CURRENT PERSPECTIVE ON HEALTH AND DEVELOPMENT AMONG POOR PEOPLE IN INDIA

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India: At a glance

India is the world's largest democracy, the second most populous country in the world (1.21 billion people according to the provisional figures of the 2011 census) and the tenth largest economy (with a gross domestic product of US$ 1847.9 billion) in 2011. India has undergone extraordinary socio-economic and demographic changes. The population pyramid has evolved with increases in both the very young and in the ageing population, as well as an urbanization process with megacities and expanded shanty towns. The urban population increased 4.6-fold between 1951 and 2001 compared to only a 2.8-fold increase in the total population. As per census estimates, India's urban population has grown from 290 million in 2001 to 377 million in 2011, accounting for over 30 percent of the country's population. Between 1980 and 2011 India's Human Development Index improved by 1.51% annually from 0.344 to 0.547 and yet the country ranks 134th out of 187 countries with comparable data.

Health and Development

India accounts for 21% of the world's global burden of disease. India is home to the greatest burden of maternal, newborn and child deaths in the world. Infant mortality rate declined from 83 per 1000 live births in 1990 to 47 per 1000 live births in 2010 and maternal mortality ratio reduced from 570 per 100,000 live births in 1990 to 212 in 2007–2009. Though, impressive advance has occurred in addressing communicable diseases such as the significant progress towards Polio Eradication, rapid changes in India's society and lifestyles have led to the emergence of non-communicable diseases (such as heart attack, stroke, diabetes mellitus, respiratory diseases and cancer), which are already responsible for two-thirds of the total morbidity burden and about 53% of total deaths (up from 40.4% in 1990 and expected to increase to 59% by 2015). Gender issues are of great concern. The worrying proportions of selective gender abortion became even more visible with the 2011 census; the female-to-male sex ratio in the 0–6-year age group declined steeply from 0.945 in 1991 to 0.914 in 2011. The Gender Equality Index (GEI) in India is 0.748. In 2008, for gender equality, India was 122nd in the ranking among 168

countries. India is losing more than 6% of its GDP annually due to premature deaths and preventable illnesses, according to a World Bank 2010 report. Total expenditure on health is 4.2% of GDP. Of this, current public expenditure is only 1.1% of GDP.

India and poverty

In the world today 1.3 billion people still live in poverty, 840 million suffer from hunger and 2 billion are malnourished. Seventy per cent of the poor are Asians, and half of the developing world's poor live in South Asia (UNICEF, 2002). More than half of the world's malnourished and underweight children live in South Asia. India carries the double burden of disease and poverty, establishing a seemingly endless vicious circle of disease–low productivity–poverty–disease (Sharma, 2003). There is a close relationship between poverty and poor health. The poorest people in every society usually experience much higher levels of child and maternal mortality. India is the leading country where most of the World's poor people's are living (Figure 1). Healthcare is expensive, and may push some people into poverty, and poor people will generally have fewer resources available for healthcare (Figure 2).

Fig 1: A few countries the World where most of the poor people's are living.

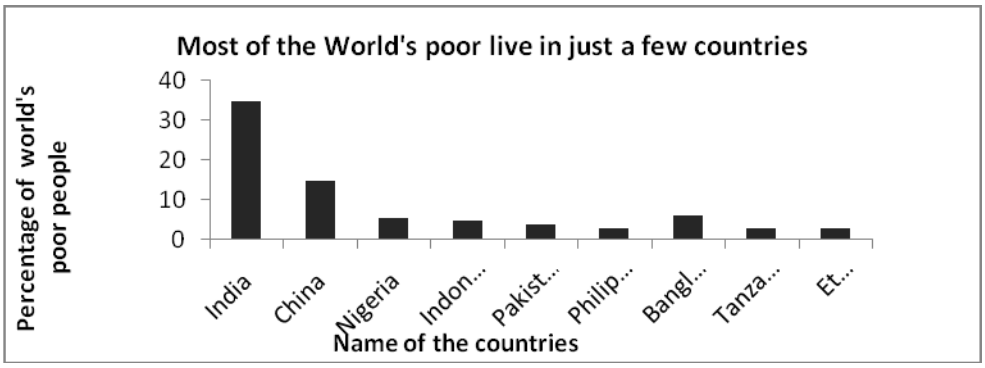
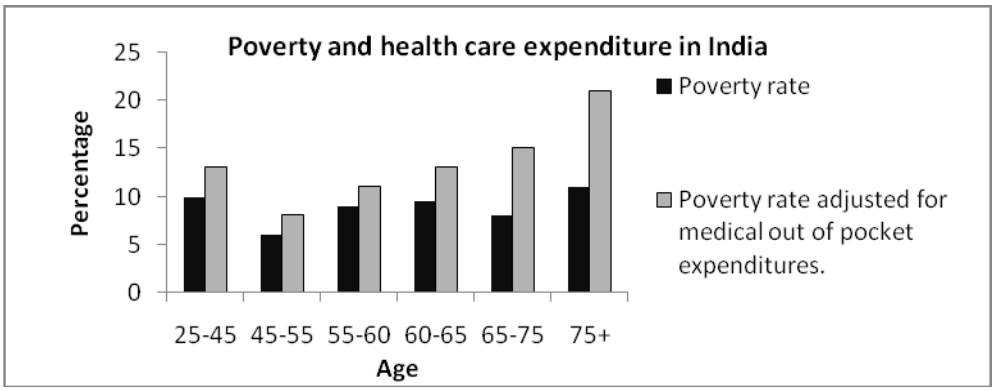


Fig 2: Poverty and health care expenditures in India (1999-2009) in different group.



Reason behind the poverty

Here are some important causes which are responsible for Poverty in India as well as in West Bengal.

a. Rapid growth of Population.
b. Immigration.
c. Poor Condition of infrastructure.
d. High amount of backward class population.
e. Traditional Agriculture Practices.

Problems related to poverty

There are serious problems related to poverty and consequences are:

a. Starvation and Death.
b. Disturbance of environment.
c. Imbalance of Economic Condition.
d. Rise of terrorist movements.
e. Poverty, significant social challenge and suicide (Manoranjitham *et. al*., 2005; Prasad *et. al*., 2006; Vijayakumar *et. al.,* 2005).
f. Distress as a result of poverty (Payne, 2000).
g. Poverty as a risk factor for mental illness (Patel, 2003).
h. The economic burden of mental disorders.
i. Mental health (Strohschein, 2005; Patel, 2006).

Poverty and diseases

The economic rise of India is likely nothing less than a fundamental realignment of the global order (Wolf *et. al*., 2006). Current income growth in these countries is paired with a rapid demographic and epidemiologic transition. The aging population and the increasing prevalence of chronic non-communicable diseases pose considerable challenges to the weak health care systems in these countries. The emerging threats from chronic diseases have not just major health implications, but also economic and financial costs (Tandon, 2005).

Adult mortality in India

The individual years of life lost are greatest for death at young ages, but even among middle-aged people, a premature death means 20 to 25 years of productive life lost, often years that would have been spent as the head of a household. Trends in mortality over the past 200 years in some areas of the world have indicated that reductions in death before old age could be achieved more widely. Specifically, death at young ages (below 30 years of age) could become a rare occurrence, and death in middle age (30 to 69 years) need no longer be common (Jha, 2002; Peto, 2002).

Avoiding the poverty traps from chronic disease

In spite of rapid economic growth in India, the health gaps between urban and rural areas and between poor and rich people are widening. The case for encompassing chronic diseases in efforts to expand health care is 4-fold.

a. These are major killers that can rob households of a lot of years of good health.
b. There are highly cost-effective interventions, as noted above and detailed in the Disease Control Priorities Project (Jamison, 2006).
c. Despite the notion that these are diseases of affluence, much of the burden of chronic disease and its risk factors are concentrated among the poor.

Approaches to control chronic disease in India for poor people

Jamison *et. al*., (2006) considered 4 approaches, for Disease Control Priorities Project.

a) Tobacco control

In India, as in most low-income countries, death in middle age increases in relative importance as the effects of smoking increase. In India, the leading causes of death from smoking are tuberculosis and heart disease, with relatively less lung cancer (Gajalakshmi, 2003). Unless there is widespread cessation of smoking, about 40 million of India's 100 million male smokers will eventually die from tobacco-related causes.

b) Hepatitis B vaccination and chronic infection

An estimated 0.4 million deaths from liver cancer occur each year in South and East Asia, many of these due to chronic infection from hepatitis B. Universal immunization with hepatitis B vaccine, which was implemented in China in 2002 but has not yet been undertaken in India, is highly cost-effective and could avert up to 90% of the estimated 1.5 million deaths from liver cancer that will otherwise occur among those born in the region in the year 2000.

c) Screening for and vaccination against cervical cancer

Nearly 150 000 women die from cervical cancer each year in South and East Asia, (Lopez, 2006) and almost all of these deaths are caused by Human Papilloma Virus (HPV). India is one of the capital countries in this aspect.

d) Low-cost combination drug therapy for vascular disease

There is considerable evidence that simple combinations of cheap drugs can be highly effective in reducing mortality among many peoples in India who already have some form of vascular disease or diabetes (Gaziano, 2006).

Diseases of poverty and the 10/90 Gap

Activists claim that only 10 per cent of global health research is devoted to conditions that account for 90 per cent of the global disease burden – the so-called 10/90 Gap. They argue that virtually all diseases prevalent in low income countries are neglected and that the pharmaceutical industry has invested almost nothing in research and development (R&D) for these diseases. Citing this alleged imbalance as justification, activists have been calling for a complete redesign of the current R&D paradigm in order to ensure that more attention is paid to these neglected diseases (Love, 2003).

Nutrition in early life and in adolescence

High prevalence of low birth weight, high morbidity and mortality in children and poor maternal nutrition of the mother continue to be major nutritional concerns in India. Although nationwide intervention programmes are in operation over two decades, the situation has not changed greatly. Some of the points have to be noticed for this aspect. Such as-

a. Fetal growth (Pojda *et. al*., 2000)
b. Nutritional status in pre-school age
c. Growth
d. Adolescent pregnancy
e. Linear components (Agarwal *et. al.,* 1992; Dasgupta *et. al.,* 1997).

Strategies for improving nutritional status and Development

In the light of the above discussion, it is necessary to discuss some strategies required for improving the nutritional status of our people. The current research highlights the need for re-examining the existing programmes, identifying their limitations, ensuring logistics and feasibility rather than proposing new programmes. The progress in improving the nutrition and health of poor people by exploiting and enhancing the synergies between agriculture, nutrition, and health through four key research components. A few strategies are following:

a. Focusing on opportunities to improve nutrition along value chains to increase the poor's access to nutritious foods.
b. Aiming to improve the availability, access, and intake of nutrient-rich, safe foods for the poor people.
c. Addressing food safety issues along the value chain, including the control of zoonotic diseases and the better management of agricultural systems to reduce the risk of human diseases.
d. Addressing the need for integration among the agriculture, nutrition, and health sectors, at both the program and policy levels.

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