University of Mysore

ABHYUDAYA

Newsletter of UGC-UPE (University with Potential for Excellence) Focus Area II   Private circulation only

Volume-1   *Issue-3*   *November-2013*   *Pages-8*   *www.uni-mysore.ac.in*

Inside...

Public Health in India: ..Page-2
Measuring Health ...Page-3
The Formation and Functions of WHO....Page-4
NRHM & NUHM..Page-5
Committees..Page-6

Karnataka Health Status

Expenditure on Health 2010-11

Public Exp. as Share of GSDP 0.87%

Per Capita Public Expenditure (in Rs) 233

Per Capita Private Expenditure (in Rs) 597

Total Fertility Rate- 2.0 (2011)

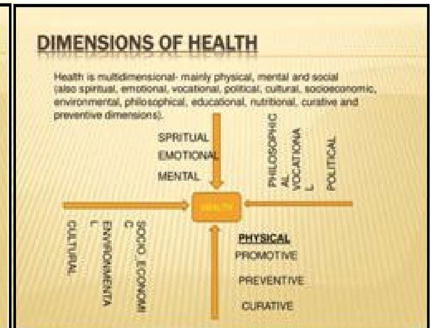
Infant Mortality Rate-35 (2011)

Life Expectancy at Birth-70.9(2011)

Health; A Multidimensional Concept

-Vagdevi H.S.

The concept of health is wide and the way we define health also depends on individual perception, religious beliefs, cultural values, norms, and social class. Generally, there are two different perspectives concerning people's own definitions of health; a narrow perspective - health as the absence of disease or disability or biological dysfunction. This limits the definition of health to the physical and physiological capabilities. Second broader perspective - the most widely used of the broader definition of health is that, Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity as defined by World Health Organization and as adopted by the International Health Conference, New York, 1946.



Health is a holistic concept and also a multidimensional one. It relates to a person as a whole. Not just the person you see, but also the person you 'feel'. Health is a triune of three parts: Physical, Mental and Emotional/Social health.

Mental Health

- Mental aptitude near or above social average.
- The ability to perceive things as they are, and not as one thinks they are.
- The ability to understand the social structure and ability to comprehend vocal and other forms of communication within that social structure .
- A reasonable ability to make judgments regarding good and bad or right and wrong.
- The ability to remember and reproduce information collected through various senses or through learning to a reasonable degree.

Physical Health

- All the body parts should be present.
- All of them in their natural place and position.
- None of them should have any pathology.
- All parts doing their physiological functions properly.
- And they work with each other harmoniously.

Emotional/Social Health.

- Able to show correct emotional response based on the stimulus.
- Able to express his/her emotions (actually, able to express the thoughts generated as a result of emotions) .
- Able to regulate the mental and physical response generated due to an emotion.

Health is Multidimensional, which is determined by Political, Socioeconomic, Cultural Environmental, Philosophical, Vocational and Nutritional factors. This means that health is a wide aspect covering almost every aspect of individual. The best definition for health that encompasses all the above was given during the Ottawa Charter for Health Promotion in 1986, the WHO said that health is: *"a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."*

Source: *World Health Organisation*

Public Health in India: Issues and Challenges

-Shivaprasad B.M

Public Health approach is a holistic approach which encompasses all elements required for healthy living. It controls disease through health promotion, specific protection and by restoration and rehabilitation. India as is moving on development process and there still persists many problems that needs to be tackled. The ever increasing population growth may affect the nation in several ways including health infrastructure. Right from the formation of the very first committee on health in 1946 (Bhore Committee) and various later committee recommendations resulted in setting up huge health care infrastructure on the basis of three tier system i.e. Primary, Secondary and Tertiary. A large number of primary health centers, community health centers and sub-centers have been established in the country.

Particulars	Required	In position	shortfall
Sub-centre	7369	8143	-
Primary Health Centre	1211	2195	-
Community Health Centre	302	323	-
Multipurposeworker (Female)/ANM at Sub Centres & PHCs	10338	8028	2310
Health Worker (Male) MPW(M) at Sub Centres	8143	3762	4381
Health Assistant (Female)/LHV at PHCs	2195	1170	1025
Health Assistant (Male) at PHCs	2195	837	1358
Doctor at PHCs	2195	2814	-
Obstetricians & Gyna ecologists at CHCs	323	215	108
Physicians at CHCs	323	192	131
Paediatricians at CHCs	323	116	207
Total specialists at CHCs	1292	691	601
Radiographers	323	30	293
Pharmacist	2518	1983	535
Laboratory Technicians	2518	1242	1276
Nurse/Midwife	4456	1647	2809

Source: RHS Bulletin, March 2008, M/O Health & F.W, GOI

Since India is passing through demographic and environmental transition which is adding to burden of diseases, there is triple burden of diseases, viz. communicable, non-communicable and emerging infectious diseases. This high burden of disease, disability and death can only be addressed through an effective public health system. However, the growth of public health in India has been very slow due to low public expenditure on health.

As per NFHS III, the pattern of health care expenditure in India shows that more than 70% of expenditure is from out of pocket i.e. by households. Estimates suggest that in India the total health expenditure is around 6% of GDP, and is dominated by out of pocket spending which is around 5%. The government/ public expenditure on health care is around 1% of GDP. Due to this low public expenditure, the reach and quality of public health services has been below the desired level.

The above table shows that the health profile of Karnataka doesn't paint an encouraging picture even after the introduction of NRHM and 108 ambulances. Low per capita health expenditure, poor sex ratio, high IMR and MMR levels are some of the major gaps in the health profile of Karnataka when compared with the neighboring states. The latest statistics from the health ministry shows that the lifestyle diseases are rampant in Bangalore and Chennai. In Bangalore, 14% and 21% people are suffering from diabetes and high blood pressure. Public health plays a predominant role in development of either individual or social. An effective public health system reduces the cost of economic burden be it individual or society as such. This shows that a holistic approach to development also include health under its umbrella. Thus, the need of the hour is effective, well covered, well reached public health service delivery. This can be effectively met with greater number of PHC's, ANM, doctors who are affordable and better medical infrastructure irrespective of rural or urban areas.

Source: *L. S. Chauhan Indian Journal of Public Health, Volume 55, Issue 2, April-June, 2011.World Health Report 2012.*

Importance of Health in Economic Development

-Nandeesha H.K.

Good health plays a substantial role in economic development. In order to explain the relationship between health and economic development, it is necessary to understand the concept of health in a broad sense. Health is not only the absence of illnesses; it is the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value. In instrumental terms, health impacts economic development in a number of ways. For example, it reduces production loss due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses. Finally, it permits the different use of financial resources that might normally be destined for the treatment of ill health.

In sum, health affects economic development directly through labor productivity and the economic burden of illnesses. Health also indirectly impacts economic development, since aspects such

(continued page-8)

Measuring Health: Indicators and the Indices

-Arjun .R

Good health is an invaluable asset for better economic productivity, both at the individual and National level; but above all, it is valued by those who own it as a prerequisite for a better quality of life and better standard of living. In this regard all those institutions that are concerned with diagnosing or investigating the Health condition or status of a person and of a society at large and those who are concerned measuring 'Health' by considering it as one of the major indicator to report Human Development of a particular region, in this very process Health is a Multi-Dimensional concept that looks at the following sub indicators such as, Death, Birth, Life Expectancy, Infant Mortality, Neonatal Mortality, Nutritional Status Among Different Age And Sex, Incidence Rate, Body Mass Index, demography profile of health that include populace in rural and urban, number of male & female, Decennial population growth, number of government and private medical institutions/ hospitals/Primary Health Centres, Number of Health Staff are the pivotal indicators that helps in understanding or drawing the health profile of a given region. They are imperative to write the Human Development Reports.

The Index Value of a Particular Indicator is Determined through Following Formula;

The Life Expectancy at Birth (LEB) index = [(female population share) × (female LEB index)-1 + (Male population share) × (male LEB index)-1]-1

$$\text{Crude Death Rate} = \frac{\text{No. of deaths during the year}}{\text{Midyear population}} \times 1{,}000$$

$$\text{Infant Mortality Rate} = \frac{\text{No. of infant deaths of age 1 during the year}}{\text{No. of live births during the year}} \times 1{,}000$$

$$\text{Neonatal Mortality Rate} = \frac{\text{No. of deaths of infant of less than 29 days during the year}}{\text{No. of live births during the year}} \times 1{,}000$$

$$\text{Post Neonatal Mortality Rate} = \frac{\text{No. of deaths of infants between 1 month to 12 months of life}}{\text{No. of live births during the year}} \times 1{,}000$$

$$\text{Under Five Mortality Rate:} = \frac{\text{No. of deaths of children under five years of age}}{\text{No. of live births of the same year}} \times 1{,}000$$

$$\text{Incidence Rate} = \frac{\text{Number of new cases of a disease occurring in the population during a specified time period.}}{\text{Number of persons exposed to risk of developing the disease during that period of time}}$$

At the end after calculating the value of required indicators the health value/index is determined by the following formula.

$$\text{Index} = \frac{\text{Actual } X_i \text{ value - minimum } X_i \text{ value}}{\text{Maximum } X_i \text{ Value - minimum } X_i \text{ value}}$$

This Health Index turns out to be one among the three Indices i.e. Health Index, Literacy Index and Adjusted Real GDP Percapita (PPP) Index to Measure Human Development of a particular region.

Source: *UNDP HDR Reports*

Women Health In India: Malnourished

-Gayathri .R

To build a strong nation one of the most important factors is the Health of women without which, all other pillars of development become weak. Health of woman is not merely a state of physical well being but also an expression of many roles they play as wives, mothers, health care providers in the family and in the changed scenario even as wage earners. Some of the important factors that influence the health of women are the reproductive health, malnutrition, awareness of available medical assistance, psychosocial factors and so on.

Women are Malnourished

Malnutrition is a frequent direct underlying cause of death among girls below age five. Gender disparity even in nutrition is evident from infancy to adulthood. The prevailing cultural and traditional practices in India worsen the health and nutritional status of women. According to a study done in Punjab, women consume approximately 1000 fewer calories per day than men and also a comparative household dietary intake in

(continued page-7)

The Formation and Functions of 'WHO' in India

-Kiranbabu .P

WHO was formed as one of the specialized agencies of UN, that demonstrates the interlinked nature of global health with global peace, with its constitution coming into force on April 7, 1948, in Geneva. At present, WHO represents 193 member states and 2 associate members. India became a party to the WHO Constitution on 12 January 1948. The WHO India office is located in Delhi. The WHO Country Office for India's areas of work is enshrined in its new Country Cooperation Strategy (CCS) 2012-2017.

WHO's secretariat focuses its work on the following six core functions:

1.Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2.Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3.Setting norms and standards and promoting and monitoring their implementation;
4.Articulating ethical and evidence-based policy options;
5.Providing technical support, catalyzing change, and building sustainable institutional capacity;
6.Monitoring the health situation and addressing health trends.

These core functions were set out in the 11th General Programme of Work, which provides the framework for work, budget, resources and results. Entitled "*Engaging for health*", it covers the 10-year period from 2006 to 2015.

Country Cooperation Strategy (CCS) 2012-2017

The WHO Country Cooperation Strategy – India (2012-2017) has been jointly developed by the Ministry of Health and Family Welfare (MoH & FW) of the Government of India (GoI) and the WHO Country Office for India (WCO). Its key aim is to contribute to improving health and equity in India. To contribute meaningfully to the national health policy processes and government's health agenda, the CCS has identified three strategic priorities and the focus areas under each priority:

Strategic priority 1: Supporting an improved role of the Government of India in global health

International Health Regulations: Ensuring the implementation of International Health Regulations and similar commitments. Pharmaceuticals: Strengthening the pharmaceutical sector including drug regulatory capacity and, trade and health. Stewardship: Improving the stewardship capacity of the entire Indian health system.

Strategic priority 2: Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population

Financial Protection: Providing universal health service coverage so that every individual would achieve health gain from a health intervention when needed. Quality: Properly accrediting service delivery institutions (primary health care facilities and hospitals) to deliver the agreed service package.

Strategic priority 3: Helping to confront the new epidemiological reality of India

Health of Mothers and Children: Scaling up reproductive, maternal, newborn, child and adolescent health services. Combined Morbidity: Addressing increased combinations of communicable and non communicable diseases. Transitioning Services: Gradual, phased "transfer strategy" of WHO services to the national, state and local authorities without erosion of effectiveness during the transition period.

Achievement of the CCS objectives calls for major adaptations in the way the WCO plans, works, organizes and delivers measurable that results towards the goal of ensuring better health for all Indians in collaboration with the government and other partners. The critical challenge for the WCO will be to adjust and scale up its capacity to provide support for the required technical excellence that would enable meaningful contributions to national health policy processes, and the government's health agenda.

Sours: *http://www.searo.who.int/india/about/en*

Child Health and Development

-Mahamadmusstaf .P.S

Every year, an estimated 26 millions of children are born in India which is nearly 4 million more than the population of Australia. It is significant that while an absolute increase of 181 million in the country's population has been recorded during the decade 2001-2011, there is a reduction of 5.05 millions in the population of children aged 0-6 years during this period. India is among the countries where child mortality rate is alarmingly high. The problem has caught attention of policy makers and researchers for several decades. The data collected and published by the Office of the Registrar General and Census Commissioner, India, show that although mortality rate among infant and under 5 children is declining over the years, there are some states where mortality rates are very high. The highest Child Mortality Rate was recorded in Madhya Pradesh (21.4) closely followed by Uttar Pradesh (20.1) and Assam (19.0). Kerala with 2.6 CMR is the best Performing State.

This shows that despite progress in health sector in the recent decades

(continued page-7)

NRHM & NUHM as Health Mission

-Srinivasa .D

Healthcare is one of India's largest service sectors. The challenges the sector faces are substantial, from the need to reduce mortality rates, improve physical infrastructure, necessity to provide health insurance, ensuring availability of trained medical personnel etc. Despite efforts by government, India's healthcare system faces challenges in providing care to its citizen. In this regard, National Health Mission plays a vital role in decreasing the disease burden, prevention and control, providing infrastructure and implementing the available programmes. National Rural Health (NRHM) and National Urban Health (NUHM) are sub missions under this broad umbrella.

The National Rural Health Mission (NRHM)

It is a lead undertaken by the Government of India to address the health needs of rural areas. It was established in April 2005. It adopted strategies to supplement the public healthcare system by partnering with the private (for-profit and non-profit) sector to provide quality healthcare accessible to poor and marginalized sections. It is initially planned to cover 18 states which have weak/poor health indicators. The Mission is an articulation of the commitment of the Government to rise public spending on Health from 0.9% of GDP to 2-3% of GDP. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team, integration of vertical Health & Family Welfare Programmes, strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream Ayurveda, Yoga, Unani, Sidda & Homeopathy (AYUSH) into the public health system. It seeks decentralization of programmes for district management of health. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.

National Urban Health Mission (NUHM)

The National Urban Health mission aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The NUHM focus on vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, listed & unlisted slum populace and other temporary migrants. It thrusts on sanitation, clean drinking water, vector control etc. The estimated cost of NUHM for 5 years period is Rs.22,507 crore with the Central Government share of Rs.16,955 crore. Centre-State funding pattern will be 75:25 except for North Eastern states and other special category states of Jammu and Kashmir, Himachal Pradesh and Uttarakhand for whom the funding pattern will be 90:10. Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing urban primary health structure. There is a provision for partnership with non government providers for filling up of the health delivery gaps. Promotion of access to improved health care at household level through community based groups: *Mahila Arogya Samittees* (MAS), The *Mahila Bachat Gat* scheme and self help groups in meeting urgent cash needs in times of health emergency and also empowering them to demand improved health services. It also provides IT enabled services (ITES) and e- governance for improving access. Under the NUHM special emphasis would be on improving the reach of health care services to vulnerable among the urban poor with city specific support strategy with a cap of 10% of the city budget.

Source: *National Health Mission – nrhm.gov.in*

Millennium Development Goals and Health

-Venugopal Gowda M.K

The United Nations Millennium Development Goals are eight goals that all 191 UN member states have agreed to try to achieve by the year 2015. The United Nations Millennium Declaration, signed in September 2000 commits world leaders to combat poverty, hunger, dise- ase, illiteracy, environmental degradation, and discrimination against women. Among eight goals three of them are to reduce child mortality, to improve maternal health, to combat HIV/AIDS.

At the end of 2012, 35.3million people were living with HIV. That same year, some 2.3 million people became newly infected, and 1.7 million died of AIDS, including 2,30,000 children. To combat people becoming infected with HIV measures have been undertaken. Expand the availability of treatment, providing the best care for people living with HIV/ AIDS and their families, expanding access and uptake of HIV testing and counselling so that people can learn their HIV status, strengthen health care systems so that they can deliver quality and sustainable HIV/AIDS programmes and services, improve HIV/ AIDS information systems, including HIV surveillance, monitoring and evaluation and operational research. 6.6 million Children under five died in 2012. Almost 75% of all child deaths are

(continued page-8)

Review of Committees on Health in India

-Deepa T.M.

Various committees of experts have been appointed by the government from time to time to render advice about different health issues. The reports of these committees have formed an important basis of health planning in India. The goal of National Health Planning in India was to attain Health for all by the year 2000. This historical survey leads to the understanding of the past health problems and the socio-political structural evolution for better health consciousness in our country.

1. Bhore Committee, 1946.

It laid emphasis on integration of curative and preventive medicine at all levels. It made comprehensive recommendations for remodelling of health services in India. Recommendations include; Integration of preventive and curative services of all administrative levels, Development of Primary Health Centres, Major changes in medical education which includes 3 - month training in preventive and social medicine to prepare "social physicians".

2. Mudaliar Committee, 1962.

It was appointed to assess the performance in health sector since the submission of Bhore Committee report. This committee found the conditions in PHCs to be unsatisfactory and suggested that the PHC, already established should be strengthened before new ones are opened. It emphasised that a PHC should not be made to cater to more than 40,000 population and that the curative, preventive and promotive services should all be provided at the PHC.

3. Chadha Committee, 1963.

This Committee was set up to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme (NMEP). The committee suggested that the vigilance activity in the NMEP should be carried out by basic health workers (one per 10,000 population).

4. Shrivastav Committee. 1975.

This committee was set up to determine steps needed to (i) re-orient medical education in accordance with national needs & priorities and (ii) develop a curriculum for health assistants who were to function as a link between medical officers and Multi Purpose Worker's (MPWs). It recommended immediate action for:

*Creation of bonds of paraprofessional and semi-professional health workers from within the community itself.

*Establishment of 3 cadres of health workers namely – multipurpose health workers and health assistants between the community level workers and doctors at PHC.

*Development of a "Referral Services Complex"

*Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission.

*Acceptance of the recommendations of the Shrivastava Committee in 1977 led to the launching of the Rural Health Service.

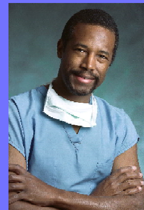
5. Bajaj Committee, 1986.

An "Expert Committee for Health Manpower Planning, Production and Management" was constituted in 1985 under Dr. J.S. Bajaj, the then professor at AIIMS. Major recommendations are :-

*Formulation of National Medical & Health Education Policy
*Formulation of National Health Manpower Policy.
*Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC.
*Establishment of Health Science Universities in various states and union territories.
*Establishment of health manpower cells at centre and in the states.
*Vocationalisation of education at 10+2 levels as regards health related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers.
*Carrying out a realistic health manpower survey.

Looking at the above committees and their recommendations, it is clear that the committees have emphasised to build health infrastructure and to increase the health staff by giving them standard training and provide them good amount of pay and incentives that would keep them energetic and confident to render their service in rural areas also. However, when it comes to the implementation of recommendations we are not up to the mark. On an average, we have 1- 2 % of GDP health expenditure in the budget. Health for poor is still in the state of poorness.

Source: National Institute of Health & Family Welfare



Health care is one-sixth of our economy. If the government can control that, they can control just about everything. We need to understand what is going on, because there are much more economic models that can be used to give us good health care than what we have now.

Benjamin Carson, Neurosurgeon

Women Health In India: Malnourished

(continued from page 3)

different parts of India shows that nutritional equity between male and female is lower in northern India than in Southern States. According to the National Institute of Nutrition more than 70% of women in Rural and tribal area are not meeting even 50% of the requirement of iron and Vitamin A and more than half of Indian women are anaemic and 2% have moderate and severe anaemia. A Study carried out by NNMB observed that anaemia was highest among lactating women (78%) followed by Pregnant Women (75%) and adolescent girls (70%)

Malnutrition of women and girls poses danger in many ways;

♦ They never reach their full growth potential;

♦ It makes them susceptible to diseases and reduces the energy that women have for daily activities such as household chores, child care and agriculture labour; and

♦ Poses risk during pregnancy

♦ Making the prevalence of chronic energy deficiency (CED) significantly higher in women

Reproductive Health

Reproductive health of the women means that they have the ability to reproduce and to regulate their fertility; and are able to undergo pregnancy and child birth safely. Reproductive health is one of major issues today; firstly, the fact that population control policies are being enforced through women as they are seen as cause and solution for population growth and secondly, alarmingly increasing problem of AIDS, STDs, increasing number of adolescent pregnancies, the growing incidence of reproductive tract infections, maternal and child mortality and morbidity, highlight the urgent need for appropriate and effective interventions of sex related matters and access to reproductive health services and information for women.

Roughly, five million abortions are performed annually in India and of these only about half a million are performed under the health services network, while another 4.5 million are done illegally. Unsafe abortion and its related morbidity and mortality are causes of concern for the reproductive health care of women in India. Also the high fertility of Indian women is one of the most detrimental social-cultural influences on nutritional status because of the metabolic stress of pregnancy and lactation.

Mistreatment and Powerlessness

Gender Based Violence (GBV) was viewed as a private or family matter until now, but WHO has considered this as a Public Health Problem. WHO estimates that at least 1 in 5 women experience violence in their lives like Domestic Violence (Physical , Psychological and Emotional abuse),Rape or sexual assault, Adolescent and adult victims of childhood sexual abuse. These kind of GBV causes not only physical injury but inflicts sever psychological pain which contribute to women's higher risk of mental health issues, particularly depression.

Hundreds of worldwide research and evaluation have shown that education of women is strongly associated with the confidence to adopt to new ways, the willingness to do and and use health services, the lowering of child death rates, the improvement of Family health nutrition, the use of family planning services and so on.

Source: *http://www.thp.org/reports/indiawom.htm*

Child Health and Development

(continued from page 4)

in India, precious young lives continues to be lost due to early childhood diseases, inadequate newborn care and childbirth-related causes. The mortality status of children in India reflects the threats in child health. The reasons for infant deaths at the earlier and later stages of infancy differ to a certain extent. Hence, infant deaths are carefully grouped in to two categories according to the age of death.

♦ The first category consists of those infants who die before they complete four weeks of life, referred to as Neonatal death cases.

♦ The Second category consists of those infants who die between 28 days and 365 days of their life which is referred as Post neonatal death cases.

The Sample Registration System, in 2010, estimated that, out of the total deaths reported, 14. 5% are infant deaths (< 1 years), 3.9% are deaths of 1 - 4 years children, 18.4% are deaths of children of 0 - 4 years and 2.7% deaths pertained to children of 5 -14 years. In spite of the recent progress in health sector, as exhibited by the statistical indicators , the situation is not adequate to ensure a bright future to the children of India. This is a multifaceted problem which is directly linked to a large extent to mother's health conditions and the safe delivery conditions and also the socio economic conditions of the family along with the country's health care system. Over the time, the nation has implemented a number of child centric programmes, much remains to be done to guarantee better health conditions to the children.

Source: *National family health survey (NFHS3) India 2005-2006*

Our greatest happiness does not depend on the condition of life in which chance has placed us, but is always the result of a good conscience, good health, occupation, and freedom in all just pursuits.

-Thomas Jefferson, US Founding Father

Importance of Health in Economic Development

(continued from page 2)

as child health affect the future income of people as it impacts on education. This indirect impact is easier to understand if it is observed on a family level. When a family is healthy, both the mother and the father can work; earn money which allows them to feed, protect and send their children to school. Healthy and well-nourished children will perform better in school and better performance in school will positively impact their future income. If parents ensure that their children reach high probability adulthood, in general they will have fewer children and they will be able to invest more in health and education for each of them. Additionally, the loss of health affects the poor to a greater extent since the main, and at times, only asset they have is their body. When they become ill they have fewer alternative solutions and suffer greater consequences.

Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy population live longer and are more productive, and save more. Good health can also alter the population growth rate in ways that promote development. Health improvements often have the greatest effect on those who are most vulnerable, children in particular. Advances in medicine and nutrition increase the likelihood that a child will survive into adulthood, and parents therefore need to bear fewer children to attain their ideal family size. High fertility, still prevalent in much of the developing world, tends to decline when child survival improves (Stark and Rosenzweig, 2006). Reduced fertility means parents can concentrate investments of time and money on a few children rather than spreading these resources across many, thus enhancing their children's prospects of leading healthier and better-educated lives. Reduced infant and child mortality lessens emotional stress on families, potentially increasing family cohesion, and gives parents more time to devote to productive activities as the need to care for sick infants decreases. Nobel Laureate Amartya Sen postulates that Health (like education) is among the basic capabilities that gives value to human life. The wealth of any nation can be measured by the health status of its citizens. This is in true confirmation of the popular adage which affirms that "Health is Wealth". In other words, health is a fundamental driver for economic growth and development. Together with education, they are the most important sectors where public attention should be focused in order to ensure greater human development.

Source: *http://www.who.int/hdp/en/*

(continued from page 5)

Millennium Development Goals and Health

attributable to just six conditions: neonatal causes, pneumonia, diarrhoea, malaria, measles, and HIV/AIDS. The aim is to further cut child mortality by two thirds by 2015 from the 1990 level. WHO promotes four main strategies, appropriate home care and timely treatment of complications for newborns, Integrated management of childhood illness for all children under five years old, Expanded programme on immunization and Infant and young child feeding. At an international level, WHO coordinates much of its policy related to maternal health through the Department of Making Pregnancy Safer (MPS). MPS was formed in 2005. The department aims to "strengthen WHO's capacity to support countries in their endeavour to improve maternal and newborn health. MPS evolved out of WHO's Safe Motherhood Initiative and focuses its work on 75 priority countries. These countries, located mostly in sub-Saharan Africa and south and central Asia account for 97% of maternal mortality.

Sours: *E-international relations.*

University with Potential for Excellence of University Grants Commission was awarded to the University of Mysore in the disciplines of Science and Social Science. In social science, the focus area of study is ***'Media and Social Development: A Case Study of Karnataka'***. The ***Newsletter ABHYUDAYA*** is an initiative to create awareness in the area of media and social development by encouraging Project Fellows to submit contributions in interdisciplinary areas of social sciences.

Core Committee of UGC UPE Focus Area-II

Prof.N.Usha rani, Prof.Y.S.Siddegowda, Prof.Muzaffar H.Assadi, Prof.R.Indira, Prof.Krishne Gowda, Prof.M.Indira, Dr.M.Devaraj, Prof.Chandrashekar, Prof.Ramesh, Dr.Nanjunda, Dr.Navitha Thimmaiah.

Editor: Prof.N.Usha Rani**; Executive Editors:** Prof.Y.S.Siddegowda & Prof.Muzaffar H.Assadi

Research Scholar Editor: Arjun.R and Vagdevi. H .S. **Designer:** Venugopal Gowda M.K.

ABHYUDAYA Newsletter is published monthly by the University Grants Commission assisted UPE - University with Potential for Excellence - Focus Area-II Project of the University of Mysore, Mysore, India. The opinions expressed by the authors do not necessarily reflect the views of the publishers. Submissions: Email; journal.msd@gmail.com