International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

Implementation Plan of Healthy Lifestyle Management Program for Rural Women (Help-Her)

Arunmozhi. M

Submitted: 25-01-2022 Accepted: 05-02-2022

ABSTRACT:
This study focuses on all women of the selected rural district to enjoy the highest attainable status of health, well-being and quality of life at every age, free of preventable NCDs, avoidable disability and premature death and to reduce preventable morbidity, avoidable disability and premature mortality due to non-communicable diseases (NCDs) particularly through the HeLP – her program. This program is designed in such a way to be delivered by trained health professionals, lifestyle management counselors and by strategic implementation practioners. The Healthy Lifestyle Team shall develop a training module to support the delivery of the program in local areas and selected organizations. To create a Lifestyle management Centres and educate Women for maintaining a better Life style program to avoid NCDs and also establish Private Public Partnership (PPP) programme in lifestyle management of rural women population.

Key words: Life style Management, Non communicable Diseases.

INTRODUCTION:

Healthy Lifestyle Management Program for women (HeLP – her) continues to receive attention of researchers in the past one decade due to a close association between increasing prevalence of non-communicable diseases (NCDs) and life style[1]. It is estimated that out of the total population of 133.92 crores in India, WHO estimated that 95.69 lakh die due to NCDs. It is almost of 63% of the total death occurrence in India. Most of The NCDs occurring in India are found to be 27% cardiovascular diseases, 9% cancer, 11% chronic respiratory diseases, 3% diabetes, 26% communicable maternal, perinatal and nutritional diseases, 13% other NCDs, 11% due to injuries[2]. Nearly 80% of the deaths occurred in low and below poverty line people. India's burden of NCDs is escalating. NCDs typically present in individuals aged 55 years or older in many developed countries, but their onset occurs in India a decade earlier (≥35 years of age).[3,4] Exacerbating this problem are the issues of multiple chronic conditions and the fact many remain undiagnosed due to lack of awareness and insufficient health-care access. At the same time, infectious and parasitic diseases still pose substantial challenges to the public health system in India, resulting in a double burden of disease and an important share of the global burden of disease. It is commented that the lifestyle and food habits of people in India would account for the increasing incidence of NCDs[5]. In examining the challenges of NCDs as may be associated with lifestyle issues an important tenet of health promotion is to consider people not as isolated individuals, but as part of a wider environment. This environment is the "setting" in which people live and work, which has a profound effect on their health. Therefore the "settings" approach to health promotion takes into account all the elements of an environment, and seeks to change those negative aspects which undermine health.

The "setting" may be the home, school, workplace, town or city[6]. Humphreys & Wakerman observed that residents of rural and remote communities experience poorer health outcomes[7]. The high cost of medical treatments for most non-communicable diseases, high level of poverty and poor access to health care increased the mortality rate among the vulnerable populations[8]. There is also the gender dimension to health behaviour, access to health information, health care and health status that provides a basis for exploring the lifestyles of men and women by place of residence. Essentially, health promotion and disease prevention from a gender perspective should address the differences between women and men, boys and girls in an equitable manner in order to be effective[9].

Due to non accessibility to public health care and low quality of health care services, a majority of people in India turn to the local private health sector as their first choice of care. If we look

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

at the health landscape of India 92 percent of health care visits are to private providers of which 70 percent is urban population. However, private health care is expensive, often unregulated and variable in quality. Besides being unreliable for the illiterate, it is also unaffordable by low income rural folks.

This project is attempted to control the spread of non-communicable diseases and reduce the growing rates of mortality due to lack of adequate health facilities, special attention needs to be given to the health care in rural areas particularly for the women. The key challenges to be looked in this project are the healthcare sector which has low quality of care, poor accountability, lack of awareness, and limited access to facilities. This project tries to bridge in the need for providing rural women to enjoy the highest attainable status of health, well-being and quality of life at every age, free of preventable NCDs, avoidable disability and premature death and to reduce preventable morbidity, avoidable disability and premature mortality due to NCDs particularly through the HeLP – her program.

Rural Women and their health issues

Gender inequality is not only a pressing moral and social issue but also a critical economic challenge. India has a larger relative economic value at stake from advancing gender equality than any of the 10 regions analyzed in a McKinsey Global Institute report, The Power of Parity: How Advancing Women's Equality Can add $12 Trillion to global growth. The report says that if all countries were to match the momentum towards gender parity of the fastest-improving countries in their region, $12 trillion a year could be added to global GDP. India could add $700 billion of additional GDP in 2025, boosting the annual GDP growth by 1.4 percentage points.

In the new development discourse, women have come to be recognized as key participants in efforts to alleviate poverty and achieve social transformation. Effecting comprehensive change from a woman's point of view calls for a transformation of gender relations, not merely superficial attention to "women's needs". Research suggests that by serving a girl at the vulnerable crossroads of adolescence, development programs can have the greatest impact not only on that girl, but can empower her to be a catalyst for change in her family and community.

A woman's health is her total well-being and this is not determined solely by biological factors and reproduction but also by effects of work load, nutrition and stress, among others[10]. There are opportunities for women that live in suburban or urban communities to access health care services and health information through Internet facilities and also to discuss with other people that have similar problems on how to cope with the condition. On the contrary, Paulik, et al, observed that rural women generally have poor health and a majority of them are financially handicapped by virtue of their level of education, gender inequality, poor remuneration and lack of good employment opportunities.

Women in rural farming communities are exposed to agricultural chemicals and pesticides throughout their lives, thus increasing the risk of certain types of diseases of the skin and female organ. They are also susceptible to injury and accidents related to the use of farm machinery, which increase the risk of disability from such accidents. Women who adopt health-promoting lifestyle will prevent and control both chronic and communicable diseases and will also contribute to achieving some of the health-related Millennium Development Goals, particularly among poor and marginalized groups. Studies into health-promoting lifestyle have received attention for many decades in many developed nations.

It has been seen that the health and nutritional status of Indian rural women becoming worse due to the prevailing culture and traditional practices in India. Indian rural women are generally vulnerable to poor nutrition, especially during pregnancy and lactation. It has been pointed out that the impact of nutritional status of the mother is more pervasive than the impact of other factors on birth weight.[11] It has been observed that the dietary intake of rural pregnant women was lower than the recommended level.[12] The incidence of anaemia was found to be highest among lactating women followed by pregnant women and adolescent girls. Epidemiological studies pointed out that worldwide 50 percent of all pregnant women are anaemic, and at least 120 million women in less developed countries are underweight.[13] In South Asia, an estimated 60 percent of women are underweight. Pregnant adolescents, especially who are underweight, are at greater risk of various complications such as obstructed labour and other obstetric complication.[14] Unawareness on health care during pregnancy thus results in negative outcomes for both the mother and the child.[15] Right and proper education to the mothers had a

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

significant influence on their nutritional status and their health. The definitive steps should be taken to educate women about the importance of health care for ensuring health pregnancies and safe childbirths.

Non-Communicable Diseases and Rural Women in India

Adams, Bowden, Humphrey & McAdams reviewed the research literature from 1983 to 1991 and reported the investigation of HPL of English and Spanish-speaking Mexican Americans carried out by Kerr& Richey in 1990, showed that self-actualisation and interpersonal support received the highest scores among both groups, with the Spanish-speaking group scoring higher. Health responsibility and exercise ranked lowest[16]. A similar result was obtained in a study conducted by Duffy, Rossow, & Hernandez in 1996 among Mexican American women and other minority groups. Self-actualization and interpersonal support received the highest scores among Asian and African American women. When compared with other groups in the sample, health responsibility ranked the highest. Asian and African American women received the lowest scores on self-actualisation, exercise, and nutrition when compared to other groups[16].

NCDs are the leading cause of death in the WHO South-East Asia Region. Each year, an estimated 7.9 million lives are lost due to NCDs, accounting for 55% of all deaths[17]. Furhermore, NCDs claim lives at a younger age in the Asia Region compared to the other WHO regions. In 2018, the proportion of NCD deaths occurring among people under the age of 60 was 34%, compared to 23% in the rest of the world. Cardiovascular diseases are the most frequent cause of NCD deaths, followed by chronic respiratory diseases, cancers, and diabetes. In addition to the four main NCDs, many other chronic conditions and diseases contribute significantly to the NCD burden in the Region, such as renal, endocrinal, mental, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and genetic disorders, as well as oral diseases including dental caries, periodontal diseases and oral cancers.

Besides being an enormous health burden, NCDs have serious socioeconomic implications. They disproportionately affect the poor, leading to loss of household income from unhealthy behaviours, poor physical capacity and loss of wages. Due to long-term treatment costs and high out-of-pocket costs, NCDs can result in catastrophic health expenditures and impoverishment. In India, Noncommunicable diseases (NCDs) have become a major public health problem in India accounting for 62% of the total burden of foregone DALYs and 53% of total deaths. Out-of-pocket expenditure associated with the acute and long-term effects of NCDs is high resulting in catastrophic health expenditure for the households. A large national survey in India found that spending on NCDs accounted for 5.17% of household expenditure. The situation in rural India raises deep concern. NCDs require regular medical attention. Rural people specifically rural women population are deprived or not getting the medical attention adequaltely which leads to reduced life expectancy of rural women. According to a macroeconomic analysis, it is estimated that each 10% increase in NCDs is associated with a 0.5% lower rate of annual economic growth.[18] In additional to exacerbating household poverty, NCDs and their risk factors exact a huge toll on national economies.

The challenges of tackling rural NCDs

There are multiple challenges to managing NCDs in rural India:

1) NCDs in rural India are affecting a relatively younger population—about a decade younger—compared to that in the developed countries. This is likely to be due to malnutrition early in life, which paradoxically increases the risk of NCDs and an unhealthy lifestyle in early adulthood. This means younger population in rural India needs to be screened for chronic diseases.

2) There is very low awareness about these diseases in rural India, leading to further challenges to inculcating lifestyle changes and prevention methods.

3) Facilities for diagnosing and treating these disorders are often not available in rural areas, resulting in late diagnosis and treatment.

4) NCDs lead to chronic expenditures on healthcare and, many times, catastrophic health expenditures, which push the families into poverty. There is no financial safety net to help people absorb the negative economic consequences of NCDs.

5) Lack of systematic mechanisms to collect data on NCDs from rural India could hamper efforts at measuring the problem, guiding interventions and monitoring them effectively.

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

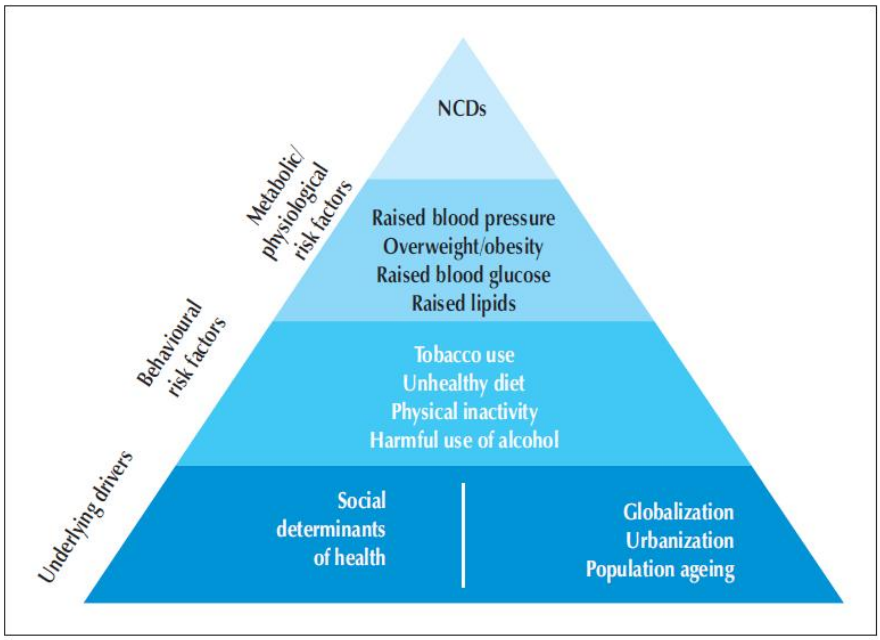
6) NCDs are typically treated by physicians with advanced level of training; since such physicians are not accessible to villagers, the best way to treat NCDs at the village level needs to be understood.
NCDs, thus, create a big challenge for healthcare systems—public as well as private—in rural India. The government-run healthcare system in rural India largely focuses on maternal and child health and infection. For instance, of the total health budget of Rs.47,343 crore in 2017-18, only R.s955 crore was allotted to the NCD programme. This system now faces the dual burden of tackling not just infections but NCDs as well.

Determinants and risk factors for NCDs

The increasing burden of NCDs is attributed to determinants such as population ageing, rapid and unplanned urbanization, underdeveloped rural hamlets, negative effects of globalization (such as trade and irresponsible marketing of unhealthy products), low literacy, and poverty (Figure 1).

From 2000 to 2025, it is projected that the proportion of the population aged above 65 years will increase from 3.6% to 6.6% in Bangladesh, from 4.4% to 7.7% in India and from 6.3% to 12.3% in Sri Lanka. As the prevalence of NCDs increases with age, these progressively aging populations will result in a corresponding increase in NCD cases.

Figure 1: Determinants of NCD



HeLP – her program

The program was designed to increase awareness of the significance of consistent increases in diseases and overweight for many years in women particularly from Australia which has occurred due to the prevalence of NCDs. It was designed to be adaptable, easily delivered and low cost. The program is based on compelling evidence that small changes in behaviour will modify risk factors for a range of diseases including heart disease, diabetes, arthritis, and cancer as well as the promotion of general wellbeing.

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

Implementation

The program uses simple messages on healthy eating and physical activity consistent with national guidelines, a combination of face to face delivery of three or one hour sessions and written and electronic resources based on building confidence, skill development and making small consistent changes to behaviour. The sessions are non-prescriptive, provide evidence based general nutrition and physical activity messages. An important element is a social context and group delivery where women support each other. On-going support is provided by mobile medical units, lifestyle management centres, SMS mobile phone, phone coaching, email or mail. The program integrates well with other local activities and strategies such as in schools and workplaces. Ultimately, the goal of the HeLP her in is to support women particularly from the rural background to improve health behaviours in order to prevent NCDs.

OBJECTIVES OF THIS PROJECT

1. To provide health care services to rural women in selected district by covering all the villages where the basic access to health service is lacking.
2. Increase access to health care in an underserved area: The primary objective of this project is to create a mobile clinic and to bring health care into a community particularly women with limited access, specifically to those who are uninsured or underinsured through illustrated world examples and models.
3. To educate and build health awareness by audio visual equipment and educational films.
4. The mobile clinic and community lifestyle counseling centre also integrates patients into existing social services and health care systems through referrals.
5. To reduce the incidence of maternal mortality, child mortality and mortality and morbidity, dehydration and malnutrition (and to introduce sense) antenatal care, post-Natal care and Immunization services.
6. To enhance the capability of rural female to look after the normal health and nutritional needs of their child and their family through proper nutrition and health education through benchmarking.
7. To make aware of public health supervisor, community organizer, Traditional Birth Attendant and volunteers of youth clubs in mother and child health and to enhance their skill and their respective rules towards service to be delivered in the project.
8. To educate the community as to the concept and philosophy of healthy living and its importance for the family, community and society and to create confidence among the people in adopting this practice and to expedite Governmental action for promotion of various measures to meet relevant needs of the people.
9. To support and supplement special health related activities and preventive programs such as literacy training for female, sanitation and low cost methods of providing safe drinking water, smokeless woven, latrine etc., from available world examples.
10. To eradicate illiteracy and to run post literacy and continuing education program for development through establishment of functional literacy center and other complementary activities.
11. To involve participation in the planning, implementation and maintenance of activities envisaged and to raise income levels and expand employment opportunities of the weaker sections of society, particularly of women and of those living below the poverty line.
12. To treat needy patients particularly to destitute women and children, to admit them in the hospital for their treatment and to supply nutritious and food for bed patients.
13. To raise the nutritional status of the community, especially mothers and children by the use of cheap, locally available and nutritious foods. To impart nutrition, education and nutrition cooking demonstration to convince mothers.
14. To evaluate the reach and effectiveness of HeLP-her programme in rural areas specifically in selected rural district
15. To arouse adequate consciousness about health and hygiene among villagers and rural women.
16. To create a Lifestyle management Centres and educate Women for maintaining a better Life style program to avoid NCDs and also establish Private Public Partnership (PPP) programme in lifestyle management of rural women population.

The framework goals

The framework is expected to drive progress in prevention and control of NCDs

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

through HeLP-her program and provide the foundation for advocacy, raising awareness, reinforcing political commitment and promoting global action to tackle these deadly diseases. The framework will also help shape a new development agenda that advances the three dimensions of sustainable development: economic development, environmental sustainability, and social inclusion.

Figure 2: Set of Voluntary Goals for HeLP-her Program to be implemented

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

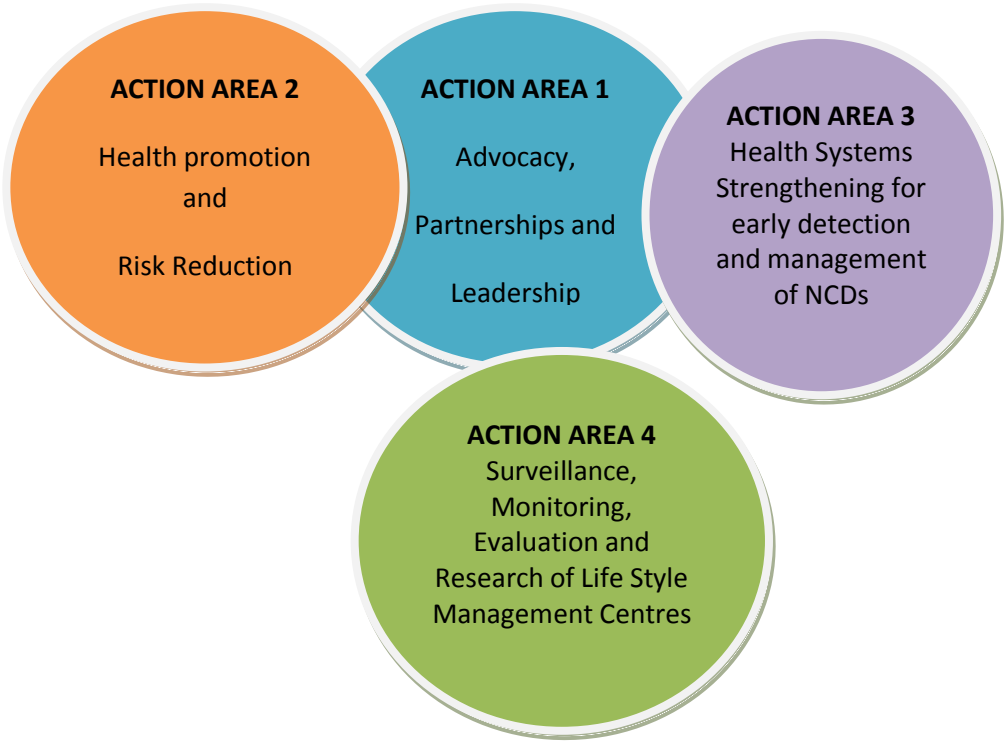


Figure 3: Strategic Action Areas to be adopted by HeLP-her program for the prevention and control of NCDs

To achieve the set of Voluntary Goals of HeLP-her program, the priority are structured around four strategic action areas. Implementation of these strategic actions will lead to a reduction in overall mortality from the four main NCDs.

All actions will be implemented, as far as possible, through close collaboration with other health programmes such as infectious diseases control, maternal and child health, immunization, school health and occupational health services.

Strategic action area 1: Advocacy, partnerships and leadership. Actions under this area aims to increase advocacy, promote multisectoral partnerships and strengthen capacity for effective leadership to accelerate and scale-up the national response to the NCD epidemic. Effective implementation of these actions will result in increased political commitment and availability of sustainable resources, and in setting functional mechanisms for multisectoral actions and effective coordination by ministries of health.

Strategic action area 2: Health promotion and risk reduction. Actions under this area aims to promote the development of population-wide interventions to reduce exposure to key risk factors. Effective implementation of these actions should lead to reduction in tobacco use; increased intake of fruits and vegetables; reduced consumption of saturated fat, salt and sugar; reduction in harmful use of alcohol; increase in physical activity; and reduction in household air pollution.

Strategic action area 3: Health systems strengthening for early detection and management of NCDs and their risk factors. Actions under this area aim to strengthen health systems, particularly the primary health care system. Full implementation of actions in this area should lead to improved access to health-care services, increased competence of primary health care workers to address NCDs, and empowerment of communities and individuals for self-care and Proper visualization and training for the lifestyle management centre staff members.

Strategic action area 4: Surveillance, monitoring and evaluation, and research of lifestyle management centres. This area includes key actions for strengthening surveillance, monitoring and research. The desired outcome is to improve

International Journal of Pharmaceutical Research and Applications
Volume 7, Issue 1 Jan-Feb 2022, pp: 669-677 www.ijprajournal.com ISSN: 2249-7781

availability and use of data for evidence-based policy and programme development.

PROPOSED ACTION PLAN OF HeLP-her PROGRAM

Activity
Covering 10 villages per month
Addressing Curative health care
Health Awareness Education
Referral services
Audio visual programmes
Creation of Lifestyle Management Centres
Networking with community
Awareness on NCDs, Mother & Child Health
Education and Communication
Project Monitoring & Reporting

IMPLEMENTATION METHODOLOGY

Step1: Evaluating the reach and effectiveness of HeLP-her programme in selected rural district.

Step2: Estimating the rural women population under one or other medical attention regularly

Step3: Facilitating Private or/and Public Partnership for providing Lifestyle management, medical and hygiene facilities.

Step4: Creating Mobile Medical Care Unit (MMCU) and Lifestyle Management Centres as long term service entities in selected rural district as model units which can be expanded for other zones, districts and throughout the state.

Step5: It is proposed to run a Mobile medical care unit (MMCU) in form of a van to provide primary medical care to those, who due to age and poverty cannot approach regular doctors, in the targeted 50 backward villages. Social worker associated with the MMCU will reach out to society by involving the local community and organizes them for health care.

Staff Requirement for the MMCU and HeLP-her Centres

Doctor: Two qualified M.B.B.S doctors will be appointed as Medical Officer for the MMCU.

Nurse: Two qualified nurses (B.Sc./Diploma in Nursing) person would be appointed as nurse.

Health Worker: The concerned person must have at least three years of work experience in the event of not being professionally qualified.

Social Worker: An experienced social worker with at least three year of work experience will be appointed.

Counselors: a person trained to give guidance on personal or psychological problems with special focus on Lifestyle management disorder shall be appointed.

REFERENCES

[1]. Aregbesola M. Public Health Issue – Non-communicable Diseases, 2011. Available at: http://www.nigerianinquirer.com. Accessed February 01, 2012

[2]. World Health Organization – Non communicable diseases (NCD) Country Profiles 2018

[3]. WHO. Indrayan A. Forecasting vascular disease and associated mortality in India. Burden of Disease in India. National Commission on Macroeconomics and Health. New Delhi: Ministry of Health and Family Welfare, Government of India, 2015.

[4]. Seigel KR, Patel SA, Ali MK. Non-communicable diseases in South Asia: contemporary perspectives. Br Med Bull 2014; 111: 31–44.

[5]. Arokiasamy P, Uttamacharya, Kowal P, et al. Chronic noncommunicable diseases in 6 low- and middle-income countries: findings from wave 1 of the World Health Organization's study on global ageing and adult health (SAGE). Am J Epidemiol 2017; 185: 414–28.

[6]. Berman A, Snyder SJ, Kozier B, Erb‟ s G. Fundamentals of Nursing Concept, Process and Practice. 8th edition; Pearson education; New Jersey; 2008

[7]. Humphreys J, Wakerman J. Primary Health Care in Rural and Remote Australia: Achieving Equity of Access and Outcomes through National Reform: A discussion paper 2010. Available at: http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/16f7a93d8f578db4ca2574d7001830e9/$file/primaryhealthcareinruralandremoteaustraliaachievingequityofaccessandoutcomesthroughnationalreformumph.pdf. Accessed October 10, 2013

[8]. Global Given. Health Screening for 12 Villages in Rural India 2017.

[9]. Stlin P, Eckermann E, Mishra US, Nkowane M, Evawallstam. Health Promotion Challenges - Gender and Health Promotion: A Multisectoral Policy Approach. Health Promotion International 2007; 21 (S1): 25 - 35 Published by Oxford University Press. Available at: http://heapro.oxfordjournals.org/. Accessed December 30, 2013

[10]. Gerrior SA, Crocoll C, Hayhoe C, Wysocki J. Challenges and Opportunities Impacting the Mental Health of Rural Women. Journal of Rural Community Psychology 2011; e11 (1) Available at: http://www.marshall.edu/jrcp/ARCHIVES/V11%20N1/Gerrior.pdf. Accessed February 04, 2012

[11]. Dharmalingam A, Navanethan K, Krishnakumar CS. Nutritional status of mothers and low birth weight in India. Matern Child Health J. 2010;14(2):290.

[12]. Durrani AM, Rani A. Effect of maternal dietary intake on the weight of the newborn in Aligarh city, India. Niger Med J. 2011;52:177–181.

[13]. Mallikharjuna Rao K, Balakrishna N, Arlappa N, et al. Diet and Nutritional Status of Women in India. J Hum ecol. 2010;29(3):165–170.

[14]. Ghosh–Jerath S, Devasenapathy N, Singh A, et al. Ante natal care (ANC) utilization, dietary practices and nutritional outcomes in pregnant and recently delivered women in urban slums of Delhi, India: An exploratory cross–sectional study. Reprod Health. 2015;12:20.

[15]. Yazdkhasti M, Pourreza A, Pirak A, et al. Unintended Pregnancy and Its Adverse Social and Economic Consequences on Health System:A Narrative Review Article. Iran J Public Health. 2015;44(1):12–21.

[16]. Adams MH, Bowden AG, Humphrey DS, McAdams LB. Social Support and Health Promotion Lifestyles of Rural Women. Online Journal of Rural Nursing and Health Care 2000; 1(1); 28-40. Available at: http://www.thefreelibrary.com/. Accessed January 10, 2011

[17]. World Health Organization Regional Office for South-East Asia. Regional Health Observatory. http://apps.who.int/searo-rho/ - accessed 13 November 2013.

[18]. Mondal S, Kanjilal B, Peters DH, Lucas H. Catastrophic Out-of-Pocket Payment for Health Care and its Impacts on Households: Experience from West Bengal, India. Future Health Systems: Innovations for Equity. Available from: http://www.chronicpoverty.org. [Last accessed on 2018 Aug 20]