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Protein Energy Malnutrition (PEM) in a Child Depicting Health Inequity (HI) in Kashmir

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ABSTRACT

WHO defines health inequities as avoidable inequalities between groups of people within countries and between the countries: Similarly, various global health agencies have provided an extract where Inequity and inequality is clearly defined. These two terms are confusing at times however they are not interchangeable. Health inequity is a situation where differences can be avoided but due to mass corruption, poor governance and in some instances cultural compulsion and exclusion leads to inequity. Health inequity is socially produced therefore it is unfair and avoidable. Example of health inequity between countries are, the infant mortality rate in Iceland is 2 per 1000 live births while it is 120 per 1000 live births in Mozambique.

On the other hand, health inequality is an unavoidable condition that results due to uneven distribution of health or resources or biological variations of genetic or other factors e.g. Elderly people, who are more likely to die than young adults and children. This case report of a child with PEM is aimed to highlight the issue of health inequity in a Paediatric age group in Kashmir, India.

Key Words: PEM (Protein Energy Malnutrition), WHO (World Health Organization), PMJAY (Prime Minister Jan Arogya Yojana)

CASE DESCRIPTION

"A" a 9 months old male baby, 2nd issue of his non consanguineous parents, partially immunized, belonging to a low socioeconomic background, hailing from Kandi Kupwara area of Jammu & Kashmir, presented to us with the complaints of gradual swelling of whole body for last 20 days that first appeared over his feet, before getting generalized. Hypo/ hyperpigmentation of skin also appeared along with areas of desquamation all over the body during the same period. Upon history taking mother narrated that baby has not been growing well since one month of his age. However, there was no history of fever, cough, respiratory distress, diarrhoea, urinary tract infections, jaundice, convulsions or any known contact with tuberculosis patient. Further digging deep into history, it was revealed that there was gross feeding mismanagement present from one month of his birth and current daily calorie deficit was 592 kcal. Developmentally baby had a significant delay in motor milestones.

On examination body weight was 5 kg that was below 3rd centile on CDC growth chart, Length was 60cm that falls below 3rd centile on CDC growth chart.

Baby was little irritable, socially less responsive, significantly pale, hair was thin, sparse and brown. Subcutaneous fat was decreased specifically over legs and buttocks, Flaky paint dermatosis and bilateral pedal oedema with ridged toe nails were present. Vitals were within normal range. Anthropometrically he was severely underweight, severely stunted and moderately wasted (MUAC=100 mm). Abdomen was distended with hepatomegaly and ascites was present evidenced by shifting dullness. Other systemic examination findings were normal. Blood investigation revealed severe anaemia with neutrophillic leucocytosis. X ray chest revealed patchy opacity consistent with pneumonia. We made the diagnosis of severe acute malnutrition with dermatosis with pneumonia. Baby was initially stabilized. Hypoglycaemia and hypothermia were addressed and further infection was treated with suitable antibiotics. Step wise approach in the management of Malnutrition was taken and it took around one month to stabilize, treat and rehabilitate the child and once baby met the criteria of discharge with special emphasis on weight gain, he was discharged home with follow-up advice. A's parents were ignorant, illiterate, daily wagers, nervous and full of anxiety about the condition of their son. But in spite of all this they were reluctant to move to a hospital for medical help for a number of reasons including, financial constraints, lack of knowledge about health facilities and insurance policies. And such disparity and indifference from authority at the helm of affairs is the main reason of poorer health condition and outcome in people from backward, rural areas of Kashmir.

CASE DISCUSSION

The responsibility of government of India is to provide healthcare to its public, but the allocated gross domestic product (GDP) is only 1.1%. It is quite surprising that more than double of health GDP is allocated for military maintenance and equipment.[1] Majority of the population is still dependent upon private medical sector which acts as a primary source health care.[2] Estimated 63% in rural areas see private medical sector as their first choice and at disposal, however; in India it is extensive and politically influential, with little desire to see implementation of universal healthcare.[3] Health professionals have been demanding to recognize universal health care in India since long.[4,5] Further the majority of Indians cannot afford private healthcare. Only 5% of households have any health insurance.[2] Talking about A's case, he belonged to a Gujjar community, a nomadic tribe living in high mountainous regions of Kashmir and there are different barriers to access health care e.g. financial, physical, geographical, government apathy, lack of transport, psycho-social and educational. "A"'s medical condition was totally preventable if it had been addressed earlier. Desperation lead them to hospital when medical condition had deteriorated and all the apathy which the family underwent could have been avoided. So it puts the health equity under question in India. Govt. must ensure equitable health services to all its population which will decrease the burden on health system and the families in particular. Infections and dreadful complication could be avoided and babies could enjoy the childhood in a special way as expected by every parent.

There is vast scope of improving disparities between normal and tribal population in India, however it needs certain strong policies and economic reforms. Although India has started certain programs to decrease the disparity in distribution of health facilities among its masses like national rural health mission in the year 2005.[6] Recent flagship scheme (PMJAY) to meet the sustained development goals is doing better to make universal health coverage a reality but corruption still

remains the biggest hurdle in implementation of such policies in full form and requires special attention so that access to health care is made simple and easy to all.

CONCLUSION

Health inequity can be minimized by disseminating the message of availability of health facilities and schemes to the poor people living in far flung areas. People in capacity working for the government must take responsibility to curb any of the hurdles preventing health equity and universal health care from reaching people in immense need of health care. This will reduce burden of ill health, mental agony among down trodden families with sick children and turn our society into a better place.

Declarations

Funding: Self

Conflict of Interest: None

Consent: Written consent taken from the guardian of the patient

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