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LEADING HEALTH, POPULATION AND FAMILY WELFARE STORIES OF THE DAY

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Stroke (Hindustan:20190624)

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ज्यादा काम से स्ट्रोक का खतरा

सेहत

नई दिल्ली | हिटी

जो लोग दस घंटे या उससे ज्यादा समय रोज ऑफिस में बिताते हैं उनमें स्ट्रोक यानी हृदयाघात होने का खतरा ज्यादा होता है। एक हालिया शोध में यह दावा किया गया है। एक शोध के अनुसार जो कर्मचारी पिछले एक दशक से कार्यालय में दस घंटे या उससे ज्यादा समय बिताते हैं उनमें हृदयाघात होने का खतरा 45 फीसदी तक ज्यादा हो सकता है।

ऐसा किया गया शोध : कामकाज के घंटों और मस्तिष्काघात के बीच में संबंध स्थापित करने के लिए शोधकर्ताओं ने 143,592 फ्रेंच कर्मचारी पर अध्ययन किया। इनमें से 29 फीसदी लोगों ने बताया कि वे 10 घंटे या उससे ज्यादा समय काम करते हैं। यह पैटर्न सालभर में कम से 50 दिन तक देखा गया। दस में से एक प्रतिभागी ने कहा कि वे कम से कम दस सालों से इसी तरह लंबे समय तक काम करते आ रहे हैं। ज्यादा काम करने वाले प्रतिभागियों में से 1,224 प्रतिभागियों को अगले सात साल में हृदयाघात का सामना करना पड़ा।

पत्रिका स्ट्रोक में प्रकाशित शोध के अनुसार जो लोग दस घंटे या उससे ज्यादा समय काम करते हैं उनमें हृदयाघात होने का खतरा 29 फीसदी तक ज्यादा होता है। शोध के अनुसार जो पिछले दस सालों से दस घंटे या उससे ज्यादा समय काम करते रहें उनमें हृदयाघात होने का खतरा 45 फीसदी तक ज्यादा होता है।

14,481 प्रतिभागियों ने यह खतरा देखा गया। यह प्रतिभागी 18 से 69 वर्ष के बीच थे और शोध में पाया गया कि युवा कर्मचारियों को हृदयाघात होने का खतरा ज्यादा था। प्रोफेसर डेसकैथा ने कहा, दस साल तक लंबे घंटों तक काम करने और स्ट्रोक के बीच में संबंध उन लोगों में ज्यादा पाया गया जो 50 साल से नीचे के थे। उन्होंने कहा कि इस बारे में और शोध करने की जरूरत है।

10 साल तक दस घंटे या उससे ज्यादा काम करने से स्ट्रोक का खतरा 45 फीसदी बढ़ जाता है

50 साल से कम उम्र के कर्मचारियों में हृदयाघात होने का खतरा ज्यादा पाया गया

रक्तचाप में वृद्धि होती है

ज्यादा लंबे समय तक बैठे रहने से मोटापा और रक्तचाप में बढ़ोतरी हो सकती है। 85 हजार ब्रिटिश और स्कैनडिनेवियन कर्मचारियों पर हुए शोध में पता चला है कि जो लोग हर हफ्ते 55 घंटों से ज्यादा काम करते थे उनकी धमनियों में कंपन होने का खतरा 40 फीसदी तक ज्यादा था।

चिकित्सा कर्मियों की चिंता

वैज्ञानिकों को चिकित्सा कर्मियों के बारे में ज्यादा चिंता होती है क्योंकि उन्हें लंबी शिफ्ट करने को मजबूर किया जाता है। प्रोफेसर डेसकैथा ने कहा, ज्यादातर चिकित्सा कर्मी लंबे काम के घंटों के मानक से भी ज्यादा काम करते हैं और इसलिए उनमें स्ट्रोक का खतरा सबसे ज्यादा हो सकता है।

कम उम्र वाले कर्मचारियों में ज्यादा खतरा

फ्रांस के शोधकर्ताओं के अनुसार ज्यादा काम करने वाले 50 साल से कम उम्र वाले कर्मचारियों में हृदयाघात का खतरा उम्रदराज कर्मचारियों की तुलना में ज्यादा होता है। यह शोध पेरिस हॉस्पिटल द्वारा किया गया है और इसे प्रोफेसर एलेक्सिस के नेतृत्व में पूरा किया गया। यूरोप में ब्रिटेनवासी ज्यादा समय ऑफिस में काम करते देखे गए हैं।

Stress (Hindustan:20190624)

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खड़े होकर खाने से बढ़ता है तनाव

वाशिंगटन | एजेंसी

बड़े-बुजुर्ग लोग हमेशा जमीन पर बैठकर खाना खाने की सलाह देते हैं क्योंकि इसके कई स्वास्थ्य लाभ हैं जैसे खाना सही से पच जाता है, मांसपेशियां सक्रिय रहती हैं और रक्त का संचार सही चलता है।

एक अध्ययन में भी यह बात स्पष्ट हो गई है कि जमीन पर बैठकर खाना खाने से कई तरह के स्वास्थ्य लाभ मिलते है। साथ ही अध्ययन में यह भी पता चला है कि जमीन पर बैठकर खाने से खाने का स्वाद बेहतर हो जाता है। जबकि खड़े होकर खाना खाने से शारीरिक तनाव बढ़ता है और खाने का स्वाद कम हो जाता है।

बैठने की मुद्रा से प्रभावित होता है खाने का स्वाद : जर्नल ऑफ कंज्यूमर रिसर्च में प्रकाशित अध्ययन के मुताबिक, अगर आप कुछ मिनटों के लिए भी खड़े होकर खाना खाते हैं तो इससे शारीरिक तनाव बढ़ जाता है। बैठने की मुद्रा खाने के स्वाद को प्रभावित करती है। शोधकर्ताओं ने विशेषतौर पर यह देखा कि वेस्टिबुलर सेंस (जो शरीर में संतुलन का काम करती है) किस तरह स्वाद संवेदी प्रणाली (जो स्वाद को प्रभावित करती है) से संबंधित होती है। यूएस में साउथ फ्लोरिडा यूनिवर्सिटी के प्रोफेसर दिपायन विश्वास ने कहा कि गुरुत्वाकर्षण बल तेजी से शरीर के निचले हिस्से में रक्त को धकेलता है। इसकी वजह से हृदय को शरीर के ऊपरी हिस्से तक रक्त को वापस लाने में काफी मेहनत करनी पड़ती है जिससे हृदयगति बढ़ जाती है। यह हाइपोथैलमिक पिट्यूटरी एड्रिनल एक्सिस को सक्रिय करता है और तनाव हार्मोन कोर्टिसोल को बढ़ाने में अहम भूमिका निभाता है। इसके बढ़ने से संवेदी संवेदनशीलता कम हो जाती है।

खाने के स्वाद के लिए बैठकर खाएं

शोधकर्ताओं ने भोजन के स्वाद और खड़े होकर खाने के बीच संबंध जानने के लिए एक अध्ययन किया जिसमें 350 प्रतिभागियों को शामिल किया गया। इसमें खड़े होकर और बैठकर खाना खाने वाले सभी लोगों को एक ही तरह का खाना परोसा गया। इसके बाद उनके अनुभवों से पता चला कि खड़े होकर खाने वाले लोगों का तनाव हार्मोन का स्तर बढ़ गया था और स्वादिष्ट खाना भी उनको बेकार लगा। वहीं जो लोग बैठकर खाना खा रहे थे उनको खाने का स्वाद बेहतरीन लगा।

Acute Encephalitis Syndrome (Navbharat Times:20190624)

http://epaper.navbharattimes.com/details/41485-69494-1.html

एक्सपर्ट्स का कहना, शरीर में ग्लूकोज का लेवल कम होने से मर रहे हैं बच्चे

'ईवनिंग मील मिले तो लीची खाकर बेमौत नहीं मरेंगे मासूम'

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■ **नई दिल्ली :** हर शाम बच्चों को ईवनिंग मील देकर लीची में पाए जाने वाले टॉक्सिन को कम किया जा सकता है। अगर बच्चा भूखा नहीं सोएगा तो लीची खाने पर भी उसे कुछ नहीं होगा। डॉक्टरों का कहना है कि लीची में भले ही टॉक्सिन होता हो, लेकिन उसमें लीथल डोज नहीं है। यानी एक लीची खाने से कोई नहीं मर सकता। मुजफ्फरपुर में बच्चों की हो रही मौत को देखते हुए डॉक्टरों का कहना है कि हाइपोग्लेसीमिया की वजह से ऐसा हो रहा है। हाइपोग्लेसीमिया यानी शरीर में ग्लूकोज का लेवल कम होने को रोकने का सबसे बेहतर उपाय है कि बच्चों को शाम का खाना अनिवार्य कराया जाए।

पटना के पीएमसीएच के डॉक्टर प्रत्यूष कुमार के मुताबिक, मौत की वजह एक्यूट इनसेफलाइटिस सिंड्रोम माना जा रहा है, जिसे यहां की भाषा में चमकी बुखार कहा जाता है। एक साथ कई तरह के इन्फेक्शन जब शरीर में एक्टिव हो जाएं, इसकी वजह से फीवर आ जाए और साथ में अचानक मेंटल चेंज होने लगे तो इसे एक्यूट इनसेफलाइटिस सिंड्रोम कहा जाता है, जिसमें जैपनिज इनसेफलाइटिस कॉमन होता है। वहीं, इंडियन मेडिकल असोसिएशन के पूर्व प्रेजिडेंट डॉक्टर के के अग्रवाल का कहना है कि हर बच्चे को मिड डे मील की तरह ईवनिंग मील अनिवार्य कर दें तो बच्चा हाइपोग्लेसीमिया का शिकार नहीं होगा।

दिमागी बुखार से बिहार में अब तक 150 से ज्यादा बच्चों की मौतें हो चुकी हैं

गांवों और कस्बों में प्राइमरी केयर हेल्थ सेंटर है जरूरी

- एक लीची खाने से कोई नहीं मर सकता
- डॉक्टरों ने कहा, हर बच्चे को मिड डे मील की तरह ईवनिंग मील अनिवार्य हो

लीची में इतना टॉक्सिन नहीं : डॉक्टर ने बताया कि 2014 में किए गए लैंसेट की स्टडी में यह बताया गया था कि लीची में MCPG और हाइपोग्लाइसीन जैसे टॉक्सिन होते हैं, जो एन्सेफेलोपैथी की वजह है। उन्होंने कहा कि रात दो बजे से सुबह आठ बजे के बीच शरीर में ग्लूकोज लेवल कम होता है, ऐसे में जब कोई बच्चा सुबह भूखे होने की वजह से लीची खाता है तो उसका टॉक्सिन अंदर जाते ही शरीर में ग्लूकोज लेवल और कम कर देता है, जिससे बच्चा हाइपोग्लेसीमिया का शिकार हो जाता है। डॉक्टर प्रत्यूष ने कहा कि अधिकतर बच्चे सुबह में ही बीमार हो रहे हैं, इसलिए कहीं न कहीं लीची को इसका कारण माना जा सकता है। लेकिन एक लीची में इतना टॉक्सिन नहीं होता कि किसी की मौत हो जाए।

कुपोषण की वजह से ग्लाइकोजन काम नहीं करता : डॉक्टर ने बताया कि लीवर के अंदर ग्लाइकोजन होता है, जो रिजर्व में ग्लूकोज कन्वर्ट करता है। लेकिन कुपोषित बच्चे में यह काम नहीं करता, जिससे बच्चा हाइपोग्लेसीमिया का शिकार हो रहा है। लैंसेट ने स्टडी के बाद सुझाव दिया था कि लीची की खपत कम किया जाए और शाम को खाना सुनिश्चित किया जाए और बीमार होते ही सबसे पहले ग्लूकोज दी जाए।

लीची के छिड़काव में इस्तेमाल केमिकल भी है खतरनाक : डॉक्टर ने बताया कि बांग्लादेश में इस तरह के प्रकोपों में एग्रोकेमिकल्स की भूमिका बताई गई है। जब लीची पेड़ में लगे होते हैं तो केमिकल्स का छिड़काव किया जाता है, जो जहरीला होता है। अगर कोई बच्चा लीची को बगैर ठीक से धोए खाता है तो उसके ऊपर लगे ऑर्गनोफॉस्फेट और कार्बामेट कीटनाशक तेजी से फैलते हैं। इससे हाई ब्लड प्रेशर, शरीर में पीलापन और हाइपोग्लाइसीमिया होता है।

जल्दी मिले इलाज तो मौत रोकी जा सकती है : डॉक्टर का कहना है कि सुबह-सुबह यह अटैक होता है, लोग ठीक से समझ नहीं पाते। आसपास कोई प्राइमरी केयर भी नहीं मिल पाता।

जबतक शहर पहुंचते हैं, फीवर, दौरे और हाइपोग्लेसीमिया की वजह से बच्चा सीरियस हो जाता है। इसे कम करने के लिए आईसीयू के साथ-साथ गांवों और कस्बों में प्राइमरी केयर हेल्थ सेंटर जरूरी है।

167 Bihar deaths since June 1, Muzaffarpur alone reports 129 (The Tribune:20190624)

https://www.tribuneindia.com/news/nation/167-bihar-deaths-since-june-1-muzaffarpur-alone-reports-129/792118.html

Site, design of 100-bed paediatrics ICU finalised

As the death toll from the current Acute Encephalitis Syndrome reached 167 in Bihar, with Muzaffarpur alone accounting for 129, the Centre said the site and the design of the proposed paediatric intensive care unit for Muzaffarpur had been finalised.

Union Health Minister Harsh Vardhan said: “The Central and state teams have finalised the site and design of a 100-bed paediatrics ICU at Muzaffarpur, which will be supported under a Central scheme.”

Dr Vardhan stated this after reviewing the status of AES cases of Bihar with senior officers of the Health Ministry here yesterday. Vardhan said there had been one death and one new admission yesterday.

There are currently 84 patients at Sri Krishna Medical College and Hospital (SKMCH), out of whom four are in critical condition and under constant watch, he added.

While the Union Health Ministry has been uploading daily information on the recent Nipah scare in Kerala, it has not officially released the statistics on the number of child admissions and deaths from AES in Bihar so far.

The Tribune has learnt from sources that there have been 167 child deaths from AES since June 1 in Bihar. Of these, 129 are from Muzaffarpur alone — 109 at the SKMCH and 20 at private Kejriwal hospital.

As many as 430 child patient admissions from AES have been reported at the SKMCH since June 1 and 162 at Kejriwal hospital.

The minister today said a multi-disciplinary Central team had been camping at Muzaffarpur for a week now.

“With the support of state and district administration, efforts of social and behavioural change at the community level and early identification and management at primary health care facilities have been strengthened,” he stressed.

600 kids afflicted in state

More than 600 children have been afflicted by the AES since June 1 in 20 of 40 Bihar districts, says state health department

Muzaffarpur has been the worst hit with 430 kids admitted to hospitals. As many as 109 have died at SKMCH and 20 at Kejriwal hospital

The deaths have been mostly attributed to hypoglycemia or a steep drop in blood sugar level in the body

CM Nitish Kumar is responsible for kids' deaths. Despite so many deaths, the state government has not taken any concrete action to prevent it. The health services have been left at God's mercy. Mr CM, mere assurance will not serve the purpose. — Upendra Kushwaha, RLSP chief

Bihar's AES crisis: 'Heat, humidity, malnutrition make Muzaffarpur susceptible' (The Indian Express:20190624)

https://indianexpress.com/article/india/bihars-aes-crisis-heat-humidity-malnutrition-make-muzaffarpur-susceptible-5796219/

The Acute Encephalitis Syndrome (AES) outbreak in Bihar's Muzaffarpur has claimed the lives of over 130 children so far.

The ICU at Sri Krishna Medical College and Hospital in Muzaffarpur. (Express photo by Ritesh Shukla)

The Acute Encephalitis Syndrome (AES) outbreak in Bihar's Muzaffarpur has claimed the lives of over 130 children so far, with two more deaths reported on Sunday. Dr G S Sahni, head of the department of paediatrics at Sri Krishna Medical College and Hospital (SKMCH), Muzaffarpur, speaks to Santosh Singh on the reasons for the spurt in the number of cases and what is distinct about the climate of Muzaffarpur that makes its residents susceptible to AES. Excerpts:

Is there anything distinct about AES cases this year?

This year, of over 450 AES registered at SKMCH so far, 90 per cent are cases of hypoglycaemia (low blood sugar levels). In previous years, such cases were 60-70 per cent of the total. That apart, the pattern has been more or less the same. The disease is characterised by high or no fever, vomiting and convulsions. Hypoglycaemia and electrolyte imbalance are common reasons for the deaths.

Heat and humidity are often linked to AES. But why did it break out so severely in Muzaffarpur when the weather condtions are common across the state?

Temperature in excess of 38 degrees Celsius coupled with 60 per cent humidity — not just during the day but also at night — make Muzaffarpur distinct and susceptible to AES. While places like Jaisalmer are hot at daytime, the nights are cool. After the 1934 earthquake, Muzaffarpur and some adjoining north Bihar districts became low-lying areas, often becoming bowls of humidity…. When I joined the hospital in 2005, there was an AES outbreak. During treatment over the years, heat, humidity and malnutrition were found to be common factors.

Dr G S Sahni, HoD of Paediatrics at SKMCH

What is the difference between AES incidence in Gorakhpur and Gaya and Muzaffarpur?

Gorakhpur and Gaya have mostly reported Japanese Encephalitis (JE) cases. Muzaffarpur's AES cases can be categorised under encephalopathy, characterised by seizures, declining ability to concentrate and personality change. But there is no inflammation of the brain, as in JE. Teams from the National Institute of Virology, Pune, Centers for Disease Control, Atlanta and Christian Medical College, Vellore, which have visited Muzaffarpur in the past, have also concluded that cases here are encephalopathy. They have backed our observation on heat, humidity and malnutrition.

Explained: What causes AES? What makes Bihar so vulnerable?

What were the test results of blood samples taken from Muzaffarpur?

The tests found it is not a viral infection. Only symptomatic treatment can be provided to AES patients. The sooner a patient reaches hospital, the more is the chance of survival. Convulsions mean brain cells are being damaged. Awareness of AES management with oral glucose (ORS) at home and intravenous glucose at the PHC or the nearest available doctor can help. SKMCH has high AES mortality rate only because several patients are brought late.

Is there any connection between litchi and AES?

My first-hand experience shows there is little connection. We have reported a one-year-old child's death due to AES. Could he eat litchi? Most deaths are in age group of two- to three-and-a-half years, when children can hardly eat litchi on their own. Also, litchi toxin can increase SGPT (a liver toxin) level abnormally, but AES patients' SGPT levels were found marginally high. Litchis are not available after the second week of June but AES cases can be reported till mid-July if there are no rains.

Litchi toxin can at best be a contributory factor for low sugar levels. Over 80 per cent of our patients have no history of eating litchis.

Acute encephalitis syndrome (AES) explained: Definition, cause, and its contrary theories

What are the health effects on AES survivors?

We have found about 3 to 4 per cent cases of memory impairment and temporary loss of eyesight.

We have only a 14-bed paediatric ICU. We have converted one ward into ICU and used other ICUs to prepare 66 beds. We are happy that the Central government has sanctioned a 100-bed ICU, which should be ready by next summer. Also, PHCs have to be improved.

Overactive Bladder (Navbharat Times:20190624)

http://epaper.navbharattimes.com/details/41485-69489-1.html

ओवरएक्टिव ब्लैडर : आसान है इलाज

■ प्रमुख संवाददाता, नई दिल्ली

हल्की सी छींक, खांसी, हंसने से आपका यूरिन निकल आता है, तो आप ओवरएक्टिव ब्लैडर की समस्या से पीड़ित हो सकते हैं। इसे मेडिकली ओवरएक्टिव ब्लैडर (ओएबी) की बीमारी कहा जाता है। डॉक्टरों का कहना है कि यूं तो यह बीमारी महिला और पुरुष दोनों में होती है, लेकिन महिलाओं में यह बीमारी ज्यादा होती है। डॉक्टरों का कहना है कि छह में से लगभग एक अडल्ट को यह बीमारी होती है, जो कहीं न कहीं उम्र के साथ बढ़ती है।

अपोलो हॉस्पिटल के यूरोलोजिस्ट डॉ एन सुब्रमणियन का कहना है कि यह परेशानी पुरुषों की तुलना में महिलाओं में अधिक है। क्योंकि महिलाओं के मूत्राशय, गर्भावस्था और प्रसव के कारण प्रभावित होते हैं। इसके अलावा उनका यूरिन पैसेज भी छोटा होता है। न चाहते हुए भी यूरिन पास हो जाने से महिलाओं की सोशल लाइफ खराब हो जाती है और बार-बार ऐसी स्थिति से गुजरने से उनकी मानसिक हालत पर भी असर होता है। इस बीमारी से ग्रस्त महिलाओं में 40 के आसपास की उम्रवाली ज्यादा हैं।

इस समस्या के बारे में दुनिया भर में जागरूकता पैदा करने के लिए वर्ल्ड कंटीनेंस सप्ताह मनाया जाता है, जो इस साल 17 से 23 जून के बीच मनाया गया। डॉक्टर का कहना है कि मरीज को इसके लक्षण पर गौर करना चाहिए, जिसमें रोजाना कितनी बार और कितना यूरिन पास करते हैं, देखना चाहिए। यह भी देखें कि हर बार यूरिन पास करने की इच्छा कितनी तीव्र होती है। अगर बार-बार ऐसा हो रहा है तो किसी अच्छे यूरोलॉजिस्ट से मिलें।

मैक्स हॉस्पिटल के यूरोलॉजिस्ट डॉ. शैलेश चंद्रा सहाय ने बताया कि कुछ मामलों में यूरिन पास करने की इच्छा इतनी तीव्र होती है कि मरीज जबतक बाथरूम पहुंचता है, उससे पहले ही यूरिन निकल जाता है। ज्यादातर लोग इस समस्या को चुपचाप झेलते रहते हैं, क्योंकि वे मानते हैं कि वे इलाज के लिए कुछ कर नहीं सकते। डॉक्टर का कहना है कि ओएबी के बारे में जागरूकता जरूरी है। चुपचाप झेलते नहीं रहना चाहिए। इसका इलाज आसान है। इलाज के कई तरीके हैं जिसमें जरूरत पड़ने पर जीवनशैली में बदलाव, डाइट, दवा और अंत में सर्जरी भी है।

Burn Out (Navbharat Times:20190624)

http://epaper.navbharattimes.com/details/41473-58403-1.html

वर्क लोड की चिंता सामान्य नहीं, बीमारी है

बर्न आउट स्वास्थ्य के लिए तब और खतरनाक बन जाता है जब इसके शिकार लोग उपचार की सही गाइडलाइन के अभाव में ड्रिंकिंग, स्मोकिंग आदि अपनाने लगते हैं

नरपत दान बारहठ

हाल ही में विश्व स्वास्थ्य संगठन ने अपने इंटरनेशनल क्लासिफिकेशन ऑफ डिजीज (आईसीडी) की लिस्ट में बर्न आउट यानी वर्क लोड के प्रेशर से उपजी थकान को भी शामिल कर लिया है। इस लिस्ट में शामिल होने के बाद अब बर्न आउट बीमारियों की श्रेणी में आ गया है। अत्यधिक काम का प्रेशर किसी कर्मचारी को ऊर्जा विहीन, असहज करता है और वह थकान महसूस करने लगता है। धीरे-धीरे यह थकान उसकी ऊर्जा को नष्ट करते हुए स्ट्रेस बढ़ाती जाती है जिससे स्वभाव में तब्दीली आने लगती है। व्यक्ति अपने को असहाय, दुविधाग्रस्त और बोझ तले दबा हुआ महसूस करता है। धीरे-धीरे नकारात्मकता, अकेलापन, उदासी, आक्रोश आदि पांव पसारने लगते हैं। इसके अलावा काम के दौरान ऊर्जावान महसूस न करना, काम करने के लिए मन से प्रेरित नहीं होना भी इस बीमारी के लक्षणों में शामिल है। मोटे तौर पर यही स्थिति बर्न आउट कहलाती है। यूं भी कह सकते हैं कि आप भावनात्मक, मानसिक, शारीरिक- किसी भी प्रकार की थकान महसूस करते हैं तो यह बर्न आउट का संकेत है।

ऐसी समस्याएं उन लोगों में अधिक पाई जाती हैं जो काम को लत बना लेते हैं या जिन पर अधिक काम करने का दबाव लगातार बनाए रखा जाता है। निजी कंपनियों, कॉल सेंटरों आदि से जुड़े कार्यस्थलों पर अक्सर ऐसे मामले देखने में आते हैं। बर्न आउट स्वास्थ्य के लिए तब और खतरनाक बन जाता है जब इसके शिकार लोग इससे बचाव और उपचार की सही गाइडलाइन के अभाव में अस्वास्थ्यकर आदतें - ड्रिंकिंग, स्मोकिंग आदि अपनाने लगते हैं। इससे दूसरी समस्याएं पैदा होने लगती हैं। कुल मिलाकर काम के बोझ का तनाव आपके संपूर्ण शरीर पर नकारात्मक प्रभाव डालता है।

एक सर्वे के मुताबिक 50 फीसदी लोग कार्यस्थल पर काम के बोझ के कारण थकान और दबाव के चलते तनाव महसूस करते हैं। यह तनाव मानसिक स्थिति को सीधे तौर पर प्रभावित करता है। लेकिन आम तौर पर ऐसी स्थिति को सामान्य माना जाता रहा है। इस

कॉमन रूम

वजह से इसे अनदेखा करने की प्रवृत्ति रही है। ज्यादा समय तक काम करने, देर रात तक जगने आदि के कारण अनिद्रा, उदासी, थकावट, छोटी-छोटी बात पर गुस्सा और चिड़चिड़ापन होता है और हम समझते हैं कि ऑफिस के वर्कलोड से ऐसा होना स्वाभाविक है। ध्यान रखने की बात है कि अगर इस समस्या को समय रहते डॉक्टरी सलाह द्वारा नियंत्रित नहीं किया जाता है तो यह स्वास्थ्य के लिए खतरनाक हो सकती है।

डब्ल्यूएचओ की यह रिपोर्ट कई मायनों में महत्वपूर्ण है। आज विभिन्न व्यावसायिक और सरकारी कार्यालयों में लाखों कर्मचारी दिन रात वर्क लोड के बोझ से दबे काम कर रहे हैं। उनके लिए स्वास्थ्य के प्रति सजग रहना बेहद जरूरी है। उन्हें इससे बचाने के लिए गाइड लाइन की जरूरत है। कार्यालयों को हेल्थ फ्रेंडली बनाए जाने की भी जरूरत है।

व्यक्तिगत तौर पर ऐसी समस्याओं से बचने का उपाय यह है कि काम को आनंद के साथ किया जाए। काम को बोझ के रूप में न लेने और एक समय में सीमा से अधिक काम न करने पर बर्नआउट से ग्रस्त होने की आशंका नहीं रहती। इसके अलावा योग, प्राणायाम, ध्यान आदि के जरिए स्फूर्ति और आत्मविश्वास में इजाफा करके भी बर्न आउट से बचा जा सकता है। सबसे प्रभावी उपाय यह है कि काम देते वक्त उच्च अधिकारी इस बात का ध्यान रखें कि कर्मचारी को वह काम मजबूरी में तो नहीं करना पड़ रहा। कर्मचारियों से सीधा संवाद और जुड़ाव स्थापित करने पर भी काम होना चाहिए। यह स्थापित तथ्य है कि दबाव में काम करने के बजाय अगर खुले मन से काम किया जाए तो कार्यक्षमता अधिक रहती है। इन सबके बावजूद अगर तनाव अधिक हो तो डॉक्टर की सलाह लेने में कोई संकोच करने की जरूरत नहीं है, खासकर अब जब डब्ल्यूएचओ ने इसे बाकायदा बीमारी करार दिया है।

हीमोफीलिया

10 हजार में से एक व्यक्ति हीमोफीलिया से ग्रस्त, उचित कदम उठाने का आग्रह (Amar Ujala:20190624)

https://www.amarujala.com/delhi-ncr/one-in-10-thousand-people-suffers-from-haemophilia

देश में हीमोफीलिया की समस्या लगातार गंभीर होती जा रही है। माकूल इलाज नहीं मिलने के कारण मरीज लगातार दम तोड़ रहे हैं। बावजूद, इस गंभीर रोग से पीड़ित महज 22 हजार रोगियों की ही पहचान हो सकी है।

हीमोफीलिया फेडरेशन इंडिया ने सरकार के सामने आठ सूत्रीय अपील जारी करते हुए हीमोफीलिया के मरीजों की परेशानी दूर करने के लिए उचित कदम उठाने का अनुरोध किया है, ताकि मरीजों को नई जिंदगी मिल सके।

डॉक्टरों के मुताबिक, हीमोफीलिया के मरीजों को जोड़ों की दिव्यांगता के साथ जिंदगी गुजारनी पड़ती है। राजधानी में हीमोफीलिया केयर पर आयोजित कार्यक्रम के दौरान इस बीमारी से संबंधित सभी पहलुओं पर विशेषज्ञों ने राय रखी।

विंग कमांडर (रिटायर्ड) एसएस रॉय चौधरी ने एक अंतरराष्ट्रीय रिपोर्ट का हवाला देते हुए बताया कि भारत में प्रत्येक 10 हजार लोगों में से एक व्यक्ति हीमोफीलिया से ग्रस्त है। देश में अब तक एक लाख 33 हजार से अधिक हीमोफीलिया के मरीज हैं, लेकिन दुर्भाग्य है कि महज कुछ हजार मरीजों की ही पहचान हो सकी है, जिनकी पहचान हुई भी है उन्हें हीमोफीलिया के लिए तय अंतरराष्ट्रीय मानकों के मुताबिक इलाज और दवाइयां नहीं मिल रही हैं।

विशेषज्ञों के मुताबिक, हीमोफीलिया के मरीजों को मौजूदा व्यवस्था की वजह से ताउम्र परेशानियां झेलनी पड़ रही है। इससे पीड़ित मरीज आजीवन इसका शिकार रहते हैं। इसे एंटी हीमोफीलिया फैक्टर्स या एएचएफ से संबंधित दवाइयों से इस बीमारी को नियंत्रित किया जा सकता है। विदेशों में विकसित किए जाने की वजह से दवाइयां महंगी हैं।

नतीजतन, दवाएं आमतौर पर सभी अस्पतालों में उपलब्ध नहीं रहती। अब तक हीमोफीलिया फेडरेशन (इंडिया) ने हीमोफीलिया से ग्रस्त 22 हजार से अधिक बच्चों की पहचान की है।

Healthcare

What ails India's health care? (Hindustan Times:20190624)

https://www.hindustantimes.com/india-news/what-ails-india-s-health-care/story-4neNGk2CUViVOfTcj437eL.html

Parties often ignore policy incentives as they know they can gain votes along caste and religious lines

A doctor treats a child with Acute Encephalitis Syndrome (AES)-like symptoms at Patna Medical College and Hospital on June 17.

More than 140 children have died of Acute Encephalitis Syndrome (AES) in Bihar in June. The Bihar government has received a lot of flak over the state's poor health infrastructure. But it is unlikely that it will pay a major political price for the outbreak. The Muzaffarpur deaths are not the only such disaster in India. Many poor people, especially children, die of entirely curable ailments. Most tragedies such as the Muzaffarpur one are the result of poor health care facilities. This can be seen from Chart 1, which plots normalised values of the child mortality rate in Indian states with their relative share in the number of doctors in the country (adjusted for the state's population) .

CHART 1 **Child mortality rates rise with decline in relative share of doctors in states**

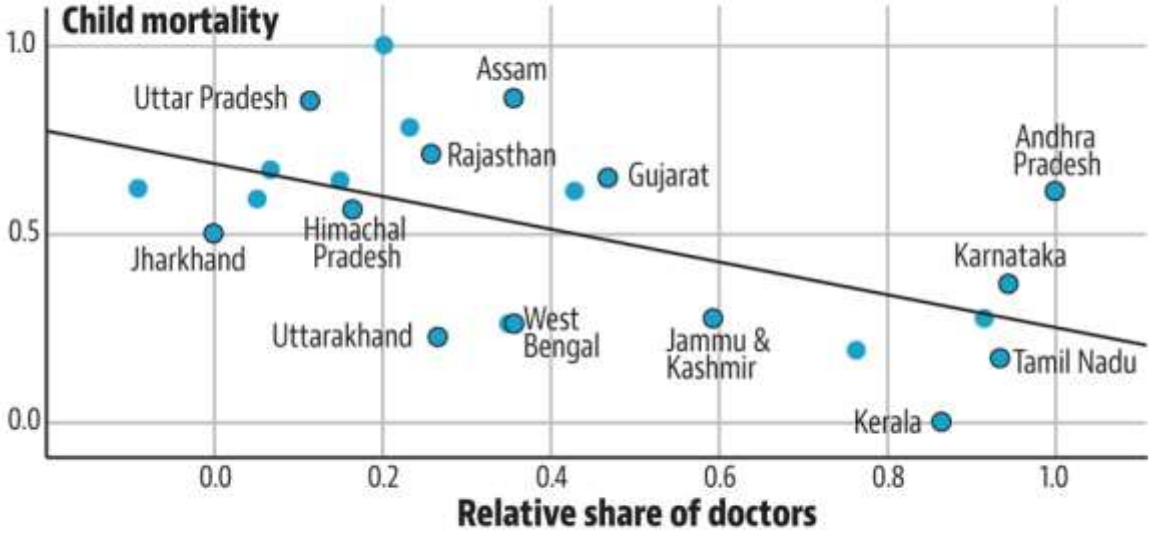


Chart shows normalised values on a scale of 0-1, where 0 is minimum and 1 is the maximum. Doctor population for 2016, State's population are from 2011 census. Child mortality rates are for 2015

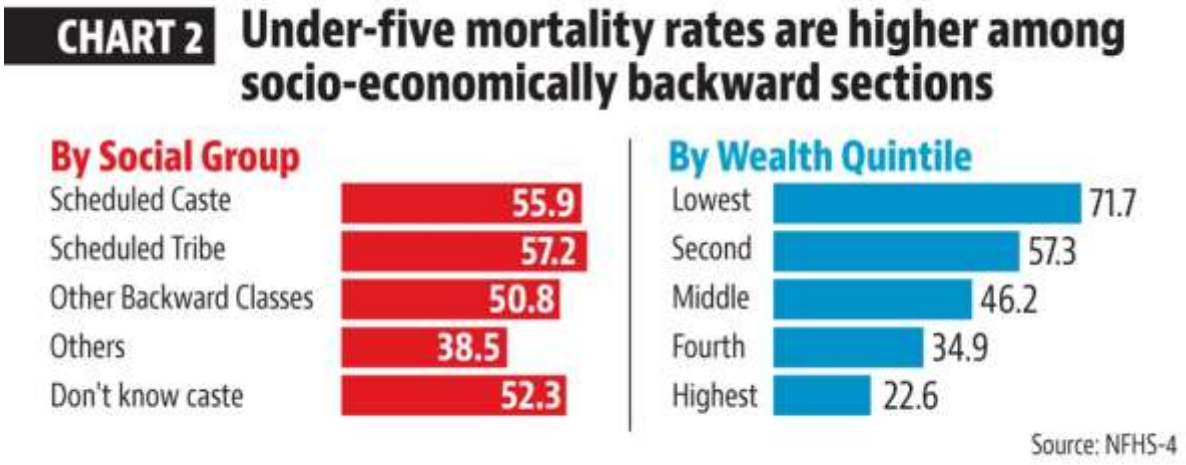
Source: CMIE

States such as Madhya Pradesh and Bihar, which have a lower share of doctors, also have higher child mortality rates. In contrast, southern states such as Kerala and Tamil Nadu fare well on share of doctors and child mortality.

It is not very difficult to generate more doctors if a state government is willing to devote resources for it. Why do governments not do this then? An even bigger question is, why are such governments not punished by voters? For, if politicians feared retribution for failing to perform such duties, they would have gone out of their way to improve matters.

In India, this question is even more intriguing. The burden of poor provision of social services such as health care has a skewed impact beyond class lines. Because the caste hierarchy in India is closely linked to economic backwardness, those at the bottom of the social ladder bear a disproportionate burden of poor provision of health care services.

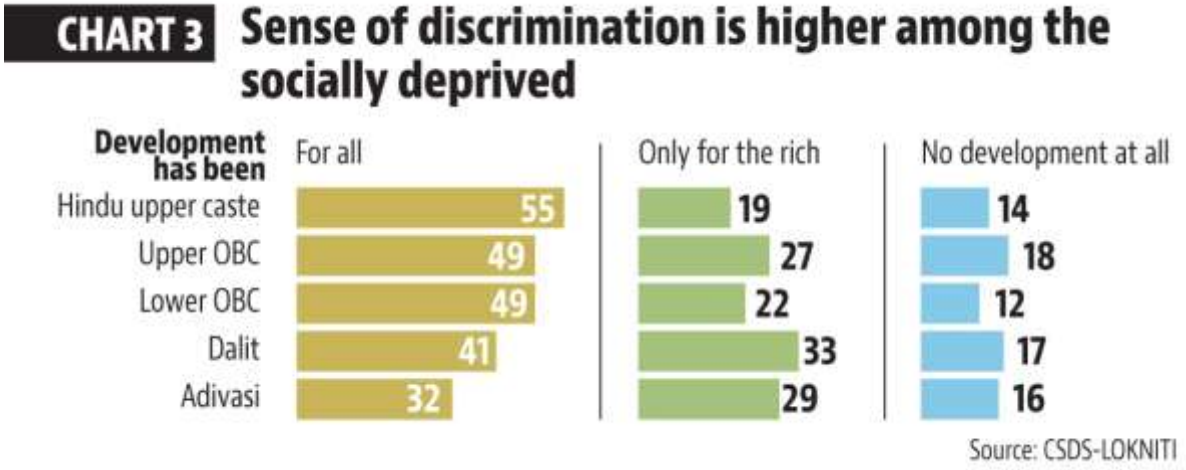
Child mortality is the highest among households not just in the lowest wealth quintile, but also Scheduled Castes and Scheduled Tribes, which are the most backward social groups. These indicators are the best among households belonging to upper castes and highest wealth quintiles.



Caste is considered to be an important factor in driving political choices in India. Why do politicians from socially deprived groups, which constitute a majority in India, not do enough to overhaul the provision of such social services?

It is not the case that there is no discontent among the socio-economically deprived sections of the population vis-àvis such policies.

For example, pre-poll survey findings from the National Election Study conducted by Centre for the Study of Developing Societies (CSDS)-Lokniti show that the feeling of development not being inclusive was greater among the socioeconomically deprived sections than the relatively better-off ones before the 2019 elections.



These grudges, it seems, did not translate into voting in the 2019 elections. The Bharatiya Janata Party (BJP) has done extremely well in parliamentary constituencies (PCs) located in India's poorest districts in the 2019 elections, showed an HT analysis by Zia Haq.

The question of why voters do not make development, or lack of it, into a political or electoral issue goes beyond what has transpired in India between 2014 and 2019.

There is also the question of why some states in India have done well do provide such services to their citizens while the others have not.

A 2015 article by Pramit Bhattacharya in Mint cited research by a US-based political scientist, Prerna Singh, to offer an interesting answer to this question. Singh looked at the experience of Uttar Pradesh and Kerala, both of which had similar levels of backwardness around the middle to late 19th century.

Kerala surged way ahead of Uttar Pradesh in terms of development outcomes later.

Singh argued in her research that the reason politicians in Kerala paid greater attention to egalitarian provisions, such as health care facilities, unlike their counterparts in Uttar Pradesh, is that their actions were driven by a sense of solidarity due to a common sub-national Malayali identity.

The Uttar Pradesh political elite, on the other hand, did not develop any such feelings and was more interested in national politics while exploiting sectarian fault-lines in the state. Singh's observations hold true in other areas as well. For example, the Kerala diaspora launched a huge effort to contribute to the relief work after the Kerala floods in 2018. Such efforts are never seen for states such as Bihar, where floods cause havoc year after year.

This kind of research tells us that the link between social services such as health care and the attitude of voters and the political elite stems from long-term social processes rather than recent political developments. While giving Singh's work due credit, Bhattacharya cited the example of the Assamese versus non-Assamese conflict taking a huge toll on socio-economic development of Assam to argue that sub-nationalism need not always lead to positive outcomes for a society.

These questions can be extended beyond the realm of social services provisions. Often, politicians implement policies that are harmful to the economic interests of a large section of voters.

For example, the legal and extra-legal disruptions to cattle markets under the BJP government have created immense economic hardships for farmers, most of whom are Hindus, in the northern and central parts of the country.

Yet, the BJP did not pay any political price for them.

A 2018 paper by Nikhar Gaikwad, a political scientist at Columbia University, has looked at this question. Gaikwad's main argument is that, in an ethnically diverse society, politicians face a choice between employing a suitable mix of identity and economic policy incentives to the electorate. Gaikwad argues that whether or not an office-driven (only interested in winning) politician plays more on identity than economic policy promises depends on two factors: "ethnic electoral bounce effect" and "identity dispersion effect".

Ethnic electoral bounce effect is described as the process wherein the ethnic community being courted by a politician mobilises in his/her favour, but it also creates a reverse polarisation among the other (vilified) community. The identity dispersion effect is described as the process which captures the divergence in intra-community preferences for the politician trying to polarise people on ethnic lines. The former could be described as Hindu-Muslim polarisation in Indian politics, while the latter captures the degree of dispersion of political preferences among Hindus and Muslims.

The identity factors need not be on the basis of religion alone. In many Indian states, caste is an equally big polarising factor in politics.

Gaikwad's main argument is that whether or not politicians prioritise economic incentives over identity politics to attract voters depends on the magnitude of both the electoral bounce and identity dispersion effects.

If a society comprises of a large share of population where voters are happy to mobilise on ethnic lines with low dispersion, politicians need not bother about giving economic incentives to voters. The reverse would hold true when larger numbers of voters belonging to the courted ethnic group are not swayed by attempts to create polarisation by playing the identity card.

His research offers an important insight into why voters might not care about poor provision of services such as health care in some societies. If political parties know that they will eventually be able to polarise voters along caste and religious lines, as is often the case in many parts of India, they will not care about offering them policy incentives such as better health care and education. This makes all the more sense, as not deploying scarce resources in such sectors gives political parties room to divert funds towards placating the influential local elite or building on existing identity-based polarisation.

Such research can also help us understand why some caste-based parties in Uttar Pradesh and Bihar continued to prosper politically despite not doing enough to take care of the underdevelopment in the state.

The social polarisation among upper castes and backward castes was reason enough for voters to keep voting for the parties despite economic policy or development-related issues being neglected.

The bottom line is that the battle for better provisioning of social and economic services cannot be fought and won without a struggle to reduce, if not eradicate, ethnic tensions in a society.

Pay closer attention to our children (Hindustan Times:20190624)

https://www.hindustantimes.com/columns/pay-closer-attention-to-our-children/story-qKb9eRpu10JGLfohO6b82L.html

Muzaffarpur highlights the lack of basic health facilities for the poor. Fixing this must be a priority

The media must understand the plight of the families while they are reporting.(HT)

A large section of politicians take pride in saying that from 2005 to 2015, India freed 27 crore people from the curse of poverty and the percentage of poverty has reduced from 50% to 28%. If this is true, then why do so many poor people die untimely deaths each year, from Kanyakumari to Kashmir? Are we living in such a boastful world in which the truth has become more dependent on statements than on facts?

The children dying of encephalitis in Muzaffarpur exposed the truth behind these figures; the truth about poverty in India. Amid sloganeering about the eradication of poverty, it remains true even today that 36 crore Indians are deprived of basic facilities with regard to health, nutrition, education and sanitation. Unfortunately, the Hindi speaking states of Bihar, Jharkhand, Uttar Pradesh and Madhya Pradesh top the charts in this regard.

More than half of the India’s poor live in these four states. Ergo, it is not surprising then that even flies and mosquitoes are causes of their deaths.

According to the Global Nutrition Report released last year, 24% of the world's total malnourished population resides in India. Of the total malnourished children, 30% live in India.

Unsurprisingly , deaths of this kind get significant media attention. But as it goes with both the media and politics, the agenda is bound to shift from one priority to the next. So, these illnesses continue to spread.

Let's take the case of Muzaffarpur. TV cameras flashing their logos on screens across the country have been coming out with new "truths" and facts since the tragedy gained traction. While some are taking doctors to task, others project nurses' statements as the universal truth. In an attempt to highlight the tragedy by ensuring that the issue of these deaths reaches the power centres of both Patna and New Delhi, many have turned this into a spectacle. Parents and relatives have lost their young ones, and it is important that the media ensures more sensitivity, caution and empathy. They must understand the plight of the families while they are reporting.

Now, let's look at the politicians. The Janata Dal United and the Bharatiya Janata Party coalition is in power in Bihar. The leaders of this coalition should have shown some seriousness at this hour of urgency but sadly, they did not. One minister said that this disease has been caused by eating Litchi while another even asked the score of the India-Pakistan cricket match during a press conference held to discuss this issue. The Muzaffarpur Member of Parliament (MP) Ajay Nishad went so far as to even blame the deaths of over 100 children on "4G" — Gaon (village), Gandagi (uncleanliness), Gareebi (poverty) and Garmi (heat). A large number of children who died of encephalitis belonged to Muzaffarpur district, which he represents. 90.14% of the total population of this district is part of the district's rural population. 24% people of the population here live below the poverty line. These are the figures from the 2011 census. As far as uncleanliness is considered, Muzaffarpur slid down 39 notches to 387th place compared to the 348th place in 2018.

Now the heat: During the months of May and June, the temperature of the district is around 45 degrees. While the MP has little to no control over the temperature of the region, the responsibility for eradicating or at the very least reducing poverty and uncleanliness definitely rests on his shoulders. When a ruckus erupted over his statement, the MP explained that it was misconstrued. This justification is not enough.

He must explain what he has done in his capacity as an MP to eradicate poverty during his tenure, along with his efforts to make the region clean. This is Mr Nishad's second stint as an MP. He, along with older, more senior representatives of Muzaffarpur must bring out a white paper on this.

Unfortunately, this is not just a problem in Bihar. The condition is the same in almost half of the country. The curse of poverty forces a large section to die avoidable deaths every day. The number of people dying in extreme weather conditions is increasing every year. There is nothing that the poor can escape. Their conditions make them vulnerable, with extreme heat

and extreme cold being a continuous struggle. Even the lack of access to basic facilities (in this case, even a hospital) has led to parents mourning the deaths of their children.

A lot has to be done to ensure that their needs become a top priority for the government, even after the TVs stop reporting on them. There's an old saying —"The poor dies in every situation." But how long will we continue to wash our hands of our duty to protect our children by simply turning such tragedies into sayings and idioms?

Hardlook: Patients, patience at AIIMS (The Indian Express:20190624)

https://indianexpress.com/article/cities/delhi/delhi-hardlook-aiims-opd-cancer-hospital-violence-doctors-protest-5796246/

The assault on doctors at a West Bengal hospital has exposed fault lines between an overburdened healthcare set-up and desperate patients. Spending a day with an AIIMS doctor, and a patient, suggests each side is well aware of struggles of the other

At Dr B R Ambedkar Institute Rotary Cancer Hospital in AIIMS. It has a special clinic for every organ, each managed by a surgeon along with three specialist doctors.

It's 8 am on Friday and several pink files have started to pile up on his desk. Dr Sunil Kumar, associate professor of surgical oncology at the country's top medical institute, AIIMS, is going through a list of patients who could possibly be scheduled for operation on Monday. A visit to the in-patient department, follow-up with patients who have been operated on, attending a four-hour OPD clinic, performing surgeries and pursuing academic projects is what makes up the day for most faculty members and doctors at Dr B R Ambedkar Institute Rotary Cancer Hospital in AIIMS.

The institute, while providing affordable medical services to patients, also has the responsibility of discovering new techniques in an ever-evolving healthcare system. Teeming with patients, the cancer institute witnesses a footfall of around 1,000 people per day. It has close to 210 beds, of which 45 are dedicated to cancer surgeries and six to the ICU. There are 70 faculty members and 100-120 trainee doctors.

Dr Kumar, who joined the institute as an MBBS student, has witnessed qualitative and quantitative changes on campus. And like almost every doctor, he has seen his fair share of stirs over violence against doctors.

“Sometimes, patience among patients is missing. But it’s not their fault. Everyone who is agitated or upset at the hospital has a reason. Violence happens because sometimes, the extent of delivery fails to meet expectations. But the problem is deep-rooted and not as simplistic as it looks from the outside. It is important to understand why someone is angry, but also why the person sitting on the opposite chair is not screaming,” he says.

Every doctor at AIIMS clears rigorous entrance tests after beating thousands of competitors across the country. According to doctors, 95% of patients visiting the hospital cannot afford facilities at private institutes. (Express: File Photo)

A meeting with a team of doctors is slated after an hour. “Generally, this time of the day, with the OPDs, is the busiest. Today, I have a clinic from 2 pm to 6 pm, so before that, I have to look after patients who are already admitted, and those requiring special attention,” says Dr Kumar, leaving for a radiology meeting.

Around 9.45 am, nine doctors sit across a table examining CT scans, MRIs and other medical reports. One by one, reports are displayed on a screen, with each doctor expressing his or her opinion on the course of treatment for each patient. The meeting lasts an hour, and the green signal is given for five patients to be operated upon on Monday. “It’s time to visit the patients,” says Dr Kumar, moving towards the wards.

“Theek hain? Koi taqleef toh nahin paani peene mein? Nigal pa rahe hain na? (Are you facing any trouble while drinking water? Are you able to swallow?)” he asks a 50-year-old patient, who recently underwent surgery for oral cancer. A communication gap, he says, partly explains increasing friction between doctors and patients.

“All said and done, patients have huge respect for doctors. All they need to know is that there are people available to help them. Any patient waiting outside the OPD for hours will be agitated if not communicated with. Each patient should be explained, realistically, without hiding facts,” he says.

The next hour is spent in four wards on the second floor. At each bed, he tries to explain the patient’s condition, spending 10-15 minutes. A group of junior doctors walk with him, noting down observations and suggestions. “Teaching and learning are not confined to a classroom. We all are learning every day with the number of diverse cases coming to AIIMS. There are many things not explained in books, but we learn about them while dealing with the human body,” he says.

Talking about the emotional breakdown of several patients, he explains how mentioning the word “cancer” frightens almost everyone.

Every doctor at AIIMS clears rigorous entrance tests after beating thousands of competitors across the country. According to doctors, 95% of patients visiting the hospital cannot afford facilities at private institutes. “The cost of cancer treatment is huge and not everyone can meet the expenses. Plus it’s not just the money but the kind of expertise doctors at AIIMS have. Given a choice, every doctor would want to join the top medical institute as it gives freedom of intellectual expression and research opportunities. Of course, money is not

equivalent to what is paid in a private set-up, but then people have a choice to make," says Dr Kumar, walking to the ground floor to attend the OPD, which is already packed with hundreds of patients.

The cancer institute has a special clinic for every organ, each managed by a surgeon along with three specialist doctors. As the clinic starts at 2 pm, the rush outside the OPD is massive, especially since facilities were shut recently when AIIMS doctors joined nation-wide protests against the assault on two junior resident doctors at Kolkata's NRS Medical College.

What purpose would simultaneous polls serve?

There are three-four patients inside the clinic at a time, and around four-five minutes are spent on each. "Achhi baat hai, you are lucky," Dr Kumar tells a patient who was suspected to have lung cancer till tests ruled it out. After 10 minutes, a stack of a patient's records is brought in. As two people try to enter, doctors request them to send only one. "But sir, he is my father, let him come inside," says a man in his late 30s.

"Bohot bheed hai, hum sabko dekhenge. You come first, we'll explain the situation and call your father if need be," says Dr Kumar.

"If it is a follow-up, we ask one person to come inside so we can explain the situation," he says. "A doctor is equally keen on giving more time to a patient. But giving extra time to one will reduce time slotted for the next. There is a huge gap between demand and supply in the health system, and specific infrastructure is required to tackle the load."

Waiting time for getting a surgery date, for instance, is almost three months.

An hour into the OPD consultation, a 50-year-old patient and a guard get into an argument. Troubled by the shouting, Dr Kumar calls the patient inside. "I don't have a valid document; will the doctor not see us? I have come from Bihar and the guard is not letting us in," says the patient, holding a sheaf of papers.

Dr Kumar writes something on the OPD card and hands it to the man: "I have given him an exemption so that doctors from our department can have a look at him. We have to take such decisions to avoid confrontations."

Dr S V S Deo, professor and head of department of surgical oncology at AIIMS, says: "Earlier, values among people were based on trust and respect for doctors, but the trend has changed in the last two-three decades. Volume and quality of time is a huge problem in India. The structure of hospitals is such that everything is left on doctors. There should be a support system in place. At times, we have to enter the OPD with a security guard. The government should work towards strengthening the peripheral system."

At 4 pm, Dr Kumar leaves one clinic and moves to another, where he is greeted by more patients. "Namastey baba ji, ab tabiyat kaisi hai?" he asks a patient, the first of many he will see over the next two hours.

Healthcare (The Asian Age:20190624)

http://onlineepaper.asianage.com/articledetailpage.aspx?id=13247424

Health for all: Docs & patients both need help

Rajeev Ahuja

Junior doctors in public hospitals in West Bengal calling off their one-week long strike that had become nationwide has come as a big relief. All is well that ends well. The fact that it has ended is a good thing. But did it end well? It's not clear. Even with new measures in place, there is no guarantee that violence against medicos — which was the immediate trigger for the strike — won't recur. Why? To know this, one needs to understand the context fully and come up with a comprehensive solution that includes both short-term and long-term measures.

To understand the context, notice a few things about the recent doctors' strike:

- Doctors had a genuine demand for workplace safety.
- The show of solidarity displayed by doctors nationwide was noteworthy.
- Doctors had to resort to strike to have their demands met — creating inconvenience to many patients.
- The reconciliation happened at the level of the chief minister of West Bengal; the Union health minister too was drawn into it.
- A PIL (public interest litigation) was filed in the Supreme Court over the safety and security of government doctors.

Each of these points conveys something important about the Indian health system. One, the doctors' fraternity coming together and speaking in a single voice moved the state administration into accepting their demands — that were genuine. This goes on to show the power of doctors' solidarity. Imagine if the doctors' fraternity were to display similar solidarity against various malpractices besotting the medical sector in India (such as diverting patients from public to private hospitals, overcharging patients, etc) — what all can they accomplish! They would have purged the sector of various medical malpractices, which is also a genuine demand. Not of doctors, but certainly of patients.

Two, it is unfortunate that doctors have to resort to a strike to have their genuine demands met. This shows that there aren't effective mechanisms within the health system to learn and address even genuine concerns of key stakeholders. Further, the conciliation at the level of the chief minister shows that the health administration is ineffective. Normally, the reconciliation ought to happen at the level of the hospital management. The nature of demands of the striking doctors was such that all those could have been met by the managements of public hospitals if they were empowered enough. It is a known fact that the managements of public hospitals lack both autonomy and accountability. Public hospitals ought to be run professionally without any political interference.

Three, the doctors' strike caused inconvenience to many patients and thereby further eroding doctor-patient trust. A strike ought to be the last resort. There needs to be alternate, softer methods to signal issues and concerns. And these signals can be picked up by any sensitive management or administration and dealt with expeditiously. A harsh approach such as a strike is probably necessitated due to an insensitive management and administration. Even so, the doctors' fraternity would do well to resort to approaches that bring patients also on the doctors' side to echo their concerns, rather than giving inconvenience to patients.

The frequent violence against medicos is a serious issue that must be dealt with properly. The fact that this problem keeps recurring every now and then indicates that states have not dealt with it properly.

Finally, there are some larger issues at hand. For example, it is a well-known fact that doctors are in short supply in India and that they are concentrated in large cities and towns. Both the Centre and states are dealing with this issue by increasing the number of seats in medical education as well as by devising appropriate incentives for doctors to serve in rural areas. Clearly, this is a long-term strategy. Digital technology is also playing an important role in the health sector. It is substituting machines for doctors, shifting doctors' tasks to paramedical staff whose supply can be increased relatively quickly. Hence, technology too will contribute towards easing the situation in the medium- to long-term. In the short-term, however, the challenge will remain: doctors will be overworked, quality of care will get compromised if doctors have to attend to a large number of patients, some patients will have to travel long distances to seek care and so forth.

Nevertheless, certain things can be done in the short-term. For example, giving proper incentives to doctors in public hospitals so that they take on the extra load willingly, and not because they have to. Any skill that is in short supply will not only command a premium but will also be in a stronger position to bargain on the other terms of employment. A big difference exists in the pay structure and working conditions of doctors in public and private hospitals. To give another example, the quality of care has also to do with not having a patients' medical record system, which currently doesn't exist in the country, but is eminently doable. Further, putting a system in place to maintain a line of communication with patients' families to report on patients' condition is another short-term fix to the problem. It's time that state health policymakers and health administrators in public hospitals recognise these and deal with them.

A lot can be dealt with at the health system level without necessarily bringing politicians or the judiciary into it. In the recent strike by the junior doctors, the Union health minister too was drawn into the matter. The minister promised to revisit this problem, which had come up earlier too, to see if something could be done at the Central level. Similarly, somebody filed a PIL in the Supreme Court on the security and safety of doctors, asking for an urgent hearing. The bench noted that the issue was important but not urgent and so decided to take it up after the summer break. This would all be avoidable if the public health system were well-functioning.

The frequent violence against medicos is a serious issue that must be dealt with properly. The fact that this problem keeps recurring every now and then indicates that states have not dealt with it properly. Addressing this problem requires both short-term and long-term responses. Long-term responses include increasing the supply and spread of doctors and harnessing the potential of digital technology. Short-term responses require doing health system-level fixes such as providing incentives to public doctors to take on additional patient loads willingly, developing a patients' record system to improve quality of care, better communication with patients' relatives in general, especially relatives of patients with emergencies who have reasons to be anxious and so forth.

As healthcare delivery gets increasingly automated, it is unclear how people would express their angst against any adverse patient outcome if machines take decisions. The communications part will probably become even more important!

The writer is a development economist formerly with the Bill & Melinda Gates Foundation and the World Bank

Hardlook: Across the table—'The whole world comes here, some difficulty understandable' (The Indian Express:20190624)

https://indianexpress.com/article/cities/delhi/delhi-hardlook-aiims-opd-cancer-ward-5796254/

On June 21, The Indian Express spent the day with Devi and trailed her youngest son Hemraj Chauhan (34) at the OPD registration counter of the cancer wing to understand the challenges patients face at the country's most prestigious Centre-run hospital.

Delhi elderly couple murder: Ailing, they didn't step out much, say neighbours

Delhi, Delhi AIIMS, Delhi hardlook AIIMS, AIIMS Delhi, AIIMS Delhi cancer, Delhi AIIMS cancer ward, Breast cancer Delhi AIIMS, Delhi AIIMS patients, AIIMS OPD, AIIMS Delhi OPD, Indian Express

Kamalesh Devi (70), who has advanced breast cancer,waits to see the doctor. (Express photo: Tashi Tobgyal)

It could well be an unremarkable journey between a western Uttar Pradesh hamlet and the national capital, separated by a few hundred kilometres and seven hours — for a day job, college admission, or a wedding.

Except, the destination for this particular journey is the cancer wing of AIIMS. And the traveller a patient of advanced stage breast cancer, 70-year-old Kamalesh Devi.

On June 21, The Indian Express spent the day with Devi and trailed her youngest son Hemraj Chauhan (34) at the OPD registration counter of the cancer wing to understand the challenges patients face at the country's most prestigious Centre-run hospital.

The arrival

A resident of Bijnor district's Mirza Alipur village, Devi left home around 6.30 am Friday, covered around 200 km in a hired car, and reached AIIMS at 1 pm, accompanied by her son Prem Raj Chauhan (45) and grandson Ashish (19).

It took another two hours for her to get an audience with the on-duty OPD specialist Dr Atul Batra, treating her since January 2019 — the first time she was brought to AIIMS following trips to the hospital's Rishikesh branch and a few local hospitals.

A resident of Bijnor district's Mirza Alipur village, Devi left home around 6.30 am Friday, covered around 200 km in a hired car, and reached AIIMS at 1 pm, accompanied by her son Prem Raj Chauhan (45) and grandson Ashish (19). (Express photo: Tashi Tobgyal)

By the time Devi arrives, the queue outside the cancer OPD has spilled onto the road outside the Dr B R Ambedkar Institute Rotary Cancer Hospital, a seven-storey facility with a capacity of 210 beds, inaugurated by the late PM Atal Bihari Vajpayee in 2003.

It takes around 30 minutes for Ashish to arrange a wheelchair for his grandmother. “They ask for Aadhaar before giving a wheelchair. Or any other valid ID,” he says.

While the medical expenditure isn’t much, Prem points out that travel expenses, Rs 4,000 for a round trip between Bijnor and Delhi, can be prohibitive, especially considering that the family has made seven such trips since January.

“A CT scan cost us Rs 700, bone scan was for Rs 600, while we were not charged for the biopsy. We have no complaints with the healthcare facilities. Saari duniya aa rahi hai idhar, thodi dikkat toh hogi hi (the entire world is coming here for treatment, a little difficulty is nothing unusual),” Prem says.

The wait

Outside, the temperature is within touching distance of 40 degrees Celsius. But Devi has nowhere to go. The waiting hall, with a low ceiling and barely adequate central air-conditioning, is packed with patients and their kin from across India, and even Nepal and Bangladesh.

Having found no space inside, a few families position themselves under ceiling fans outside the waiting hall. Devi’s wheelchair sits on steps leading to the drinking water taps outside.

She is exhausted, visibly short of breath, and in pain. A few red bangles hang loosely from her hands, the cotton salwar kameez barely fits her, but streaks of grey have failed to overshadow her thick black hair.

What purpose would simultaneous polls serve?

But until Hemraj arrives from Gurgaon, where he is employed with the technical team of a private insurance firm, Devi has no option but to wait. “Hemraj handles all the paperwork. He will get the parchi (slip) required for a follow-up appointment,” Prem says.

The unrelenting heat is making Devi nauseous. She has had one round of radiotherapy and since then, she’s been put on medicines, her family says.

At 2.30 pm, she reaches out to Ashish for water, who fills a steel glass they carried along with some namkeen, a pillow, a torn cloth and a bundle of clothes.

Devi fails to take even a sip. “Khana toh dur ki baat (Food is out of question),” Ashish says.

A little later, Devi gestures that she wants to get off the wheelchair and sit on the ground.

Ashish and Prem help her sit on her haunches, reclined against a pillow. A few minutes later, she expresses her desire to lie down, prompting Ashish to lay out the torn piece of cloth.

The queue

The waiting lounge on the ground floor of IRCH is buzzing. Private security guards, equipped with portable microphones for them to be audible, are busy maintaining discipline and order, shouting dos and don'ts every few seconds.

An information desk is to the right, followed by a help desk and 10 counters — for general enquiry, submission of reimbursement forms, collection of certificates, familial cancer care, new cases, old cases, revisits, disbursal of investigation reports, and daycare appointments.

On the left is the 'board room', which houses the breast cancer OPD, followed by the chemotherapy unit, the CT scan ward and two toilets.

Since Devi's case is a revisit, Hemraj walks straight to the counter, which continues to be crowded well after 2 pm as many appointments were rescheduled to Friday in the wake of the recent doctors' strike.

The slip he is handed reads 92. "But it hardly means anything — patients are not called as per the number. Communication is a major area of concern for patients. Many, especially first-timers, are confused about the counters they should queue up at. Guards are also under a lot of pressure but they should be trained not to act rude and to talk politely, with empathy," Hemraj says.

At 3.35 pm, the guard stationed inside the board room calls out Devi's name. Hemraj rushes outside to fetch her, but by the time she is wheeled inside, the guard has shut the door to the OPD. "Aapko jab bulaya gaya aap nahi aaye, ab intezar kijiye, andar bohot bheed hai (You didn't come when your name was called, now you wait, it is very crowded inside)," the guard says.

Twenty minutes later, the doors open again, and Devi is taken inside.

Cancer

Cancer incidence increasing in Rajasthan (The Hindu:20190624)

https://www.thehindu.com/news/cities/kolkata/cancer-incidence-increasing-in-rajasthan/article28119703.ece

Five types constituted over 90% among males, over 70% among females

With incidence of cancer progressively increasing in Rajasthan, those of the head and neck among men and breast among women have emerged as the leading forms of the disease in the State, characterised by the development of abnormal cells.

Patterns revealed

The patterns of cancer have been revealed in an International Classification of Diseases-coded Registry of Cancer developed for the first time by a cancer speciality hospital here recently. The Registry of Cancer has identified five leading cancers in males and females, besides highlighting the pattern in the two genders.

Men constitute 57% and women 43% of all the cancer patients in the State, S. G. Kabra, director (clinical services) at Bhagwan Mahaveer Cancer Hospital, said here this past week. He said the five leading cancers constituted over 90% of all cancers among males and over 70% of all cancers among females.

Cancers of lip, oral cavity and pharynx, respiratory and intrathoracic organs, digestive organs, lymphoid, haematopoietic and related tissues and genital organs are the leading forms of malignancy among men in the State. Among women, the leading cancers are those of breasts, genital organs, digestive organs and benign neoplasm.

Dr. Kabra said while the growing incidence of cancer was a cause for concern for healthcare providers in the State, reliable statistics were not available to plan treatment or provide free medicines. “Unless the State government makes cancer a notifiable disease, reliable comprehensive statistics of the disease will not be available,” he said.

Dr. Kabra said the percentage occurrence of cancer in Rajasthan was constant during the last five years for which the ICD-coded statistics were available. As Bhagwan Mahaveer Cancer Hospital receives patients from all over the State, the representative sample of 9,181 patients treated during 2018 depicts a fairly accurate pattern of the disease.

‘Donate a Life’

The hospital has also established a “Donate a Life” fund, with the help of philanthropists, trusts and donors, for treatment of children from poor families suffering from blood cancer. The fund’s beneficiaries are children below 14 years suffering from three types of curable blood cancers – low-risk acute lymphoblastic leukaemia, acute promylocytic leukaemia and Hodgkin's lymphoma.

Chikungunya

ILS develops antibodies against Chikungunya infection (The Hindu:20190624)

https://www.thehindu.com/sci-tech/health/ils-develops-antibodies-against-chikungunya-infection/article28119103.ece

Preventive measures: Workers during a fogging drive to repel mosquitoes in Delhi.

Helps unravel virus pathogenesis; institute will partner with a biotech company for product commercialisation

The Institute of Life Sciences (ILS), which functions under the Department of Biotechnology, has entered into a non-exclusive license for product commercialisation after having successfully developed antibodies against the Chikungunya viral (CHIKV) infection.

The antibodies were developed following decade-long research on the CHIKV infection at the ILS laboratory headed by Dr. Soma Chattopadhyay, a senior molecular virologist. In fact, Dr. Chattopadhyay has been selected for the Biotech Product, Process Development and Commercialisation Award 2019 by the Department of Biotechnology.

The ILS will partner with a biotechnology-based company for product commercialisation and marketing of antibodies in a 60:40 profit sharing basis.

Significant impact

“Generation of antibodies has had significant impact on the progress of CHIKV-based research. It will help researchers unravel myriad aspects of virus pathogenesis. Moreover, with greater light shed upon the CHIKV infection biology using these antibodies, research communities are now a step closer to developing efficacious antivirals and other control strategies against the Chikungunya virus,” said Dr. Chattopadhyay.

“With no prior antibodies reported against CHIKV, Dr. Chattopadhyay’s group was the first to develop and characterize novel, highly sensitive and specific polyclonal antibodies against the non-structural proteins - nsP1, nsP3 and nsP4 of CHIKV. Furthermore, her laboratory has also developed and characterized a monoclonal antibody against nsP2 of CHIKV,” said ILS in a statement.

Lack of information

The molecular virologist, who has 20 years of experience in the field, and her team, started working on this aspect as there was hardly any information on the basic mechanisms underlying CHIKV virus infection and pathogenesis.

“These CHIKV proteins were chosen as targets specifically for their critical role in virus survival as they largely govern the overall process of replication and infection in host cells. Development of these antibodies [nsP2 monoclonal, nsP1, nsP3 and nsP4 polyclonals] was therefore crucial to perform experiments pertaining to CHIKV infection, and thereby advance our basic knowledge ” said the scientist.

ILS sources said the antibodies against CHIKV were receiving a tremendous response, and were being purchased by research laboratories across world.

Superbug

Plants may be spreading superbugs to humans (The Hindu:20190624)

https://www.thehindu.com/sci-tech/science/plants-may-be-spreading-superbugs-to-humans/article28118407.ece

Researchers have now shown how plant-foods serve as vehicles for transmitting antibiotic resistance to the gut microbiome.

Spell threat to global public health.

Plant-based foods can transmit antibiotic resistance to the microbes living in our gut, a study has found. Antibiotic-resistant infections are a threat to global public health, food safety and an economic burden.

To prevent these infections, it is critical to understand how these bacteria are transmitted.

Researchers have now shown how plant-foods serve as vehicles for transmitting antibiotic resistance to the gut microbiome.

“Our findings highlight the importance of tackling food-borne antibiotic-resistance from a food chain perspective including plant-foods and meat,” said Marlene Maeusli, a PhD candidate at the University of Southern California.

Spread of antibiotic-resistant superbugs from plants to humans is different from outbreaks of diarrheal illnesses caused immediately after eating contaminated vegetables. Superbugs can asymptomatically hide in (colonise) the intestines for months or even years, and while escaping, cause an infection.

The researchers developed a novel, lettuce-mouse model system that does not cause immediate illness to mimic consumption of superbugs with plant-foods.

They grew lettuce, exposed the lettuce to antibiotic-resistant E. coli, fed it to the mice and analysed their faecal samples over time.

“We found differences in the ability of bacteria to silently colonise the gut after ingestion, depending on a variety of host and bacterial factors,” said Mr. Maeusli.

“We mimicked antibiotic and antacid treatments, as both could affect the ability of superbugs to survive passage from the stomach to the intestines,” she said.

Exposure to one type of antibiotic did not increase the ability of superbugs to hide in the mouse intestines, whereas a second antibiotic resulted in stable gut colonisation after ingestion.

Ingestion of bacteria with food also changed colonisation, as did administering an antacid before ingesting the bacteria.

“We continue to seek the plant characteristics and host factors that result in key microbial community shifts in the gut that put us at risk for colonization and those that prevent it,” said Maeusli.

“The environment and human health -- in this context via agriculture and microbiomes -- are inextricably linked,” she said.

Vitiligo (The Asian Age:20190624)

http://onlineepaper.asianage.com/articledetailpage.aspx?id=13247350

DRDO team eyes improved vitiligo remedy

AGE CORRESPONDENT
NEW DELHI

Herbal drug Lukoskin developed by the Defence Research and Development Organisation (DRDO) for management of leucoderma or white skin patches seems to be finding greater acceptance among patients suffering from the medical condition that carries huge social stigma. Buoyed by the positive results, the DRDO team is now working on an improved version of Lukoskin.

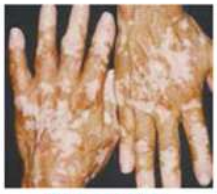
In a recognition for the drug's efficacy, the Narendra Modi government conferred DRDO senior scientist Hemant Pandey with the prestigious "Science Award" on National Technology Day for developing Lukoskin to fight vitiligo, the medical term for the disease that causes loss of skin colour in blotches.

As people mark June 25 as World Vitiligo Day, Dr Pandey, who presently heads herbal medicine division of the DRDO's lab Defence Institute of Bio-energy Research (DIBER) at Pithoragarh said he is working on an advanced version of Lukoskin which is presently manufactured and marketed by Delhi-based AIMIL Pharma Ltd.

"There are various remedies of vitiligo — allopathic, surgical and adjunctive. But none of the therapies has satisfactorily cured the disease. These are either costly or have very low level of efficacy and develop side-effects like blister and irritation in the skin with the result most of the patients discontinue the treatment," said the scientist

Vitiligo is not contagious or life-threatening. The world wide incidence of leucoderma has been reported to be 1-2 per cent. In India, its incidence is around 4-5 per cent.

"We developed the formulation from Himalayan herbs after exhaustive scientific studies," said Dr Pandey, who earlier received the Agri-Innovation Award for developing the Lukoskin that is available in the form of ointment and oral liquid.



HERBAL HELP

- Herbal drug Lukoskin has been developed by DRDO for management of leucoderma or white skin patches
- DRDO's Hemant Pande, a senior scientist, won the 'Science Award' on National Technology Day for developing the drug
- Lukoskin, which is presently manufactured and marketed by Delhi-based AIMIL Pharma, has been developed from Himalayan herbs
- The drug is available in the form of ointment and oral liquid

The ointment has seven herbal ingredients having properties such as skin photo-sensitiser, anti-blister, anti-irritation, anti-septic, wound healing and copper supplementing properties while the oral dose has been formulated to check the emergence of new spots, added Dr Nitika Kohli, an ayurveda expert.

In some parts of Rajasthan and Gujarat, incidence of vitiligo is as high as 5-8 per cent, much about the national average of 1-2 per cent.

"This skin disorder is considered a social stigma in India where people confuse it with leprosy which, in fact, is bacterial infection," added Dr Pandey.

But this auto-immune condition can be life-altering. Some people develop low self-esteem and serious depression, an observation which prompted Dr Pandey to work on advanced version of Lukoskin drug for better results.

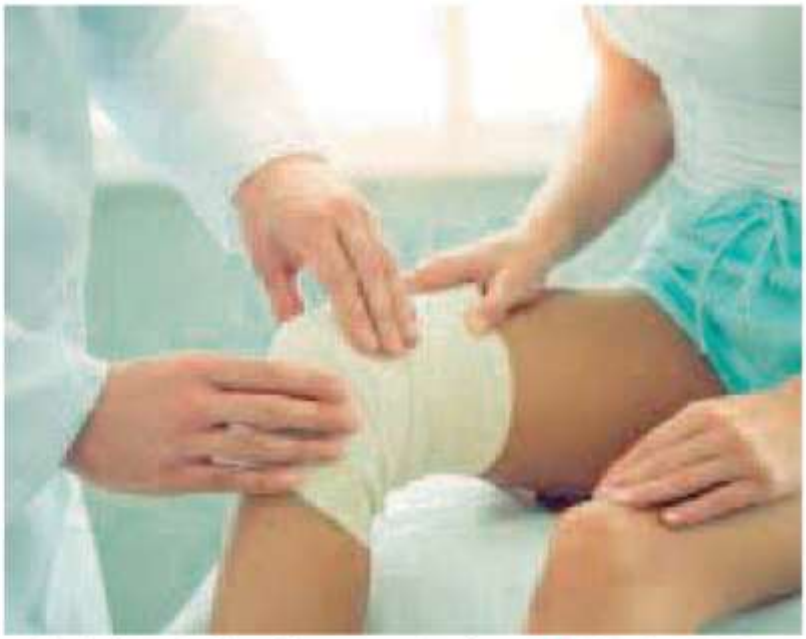
The fact that vitiligo does not impact one's physical activities is demonstrated by some of the celebrities and public figures who carried out their public life without any inhibition. These include people like late American singer Michael Jackson and Union minister S.K. Gangwar.

Arthritis (The Asian Age:20190624)

http://onlineepaper.asianage.com/articledetailpage.aspx?id=13246399

WEAK IN THE KNEES

WHILE A VARIETY OF CAUSES CAN SET OFF AND AGGRAVATE ARTHRITIS OF THE KNEE JOINTS, MEDICAL MANAGEMENT, LIFESTYLE CHANGES AND THERAPY CAN PROVIDE SOME AMOUNT OF RELIEF



KANIZA GARARI
THE ASIAN AGE

An estimated 15 crore Indians suffer from knee problems, making it the fourth major disability burden in the country. Similarly, the incidence of knee arthritis is as much as 15 times higher than in the West.

Overuse of the knees in terms of squatting, lifestyle changes, obesity, injuries and also a decrease in bone mineral density in post menopausal women are some of the major causes. Age related degeneration is also one of the major reasons for the increasing incidence of knee arthritis even as life expectancy has increased, explains Dr M. Hari Sharma, Senior Consultant Orthopaedic surgeon at Apollo Hospitals.

Q Why is knee arthritis emerging as the fourth major disability burden in India when compared to the West? What are the reasons for knee arthritis?

Knee arthritis is emerging as a major disability burden in India due to its association with the lifestyle and habits of the Indian population, where squatting and sitting cross-legged dominate the day-to-day activities. The overuse of knees in Indians is found to be higher than in the Western population.

Dr M. Hari Sharma, Senior Consultant Orthopaedic surgeon, Apollo Hospital, Hyderguda

Q It is stated that knee arthritis in Indians is 15 times more than in Western nations. Does it affect both men and women equally?

With diagnosis improving and more awareness among the people, the disease is being detected better. The incidence is now showing 15 times more than the West. But women are suffering more than men due to the estrogen deficiency. The decrease in the bone mineral density, commonly seen in post menopausal and post hysterectomy Indian women is also one of the main causes. The incidence of osteoarthritis in the female population is significantly higher when compared to the male population.

Q What are the activities of Indians which lead to overuse of the knees?

Frequent squatting predisposes one to develop arthritis of the knee. Prolonged squatting is a strong risk factor for tibiofemoral knee OA. Sitting cross-legged and kneeling also considerably increases load on the joints.

Q What is the role of injuries in causing knee arthritis?

Repetitive occupational related injuries, injuries like joint trauma, meniscal or cruciate ligament injuries are more likely to accelerate the degeneration in the knee joints.

Q Is it easy to diagnose or does it take a long time for the body to show the symptoms? Also, what are some of the common symptoms?

In the early phase of the disease, patients experience localised joint pain, which worsens with activity and is relieved by rest. As the disease progresses, severe pain is present during the rest period also. There can also be shooting pains noted while climbing stairs or standing for too long.

Repetitive occupational related injuries, injuries like joint trauma, meniscal or cruciate ligament injuries are more likely to accelerate the degeneration in the knee joints

Q What are the mechanisms to cope with knee pain?

Medication NSAIDs/analgesics to reduce pain, inflammatory cascade, chondroprotective agents for articular cartilage of knee joints, viscosupplementation when required and weight reduction.

Q What are the methods to control the deterioration of the knee once it sets in?

Methods to control the deterioration of the knee are:

- Avoid squatting / uphill walks and runs, stair climbing/sitting cross-legged.
- Regular physiotherapy to strengthen muscles around the knee joint.
- Correction of estrogen deficiency and bone mineral density in females.
- Weight reduction in obese / overweight individuals.

Q Can those who suffer from knee pain exercise in the gym, walk, swim or carry out free hand exercises at home? What are the limits that they must draw?

Aerobic exercises like walking, cycling and swimming can be taken up in patients with osteoarthritis. They help in increasing muscle tone, bone density and range of motion. However, high-intensity activities like running, football, basketball, etc. should be avoided. Ultimately, exercise is patient dependent and should be planned according to individual circumstances and comfort level.

Q Often, knee replacements are suggested but how long must a person wait and try natural remedies before opting for replacement? Who is qualified for a knee replacement and who must avoid it?

Surgery and total knee replacement is recommended for patients with severe deformity and instability. If the person cannot do daily activities and is severely handicapped, then only it is advisable. Otherwise, medical management and therapy must be opted for.