

Key player in sustainable development health essay

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In the starting of 20th century women emerged as a key player in sustainable development and also involved equally in all the development works, establishing new patterns that are sustainable. However, in country like India a lot of social and cultural groups exist where women have to depend on various castes, classes and religions that yield in complexion in her life. Health is not only the absence of disease or infirmity but it is a condition that meets complete physical, mental and social vigour. Starting from the girl child this is the state which need attention as it is alarming threat to the country by rapid decrease in the child sex ratio. The sex ratios declined from 958 girls to every 1000 boys in 1991 to 934 girls to every 1000 boys in 2001. In some states in north western and western part of India the ratio goes down with less than 900 girls to every 1000 boys, and having its most terrible conditions in Punjab, Haryana, Himachal Pradesh and Gujarat where ratio is very bad going below 800 girls to every 1000 boys(RGI, MOHFW, UNFPA, 2003). In rural areas as well as in whole country the infant mortality rates are higher for females in comparison to that of males. There are some risk factors also associated with women life in India like access to health care, nutritional aspects like diet, cultural beliefs, careless attitude, family attitude, personal hygiene, gender discrimination, and work load of house hold work. Access to health care units, which are now setting up by government in rural areas, is not supported in terms of social aspects as it has a lot of limitations and boundaries. Lower nutritional intake is also creating major health problems in rural India. Nutritional deficiencies causes severe diseases like mottle enamel, anaemia and night blindness which may lead to complete blindness. The urgent need of era is to take care

of these women by providing them proper health care facilities as well as education to them and their children which will make the future. This can be successfully achieved with the involvement of Sociologists, Psychologists, Medical and paramedical professionals also with the active participation of community's old people and women itself. Income will also play a major role in making women health conscious and become healthy to become part of new developing India.

Problems faced by women in rural India

Starting from the main problem of lack of nutrition in women which is the threatening and dangerous. Women need high quality nutrients in the condition of pregnancy and nursing while in some areas of India women eats at the last of the family and least which is making it more vulnerable to anemia which is due to lack of essential nutrients and studies showed that mainly pregnant women die every year by suffering from anemia. Lack of nutrition also affects the children who are taken care by them as nursing and result in impaired physical and mental development (Dunbar, 2011).

Reproductive health is also a serious problem persist in India as Indian women feel embarrassed to talk about their reproductive health. However, the changing era has showed some new ideas as women are talking about gynaecological and sexual disease with ANMs or ASHAs. Maternal mortality is also a serious concern not only in rural areas but also in urban ones. The causes of deaths are bleeding during pregnancy and child birth and anemia, poor weight gain of women during pregnancy and unsafe abortions.

Luxurious life style and feeding habits in women leads to the problem of infertility which results in mental health as well as impair social and marital

relationships (Mishra, 2006). Women health in India will be studied under the heads like what are the lacunae and how we can overcome to those lacunae going through all the systems prevalent in India and how they operate, are as follows:

2. 1 Public infrastructure:

In rural areas of India healthcare facilities has been developed in three tier structures based on prearranged population norms. Starting from the upper most tier that is community health centres (CHC) are established and maintained by the state government under the Basic Minimum Service Programme (BMS) and Minimum Need Programme (MNP). The group of four medical specialists including Surgeon, Physician, Gynaecologist and Paediatrician supported by twenty-one paramedical and other staff members. A community health centre is equipped with advanced medical facilities consist of thirty in-door beds, laboratory facilities, operation theatre, X-ray and labour room. A community health centre also work as a referral centre for four primary health centres which comes under its jurisdiction areas and provide facilities for obstetric care and specialist expertise. Second tier in rural health care structure comprises of Primary Health Care (PHCs) that is engaged in providing integrated curative and preventive health care to the rural population with specially stressed on preventive and promotive points, which include promotion of better health and hygiene facilities, tetanus inoculation of pregnant women etc. primary health care are also established and maintained by state governments under the Minimum Need Programme (MNP) or Basic Minimum Service Programme (BMS). The staff consists of a medical officer which is in charge of Primary Health Care and

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supported by fourteen paramedical and other staff members. As Community Health Centre it also works as referral unit for six sub-centres working at village or gram panchayat level. The facilities provided at primary health care are that it has four to six beds for in-patients. The primary health care are indulge in activities like curative, preventive and family health care services. The lowest tier of the public infrastructure comprise of sub-centres operating at village level. It is the first contact point between the people of respected area and the primary health care system. Staff of sub-centres consists of Auxiliary Nurse Midwife (ANM) and one male Multi-purpose worker (MPW-M). A lady designated as Lady Health Worker is the in charge of six sub-centres. Each lady health worker care of minor ailments and provide basic drugs for that. The lady health worker also dedicated to provide their services to village people in several aspects like family welfare, nutrition, immunization, maternal and child health and control of communicable diseases. Sub-centres are also devoted to bring behavioural changes in reproductive and hygiene practices that are in tradition in that area.

2. 2 Human resource

Absence of trained medical professionals, absenteeism and health infrastructure are the main lacunae in the related to human resources. Peoples engaged in rural health care system having a difficult time attracting, retaining and making continuous presence. A shortfall of all the cadres in all posts starting from medical professionals to health assistant and supported staff members exists in all parts of the country. In family welfare programmes a large shortfall of male health workers has been found. In addition to the above mentioned condition there is also a problem of poor

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involvement and participation of those who are employed. It is found that there is a great extent of absenteeism with health and education providers. Data collected by a research showed that there is absenteeism among primary health providers in India 40 percent. The problem of absenteeism is not limited to one area of the country but is having a widespread network in all parts of the country. Employees having high rank have found been to be more absent than lower ranked ones. It was also found that the employees of government health care facilities found absent from there are being indulged in their own private clinics in the mean time they being absent (Choudhury et al. 2006). There are also some supporting aspects of absent employees that help them to be absent with good excuses like road connectivity, poor transport facilities and electricity supply in rural areas, and supply of medicines and medical equipments.

2. 3 Presence of private players

The private sectors got a dominant place in health care facilities in urban areas and now moving to rural areas. It is found that the persons seeking treatment, 78 percents are availing private non-institutional facilities and 58 percent rural patients are moving toward private hospitals. The dependence on private sectors is not limited to only rich families but poor families had also been found to consult private doctors and utilization for public facilities is also higher among poor families (NSSO, 2004). The government health service has been get lower votes despite higher cost of private doctors and their services. The reason behind that is lack of well skilled personnel and adequate infrastructure facilities and if present there is lack of accessibility, availability of service at place and time required.

2. 4 Finance in health care

In rural and urban areas there is same number of hospitalization in all cases except in diseases related to heart where more cases of hospitalization are found in urban areas. The average spending on health services for both hospitalization and non-hospitalization cases in rural areas are lower than in urban areas. However, the expenditure on per person health is lower in urban areas than in rural areas as they spend more money on health services for a person's treatment. A good amount of charges are being paid by patients while it is a rural or urban for getting health care services but the problem remains as to who will pay for the infrastructure and health care facilities that lacks and discussed in above paragraphs. Obviously it is not the user but the government have to come along some new ideas and strategies dividing share in central and state government budget. Some NGO's are also playing well in health care facilities and working successfully on health and development issues. The NGOs tied up with state owned National Insurance Company and designed a health insurance product that fulfil the demand for health facilities to rural persons as and when they feel a need for it. Also special arrangements made for the people living below poverty line that they receive free treatment in public health facilities. Lack of awareness and knowledge about various schemes that are available in rural areas is one of the hindrances in the success of rural health insurance. In the lack of awareness of insurance schemes the rural people borrow loans (Health Care Management, January, 2006). (<http://www.expresshealthcaremgmt.com/200601/focus01.shtml>).

How we can achieve the goal

Using information technology to improve the delivery of health services is the best way to overcome from the problems persists in rural areas. In the way with information technology distance health care is also a good solution where expert advice will be made available at a centre point and is accessed as and when required by the patient with the help of internet or telephone.

3. 1 At Primary health care

Primary health care unit would be equipped with basic diagnostic equipments that can be operated by doctors or supporting staff like Auxiliary Nurse Midwife (ANM) and doctor can provide expert interventions from a distance on the data collected and observed by ANM. The nurses of primary health care unit should be trained in such a way that they can maintain a medical history and record of every consultation, thus building up a patient database for further reference. A symptom-based diagnostic application which is computer operated will help the nurse in handling common ailments directly by applying simple remedies and only refer that patient if problems are o more complex to secondary health care.

3. 2 At Secondary health care

Online connectivity of the hospitals or secondary health care units to the primary health care will help in saving the time consumed by OPDs done by doctors at government hospitals at block or districts level and providing the facility like OPD at primary health care. The patients will only refer to doctors by ANM if the problem is complex or serious with a unique ID printed on a smart card that will help in reducing queues at hospitals. If there is a need

for tests, online registration with the help of unique id will help in making the patient to know the appropriate time to visit the hospital and with required money.

3. 3 Mobile health care

High quality consultation and diagnostic services in rural India can be provided with the help of the concept of mobile health care. In which blood sample collection, an ultra sound or an X-ray facilities will be provided on a mobile health care clinic. It will help in saving time and money in rural areas that often spend in moving from villages to town. The mobile health clinic will also have the facility to distribute medicines required to village patients. Doctor also moves with mobile health care and is able to consult the serious cases and if extreme care is required the patient will refer to tertiary health care unit.

3. 4 Tele-preventive medicines

The term ' tele-preventive medicine' (<http://www.pitt.edu/~super2/GRANT/sig.htm>) is defined as the use of the internet to collect information from large number of people (both healthy and sick) to prevent outbreak of disease. Developing the database related to serious diseases on internet will help the new practitioners to get the help from internet and to cure the disease with the help of matching data available on internet related to disease. A UNICEF sponsored study in West Africa used GIS to map villages with high rate of Guinea-worm disease (<http://home.myuw.net/bjtemp/afr.html>). The same work is also going on in India in the National Institute of Epidemiology to map the effect of leprosy vaccine trials.

3. 5 National Rural Health Mission

In April 2005 government of India had launched a health programme named National Rural Health Mission (NRHM), which is aimed to provide effective health care to rural population in all parts of the country with special focus on eighteen states namely Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal, and Uttar Pradesh. The mission will cover all the villages of related states with the help of Accredited Social Health Activists (ASHA) who linked with the villages and health centres. The ASHA advise village people about immunization, hygiene, contraception and sanitation for many diseases and refer patients to health care centres. For working with villages and providing their best services like promoting universal immunization, referral and escort services for rural people ASHA will receive performance based compensation. National Rural Health Mission have some goals related to health in rural areas like reduction of infant mortality rates and maternal mortality rates, child health, water, sanitation and hygiene, prevention and control of communicable and non-communicable disease, population stabilization, gender and demographic balance and promotion of healthy life styles. To achieve the above mentioned goals NRHM is working with some strategies like train and enhance Panchayati Raj Institutions to control and manage public health services, developing a health plan for each village, strengthening the sub-centres, provision of 24 hours services at primary health care centres etc (Ministry of Health & Family Welfare 2005).

([http://www. corecentre. org/nrhm](http://www.corecentre.org/nrhm))