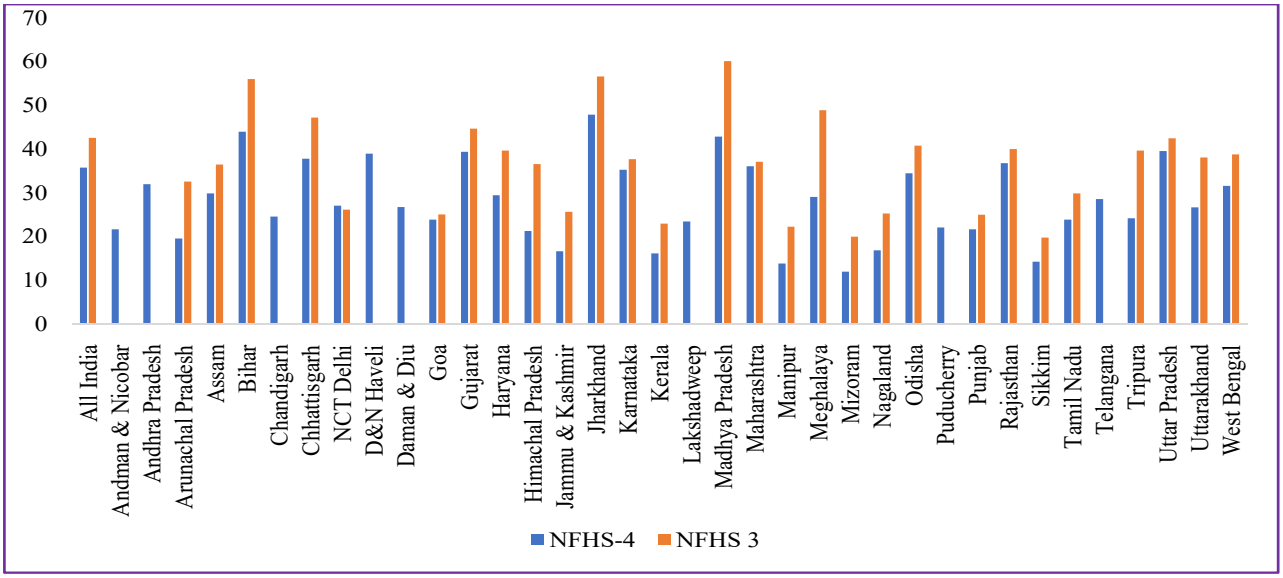
In the last decade, India has made some improvements in tackling malnutrition. For instance, stunting has declined from 48% in 2005-06 to 38.4% in 2015-16. Similarly, underweight prevalence has reduced by 0.68 percentage points from NFHS-3 to NFHS-4. However, gaps remain. According to the National Family Health Survey-4 (NFHS-4), over one-third of all under-five children are stunted (low height for age), every fifth child is 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 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.[1]

A World Bank estimate[2] indicates reducing stunting in the country can raise the GDP of India by 4-11%. On the other hand, the Global Nutrition Report estimates a return USD 16 for every USD 1 spent on health and nutrition.[3] Additionally, undernutrition is the prime risk factor 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.

Another challenge is that there is a large disparity in nutritional outcomes between states (Figure-1) as well as population groups. For instance, according to NFHS-4 data, the states which have the maximum population of undernourished people are Bihar and Madhya Pradesh. The problem of overweight people, on the other hand, is more acute in Andhra Pradesh, Sikkim and Goa. Anaemia levels in women range from 45% in Karnataka to 63% in Haryana.

Figure 1: Underweight prevalence in children (0-5 years)

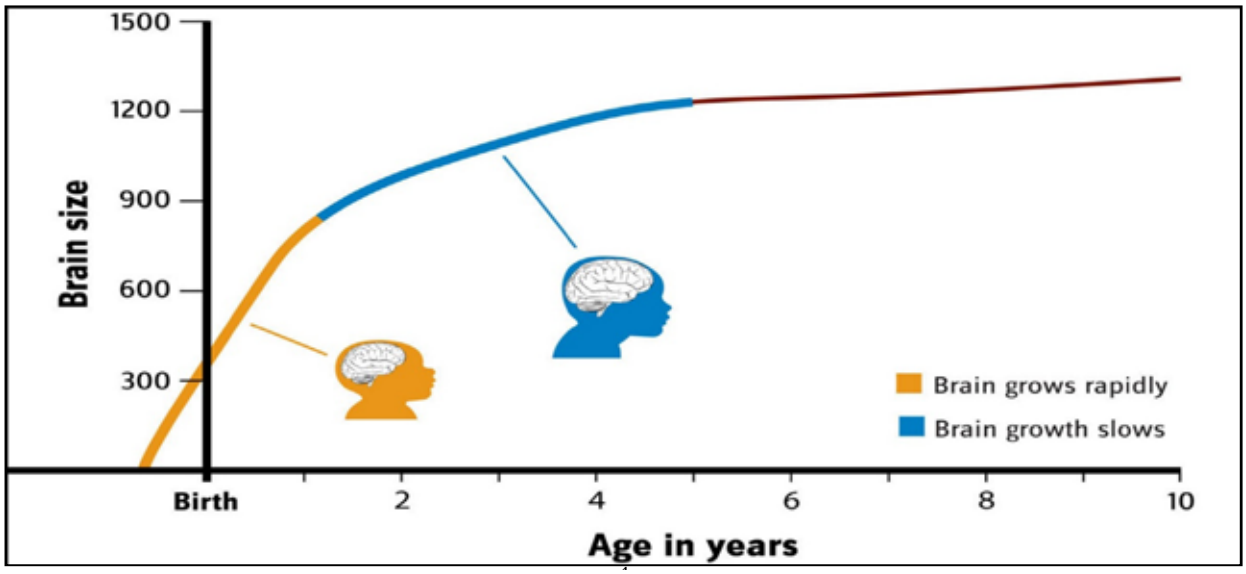


Early onset of malnutrition causes irreversible damage with reduced cognitive and physical growth and development, increased susceptibility to diseases, diminished capacity to learn, poor performance in school and a lifetime of lost earning potential. This, in order to fully realize the potential of our children, capitalize on our demographic dividend and catalyse economic growth, urgent measures are necessary as nutritional deficiencies in childhood have a compounding 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, diarrhoea 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. A comprehensive

Figure 2: The first two years of life are the key[4]



and coordinated approach is therefore 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 by the Prime Minister 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. Through a targeted approach, technological interventions and convergence, the program strives to address malnutrition holistically.

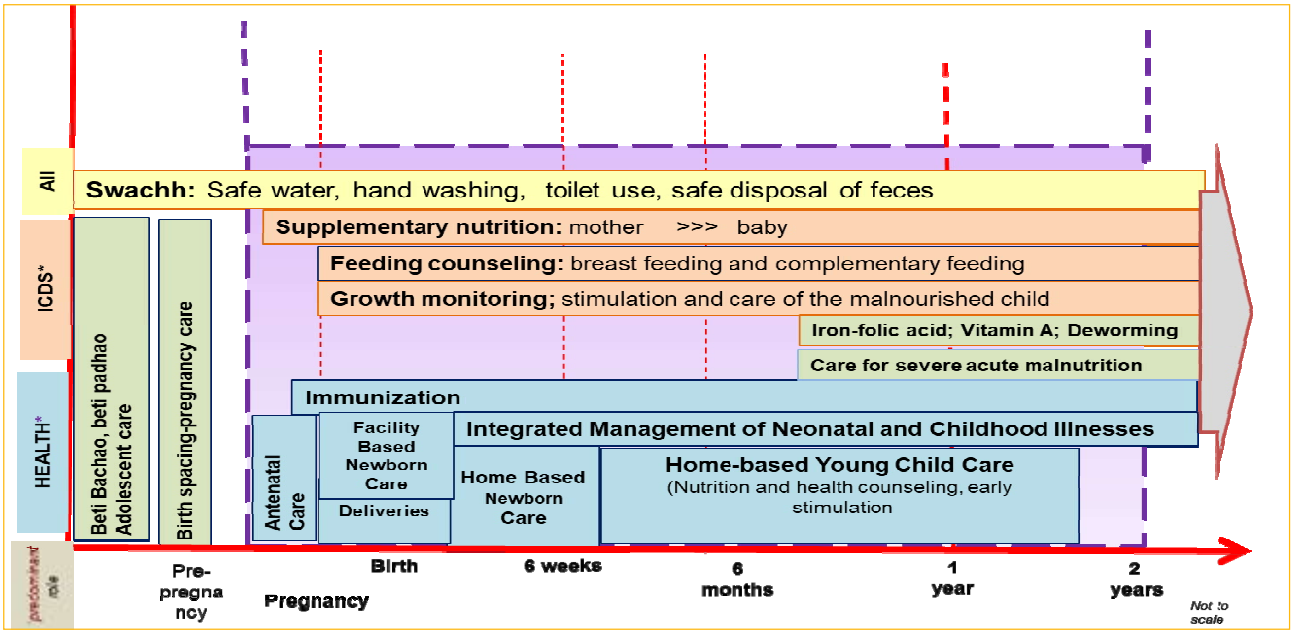
Pillars of the *Abhiyaan:*

One of the most important pillars of the *POSHAN Abhiyaan* is **programmatic convergence** for enabling the development of a shared understanding of roles and responsibilities as well as mutual accountability mechanisms across sectors. For instance, agriculture plays a crucial role in enabling the availability of nutritious food. However, within the policy arena, agriculture and nutrition are largely treated as separate issues. Similarly, although women play a key role in providing good care within the household, including nutritious food, gender-related policies rarely emphasise these vital linkages. Further, linkages with programs in sanitation are critical because although the percentage of the population defecating in the open has reduced, the density of open defection has increased, resulting in an enhanced exposure to disease causing pathogens. Such an approach would draw upon various programs in health, sanitation and gender, among other 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**. Studies indicate that 80% of the brain development occurs during this stage (Figure 2). Home visits would be conducted by frontline health workers, thereby shifting the approach from centre-based to outreach-based. This will enable the entire family to be sensitized, instead of being restricted to mothers who visit *Anganwadi* Centres. Thus, in addition to ensuring the availability of age-appropriate complementary foods, counselling families about the importance of feeding practices will be a critical element of the *POSHAN Abhiyaan*. It will ensure compliance with infant and young child feeding practices and the ability to take early corrective action, as required. Further, there will be an emphasis not just on food but a range of essential healthcare measures (Figure 3), including birth spacing, delaying age of marriage, exclusive breastfeeding for 6 months and immunization (Rota Virus and Pneumococcal).

For optimal nutritional outcomes, coordination among the different frontline workers (Accredited Social Health Activists, Auxiliary Nurse Midwifes and *Anganwadi* Workers) is essential. To enable this, the *Abhiyaan* will also focus on providing **joint**

Figure 3: Package of interventions to be provided during the first 1,000 days of a child's life[5]



incentives to motivate the frontline workers for improving nutrition outcomes. This will allow them to develop a shared understanding of the tasks at hand. Moreover, they will be provided with the relevant technology tools for real-time monitoring as well as feeding information up to the state and central levels.

Incentives will also be provided to states and districts based on the improvements to the nutritional status of their respective populations in the form of both high absolute levels of achievement as well as positive changes in key indicators. Further, **greater flexibility will be given to states** so that they can focus on health and nutrition interventions that best address their needs. The geographic spread and diversity of India calls for customized interventions. The sub-group of Chief Ministers set up to review Centrally Sponsored Schemes had universally recommended a flexible component in every scheme besides decentralized decision making by states on the pattern of the *Rashtriya Krishi Vikas Yojana*. Additionally, the success of the *Atal Bal Mission* in Madhya Pradesh which provided some untied funds at the district level from state resources to supplement grants under the Integrated Child Development Services is a case in point.

Another important pillar of the *POSHAN Abhiyaan* is **enabling the scaling up of innovative and impactful service delivery models across states**. For instance, some states have adopted innovative approaches for home-based counselling and tracking of pregnant and lactating mothers as well as children under three years. In Chhattisgarh, *Suposhan* volunteers were assigned to look after a group of undernourished children at the community-level. Similarly, in Bihar, female volunteers take the responsibility of counselling and linking families with ICDS and related health services. In Maharashtra, the interaction between health and nutrition functionaries was institutionalised for addressing several under-nutrition in children through the Child Development Centres in health institutions like Primary Health Centres.

Last, but perhaps, most crucial, is the emphasis laid by the Prime Minister on taking the *POSHAN Abhiyaan* beyond a routine Government programme and making it a ***Jan Andolan***, a people's mass movement.

Educating Communities:

Household choices with respect to food types and preparatory practices impact outcomes in nutrition to a great extent. A major challenge is that

National Nutrition Month (Poshan Maah) witnesses overwhelming People's participation

September was celebrated as the Rashtriya Poshan Maah across the country to address the malnutrition challenges and sensitize our countrymen regarding the importance of holistic nutrition. Poshan Maah aimed at making people aware of the importance of nutrition & giving individual access to government services to support supplement nutrition for their children & pregnant women /lactating mothers.

Ministry of Women & Child Development as the nodal agency, launched Rashtriya Poshan Maah or National Nutrition Month, across the length and breadth of the country on the 01st of Sep 2018. With wide range of activities focussing on antenatal care, anaemia, growth monitoring, girl's education, diet, right age of marriage, hygiene and sanitation, eating healthy as themes were organised during the Poshan Maah. Entire range of themes were exhibited and showcased in form of food melas, rallies, school level campaigns, anaemia tests camps, recipe demonstration, radio & TV talk shows, seminars all across country. As per latest reports, 23 lakhs activities across the country were recorded on Jan Andolan Dashboard wherein approximately 27 crore people were reached through these activities in this nationwide exercise, out of which one third were men. In order to keep the momentum of the awareness being generated country wide, the Ministry will be awarding Exemplary performers with Poshan Awards on the 10th of this October. He also added that National Institute on Nutrition will come out with Status of India Nutrition report next year. This report, dealing with various parameters of nutrition will now be compiled annually to give more frequent feedback on status of nutrition in the country. The secretary also disclosed that the ICDS-CAS rollout is also moving at a good pace and more than 4 lakh Anganwadis will be covered by this IT tool by December this year.

families are often unaware that the young infant is slipping into malnutrition until it becomes patently visible. Educating communities about nutritious food, effective and hygienic food preparation and storage as well as improved water and sanitation is important for enabling them to make more informed choices. The success of the nutrition effort in other countries 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.

The month of September was celebrated as the National Nutrition Month *(Rashtriya Poshan Maah)* to take the message of nutrition to the last household. Going forward, it is important that a simple, common, comprehensive Social and Behavioural Change Communication (SBCC) strategy is developed which is jointly owned by all ministries and departments. This strategy would be implemented by field workers for driving social and behavioural change at the field level.

Platforms such as the monthly Village Health and Nutrition Days need to be utilised for providing counselling services to mothers and children. Further, it will be important to promote the ownership of nutrition initiatives by *Panchayati Raj* Institutions and Urban Local Bodies. These institutions have the potential to strengthen program implementation and monitoring by increasing the involvement of local communities, ensuring accountability of functionaries and facilitating programmatic convergence. Approximately 6.4 lakh Village Health Sanitation and Nutrition Committees (VHSNCs)[6], recognized as sub-committees of *Panchayats*, provide a platform for convergence at the field level among various initiatives including the National Health Mission, ICDS and *Swachh Bharat*. This can help to address the multiple determinants of undernutrition synergistically.

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 behaviours such as allowing the female members of the household to consume food only after all the male members have finished eating.

Despite significant economic growth over the last two decades and the consequent social gains it has engendered, the prevalence of pernicious and often invisible malnutrition continues to present a daunting challenge. While progress has been made, we are still lagging behind other emerging economies such as Brazil (stunting – 6.1%, wasting – 1.6%), China (stunting – 6.8%, wasting – 2.1%) & Mexico (stunting – 13.6%, wasting – 1.6%) which fare far better than us on key nutritional outcomes.

A recent World Bank report[7] estimates that about two-thirds of the workforce in India earns on average 13% less than what they would have if they had not been stunted during childhood. Another World Bank study[8] calculates that malnutrition costs India's GDP between 2 and 3 percentage points every year. With the launch of the *POSHAN Abhiyaan*, we have a historical opportunity to change these statistics and conquer malnutrition.

Disclaimer: The views expressed are of the authors alone.

Footnotes:

1 https://www.savethechildren.in/sci-in/files/d1/d14f6726-6bca-431c-9529-ce3b316ea136.pdf.

2 http://www.worldbank.org/en/news/feature/2016/06/29/india-investing-in-a-childs-early-years-for-a-stronger-economy.

3 https://www.globalnutritionreport.org/files/2017/11/Report_2017.pdf

4 Image sourced from Dr. Vinod Paul, Member (Health and Nutrition), NITI Aayog

5 Image sourced from Dr. Vinod Paul, Member (Health and Nutrition), NITI Aayog

6 https://nrhm-mis.nic.in/Pages/RHS2014.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F%28A%29%20RHS%20-%202014&FolderCTID=&View={131616BC-2B52-434A-9CB2-F7B1E4B385B4}

7 http://documents.worldbank.org/curated/en/528901533144584145/The-aggregate-income-losses-from-childhood-stunting-and-the-returns-to-a-nutrition-intervention-aimed-at-reducing-stunting

8 http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/ 223546-1147272668285/India Undernourished Children Final.pdf

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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 the existing mechanisms and foster newer strategies for tackling anemia, focused on six target beneficiary groups, through six interventions and six institutional mechanisms, to achieve the envisaged target under the POSHAN Abhiyan. A Toolkit was also released for Anaemia Mukt Bharat & Home-Based care for Young Child programmes.

The strategy focuses on testing & treatment of anaemia in school going adolescents & pregnant women using newer technologies, establishing institutional mechanisms for advanced research in anaemia, and a comprehensive communication strategy including mass/mid media communication material. A web-portal anemiamuktbharat.info has also been developed as part of the monitoring mechanism of the strategy, which would provide survey data on anemia across beneficiary groups, target prevalence of anaemia as per POSHAN Abhiyan and quarterly HMIS based reporting of programme implementation coverage upto the district level.

The programme is envisaged to be implemented as an extension to the existing HBNC programme and will be rolled out in a phased manner. In the first phase (F.Y 2018-19) the programme will be rolled out in all the identified Aspirational Districts. In the second phase, all the remaining districts under Poshan Abhiyan will be included and in the third phase programme this shall be expanded to cover all the districts in the country. Under the HBYC programme, five additional home visits (in every three months) by ASHAs are proposed after the last visit on 42nd day, as in the existing HBNC programme. Thus, the contact of new-born with the health system is extended till 2nd year of birth.

India has taken huge strides in reducing Maternal Mortality Ratio (MMR) and achieving MDGs and these initiatives will address the burden of anaemia and under-nutrition among children in the country . With an average prevalence of 40 percent across all age groups, anaemia still is a challenge which needs attention. The Home-Based Care of Young Child (HBYC) programme has an objective to reduce child mortality and morbidity by improving nutrition status, growth and early childhood development of young children through structured and focused home visits by ASHAs with the support of Anganwadi workers (AWWs).

ASHA will ensure exclusive breastfeeding till 6 months of life, adequate complementary feeding after 6 months, Iron and Folic Acid supplementation, full immunization of children, regular growth monitoring, appropriate use of ORS, appropriate hand washing practices and age appropriate playing and communication for children during each home visit. Dedicated skill building, additional incentives, provision of additional commodities and additional home visits for SNCU discharged & sick-newborns are also included in the programme.

HEALTH CARE FOR INDIA'S REMOTE TRIBES

Dr Uma C. Saha & Dr Kalyan B. Saha

To help health providers such as ASHA, AWW, ANM etc. deliver quality healthcare services dealing with complex healthcare scenarios of tribal regions, upgraded capacity building initiatives needs to be in place. There is also a need to improve the incentive mechanism for the service providers in the remote tribal areas in terms of its adequacy and promptness of its availability which will boost their morale to serve better.

India is a home to a large variety of indigenous people, they represents 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 of India constitute 8.6 per cent of its total population and at present ,there are 705 Scheduled 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 is in Madhya Pradesh (12.23 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 facilities, the lack of all-weather roads and affordable transportation, insensitive and discriminatory behaviour 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 raise their health awareness and improve their accessibility to primary health care could not bring about desired impact. Not surprisingly, tribal people suffer illnesses 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 fertility 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 have high prevalence of malnutrition-stunting and underweight- especially among preschool children and anaemia among the women in general.

The other widely prevalent health problems in tribal areas apart from malnutrition and anaemia include communicable and tropical diseases like malaria, other parasitic diseases and diarrhoea. Dr. Soumya Swaminathan, the former Director General, Indian Council of Medical Research expressed her concern over the prevalence of chronic diseases such as hypertension and diabetes mellitus, hitherto rare in these populations, is rising, and stroke and heart disease are now the leading causes of death. Another health concern mentioned by her 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. Similarly, deaths due to malaria occur disproportionately among tribals (Swaminathan, 2014).

Kyasannur Forest Disease (KFD) is also reported to be a looming threat to forest tribes with occasional deaths (*Akhter & Akhter, 2018)*. 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 behaviour.

Challenges and Need of the Hour:

Lack of awareness of health issues:

Because of high illiteracy, poor educational level and insufficient exposure to the external world tribal could not identify what is good or what is bad for them. They can't follow the preventive measures adequately due to misconception existed among them on disease transmission and thus remain vulnerable to many preventable diseases. The health services remain grossly underutilized among the tribal populations (NFHS-4; Saha *et al*. 2013). Without awareness of health issues, most tribal populations tend to fall ill more frequently and wait too long before seeking medical help, or are referred too late by untrained village practitioners.

Raising awareness of health issues is the first step towards improving health outcomes. In the past, most health awareness campaigns, which need significant investments over long periods of time for noticeable impact, were planned by the medical community instead of by communications experts. The form and content of health messages was not

pre-tested to ensure proper comprehension and absorption by target groups (The World Bank, 2012). Moreover, the campaigns' meagre effect was easily nullified by the tribal population's poor experience with health workers. So there is a requirement of local need based IEC strategy which is culturally acceptable to the tribal population concern.

ICMR-National Institute of Research in Tribal Health located at Jabalpur demonstrated designing of theatre 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. The service utilization has improved considerably in the study area with sharp decline in slide malaria positivity rate. Though there are many factors in the decline of malaria in the area, but the IEC strategy had a strong role in control of malaria and also builds a good example of public private partnership in this effort (Saha *et al.* 2015).

Health facilities in remote tribal areas:

There is always a scarcity of health care facilities in terms of infrastructure, inadequate or no drug and diagnostics and personnel in tribal areas. Further, difficult terrains in tribal areas also make existing facilities inaccessible in the area. In many tribal areas, existence of insurgency adds to the problem as service staff are reluctant to be posted there or remained absent in fear of consequences and this also acts as demotivating factor to serve tribal areas as a result a large number of staff positions lay vacant. It was also observed that where brick-and mortar health facilities were set up, they were often insufficiently equipped with drugs and medical supplies and faced a shortage of trained doctors, nurses and paramedical staff. Further vehicles frequently broke down because of poor maintenance.

Mobile medical camps to improve outreach in remote tribal populations would play a major role. The success of mobile clinics depends on effective management of medical personnel, as well as on the availability of drugs, diagnostic facilities and vehicles so that the delivery of services remains assured and consistent. It is also felt that there is a need to procure the drugs and diagnostic kits in time to effectively tackle the crisis.

As tribal populations find it difficult to navigate through the complexities of medical facilities, health workers from tribal communities may become the link between the healthcare facilities and tribal communities to guide patients, explain doctors' prescriptions, help patients take advantage of welfare schemes, and counsel them on preventive and promotive health behaviors. Further, to help healthcare providers, particularly the frontline health providers such as ASHA, AWW, ANM etc. deliver quality healthcare services dealing with complex healthcare scenarios of tribal regions, upgraded capacity building initiatives needs to be in place. There is also a need to improve the incentive mechanism for the service providers in the remote tribal areas in terms of its adequacy and promptness of its availability which will boost their morale to serve better.

Lack of emergency transportation:

Typically, pregnant women or sick persons from remote tribal hamlets are unable to make it to health facilities in time for institutional deliveries or emergency medical care for want of easily available and affordable transportation. There is a need to improve the road connectivity along with regularity and frequency of the public conveyance and telecommunication facilities in the outreach areas.

Discriminatory behaviour by health care providers:

There are deep-rooted cultural chasms between tribal groups and the largely non-tribal health care

providers, resulting in insensitive, dismissive and discriminatory behaviour on the part of health care personnel. In addition, many tribal populations face language barriers while accessing health care since their dialects are not easily understood, even by urban populations of the same state. Tribal people are frequently exploited for informal payments and are often referred to private chemists or medical practitioners with mal-intent. This is one of the main reasons why disadvantaged groups prefer to self-medicate or visit traditional healers rather than public or private health facilities. During training of health care staff, these issues should be addressed such as to reduce the discriminatory behaviors.

Financial constraints:

As most of the rural tribal populations live below the poverty line, the lack of funds influences how much and what type of health care they receive, and determine whether households are able to maintain their living standards when one of their members falls ill. Poor tribal people often have to borrow money, mortgage land or animals, or their jewellery to meet medical expenses, or else let the sick person die. They also cannot sustain the opportunity cost of a doctor's visit, much less of a protracted hospital stay, often dropping out half-way through a course of treatment as it means leaving their crops, animals, and family unattended. 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 targeted population.

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

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FINANCING RURAL HEALTH CARE

Dr K. K. Tripathy

The delivery of health services in India, 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. In this context, an attempt is made here to look into the Government's recent commitment and efforts for ensuring 'Health For All'.

The health sector, one of the vital dimensions of human development, falls primarily in the domain of federal State Governments as per the Indian Constitutional assignments. 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. In this context, an attempt is made here to look into the Government's of recent commitment and efforts for ensuring '**Health For All'**.

Rural Health Infrastructure:

India's rural health care delivery is characterised 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. While SCs are the most peripheral and the first contact point between primary health care system and the community and are responsible for bringing about behavioural change and providing services in relation to maternal and child health, family welfare and nutrition, immunisation and

control of communicable diseases, PHCs are the first contact between the village community and the medical officer. The PHCs are the main catalytic and vital organs to ensure the government's vision of health for all. As on 31st March, 2017, there were 1,56,231 Sub-Centres, 25,650 PHCs and 5,624 CHCs operating in India.

The SCs, PHCs and CHCs have increased in numbers between 2005 and 2017. However, these are not sufficient to meet their respective population norms (**Table 1**), thereby, adversely affecting smooth and door-step delivery of health care in rural areas. The coverage of rural health facility as on 31st March, 2017 indicates that additional efforts are required to establish more number of health facilities to match the norm of the health infrastructure in rural areas.

Table 1: Health Facility Status in 2017 by Population Norm

SN	Health Facility	Population Norm [Difficult Area – Plain Area]	Status [in 2017]
1	2	3	4
1	Sub Centre (SC)	3,000 – 5,000	5,337
2	Primary Health Centre (PHC)	20,000 – 30,000	32,505
3	Community Health Centre (CHC)	80,000 – 1,20,000	1,48,248

(Source: Rural Health Statistics, GoI (www.nrhm-mis.nic.in)

Health Outcomes & Goals 2020:

India has witnessed significant progress in achieving health outcomes in the last two decades. However, various key health indicators viz. Infant Mortality Rates (IMR), Life Expectancy, Malnutrition and Maternal Mortality Rates (MMR), etc. have remained below the satisfactory benchmark level and have not kept pace with the overall growth in the country's Gross Domestic Product and Gross National Income. There are also vast variations in health outcomes and service coverage between different parts of the country. This is because India's health is characterised by low levels of public spending on health care, inadequate delivery of health care services, low emphasis on preventive health, heavy dependence on private health care providers and larger share of out-of-pocket expenditure in total health care spending. Considering the current achievements in the health outcomes and the availability of health infrastructure, the government has envisioned a set of specific health goals to be achieved by 2020 (**Table 2**).

National Health Policy 2017:

The Union Government announced the revised National Health Policy, 2017 (NHP 2017) on 15.3.2017 with a view to achieve universal health coverage and deliver quality health care services to all at an affordable cost. NHP 2017 looked at problems and solutions holistically with the private sector as strategic partners and attempted to address health security by not only ensuring patient centric and quality health care interventions, but also sought to increase investments in the promotive and preventive healthcare in India.

One of the main issues before the NHP 2017 was 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 health care levels. Considering the less than adequate spending on health services, the policy advocated a comprehensive, integrated and accessible public healthcare system and, *inter alia*, envisaged the following:

Table 2: India's Specific Health Goals to be achieved by 2020

SN	Indicator	Existing [Year of Estimate]	Target 2020
1	2	3	4
1	MMR (per 1 lakh live births)	167 [2013]	120
2	IMR (per Thousand live births)	40 [2013]	30
3	Under 5 Mortality Rate (per Thousand live births)	48 [2015]	38
4	Total Fertility Rate (TFR)	2.3 [2013]	2.1
5	Incidence of TB (per 1 lakh population)	217 [2015]	130
6	Out of Pocket spending on Health Expenditure (% to total Health Expenditure)	62.4 [2014]	50.0

***(Source:** Compiled from Statistics published by NITI Aayog, 2017(www.niti.gov.in)*

- 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 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.
- Ensuring access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and progressive assurance for health.
- Reorienting and strengthening Public Health Institutions across the country, so as to provide universal access to free drugs, diagnostics and other essential healthcare.
- Achieving significant reduction in out of pocket expenditure due to healthcare costs,
- Ensuring voluntary service in rural and under-served areas on pro-bono basis by recognized healthcare professionals under a 'giving back to society' initiative.

Financing Health Care:

Health forms an integral part in the overall socio-economic development of the nation. Compared with other developing nations, the health status of India is still lagging behind in adequate public spending on medical, public health and family welfare. The gap is also quite sharper between the actual spending and the required amount in relatively economically backward states within the country. Considering the importance of health infrastructure status and the national health goal targets, the government has initiated various reform measures to augment spending on health care through specific purpose transfer to the States by allocating grants under various health care schemes. A review of budgetary allocations under the Ministry of Health and Family Welfare (**Table 3**) indicates that health care schemes got a paltry 2 per cent hike in its 2018-19 budgetary allocation vis-à-vis the Revised Estimates of 2017-18. National Rural Health Mission – that caters exclusively to the rural health care delivery got Rs. 1,179 crore less in 2018-19 over 2017-18.

Table 3 indicates that there is a considerable increase (36%) of fund allocation in 2017-18 over 2016-17. However, the BE 2018-19 for health care registered only 2% increase against the RE of 2017-18. Data from NITI Aayog indicates that the Budget 2018-19 allocated 36% less for health care against its allocation of Rs. 65,000 for that year. Further, it has allocated Rs. 1,00,000 crore for health during 2019-20 keeping in view the requirement of enhanced public expenditure on health care in India and the urgency in achieving the health outcomes committed by the government.

Table 3: Head-wise Major Allocations on Health Care Schemes (in Rs. Cr.)

SN	Health Care Schemes	2016-17 (Actuals)	2017-18 (RE)	2018-19 (BE)	Change in 2018-19 over 2017-18 (%)
1	2	3	4	5	6
1	National Health Mission (NHM) *of which*	22,454	30,802	30,130	2
(a)	National Rural Health Mission	19,826	25,459	24,280	5
(b)	National Urban Health Mission	491	652	875	34
(c)	Others	2,137	4,691	4,975	6
2	Autonomous Bodies (AIIMS/PGIMER etc)	5,467	6,971	6,900	1
3	Pradhan Mantri Swasthya Suraksha Yojana	1,953	3,175	3,825	20
4	National AIDS and STD Control Programme	1,749	2,163	2,100	3
5	Rastriya Swasthya Bima Yojana	466	471	2,000	325
6	Family Welfare Schemes	575	788	770	2
7	Others	6,331	8,924	8,875	1
	Total	**38,995**	**53,294**	**54,600**	**2**

Notes: RE: Revised Estimates; BE: Budget Estimates

***(Source:** Demand No. 42 & 43, Ministry of Health & Family Welfare, Union Budget 2018-19 [indiabudget.gov.in])*

Budget 2018-19 & 'Ayushman Bharat' Programme:

Union Budget 2018-19 underscored renewed importance to universal health care delivery to realize India's demographic dividend. It 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 Rs. 1,200 crore to finance 1.5 lakh Health and Wellness Centres to revolutionise India's health system by bringing health care system closer to the homes of the needy. These centres are required to provide not only comprehensive health care, including for non-communicable diseases and maternal and child health services, but also to provide free essential drugs and diagnostic services. Considering the ever-increasing out-of-pocket expenditure on health by lakhs of families for indoor treatment in hospitals, the government decided to launch a flagship National Health Protection Scheme to cover over 10 crore poor and vulnerable families providing coverage up to Rs. 5 lakh per family per year for secondary and tertiary care hospitalization.

The funds allocated for *Ayushman Bharat* – Health Protection Mission/Rashtriya Swasthya Bima Yojana (now be read as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana) for 2018-19 is Rs. 2,000 crores. This is an entitlement-based scheme where poor and vulnerable people in rural areas who belong to Socio-Economic Caste Census (SECC) deprivation criteria are covered under the scheme. In addition, the existing 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. The identified beneficiary families are entitled for health insurance coverage of Rs.5,00,000 per family per year, on family floater basis, for hospitalisation in any empanelled hospitals (both Public and Private), as per the approved package and package rates anywhere in the country.

Conclusion:

The present government has prioritised expenditure on health care delivery through one of its laudable innovative schemes – *Ayushman Bharat* aiming at enhanced productivity and well-being of the people. The health care budgetary support to the existing initiatives and innovative schemes may not be adequate keeping in view the health needs of the citizens and the country's performance in achieving mandated health outcomes under Millennium Development Goals. A recent estimate indicates that the public expenditure on health care in India is only 1.4% of the country's GDP whereas the world average is 6%.

The primary health care yields better health and development outcomes at much lower cost. The health outcomes of rural areas such as IMR, Under Five Mortality Rate (U5MR), TFR, etc. are relatively poor as compared to urban areas and there should, thus, be continued and concerted focus on healthcare needs of rural areas.

Government of India's Rural Health Statistics indicates that community level health facilities are not as per the required norms and there is a shortage of medical practitioners and support staff in public health facilities in rural areas. Public Health being a State subject, the primary responsibility to provide health care services to the poor and vulnerable population including urban and rural areas, arrangements of trained medical and paramedical staff, etc. lies in the domain of respective State/UT Governments. However, under NHM, technical and financial support is being provided by the Union Government for strengthening of healthcare systems in States/UTs including support for engagement of human health resources.

A PRS Legislative Research study (www.prsindia.org) indicates that about 86% of rural population are not covered under any scheme of health expenditure support of the Government. High out-of-pocket expenditure for health care pushes a sizable rural population below the poverty threshold. In this context, effective implementation of *Ayushman Bharat* – Pradhan Mantri Jan Arogya Yojana would bridge the gap between actual health expenditure and required spending by rural citizens of the country. Though the recent specific schematic intervention has the propensity to maximise social welfare of the people and to develop human capital, it is required that such increased allocation and blanket health care protection benefits are not cornered by relatively better off/affluent individuals.

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HEALTH CONCERNS OF ADOLESCENT GIRLS

Dr Sucharita Pujari

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 families.

Adolescence is a critical period in a girl's life because of significant changes in physical, emotional and social aspects of life. Adolescents aged 10–19 years, constituting, a large cohort of young people represents a great demographic dividend with the potential to contribute to India's economic growth and development (Sivagurunathan et al 2015; Singh & Ram, 2010).

About 21 per cent of Indian population is adolescent and forms a major demographic and economic force facing the challenges like poverty, lack of access to health care services, unsafe environments etc. Adolescence is a time of great vulnerability for girls at the same time this is a stage to leverage development and opportunity to disrupt poverty. Irrespective of her stay in school or not, she faces an increased risk of early marriage, early pregnancy, maternal morbidity etc. In order to realize this potential to the fullest, young people must be healthy, educated and equipped with information skills and confidence that would enable them to contribute to their communities and the country's socio-economic growth.

Addressing the challenges during this phase with relevant information on various facets of life like health, nutrition, lifestyle related behavior, employment and livelihood opportunities to promote good health and nutrition 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 families.

Health Challenges :

The health status of adolescents determines the health status in his/her adulthood. Though adolescence is usually a healthy period, several risk factors of adult diseases which begin in adolescence can be prevented with proper interventions during this period, though with challenges. Exclusive data pertaining to the adolescent health issues in Indian scenario is not available. However based on available literature across the globe, it is observed that many of the adolescents die prematurely due to various reasons that are either preventable or treatable and many more suffer from chronic ill health and disability. 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 families.

Adolescent girls often lack social support, and community social norms can create barriers to their economic and social advancement. Rural adolescent girls continue to face issues related to limited decision making, mobility, access to resources as well as in egalitarian gender role attitudes and this is particularly evident with regard to purchase of personal items, visiting places outside their immediate neighborhood, the timing of marriage and choice of partners and the pursuit of secondary school/higher education. Girls have limited access to resources and very few have a bank or post office account either in their name or jointly with someone else. Many girls are married as children and assume adult roles of motherhood (UNESCO 2015, UNICEF 2013, Madhuri et. al 2011). Research on nutritional status of adolescents in India reveals that more than 80 per cent of the adolescent girls are either malnourished or anaemic having a low BMI. Knowledge and attitude regarding health and hygiene, exclusive breast feeding and menstrual hygiene and practices among the adolescents were either very poor or incorrect. These gaps in knowledge on reproductive health and family formation need to be addressed through innovative ways of health education in a non-threatening environment at the school and community levels. Though there has been significant improvement in the knowledge regarding small family norm, legal age at marriage and dietary care during pregnancy yet attitude towards health and hygiene is poor (Bharati and Kumar, 2015; Gopal and Premarajan 2014; Arora and Mittal, 2013)

UNICEF (2013) study on "Adolescents in India" based on review of existing evidence and programme and policies reveal that though there is ample data on adolescents but they are mostly focused on the 15 to 19 year olds, whereas adolescents aged 11 to 14 years are under studied and that it is important to acknowledge that their needs are distinct from those aged 15 to 19 years.

Government Schemes :

Recognizing the above situation, the central government launched two schemes to address the needs of adolescent girls, especially amongst the disadvantaged communities. Kishori Shakti Yojana (KSY). The scheme was launched in the year 2000 to improve the health and nutrition status of adolescent girls and to promote their around development mainly knowledge and awareness of health, nutrition, personal hygiene, family welfare and management and to upgrade the home-based and vocational skills another scheme Nutrition Programme for Adolescent Girls (NPAG) was launched in 2002-03 for adolescent girls in 51 selected districts to address under nutrition of girls. Because of limited financial assistance and coverage under KSY and NPAG, the government has combined the existing two schemes into a pilot scheme with comprehensive coverage and launched as Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA. The scheme aims to support the empowerment and development of adolescent girls aged 11-18 years by making them self-reliant, improving their health and nutritional states, promoting health awareness, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH), family and child care, life skills education and vocational training along with mainstreaming Out Of School Adolescent Girls (OOSGS) into formal and non-formal education. It covers in-school adolescent girls in the same age group for certain key services. The scheme is being implemented in 205 districts across the country. The target group of the scheme is divided into two age specific sub-groups i.e. 11-14 years and 15-18 years to address the age appropriate specific needs, interventions on health and personal hygiene care planned differently to meet the needs of two sub-group girls.

The main emphasis of the scheme is out of school girls and intends to provide all 11-18 year OOSGs nutritious fund under the nutritious

component through Take Home Ration or Hot-cooked Meal served at Anganwadi Centre. The mainstreaming of OOSGs into formal/non-formal school education is through establishing convergence with school education department. The non-nutrition component provides OOSGs to receive IFA supplementation, Health checkups and referral services, Nutrition and Health Education, counselling / guidance on family welfare, adolescent reproductive and sexual health, child care practices, life skill education for accessing public services. The out of school girls in the age group of 16-18 years are also provided vocational training under the National Skill Development Programme (NSDP). To organize and mobilize the adolescent girls, the girls were formed into groups called as "Kishori Samooh" who would assemble at the Anganwadi Centre (AWC) on regular basis for collective action, counselling and guidance activities.

The Nutrition component of the SABLA scheme covers In-School Girls (ISG) in the age group of 14-18 years are covered and Mid-day Meal Scheme. Under non-nutritional component, ISGs also meet at the AWC at least twice a month and more frequently (once in a week) during holidays. Both groups are meant to receive life skills education, nutrition, health education and awareness about socio-legal issues. The scheme also aims to create a space to enable increased interaction between in school girls and out of school girls for motivation and encourage the out of school girls to join the school education.

The scheme enables the girls for self-development and empowerment by improving health and nutritional status, increase their awareness with regards to health, hygiene, nutrition, Adolescent Reproductive and Sexual Health, family and child care, up-grade their house-based skills, life skills and vocational skills. It also intends to main stream out of school girls into formal and non-formal education and informs and guides them to access the public services such as post office, primary health center, police stations, etc, in addition to life skills education.

Case Study of Rural Rajasthan:

In view of the above background, the present article draws findings from a community based study conducted in June 2017 among adolescents' girls in six villages in Udaipur district in Rajasthan.

The findings show that more than 90 per cent of the adolescents' girls out of 171 interviewed were well aware of what constitutes health education. Many knew that ill effects of smoking, eating junk food and believed that good health is an outcome of the habits of the individual which was a very positive outcome of the study. The respondents were aware that not taking good care of one's body, may lead to infections and diseases. However knowledge regarding over cooking of the food and subsequent loss of nutrient value was considerably less. By and large the respondents had fair enough knowledge with regards to maintaining a good physical health.

With regards to personal hygiene, it was observed that most of the girls agreed that hands should be washed before eating and serving food and that one should rinse mouth regularly after eating etc.

However, it was also observed that when it comes to menstruation, many still thought that use of sanitary napkins may cause rashes and itiching and so many , from poor households, refrained themselves from using sanitary napkins which is considered a taboo and were more comfortable using cotton cloth during menstruation. The preference for cloth instead of sanitary napkins was more among tribal girls. One reason could be poor economic status of the household. Unless sanitary napkins are available free of cost through schools and anganwadi centres, girls were reluctant to use them.

It was observed that a large number of households in the villages under study use public water tap as major source of drinking water. Boiling water and filtering water through cloth were found to be most common methods for purifying water as nearly all the girls reported of the same though a slightly higher proportion felt filtering water through cloth was most effective as it keeps the germs away. Knowledge regarding other methods of purifying water was low among the respondents.

There is by and large good knowledge with regards to prevention of open defecation. The girls were aware of the ailments that may happen due to open defecation. They felt that every household should have a toilet facility. However it is another thing whether the toilet are being used or not. On being asked about the disposal of garbage waste, it was observed that most believed that garbage should not be thrown in the drainage and that it should be disposed of at a separate place. Knowledge about disposing wet and dry waste separately was however poor among the respondents.

One-third respondents did not have any knowledge regarding correct age at menarche. Some used sanitary pads available through anganwadi centres but no proper disposal method is being followed followed. Sanitary pads are either burnt or wrapped and thrown at the backyard. FGDs findings show that tribal out of school girls mostly use cloth as absorbents during menstruation. It was also found that there are strict restrictions imposed on the girls during menstruation such as restrictions from entering into the kitchen or inside areas of worship and other rooms. Most are asked to sleep on a mattress on the floor in a separate room, believing in the notion of pollution and purity. Some girls also reported remaining absent from school during the time of menstruation.

The above observations clearly show that although knowledge regarding health and hygiene is quite good but there is a need for more effective transmission of knowledge and hygiene practices related to menstruation. A lot of cultural and ritual barriers were observed during menstruation. More concrete interventions at the policy level have to be initiated. Myths regarding menstruation still prevail among many rural communities in India. In the context of the above study, early marriage of girls is also an issue of concern as poor nutrition, and early childbearing and reproductive health complications compound the difficulties of adolescent physical development.

Conclusion:

Though India has 113 million adolescent girls, which is nearly 10% of its population, they are a largely invisible group. Policies and programs are largely aimed either at children or at women, leaving adolescent girls in the gap. Girls do need an effective platform where they can voice their issues and opinions other than their schools and anganwadi centres. Much more needs to be done in terms of innovative strategies involving adoles-cents in all stages of programme development to ensure programme sustainability.

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National Health Profile-2018 Released

An Analytical Report of the National Health Profile-2018 prepared by the Central Bureau of Health Intelligence (CBHI), under the aegis of the Directorate General of Health Services at Patna, has been released by Shri Ashwini Kumar Choubey, MoS for Health and Family Welfare.

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.

Under the Collection of Statistics Act 2008, over 20 lakh healthcare establishments like hospitals, doctors, clinics, diagnostic labs, pharmacies and nursing homes would be enumerated under this census capturing data on over 1400 variables.

Approximately 4,000 trained professionals are religiously working to approach every healthcare establishment for information collection. The Indian Space Research Organisation (ISRO) is the project technology partner adhering to paramount Data Security.

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.

The vision of the NHRR project is to strengthen evidence-based decision making and develop a platform for citizen and provider-centric services by creating a robust, standardized and secured IT-enabled repository of India's healthcare resources. NHRR will be the ultimate platform for comprehensive information of both, Private and Public healthcare establishments including Railways, ESIC, Defense and Petroleum healthcare establishments.

NHRR will cohesively work with Ayushman Bharat - National Health Protection Mission (AB-NHPM) and Central TB Division (CTD) on an integrated plan for the larger benefit of ensuing Hospital empanelment and private sector engagement. This web based database of healthcare resources with visualization will immensely support the healthcare policy makers to enable evidence based decision making to strengthen the Indian health system.

The NHRR project involves conducting a national census for all public and private healthcare facilities including hospitals, doctors, clinics, blood banks, pharmacies, diagnostic labs etc. The aim of the project is to develop a comprehensive platform for over 25 lakh healthcare establishments. The platform will be very useful for all key stakeholders – government, private health establishments and the public.

The key expected outcomes of the NHRR project are to provide comprehensive data on all health resources including private doctors, health facilities, chemists, and diagnostics labs, establish a National Health Resource Repository for evidence based decision making – aligned with Digital India mission. It shall also enhance the coordination between central and state government for optimization of health resources, making 'live' and realistic state PIPs and improving accessibility of data at all levels, including State HODs, thus, decentralize the decision making at district and state level.

(Source : PIB)

ADOLESCENT HEALTH

Dr Prashant Kumar Bajpai

There are about 253 million adolescents (10-19 years) living in our country out of which, more than sixty per cent live in rural areas. They are a huge opportunity for the nation. They can transform the social & economic fortunes of the nation. There is a need for the development of mental, social and educational aspects of adolescents. Thus, we require programmes that recognize the special needs of this age group in a supporting and non-judgmental manner.

World Health Organization (WHO) defines an adolescent as any person between the ages 10 and 19 years. But the age is not the full story. Age is only a simple way to define it. It is only one feature of adolescence. There are many physical and psychological changes that occur during this phase of life. Moreover, adolescence is classified further into:

1. Early adolescence
2. Late adolescence

Early adolescence: Period between the ages of 10 to 14 years. At this stage, there is the start of physical changes in the body. Many external and internal changes occur in the body of an adolescent during this phase.

Late adolescence: The period between the ages of 15 to 19 years. Some authors divide adolescence into three age groups:

1. Early adolescence (10 to 13 years).
2. Middle adolescence (14 to 16 years).
3. Late adolescence (17 to 19 years).

There are about 253 million adolescents (10-19 years) living in our country out of which, more than sixty per cent live in rural areas. They are a huge opportunity for the nation. They can transform the social & economic fortunes of the nation. There is a need for the development of mental, social and educational aspects of adolescents. Thus, we require programmes that recognize the special needs of this age group in a supporting and non-judgmental manner.

Problems in the Adolescent Age Group:

1. Teenage pregnancy:

a) About 47 per cent of Indian women are married before the age of 18 years. (NFHS 3).

b) Unmet need for family planning in the 15-19 years age group is 27 per cent (NFHS 3).

c) About one-fifth of the pregnant girls (below 20 years of age) have no antenatal checkups.

d) Perinatal deaths and infant mortality are higher in girls aged less than 20 years.

e) The incidence of low birth weight babies is higher among adolescent mothers.

2. **Malnutrition:** NFHS 3 data showed that about 56 per cent of females and 30 per cent of males

Snapshot: Adolescent Health and Facts

- 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-4, 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 Survey, 14.6 percent of students in class 8th -10th used any form of tobacco; 4.4 percent smoke cigarettes; 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 divided 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 (10-19 years) comprises 20.2 percent of the rural population of India.
- Data from NFHS-4 showed that 10.2 percent of adolescent females (10-19 yrs) never went to school. Similarly about 7.5 percent male adolescent had no schooling.

in the 15-19 age group are anaemic. In this age-group, 47 per cent females and 58 per cent males were thin. Data also showed that 2.4 percent females and 2 percent males were obese.

3. **Violence/risk-taking behaviour:** Four risky behaviours such as sexual activity, substance abuse, risky driving and violence cause nearly half of the morbidity and mortality among adolescents.

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 Swasthya Karyakram (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 Shakti 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, life 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.

Figure: Saathiya Salah Mobile Application (android)

4. **Substance abuse:** Alcohol use during adolescent age leads to increased risks for injury, violence, and suicide attempts. Tobacco use during adolescent phase causes addiction to nicotine later in the life.
5. **Sexually transmitted infections including HIV/ AIDS:** Adolescent females are more susceptible to sexually transmitted infections than adult males because the immature lining of the cervix and the relatively low level of acidity in the vagina render it more susceptible to infection (especially in early adolescence).

Development of Adolescent Health Programmes:

It is well known that different groups among adolescents like early & late, male & female, married and unmarried, rural and urban adolescents differ in their needs. So the needs for programmes and policies are different for different types of adolescent groups. 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. These principles are:

1. **Life-course approach**: Interventions started from early childhood through their late adolescence for this generation and the next.
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 rights-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:** Programme should take consideration of similarities and differences between and within the Region of the country and also between adolescents themselves.
5. **Equity**: It builds on the concepts of heterogeneity and human rights. This principle helps to ensure that the state gives sufficient consideration to vulnerable adolescents.

A publication for Adolescent Health in South-East Asia Region by World Health Organization showed that in India:

- About 19 percent females and 35 percent males (aged between 15 to 19 years) have comprehensive knowledge of HIV.
- About 23 percent of adolescent females have Body Mass Index below 18.5.
- Current cigarette smoking and current tobacco use among 13–17 year age group old students were 1.2 and 3.6 percent.
- Among 13–17-year-old students 8.0 percent ever used alcohol. About 2.8 percent of adolescents are users of any drug one or more times in the past 12 months), and 1.9 percent used multiple

substances (alcohol, tobacco, and/or marijuana)

- Vulnerable or out-of-school adolescents (lower secondary school age) are about 14.8 percent.
- Unmet need for family planning among 15–19-year-olds was 27.0 percent.
- Maternal mortality ratio (per 1000 live births) in 10–19 years females in the year 1990 was 254.6; in the year 2000 became 220.6 which was further reduced to 121 during the year 2015.

Rashtriya Kishor Swasthya Karyakram (RKSK)

RKSK identifies 6 strategic priority areas for adolescents:

- **Improve nutrition**: Reduce the prevalence of malnutrition, Reduce the prevalence of iron-deficiency anaemia.
- **Improve sexual and reproductive health**: Reduce teenage pregnancies, Improve birth preparedness, provide early parenting support for adolescent parents, Improve knowledge and behaviour, in relation to SRH.
- **Enhance mental health**
- **Prevent injuries and violence**
- **Prevent substance misuse**
- Address NCDs

Interventions under RKSK:

- **Adolescent Friendly Health Clinics (AFHCs):** In India, 7298 AFHCs have been established and about 60 lakh adolescents avail services in a year.
- **Weekly Iron Folic Acid Supplementation (WIFS):** Programme aims to cover a total of 11.6 crore beneficiaries both in-school and out-of-school.
- **Menstrual Hygiene Scheme:** Rs. 44.76 crores have been allocated through National Health Mission to the Eighteen States for decentralized procurement of Sanitary Napkins during the FY 2017-18.
- **Peer Education (PE) Programme:** About 1.93 Lakh PEs have been selected and are being trained.

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 Acid (IFA) supplementation, Health check-up and Referral services, Nutrition & Health 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.

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).

Peer Educators:

- Act as a catalyst for generating demand for the adolescent health services.
- Impart age-appropriate knowledge on key adolescent health issues.

Health Ministry has launched the Saathiya Resource Kit (including 'Saathiya Salah' Mobile App). This Resource Kit comprises:

- Activity Book.
- Bhranti-Kranti Game.
- Question-Answer Book.
- Peer Educator Diary.

A mobile app named 'Saathiya Salah' (downloadable from Google play-store) is launched by the government. This application is a ready information source for the adolescents in case they are unable to interact with the Peer Educators. The mobile app is also linked to a 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 the toll-free helpline.

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Accredited Social Health Activist (ASHA): Key Components of Healthcare Delivery in Rural India

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist, ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Following are the key components of ASHA:

- ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
- She should be a literate woman with due preference in selection to those who are qualified up to 10 standard wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.
- Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.
- ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.
- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.
- She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
- ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
- ASHA will mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
- She will act as a depot Holder for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Contraceptions etc.

(Source: Website of National Health Mission, M/o Health & Family Welfare)

MOBILE CONNECTIVITY FOR RURAL HEALTH

Keshav Chaturvedi

During the last five years, rural life has witnessed a dramatic shift. The agent that has brought change even in remotest areas is mobile phone. It has acted as an enabler and force multiplier for the healthcare workers and the general people alike. The communication access has fundamentally altered the reach, efficacy and effectiveness of ASHAs, Aganwadi workers and ANMs (Auxiliary Nurses and Midwifery).

Marshall McLuhan, one of the world's foremost communications 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 in the rural areas of India.

Today's rural India is a curious mix of old beliefs and brand new aspirations. And there is a constant tussle between the two. While the social set up is as regressive as it used to be a century ago, still it fires young minds to dream big and soar high to achieve their goals.

The struggle between regressive tendencies and aspirational living is more pronounced in the health sector. The makeup of the rural community is such that it rarely offers a chance to break the status quo as we saw in the blockbuster movie *Dangal*. In the movie a father tries to convince his friend, the owner of the *akhada* (wrestling gym) to let his daughters train. But he flatly refuses citing the age old traditions as well as the fear of social pressure from the villagers. This small scene is symptomatic of the malice that runs deep in the rural setting.

Since the Millennium Development Goals were formulated by the United Nations in the year 2000 the Indian Government undertook large scale efforts to meet its objective number 4,5 and 6 of reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

A lot of success has been achieved but a lot needs to be done. We now have data for the last 15 years and that big data can come in handy to create area specific communication strategies for deeper and impactful messaging and actionable information.

Persistent Challenge:

As most of the ground level workers like women working in Angawadi or ASHA workers will tell you, individuals are easy to convince but it's the group that acts as a nemesis against any new idea.

The dominant strain in any group is to maintain the status quo and the strength they enjoy in their numbers can pulverise even the strongest individual into submission, especially if they are living cheek by jowl with the same group.

Second challenge is fear of the unknown. I remember an urban middle class educated man in Lucknow staunchly resisting immunisation of his grandsons as he read a story about contaminated shots killing three newborns in Odisha. 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. And then there were few feedback mechanisms to ensure constant upgradation of services offered to the citizens.

Mobile, the Great Enabler:

The challenges mentioned above beset the majority of people everywhere, especially in rural areas. In such a scenario the initial messaging of creating awareness remains important but day to day follow up and constant communication plays a 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. The agent that has brought change even in remotest areas is mobile phone. It has acted as an enabler and force multiplier for the healthcare workers and the general people alike. The communication access has fundamentally altered the reach, efficacy and effectiveness of ASHAs, Aganwadi workers and ANMs (Auxiliary Nurses and Midwifery).

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 focussed.

With mobile phones sets proliferating everywhere, a single ASHA worker can cover a lot more ground in a day than she used to do in pre-mobile days. She can also coordinate a lot of activities and keep a tab on the progress of the people on her watch. This makes the two way communication between the service provider and the receiver very efficient and quick.

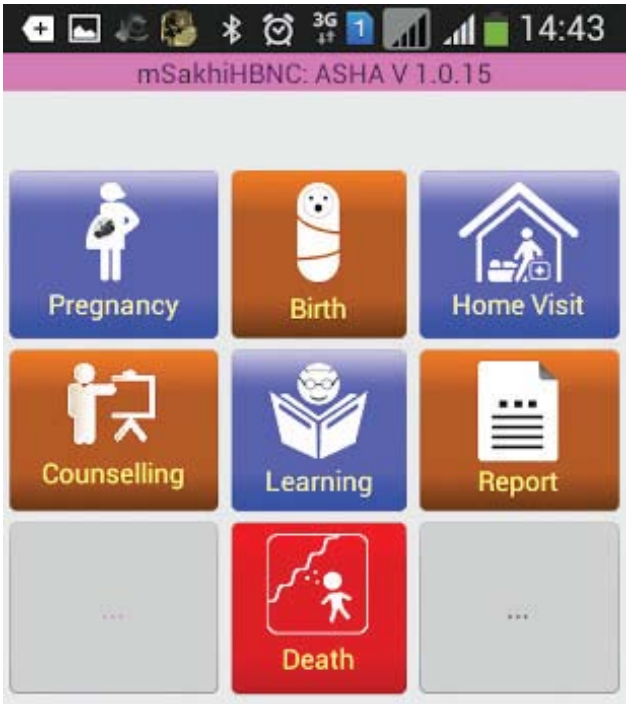
In many places ASHA workers as well as Anganwadi workers have created WhatsApp groups and communicate with their group of women spreading awareness about the new government schemes, the date of regular check for the pregnant women and for neo-natal care and well as information about immunisation drives.

Those members of the group that can't type can use the voice messaging facility to share their concern or question and can get information from ASHA workers from other members of the group who have earlier faced the same problem.

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 with a population of 15 million people, was downloaded by 12000 health workers. Initial reports suggests the app helped them to be in constant touch with their supervisors, track and report health related data of the community they are working with and also help the new parents in teaching them how to save their newborn from various illnesses. In case of urgent medical assistance, they can immediately tell the parents to connect with a doctor nearby as they can quickly access the database of all the doctors in the area and check on their availability.

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 the toll free number is meant to create



awareness among the citizens about the health issues faced by the society in general and individuals in particular. This is something that can be accessed by a villager from Bhuj to Bankura and Taran Taaran to Tirunelvelli. The app also lists government schemes and how to access them online.

Online registration system and MeraAspatal apps have created a completely new paradigm for every citizen of the country especially people in the rural areas. Generally rural areas don't have access to high quality healthcare facilities closer to their home. So they have to depend on nearby cities of faraway big towns. A lot of time is wasted in ferrying the patients, seeking appointments, collecting reports etc. 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. This initiative has plugged an important loophole in the entire government functioning. The earlier complaint diary has been replaced by an online system which is more transparent and safe. The complainant even from a remote rural area feels empowered to lodge a complaint without any fear.

Apart from this, the government has launched many apps to provide healthcare interventions and they have been especially successful in rural areas as they have bridged the spatial gap and cut the access time of the service to zero. Now the communication is instant and the action is spontaneous.

A few such initiative like Mission Indradhanush (launched in 2016) which tracks the immunisation of children and helps the parents in carrying out timely and complete immunisation programme. Similarly, India fights Dengue, NHP Swasth Bharat, NHP Directory Service, Pradhan Mantri Surakshit Matritva Abhiyan App and others have been able to not only act as the first port of call for generating awareness among the people, but also becoming an equal partner in information dissemination by actively seeking their feedback.

Another intervention that uses 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, child birth and child care. Till date, close to 6 crore successful calls have been made under Kilkari in Bihar, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand. It means close to 84 lakh women have received the full series of 72 messages.

Conclusion:

Communication interventions are needed at three critical 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 systems, reorienting the focus and service delivery mechanism for deeper and effective penetration of services.

Like in the case of reproductive health and child care initiatives where the objective was to bring down infant mortality, maternal mortality and morbidity rates by provide timely delivery of antenatal and post natal care services as well as immunisation children.

The effort over the years have 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.

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TELE-MEDICINE: A NEW HEALTHCARE OPPORTUNITY

Ayush Mishra

Tele-medicine is used across the world as one of the most powerful public health tools. Countries like USA and South Korea are using it practically since the 1980s. Today, it is effectively practiced even in under-developed countries of Africa such as Zambia (where it was used during the EBOLA outbreak). In India and especially in a small-town rural health perspective, tele-medicine can add much larger value as compared to any other country. African countries have patients but not technology players and even good doctors, developed countries by virtue of being developed have little need, developing countries in SE Asia and LATAM are best positioned to use tele-medicine to their rural health advantage. India is at the top of this dynamics because we have the best doctors in world and best technology innovators.

I was recently watching a heated TV debate on Prime Minister's "Ayushmann Bharat Scheme". Now, in my personal view, this is biggest social reform that our country has witnessed since ages. This scheme is a stepping stone for many things positive in the rural India. This is a step where the Prime Minister and his team deserves a pat on back and commands appreciation from all quarters.

However, during the TV debate, a couple of the political critics gave thumbs down to the scheme stating that rural India doesn't have the infrastructure required. Even if you have money to pay for rural health where do you have the doctors, hospitals, etc?

I am not a political pundit myself but as someone who finds passion in addressing Indian healthcare needs, I started thinking – What if this criticism holds tight in practical world? If this come true, it will be a huge challenge for Ayushmann Scheme in many rural areas.

The solution to this is extremely simple and practical. The solution is Tele-medicine. India has roughly 550 Million internet users today out of which 210 million users are rural users. A 210M rural population today have access to internet. That makes tele-medicine one of the strongest solutions for India's poor public health infrastructure at rural and small city level.

Now let me share another story. A young college going boy meets a terrible road accident

in a small UP town when his bike is hit by a mad truck. He is taken to a local hospital and undergoes immediate surgery. However, his condition deteriorates, and his parents are told to look towards Delhi in case they want to save their son's life. "Patient ko jaldi se Delhi le jaaye" is what his doctor told his father.

His father, a common man working in a bank, is faced with immense stress and dilemma. He will have to assess

- Where to go in Delhi? How to go?
- How much will be the cost so that money is arranged in advance?
- And most importantly, will my son live if I take him to Delhi?

Fortunately, the family figures out someone who is a relative and a doctor at Apollo Hospitals, Delhi. This is in 2007 so there was not even Practo (a Health App) at the time.

The relative kindly enough connected the patient's father to a very senior surgeon at Apollo Hospitals through a telephone call. The call lasted for just 10-15 mins, but it changed everything for the patient's father. He felt re-energized and re-invigorated. He now knew the right direction and practical next steps. Later, the patient went under surgery in Apollo and lived. However, the patient lost his leg due to the long wait in decision making, when the infection crept in.

Still, the telephone call with the Apollo doctor was instrumental in guiding the patient's family. This is an amazing example of the power of Tele-medicine in smaller cities. Imagine, if at that time there was a tele-medicine clinic in that small UP city which connected that city to biggest doctors in Delhi. The patients would have saved such crucial time in decision making and who knows might have saved him his leg as well. Now, Ayushmann Scheme or a second opinion is just one of the hundred areas that requires Tele-medicine. There are many other.

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 Tele-medicine :

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.
- NEHA and Digital India are using e-health means and programs in their campaigns.
- 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.

Effective use of Tele Medicine by Hospitals

- The Apollo hospitals were one of the first to set-up a tele-medicine facility in a rural village called Aragonda 16 km from Chitoor (population 5000, Aragonda project) in Andhra Pradesh.
- All India Institute of Medical Sciences (AIIMS), New Delhi.
- Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGIMS) Lucknow.

- Post Graduate Institute of Medical Education and Research (PGIMER) Chandigarh.
- A Coronary Care Unit inaugurated in Siliguri District Hospital, Siliguri, West Bengal.
- Bankura Sammilani Hospital, Bankura, West Bengal inaugurated on 21 July 2001.
- The latest to join in is Medanta Medicity hospital who launched their Medanta E Clinics website for tele-consultation.

If government is promoting and big hospitals are interested in pursuing tele-medicine, then what is the challenge?

A tele-medicine delivery is a 3-stakeholder process:

- **Stakeholder 1:** The hospitals or doctors sitting (generally) in a big city and offering their services to patients via tele-medicine to rural patients.
- **Stakeholder 2:** The technology provider or tele-medicine facilitator who provides the platform and technology to connect doctors in big cities to patients in small cities.
- **Stakeholder 3:** The patients/a small clinic/ primary care centre based in rural areas who wish to receive tele-medicine services from big hospitals/doctors sitting in big cities.

The biggest challenge and hence also the opportunity lie with the Stakeholder 2: Technology platform/facilitator. Without the facilitator there is no tele-medicine. Currently, there is a lack of "Independent facilitators".

We need to understand this from an operations and practicality standpoint. Apollo hospitals or Medanta or any other are the care providers. It is unfair that we expect them only to be the facilitator also. It is extremely unfortunate that hospitals must lead from the front and be their own facilitators in tele-medicine area. Imagine, you are a company that specializes in making tea but because there is no-one who makes cups you are forced to make cups also. This is unfair and digressing for the tea makers who now must focus on something they shouldn't. Some government programs did support these hospitals with providing technology for them via ISRO and other sources but again Government is not the one who should be making cups for tea as well.

Ideal Facilitators:

It must be the private players, technology start-ups, private inventors and investors. It is a huge business opportunity and the private sector must take charge so that hospitals can focus on what they do best – Care for Health. There are private players who work in tele-medicine domain, but they are mainly focused on creating devices that enable tele-medicine. Few companies who are prominent in this space includes Neurosynaptic, Cardiotrack, etc.

In the past few years, few companies have taken up the challenge of creating a network of tele-medicine facilities across rural India. Private players such as Glocal Health, Tattvan E Clinics and a few others are working towards this direction but there are miles to go before this becomes the national phenomenon as it deserves to be.

Is Tele-medicine quality comparable to face to face connect?

Many of the historical tele-medicine debates have touched upon the effectiveness and quality of a tele-medicine consultation. My 2 cents on the argument are as below.

For argument sake, a friendly conversation between 2 friends is always the most enriching human experience but did that stop from Facebook to happen. Did Facebook not add value to a friendly conversation? The point is that this is the world we are living in and we are living in for good with rapidly changing technology.

Now, most people would argue that a Facebook conversation doesn't require a technical skill-set but a healthcare conversation between doctor and patient require much higher amount of sophistication. I absolutely agree with this. Let me present few technologies that are available in India today for enabling a tele-consultation.

When Apollo set-up a tele-medicine facility in a rural village in Andhra few years back, they were just using a webcam and a telephone line. Something like a skype call where the doctor was just able to see and speak with the patient without any kind of examination. However today, things have changed massively. In today's tele-medicine consult between a rural patient and a doctor sitting in Delhi, the doctor can:

- See and talk with patient in real time.
- Take "Real Time" vitals such as, 12 channel ECG, Pulse oximeter. Height and weight. Blood Pressure.
- Glucose level for Diabetes and other chronic patients.
- ENT camera.
- Fetal Doppler for pregnant women.
- Thermometer to measure temperature.
- Optical reader for eye patients.
- Spirometer.
- And an electronic stethoscope where the doctor can hear the real time auscultation voice of a patient heartbeat sitting thousands of miles away.
- Many kinds of blood tests, etc.
- The patient doesn't need to keep track of their prescription, the tele-medicine software does it for them.
- Some solutions even use Artificial Intelligence to predict patient's health based on all vitals which helps the consulting physician understand the patient better.

Not only tele-consult, we have practical technology to do even tele-pathology and tele-radiology. There are a few who are doing it as well.

The Business of Tele-Medicine:

Currently in India, tele-medicine revenue comes majorly from the companies who makes these devices for tele-medicine. Only a handful of private companies are facilitating tele-medicine in rural and small cities. However, the opportunity is huge to say the least. An average of 30-35% of admissions in big city hospitals come from small cities and villages from nearby areas. This is a huge number. It effectively means that each year millions of Indians travel to far of cities from home for better healthcare requirements.

This is a huge opportunity for any private player to invest in the system. A country as big as India offers a playground for healthcare visionaries to experiment, fail and create a solution that works.

Imagine, a solution where we can reduce the travel and hassle of these millions of Indians each year and save time and money for them. A solution where they can get access to these state of art hospitals from their own homes. A person in a small Indian village as empowered in healthcare as any person living in New Delhi. That is the power of Tele-medicine.

Conclusion:

Tele-medicine is used across the world as one of the most powerful public health tools. Countries like USA and South Korea are using it practically since the 1980s. Today, it is effectively practiced even in under-developed countries of Africa such as Zambia (where it was used during the EBOLA outbreak).

In India and especially in a small-town rural health perspective, tele-medicine can add much larger value as compared to any other country. African countries have patients but not technology players and even good doctors, developed countries by virtue of being developed have little need, developing countries in SE Asia and LATAM are best positioned to use tele-medicine to their rural health advantage. India is at the top of this dynamics because we have the best doctors in world and best technology innovators. As far as I see, I foresee a scenario where all 600+ districts have access to best of country's healthcare and there is only one thing that can make it possible – Its Tele-medicine.

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SWACHH BHARAT MISSION: INDIA'S SANITATION REVOLUTION

V. Srinivas

The Swachh Bharat Mission sought to reform the sanitation sector with the primary focus being on behavioural changes as the fundamental tool for achievement of Open Defacation Free outcomes. The Swachh Bharat Mission represents a national movement with diverse stakeholders comprising of Central Ministries, State Governments, local institutions, non-government and semi-government agencies, corporates, NGO's, faith organizations and media. This approach is based on the Prime Minister Narendra Modi's call that Swachhta has to be everyone's business and not only that of the sanitation departments.

Public sanitation was a subject about which Gandhiji was deeply interested throughout his life. Gandhiji devoted a great deal of time to instilling in Indians an appreciation of the importance of sanitation and tried to rouse the Nation's consciousness on this vital issue. It is important to note Gandhiji published works devote significant attention to the cause of public sanitation, on parity with his focus on Satyagraha, Ahimsa and Khadi.

Gandhiji vision of an ideal village was one with perfect sanitation, village lanes and streets free of all avoidable dust. In his book "Ashram Observances in Action", Gandhiji writes that sanitary service is an essential and sacred service and yet it is looked down upon in society, with the result that it is generally neglected and affords considerable scope for improvement. The Ashram, laid emphasis on engaging no outside labor for this work. The members themselves attend in turns to the whole of the sanitation. The Ashram designed simple, easy to use latrines that did not require a scavenger to clean. The Sevagram Ashram rules laid down that it was necessary that inmates must wash their hands with pure earth and pure water and wipe them with a clean napkin.

Public Sanitation has been accorded significant importance in Gandhiji life in South Africa. In 1898, the Gandhiji family was living in Durban and it was a practice that Gandhiji or Kasturba would clean out the chamber pots themselves. Gandhiji asked his wife to clean the pot and that too cheerfully. Kasturba replied that he could keep his house and let her go. Gandhiji, in his anger, proceeded to open the gate and throw her out when she reminded him that he was going too far and that she did not have

any relatives to harbor her in South Africa. Only then did Gandhiji close the gate.

In his book "Satyagraha in South Africa", he describes his life on Tolstoy Farm - "The spring was about 500 yards away from our quarters and the water had to be fetched on carrying poles. Here we insisted that we should not have any servants… Everything therefore from cooking to scavenging was done with our own hands…The lion like Thambi Naidoo was in charge of sanitation…In spite of the large number of settlers, one could not find refuse or dirt anywhere on the farm. All rubbish was buried in trenches sunk for the purpose …A small spade is the means of salvation from a great nuisance." Everyone in the Ashram had to sanitary service, which was looked upon as a universal duty. Gandhiji concern about sanitation extended not only to ashrams but also to all aspects of human activity.

In his book "My Experiments with Truth" Gandhiji writes, plague broke out in Bombay in 1897 and there was panic all around. Gandhiji offered his services to the State in the sanitation department. Gandhiji laid special emphasis on inspection of latrines and carrying out improvements. In his inspections of untouchables' quarters Gandhiji found that they were beautifully smeared with cow dung and the few pots and pans were clean and shining. There was no fear of an outbreak in those quarters.

Gandhiji sensed a relation between poor sanitation and untouchability. People neglected sanitation because it was the untouchables sphere of responsibility. They treated the untouchables badly because the untouchables were performing a dirty task. Gandhiji felt that untouchability must be abolished and at the same time the conditions of public sanitation must be improved. Following independence, untouchability has been abolished by law and constitutional provisions for reservations in government jobs have been made. Once the curse of untouchability was lifted and constitutional provisions for reservations put in place the progress made by these communities has been significant. Gandhiji vision is embellished in the Fundamental Rights – Article 17 Abolition of Untouchability – 'Untouchability" is abolished and its practice in any form is forbidden. The enforcement of any disability arising out of "Untouchability" shall be an offence punishable in accordance with law.

The Government celebrates Gandhi Jayanti - October 2 as Swachh Bharat Diwas. Government also celebrates a 2-week sanitation fortnight -Swachhata

Hi Sewa campaign to mark the fourth anniversary of the Swachh Bharat Mission to provide an impetus to the largest sanitation campaign of India. The Swachh Bharat Mission has become a massive peoples' movement.

The Swachh Bharat Mission sought to reform the sanitation sector with the primary focus being on behavioural changes as the fundamental tool for achievement of Open Defacation Free outcomes. Inclusiveness under the Swachh Bharat Mission was achieved by designing public and community toilets keeping in mind the special needs of menstruating women, the elderly, the specially abled and small children. Further the Mission sought to promote gender sensitive information, education and communication/ behavioural changes. The Mission issued Gender guidelines in 2017 and Menstrual management guidelines in 2015.

The Swachh Bharat Mission represents a national movement with diverse stakeholders comprising of Central Ministries, State Governments, local institutions, non-government and semi-government agencies, corporates, NGO's, faith organizations and media. This approach is based on the Prime Minister Narendra Modi's call that Swachhta has to be everyone's business and not only that of the sanitation departments.

A host of special initiatives and projects have come out in quick time. The Inter-Ministerial Projects included Swachhta Pakhwadas, Namami Gange, Swachhta Action Plan, Swachh Swasth Sarvatra campaign, School Sanitation drives, Anganwadi Sanitation drives, Railway Sanitation etc. The inter-sectoral collaborations included Swachh Iconic Places, Corporate Partnership, Inter Faith Cooperation, Media engagement and Parliament engagement. Swachhta Action Plans were developed by 76 union ministries and departments and web based portal was developed to monitor progress and highlight implementation status. Women Swachhagrahis were appointed and Swachh Shakti Awards were instituted to further enhance women involvement with the program. The Swachh Bharat success stories said that accessible and secure toilets had made a big difference to the lives of village communities, as they did not have to travel distances in the dark to relieve themselves. Further the health risks of open defacation were greatly reduced by having a toilet in the house.

The Swachh Bharat Mission transformed the implementation modalities, scaling up implementation to a hitherto all-time high. The Swachh Bharat Mission is a highly successful mission – the achievement numbers are very impressive. As of July 2018, the rural sanitation coverage has reached 87.5 per cent, 7.7 crore toilets have been constructed, 413 districts have been declared open defacation free (ODF), 3.97 lac villages have been declared ODF and 19 States have been declared as ODF. A Swachh Sarvekshan is being conducted across the country to rank the districts and States on their performance on key Swachhta parameters.

Every fortnight, the Ministry of Sanitation and Drinking Water publishes a newsletter *Swachhta Samachar* which highlights the activities of various Ministries and States on Sanitation. The journey from Satyagraha to Swachhagraha has been depicted in various publications. The approach involved behavioral changes, resource allocation, community mobilization and depicting the swachhagrahis as the modern day satyagrahis. During the Champaran Satyagraha, volunteers went about cleaning the village and teaching the villagers the basics of hygiene.

The Swachh Bharat movement has become very visible with individual Ministries incorporating the Swachh Bharat Mission into their programs and Swachhta Pakhwadas are being observed all across government. The Ministry of Health and Family Welfare observed the Swachta Pakhwada in all health institutions and public health facilities of India with the tagline "Swachhta Se Siddhi". The Ministry of Environment and Forests integrated Swachhta with World Environment Day through the "Beat the Plastic" Campaign. Intensive cleaning of 24 beaches and 24 river fronts was taken up across the country. 10,000 school students participated in the mini-marathon-environment in New Delhi. The Ministry of Coal introduced the concept of Green Haat in villages surrounding coal mines. Installation of sanitary napkin vending machines was taken up in schools and postage stamps on swachhta were released. The Ministry of Labor & Employment took the initiative of a "no polythene" drive and ban plastic in their office premises of Shram Shakti Bhavan. The Ministry of Science and Technology conducted workshops on cleanliness and waste management, including a campaign on discouraging plastic usage. The Ministry of Power organized various activities like drawing competitions, debates, quizzes, essay writing, speeches and nukkad nataks for awareness generation.

States joined with their own innovative programs. Bihar launched the Swachh Jeevika Campaign on July 1, 2018. The campaign to be implemented over 45 days seeks to mobilize toilet construction in 36.4 lac self-help group members associated with Bihar's 'Baal Jeevika' Program. The campaign commenced with "Gaddha Khodo" drive in which pits were dug for 1.2 lac toilets across the State of Bihar.

Kaya Kalp (Clean Hospital) Campaign:

The Ministry of Health and Family Welfare launched Kaya Kalp (Clean Hospital) Campaign on 17th June 2015 under the Swachh Bharat Abhiyan. The implementation experience in individual departments was one of seriousness of purpose and intense passion amongst all stakeholders. The AIIMS Institutional response was to launch "Clean and Green AIIMS" campaign. I was closely associated with the Kaya Kalp (Clean Hospital) Campaign in AIIMS for nearly 3 years. The AIIMS received 2 National Awards under the Kaya Kalp (Clean Hospital) Campaign in 2016 and 2017 and was adjudged the cleanest hospital in India in 2017. It was a phenomenally successful campaign, implemented in India's largest public hospital with 33.41 lac out patients per annum, 2362 in-patients and 12000 employees. The massive increase in footfalls represented a challenge for sanitation.

The key result areas of the Clean and Green AIIMS campaign were identified as Sanitation and

Hygiene, External Environment, Hospital Upkeep, Hospital Support Services, Waste Management, Infection Control, Hygiene promotion and Feedback. The implementation framework envisaged constitution of a core committee under the chairmanship of Director AIIMS, with sub-committees being constituted in each of the key result areas. A phased action plan was drawn up for implementation with monthly review meetings and feedback to the core committee. An internal assessment was made mid-way to analyze the shortfalls and strengthen implementation.

AIIMS introduced mechanized cleaning operations in the outer areas, increased manpower deployment and incorporated a quality based cost selection in its tender processes. The mechanized cleaning was introduced through a memorandum of understanding between AIIMS and HLL Life Care Ltd., for mechanical cleaning of the outer areas. Signages were put up across the AIIMS campus along with additional dust bins across all AIIMS campuses. Electronic scroll boards for health and hygiene promotion were introduced. The increased mechanization was carefully decided based on internal consultations. A risk stratification of the AIIMS Hospital areas into high risk, moderate risk and low risk areas was undertaken as per the National Guidelines for Clean Hospitals. Sanitation rounds and checklists were prepared and weekly rounds were conducted by the Hospital Administration department, the residents in hospital administration inspected on a daily basis, the faculty in-charge of sanitation inspected on a twice every week and the Medical Superintendent inspected on a weekly basis. Sanitization and scheduling of checklists based administrative rounds by residents and faculty of Department of Hospital Administration were introduced.

AIIMS introduced washroom check lists for sanitation staff in all private wards. Washroom checklists were introduced in other areas in a phased manner. Training programs were conducted for sanitary supervisors on several aspects of Bio-Medical waste and infection were conducted. The Bio-Medical Waste and Infection Control protocols were established and a group of sanitary experts in the subject were created. AIIMS conducted Swachh Sammellans – monthly reviews and training workshops were regularly conducted.

AIIMS introduced a major campaign for hand hygiene. A robust infection control was already in place and an attire code was introduced. A major infection control team of nurses with monthly lectures were conducted. Resident Doctors were trained in high risk areas infection control practices and lectures were conducted as part of their induction program. Independent training modules were formulated for Group C staff and outsourced staff. Presentations on Kaya Kalp in Hindi were prepared for a wider audience, and survey forms for feedback from out-patients were introduced.

The Clean and Green AIIMS campaign indicated the success that a dedicated team of officials can achieve in high pressure, high visibility Institution. The institutional success story reinforces the belief that Swachh Bharat shall be achieved through introduction of mechanized cleaning practices, higher deployment of sanitation staff, improved IEC practices, high number of signages, training and creation of specialized cadres and enhanced supervision.

(The author has served as Deputy Director (Administration) AIIMS from December 2014-March 2017 when AIIMS received the National Kaya Kalp Awards for Clean Hospital Campaign for 2015 and 2016.
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Japanese Prime Minister offers support to Swachh Bharat Mission

Prime Minister of Japan Mr. Shinzo Abe has offered his Government's support to the Swachh Bharat Mission. Mr Abe said that Japan will cooperate with India, which promotes the Clean India initiative under Prime Minister Modi's leadership.

He further underscored Japan's commitment to realize healthy societies in Asia and congratulated India on the success of the Mahatma Gandhi International Sanitation Convention. "Securing clean water and improving sanitary conditions is a common challenge in the world. We hope for the further progress of each country's efforts to address the challenge through active discussions at this convention (MGISC)".

The Mahatma Gandhi International Sanitation Convention (MGISC) was a four-day international conference that brought together Sanitation Ministers and other leaders in WASH (Water, Sanitation and Hygiene) from around the world. A host of national and international dignitaries attended the event, which was inaugurated by the President and addressed by the Vice President of India.

PM Addresses Concluding Session of Mahatma Gandhi International Sanitation Convention

The Prime Minister, Shri Narendra Modi at the Mahatma Gandhi International Sanitation Convention (MGISC), at Rashtrapati Bhavan Cultural Centre, in New Delhi on October 02, 2018. The Secretary General of the United Nations, Mr. Antonio Guterres, the Union Minister for External Affairs, Smt. Sushma Swaraj, the Union Minister for Drinking Water & Sanitation, Sushri Uma Bharti, the Minister of State for Communications (I/C) and Railways, Shri Manoj Sinha, the Minister of State for Housing and Urban Affairs (I/C), Shri Hardeep Singh Puri and the Minister of State for Drinking Water & Sanitation, Shri Ramesh Chandappa Jigajinagi are also seen.

The 4-day Mahatma Gandhi International Sanitation Convention concluded on 2nd October, 2018. Giving his concluding address, the Prime Minister said that it was Mahatma Gandhi's inspiration, that led to the Swachh Bharat Mission. He added that inspired by Mahatma Gandhi, Indians have made the Swachh Bharat Mission the world's biggest people's movement. He said that rural sanitation, which stood at 38 percent in 2014, has now reached 94 percent. More than 5 lakh villages are now ODF, he added.

MGISC has been a 4-day international conference that has brought together Sanitation Ministers and other leaders in WASH (water, sanitation and hygiene) from around the world.

The Prime Minister, Shri Narendra Modi visits Mini Digital Exhibition accompanied by the Secretary General of the United Nations, Mr. Antonio Guterres at the Mahatma Gandhi International Sanitation Convention (MGISC), at Rashtrapati Bhavan Cultural Centre, in New Delhi on October 02, 2018.

The Prime Minister visited a Digital Exhibition, accompanied by the Secretary General of the United Nations, Mr. Antonio Guterres. From the dais, the dignitaries launched commemorative postage stamps on Mahatma Gandhi, and a medley CD based on Mahatma Gandhi's favourite hymn – "Vaishnav Jana To." The Swachh Bharat Awards were also distributed on this occasion.

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