HEALTH NOITALUPOPDNA - SEUSSIDNASEVITCEPSREP

[NITELLUBEAHINGNITAROPROCNI (TSE. 1968) HCRAESERNOITALUPOPFOLANRUOJEHTDNA (DTSE. 1974)]

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IMPROVEMENT IN KNOWLEDGE AND PRACTICES OF ADOLESCENT GIRLS ON REPRODUCTIVE HEALTH WITH FOCUS ON HYGIENE DURING MENSTRUATION IN FIVE YEARS

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ABSTRACT

To find out the improvement of knowledge and practices of menstrual hygiene among adolescent girls (AGs), NIPCCD conducted a study in 2007 and a repeat study in 2012. Five hundred AGs who had attained menarche were interviewed from one district each of Assam, Delhi, Karnataka, Madhya Pradesh and Uttar Pradesh using a pre-designed, pre-tested questionnaire. In 2012, a significant increase was observed in literacy levels ($p < 0.05$); awareness regarding onset of menstruation ($p<0.001$); use of sanitary napkins ($p<0.01$) and indigenous pad using cotton and gauze ($p<0.001$); consultation with medical officers, AWW and ANM for guidance and treatment regarding vaginal infections ($p<0.001$) among the AGsas compared to 2007. Regarding socio-cultural practices, no ceremony was performed on attainment of menarche in 2012 among any AGs as against 56.8 per cent in 2007. It was observed that there was lack of accurate information on RTI/STI among AGs both in 2007 and 2012 and low awareness regarding Government programmes pertaining to improving reproductive health.

Key words: Adolescent Girls, Menstruation, AWW, ANM, Practices, Sanitary Napkins,Socio-cultural practices, Reproductive Health.

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EFFECTIVE RCH PROGRAMME: A KEY-SOLUTION TO THE SPILLOVER POPULATION OF INDIA

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ABSTRACT

The concept of Family Welfare Communication has been a neglected area in India although it is the first-ever country in the globe to initiate a nation-wide family welfare programme way back in 1952. Currently, India adds a person to its population in every two seconds but the irony is that one-third of its population lives in drastic conditions. One of the major reasons for this sorry state of affairs is that 'our communication for their welfare is very blurred'. Everything goes well in India when it comes to 'planning' of any developmental project or any welfare programme but it severely falls flat on the surface due to poor 'implementation'. The existing practice by most of our policy-makers or researchers pertaining to family welfare or population stabilization is more or less stereotyped and hackneyed by nature. To make the things worse, by and large, we have more quacks in the field of Family Welfare Communication than real communication professionals. To make the family welfare programme in the country a success and to bring the desired changes, we badly require 'communication alchemists' with maverick ideas forthwith[1]. As far as population stablisation in India is concerned, political unwillingness acts as a roadblock. Population, poverty and illiteracy form a vicious circle, each contributing to the other. Moreover, India's food security is not satisfactory. We don't have the required water resources and in recent future, we might witness water famines. Today, whatever problems we are facing, whether it is housing problem, or food, or illiteracy, transportation, water, mass migration or unemployment, etc; all are unpleasant products or by-products of uncontrolled spiraling of population.

This paper describes how the demands of the Indian population is over-powering the country's capacity on various fronts. The author advocates how the Reproductive and Child Health (RCH) component of the National Health Mission (NHM) could prove as a change-maker in India's strategy to stabilize population.

Key words: IEC, RCH, NRHM, Family Welfare, Census, Population Stabilisation.

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SOCIO-ECONOMIC DISPARITY IN CARE-SEEKING BEHAVIOUR FOR ANTE-NATAL CARE AND PREGNANCY COMPLICATIONS AMONG INDIAN WOMEN

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ABSTRACT

Ante-natal period is crucial for the survival of mothers and babies. Ante-natal complications leading to maternal mortality can be diagnosed and managed effectively during the ante-natal period. Socio-economic disparities influence ante-natal care (ANC) seeking behaviour of pregnant women. The current study focuses on the socio-economic differentials among Indian pregnant women seeking ANC for pregnancy complications. Analysis of DLHS-2 data was done for286 districts reporting maternal deaths. Out of total women studied, 35 per cent of them reported pregnancy complications. Out of the total women with pregnancy complications, unfortunately,only 45 per cent ofthem sought treatment. Routine and ANC for pregnancy complications was sought less frequently by the rural, poor, older, high parity, less educated, and women from socially backward classes and certain religious groups. Most of the women (4/5th) sought care from doctors and more than half of them approached a private institution for availing of care. The authors of this study are of the view that socio-economic inequities among women need to be minimized through a provision of quality and equitable care to manage complications to ensure better maternal outcomes.

Key words: Pregnancy complication, Ante-natal care, Socio-economic disparity, Ante-natal complications.

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RISK FACTORS FOR HYPERTENSION IN INDIA AND CHINA: A COMPARATIVE STUDY

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ABSTRACT

To identify the different risk factor for hypertension has differently impacted in India and China. A systematic review focusing on the seven independent variables was conducted. All published studies conducted in India and China with study sample of at least 130 adult population living in urban and rural areas and describing the prevalence and risk factors (age and sex, unhealthy diet, overweight and obesity, alcohol, physical inactivity, tobacco) of hypertension in India and China were included for this review. A total of 60 relevant articles which were extracted, 36 articles met the inclusion criteria. Through analyse the risk factors for hypertension,the review shows China has faced more challenges than India. This has been found that the per capita salt in-take is higher than five grams in both the countries as recommended by the WHO.

Keywords: Hypertension, Risk-factors, Prevalence of hypertension,

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A STUDY OF SATISFACTION AMONG POOR PATIENTS HOLDING HEALTH INSURANCE CARD WITH HEALTH CARE SERVICES AT TWO DISTRICT PUBLIC HOSPITALS IN VIETNAM

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ABSTRACT

*By 2008, the Health Insurance Law was passed in Vietnam to help the poor get access to formal health services. It stipulates that the poor are provided a free health insurance card that has a provision of 95 per cent reduction in hospital fees. However, since the introduction of the Health Insurance Law,no assessment has been done yet to know whether the poor patients are satisfied with the services. This study was conducted to assess the satisfaction of the poor patients holding the health insurance cards with regard to the health care services in two public hospitals at the district level, and to put up recommendations for developing appropriate policy in the future. The research only evaluated two aspects of satisfaction: (i) satisfaction with the hospital procedures prior to treatment that include scheduling an appointment, waiting time, costs, and procedure for payment; and (ii) satisfaction with the communication and interaction of health-care staff and doctor with patients. The results showed that the poor patients are not fully satisfied with the services they received. Overall, the mean scores of satisfaction were between 3.5 and 3.6. in comparison tosome foreign studies that have a satisfaction level score of over 4. It reflects that the Vietnamese poor are unsatisfied with the health-care services they are provided with. The poor patients are not really satisfied with the procedures prior to treatment, particularly the waiting time for registration and examination. This study also showed that there is no discrimination in the provision of health-care services between the two target groups i.e. the poor with health insurance cards and the general public. This non-discrimination attitude is seen not only in the hospital regulations and procedures but also in the attitude of the medical staff and doctors at the hospitals towards the poor patients. Hence, it is observed that the government's health insurance policy for the poor is partly effective. It is suggested that two hospitals should introduce scheduled appointments for examination to reduce waiting times;*must d*evelop and maintain feedback systems in public hospitals to minimize the inappropriate attitude of medical staff in general and doctors in particular; and should introduce and implement a strict bonus and penalty system for the hospital staff based on the feedback.*

Key words: Health-care services, Satisfaction, Health insurance card, Poor-patients, General patients.

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COMMUNITY HEALTH WORKER: A TOOL FOR COMMUNITY EMPOWERMENT

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ABSTRACT

Community health workers (CHWs) are broadly defined as community members who work almost exclusively in community settings and serve as a link between health-care consumers i.e. community and the health-care providers. This position helps them to identify the problems of the community people in a better way and to find out solutions for these problems with community involvement and participation. As the community health worker mainly engages women, the women are empowered by attaining the role of decision-makers who take important decisions not only for themselves but also for the entire community in relation to health and social determinants. The community is empowered to take timely and appropriate decisions for their own well-being and health. As the community health workers make the community aware of the various government programmes related to health and about government-run health facilities and services, the people in the community are coming out in greater numbers to avail of such health care services. This, in turn, has shown up many positive health outcomes that have been achieved in India after the ASHA programme under NRHM has been introduced. This paper describes the role of community health workers in making the community empowered to take decision for better health-care services for improving health and well-being.

Keywords: Community Health Workers, ASHA (Accredited Social Health Activist), Women, Empowerment.

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