Draft

INTEGRATED HEALTH AND POPULATION POLICY CHHATTISGARH

2006

C O N T E N T S

PREAMBLE

The Chhattisgarh State Integrated Health and Population Policy 2006 reiterates the commitment of the State to promote health for all and to provide quality healthcare services, especially to those in remote and difficult areas. The Policy aims at sustainable human development by ensuring that every citizen has adequate access to the basic essentials of life, reducing socio-economic disparities, improving the quality of life, and stabilising the population. Securing the rights of disadvantaged and marginalised groups would be given the highest priority with the aim of eliminating discrimination and responding to the aspirations of the people so that they can successfully contribute to national reconstruction and social change. Women's empowerment and gender equity would be the cornerstone of this policy.

To achieve the goals of National Population Policy 2000 and National Health Policy 2002, the Chhattisgarh Integrated Health and Population Policy takes a holistic view of population stabilisation and improving reproductive and child health services with special attention to decentralised governance. To this end the Policy will strengthen the Panchayati Raj Institutions (PRIs) and build their capacities to fulfil this role.

Recognising the pivotal contribution of socio-economic determinants to health, the Policy seeks to integrate issues related to social determinants with measures for improving healthcare services. Achieving health equity as part of building a more equitable society would therefore be its focus.

The National Rural Health Mission (NRHM) 2005 with its stated goal—"*to promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralisation and improving local governance*"—has brought back the primacy of *Health for All* and comprehensive primary healthcare and provides a platform to foster desired intersectoral coordination that is essential to address social determinants and improved healthcare services in an integrated fashion.

The Chhattisgarh State Integrated Health and Population Policy would be consistent with separate policies that may be formulated for related social sectors and these policies read together would constitute the charter of social development for the people of the state.

VISION

The Government of Chhattisgarh commits itself to achieving the highest attainable level of physical, mental, and social health of its citizens through processes that will empower local communities and citizens, be equitable and gender sensitive, and reduce poverty in the State. Universal access to comprehensive quality primary healthcare with adequate referral linkages would be the key strategy to realise this vision, as envisaged by the State's Vision 2020 document and the Millennium Development Goals.

The State will respond to the health needs of the people and will be guided by principles of transparency, accountability, and community participation involving stakeholders from the public, private, and non-governmental organisations (NGOs) to create a society enjoying healthy productive lives in harmony with their social responsibilities and contributing to a national resurgence.

The State is committed to achieving population stabilisation through a life-cycle approach by promoting informed choice, empowering women and communities, and paying special attention to reproductive and child health issues of disadvantaged populations living in remote areas.

SITUATIONAL ANALYSIS

Introduction

The State of Chhattisgarh was carved out of the eastern part of the State of Madhya Pradesh and came into existence on 1 November 2000. The new State initiated several measures to improve the status of its people and to move towards universal access to healthcare. Addressing the issues of distress caused to the people due to ill health and under-nutrition and revitalising the public health sector were a challenge. The physical inability to ensure outreach coupled with the poor economic status of the rural majority have been major constraining factors in improving the health and health service indicators in the State. Recent State health sector reforms and related State and central initiatives have accelerated the pace of strengthening the public health sector.

Demographic Profile

More than 43 per cent of the population of Chhattisgarh comprises Scheduled Tribes (ST, 31.8 per cent) and Scheduled Castes (SC, 11.6 per cent). Table 1 presents the evolution of the demographic profile of the territory that now forms the State of Chhattisgarh.

Table 1. Demographic Profile of Chhattisgarh

Demographic Profile	Chhattisgarh	India
Population (2001)	20,833,803 (2.02%)	1,028,737,436
Males	10,474,218 (50.28%)	532,223,090
Females	10,359,585 (49.72%)	496,514,346
Rural	16,648,056 (79.91%)	742,490,639
Urban	41,85,747(20.09%)	286,119,689
Scheduled Caste	2,418,722 (11.6%)	166,635,700 (16.2%)
Scheduled Tribe	6,616,596 (31.8%)	84,326,240 (8.2%)
Decadal Growth Rate (%)		
1981-1991	25.73	23.87
1991-2001	18.27	21.54
Change in Decadal Growth Rate (%)	-7.46	-2.33
Child Population in age group 0-6 years	3,469,774 (16.68%)	163,819,614 (15.9%)
Males	1,756,441 (16.80%)	84,999,203 (16.0%)
Females	1,713,333 (16.56%)	78,820,411 (15.9%)
Density of Population (per sq km)		
1991	130	267
2001	154	325
Difference	+24	+58
Sex Ratio (Females/1000 males)		
1991	985	927
2001	989	933
Difference	+4	+6
Sex Ratio (0-6 age group)		
1991	984	945
2001	975	927
Difference	-9	-18
Total Fertility Rate	2.79	3.0

Source: Registrar General of India, The Census of India, 2001.

Key Health Indicators

Table 2 presents the key health indicators for the State.

Table 2. Key Health Indicators for the State of Chhattisgarh

Health Indicators	Chhattisgarh	India
Birth Rate	25.2	25.0
Death Rate	8.5	8.1
Infant Mortality Rate (IMR)	70	63
Life Expectancy at Birth (1991)	61.4	57.3
Maternal Mortality Ratio (MMR)	498	406

Source: Mortality and Fertility Data based on Sample Registration Survey Bulletin 2005, National Family Health Survey-II, 1998-99.

For improving health awareness and utilisation of health services and to enhance the community's capacity to plan and cater for its own basic health needs the State initiated in November 2001 the Mitanin (community health volunteer) programme, the nation's largest community volunteer health programme. At present over 60,000 trained Mitanins provide voluntary health service in all the State's hamlets. Other than its direct contribution to increased health awareness, the programme focused public attention at all levels on the need to increase State investment in the public health sector.

In the health sector the State of Chhattisgarh has stressed upon systems development and capacity building focusing on the creation of adequate facilities with adequate sanctioned staff, infrastructure development, operationalisation of first referral units, management training, better drug distribution and logistics, better behaviour change communication (BCC) strategies and the development of information management systems. An updated disease surveillance system has also been put in place.

The State has also initiated a number of administrative and policy initiatives for human resource development, a drugs and supplies policy, recruiting and incentivising staff working in medically under-served areas, addressing workforce issues and, promoting rational drug use.

The State has drawn up sector-wise health development plans under the sector investment programme, the RCH-II programme and the state partnership plan with the European Union.

Significant recent achievements in health services have been the near- eradication of polio and yaws and a marked reduction in leprosy. However, diarrhoeal disease, malaria, and tuberculosis remain major public health problems. Malaria is endemic in the State with an annual parasitic index (API) of 10.21 in 2002 and an annual incidence of over 1,00,000 cases reported in the public system alone.

HDI and Socio-Economic Disparity

Chhattisgarh ranks 21st in the Human Development Index of the UNDP (United Nations Development Program) for the year 2005, with an index of 0.471. In the Social Development Index of the Council of Social Development in 2006 it ranks 16th for urban areas with an aggregate index of 36.35 and 15th for rural areas with an index of 28.87. In the Social Deprivation Index of the Council for 2006 the State stands at 52.29 for the rural population and 57.74 for the urban population.

The National Sample Survey Organisation (NSSO) Survey of 1993-94 measured the purchasing capacity necessary for basic calorie requirements. Table 3 cites the poverty level, i.e. official poverty level (OPL) and expert group poverty level (EGPL). It is seen from the table that the level of poverty, deprivation, and exclusion in the State is very high notwithstanding its immense industrial and mineral resources.

Table 3. Poverty Level in the State of Chhattisgarh

	1987-88		1993-94	
	OPL	**EGPL**	**OPL**	**EGPL**
All	55.35	45.27	38.91	28.64
Rural	58.47	46.72	38.21	25.74
Urban	35.38	35.99	42.21	42.21

Note: OPL—official poverty level; EGPL—expert group poverty level.
Source: http://chhattisgarh.nic.in/development/development.htm

Literacy

Table 4 presents the literary rate for the State.

Table 4. Literacy Rate in the State of Chhattisgarh

		Chhattisgarh	India
Literacy Rate (%) 1991	Total	42.90	52.2
	Males	58.07	64.1
	Females	27.52	39.3
	Gender Gap	30.54	24.8
Literacy Rate (%) 2001	Total	64.7	64.8
	Males	77.4	75.3
	Females	51.9	53.7
	Gender Gap	25.5	21.6
Decadal Difference (1991-2001) in Literacy Rate	Total	21.8	12.6
	Males	19.8	11.2
	Females	24.4	14.4

Source: Registrar General of India, The Census of India, 2001.

Basic Amenities

Health gains relate more to access to basic determinants of health such as food, water, and sanitation than to medical care for diseases, many of which result from this lack of access. It is seen from Table 5 that there is a high degree of deprivation in such access. Addressing these deprivations is a challenge confronting the State.

Table 5. Access to Basic Amenities in the State of Chhattisgarh

Access fo Basic Amenities	All	Rural	Urban
Electricity	31.8	25.4	61.2
Safe drinking water	51.2	45.1	79.6
Toilets	10.3	3.3	42.4
All three	7.6	1.5	35.6
None	36.1	41.9	9.6

Source: http://chhattisgarh.nic.in/development/development.htm

Public Health Services

It would be seen from Table 6, which presents development of health infrastructure including health personnel during the period 2001-2006, that while the infrastructure has grown there is a shortfall in health personnel. Women's health, mental health, disability, HIV/AIDS are still neglected. Table 7 reflects the key indicators based on the *National Family Health Survey – II, 1998-99*, and *District Level Household Survey, Reproductive Child Health, 2002-2003.*

Table 6. Health Infrastructure in Chhattisgarh

Particulars	Situation on 2001	Situation in 2006	Shortfall
Community Health Centres (CHCs)	116	132	0
Primary Health Centres (PHCs)	512	712	0
Sub Centre	3818	4692	0
Multipurpose Worker Male MPW(M)	3818	2940	878
MPW (Female)/Auxiliary Nurse Midwife (ANM)	3818	4334	667
Doctors at PHCs	516	817	0
Staff nurse	764	590	174
Specialists (Total)	464	210	254
Doctor Population Ratio 1:3100			

Source: Bulletin on Rural Health Statistics in India, 2005 and State Health Resource Centre, Chhattisgarh, 2006

Table 7. Key Reproductive and Child Health Indicators, Chhattisgarh and India

Indicators	Chhattisgarh	India
Births of order 3 and above (%)*	44.9	42.0
Pregnant women with any ANC (%)*	41.7	73.4
Institutional Delivery (%)*	20.2	40.5
Children with full immunization (%)*	60.9	47.6
Exclusive breastfeeding (%)	81.7	55.2
Children who received vaccinations (%)		
BCG (%)	74.3	71.6
DPT (3 doses) (%)	40.9	55.1
Polio (3 doses) (%)	57.1	62.8
Measles (%)	40.0	50.7
All vaccinations (%)	21.8	42.0
Incidence of Anaemia/Malnutrition		
Children age 6-35 months with anaemia (%)	87.7	74.3
Children age 6-35 months with moderate/severe anaemia (%)	63.8	51.3
Women with anaemia (%)	68.7	51.8
Children chronically undernourished (stunted) (%)	57.9	45.5
Children acutely undernourished (wasted) (%)	18.5	14.5
Children underweight (%)	60.8	47.0
Marriage		
Girls marrying below 18 years of age (%)*	31.1	28.0
% never married among women age 15-19 (%)	65.8	66.4
Fertility and Fertility Preferences		
Total Fertility Rate (for past 3 years) (%)	2.79	2.85
CPR*	46.6	53.0
Current Contraceptive Use		
Any method (%)	45.0	48.2
Unmet Need for Family Planning		
% with unmet need for Family Planning (%)	13.5	15.8
Infant Mortality		
Infant Mortality Rate	80.9	67.6
Under-five Mortality Rate	122.7	94.9

Indicators	Chhattisgarh	India
Safe Motherhood and Women's Reproductive Health		
Births whose mothers were assisted by health professionals (%)	32.0	41.7
Awareness of AIDS		
Women who have heard of AIDS (%)	19.6	40.3

*Source: National Family Health Survey – II, 1998-99; * District Level Household Survey, Reproductive Child Health, 2002-2003*

Health Sector Reforms

The State needs to adopt short- and medium-term pragmatic and strategic plans based on a realistic assessment of available human, financial, and other resources. If not, it would detract from public confidence in public sector health services, particularly at primary health centres (PHCs). Poor credibility would mar the functioning of all programmes. To improve its own credibility in the health sector the State will adopt medium-term plans and expenditure frameworks to guide reforms.

GOALS & OBJECTIVES

The following are the policy objectives:

1. **To ensure universal access to comprehensive primary healthcare**

2. **To ensure equity in delivery of quality healthcare services**

3. **To ensure adequacy of health infrastructure and health systems and to develop human resources for healthcare**

4. **To achieve population stabilisation through vigorous implementation of quality reproductive healthcare, including family planning and other relevant social development measures by adopting an intersectoral strategy**.

In pursuit of these objectives, the State envisages achieving the socio-demographic goals by 2016 against the current level a given in Table 8.

Table 8. Socio-demographic Goals of the Integrated Health and Population Policy of Chhatisgarh for 2016

Sl No	Indicator	Current Level	Goals for 2016
1	Birth rate	25.2	<15
2	Death rate	8.5	<5
3	Life expectancy at birth	61.4	72
4	Infant mortality rate (IMR)	70	30
5	Child mortality rate	122.7	60
6	Maternal mortality ratio (MMR)	498	100
7	Total fertility rate (TFR)	2.79	2.1
8	Contraceptive prevalence rate (CPR) (%)	39.9	65
9	Registration of births, deaths and marriages	-	100
10	Unmet needs of family planning	13.5	0
11	Median months of use of spacing methods	31.6	48
12	Median age at marriage among women	18.1	21
13	Median age at first childbirth among women	18.1	21
14	Ante Natal Care (ANC) registration in the first trimester (%)	26.7	100
15	Percentage of safe delivery	42.13	100
16	Percentage of institutional delivery	21.05	80
17	Access to emergency obstetric care at PHC level	-	100
18	Fully immunised children (%)	57.58	100

Sl No	Indicator	Current Level	Goals for 2016
19	Percentage of children received Vitamin A	35	100
20	Use of ORS (oral rehydration solution) for management of childhood diarrhoea (%)	48.4	100
21	Percentage of children with Acute Respiratory Infection (ARI)	61.6	0
22	Malaria Prevalence Annual Parasitic Index (API)	10.21	<2.1
23	Prevalence of leprosy, measles, polio, yaws, cholera, tetanus	-	0
24	Children having primary education (%)	72.1	100

The objectives also envisage the provision of universal early childhood care and elementary education, universal access to safe drinking water and sanitation, ensuring food security and livelihood to all sections of the population, and while achieving these targets to make the services accessible, affordable, equitable, gender sensitive and people friendly.

STRATEGIC DIRECTIONS

Decentralised Planning and Implementation

PRIs are an important means to decentralise planning and implementation in the context of National Population Policy 2000 and National Health Policy 2002. To realise their potential, administrative and financial powers would be delegated to these local self-government institutions. Representative subcommittees in each tier of the Panchayati Raj system will be formed to play an active role in planning and monitoring programme implementation. These committees would be statutory committees and would act for the health sector as well as for allied social sectors taken together, thus creating an institutional framework for convergence. By specifically providing for representation of elected women, community-level women activists like Mitanins, and community-based organisations (CBOs) or any other forms of women movements, women's participation in decision-making and mainstreaming of gender concerns would be ensured. The Panchayat Health Committees would also coordinate with the State department and local women's CBOs like self-help groups to ensure that in every habitation hamlet-level health committees, trained community health activists (Mitanin), and peer educators are available. Periodic training programmes would be institutionalised for both elected PRI members and their administrative and technical support staff. Institutional mechanisms for PRIs to access technical assistance for planning and programme management would be put in place. The performance of Panchayats would be measured on a set of indicators, called Health and Human Development Index, which will be periodically published. This would enable correction of uneven development between Panchayats and within Panchayats by funnelling resources to the Panchayats and sections performing poorly. With growth of capabilities with institutional technical assistance and democratisation with adequate transfer of powers, PRIs especially at the block and district level would be given control over all the health facilities and functionaries in their areas. The state is committed to this goal.

Community Participation

Health is not a consumable commodity or a desirable set of practices imposed by a benevolent state on a passive beneficiary. Health should be produced and sustained at the level of the family as community. It requires not only community participation but adequate community control over the processes that generate health. With this perspective the State will develop mechanisms to involve communities in problem identification, planning, implementing, and monitoring of healthcare programmes. In choosing community representatives the State would be sensitive to socio-cultural, economic, geographical, and gender differences. For issues that are best addressed locally by people acting together—for example in the control of vector-borne diseases or the promotion of sanitation—community initiatives and collective local action would be promoted. To this end local institutional arrangements would be promoted such as village health

committees, self-help groups, youth clubs, and other spontaneous forms of CBOs. Providing the nodal point for these community efforts at the level of the habitation and village would be a number of trained and sensitised volunteers and peripheral government functionaries, particularly the Mitanins, Anganwadi worker, village nurse (multipurpose health worker) and primary school teacher.

At the level of the State, district and block NGOs would play a major role in ensuring community participation and promoting the concerns of marginalised sections and regions. They will identify unserved and underserved areas for primary healthcare services, including reproductive health, and prepare plans to provide need-based, culturally appropriate, and people-centred quality care that is responsive to people's felt needs. Guiding them to ensure the successful implementation of these plans will be PRIs, Panchayats Extension of Scheduled Areas (PESA), and the State government.

Comprehensive Primary Healthcare

Comprehensive primary healthcare involves ensuring universal access to promotive, preventive, curative, and rehabilitative healthcare linked together with good referral systems responsive to the health needs and aspirations of the people at all levels of social and economic development. Equitable distribution, community participation, intersectoral coordination, the use of appropriate technologies, and accountability are essential aspects of this process.

in the context of Chhattisgarh comprehensive primary healthcare in curative care services would mean in the least access in every habitation to basic 10 to 15 essential drugs and a trained health volunteer, at the village level, to a trained nurse, access to a medical curative facility with about 30 to 50 drugs within an hour and to a centre providing hospitalisation and basic emergency care—the first referral level—within two hours using readily accessible transport.

The Government will notify the package of services guaranteed in each facility—the health subcentre, the PHC, the CHC (first referral unit), and the district hospital (secondary referral centre). This package will be comprehensive, covering communicable and non-communicable diseases, and will be upgraded annually to reflect acceptable standards of care. In preventive care the State will define the minimum guarantees in terms of access to food, drinking water and sanitation, elementary education and health education, safe working and living standards, and minimum environmental quality standards. Promotion of healthy lifestyle and protection from harmful practices, especially tobacco, liquor and other addictions, would be important components of comprehensive healthcare.

Equity in Healthcare

In achieving adequate status of health for the State as a whole the Policy will also ensure health equity. This will imply in practical terms ensuring that in all crucial indicators of health (IMR, MMR, disease prevalence rates) and health service (doctor-population ratio, hospital bed-population ratio, immunisation ratio, access to maternal care indicators, etc.) there are no significant differences between different economic or social groups. Affirmative action will be taken to ensure proportionately higher allocation of resources and services to groups that are currently more disadvantaged to enable them to close the gap and reach the State averages.
The concept of equity encompasses a wide number of parameters, which include economic class, gender, marginalisation by community, by religion, or by region, and criteria of vulnerability like age groups (old, very young, adolescent), homeless, migrants, urban slum dwellers, commercial sex workers, children without adult protection, physically and mentally challenged, and destitutes.

In this context, achieving gender equity is a major challenge facing the State. Though relative to other states Chhattisgarh shows a better gender equity situation, it has been noted with concern that the sex ratio in the 0 to 6 age group is declining. Addressing this requires not only rigorous enforcement of The Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 but better access to social services for the girl child and a determined campaign against son preference in communities. The past bias towards focusing on some aspects of reproductive health like fertility control has been replaced with a more comprehensive understanding of reproductive health, where reproductive health is seen as a subset of the larger agenda of women's health issues. While endeavouring to provide the highest quality of reproductive health as part of a life-cycle approach, the Policy recognises that addressing gender inequities requires mainstreaming gender concerns in all aspects of healthcare management. To attune women's healthcare to become part of a process of their empowerment women's participation in decision-making and leadership and collective action by women will be promoted.

Women form the majority of healthcare providers in the State; this trend is likely to grow. Women serve as health volunteers, midwives and nurses. They would increasingly be part of the workforce as technicians, pharmacists, and doctors as well. These trends will be encouraged. At the same time, the needs and concerns of women healthcare providers will be built into health workforce management policies.

Innovative, flexible, collaborative approaches will be adopted for meeting the health needs of vulnerable groups. To bring in the required high levels of motivation the State will seek active partnership with NGOs and promote policies conducive to their sustainable work.

For geriatric healthcare health services for the elderly will be integrated with primary healthcare. The establishment of appropriate geriatric healthcare facilities will also be facilitated.

Quality and Standards of Healthcare

To ensure health outcomes and patient satisfaction standards and quality of care parameters will be developed for different levels of healthcare. This will be done in consultation with health professionals, public health experts, and informed public opinion. The standards will be periodically upgraded to keep abreast of national and international best practices. The standards will include standard clinical management protocols with rational use of drugs and diagnostics for all categories of healthcare providers and continuing medical education to ensure that such protocols are adequately taught to healthcare providers.

In public health institutions, hospital management committees assisted by technical assistance agencies will ensure achievement of these qualities of care standards. Hospital management committees will be provided with the requisite resources, powers, and technical assistance. Systems of accreditation will validate these achievements and convey them into the public domain. In the private sector a system of voluntary accreditation will facilitate a constant enhancement of quality of care. A well-enforced regulatory mechanism will ensure that basic minimum quality in terms of costs, appropriateness, effectiveness, and ethics of care are guaranteed to the public. Similar standards of care will be ensured in the non-profit-oriented sector as well.

Supplementary mechanisms to ensure quality of care will be a well-publicised citizen's charter, adequate mechanisms of social audit, community monitoring, and statutory grievance redress mechanisms.

Appropriate legislation to turn these means into health rights will be adopted.

Behaviour Change Communication

The goal of the strategy of behaviour change communication (BCC) is to encourage individuals, families, and communities to make informed decisions concerning healthcare through programmes of health communication which facilitate behaviour change. The State's BCC strategy framework prioritises the use of interpersonal communication with suitable aids, locally appropriate print media and local cultural art forms especially in the 'kalajatha' format as main vehicles of effective communication. The assistance of electronic media, both radio and television, will also be sought.

The content of all BCC programmes will be appropriate to local contexts and audience groups, with careful normative research and evaluation studies. There will be a need to engage a wide variety of communicators beyond the staff of the public health system to make the programmes more effective.

Greater dialogue between individuals and within families and communities will be needed on issues of health to promote change in societal behavioural norms on health, particularly reproductive and child health. The cornerstone of this dialogue would be better quality of interpersonal communication between trained health volunteers and healthcare providers and the families they serve. To undertake these newly defined tasks and enhance the image of health functionaries capacity building will be required at all levels.

Districts will become the natural focus for convergence of governmental and non-governmental efforts for holistic BCC through participatory planning and programme implementation.

Intersectoral Coordination

Intersectoral coordination is essential to adequate address many social determinants of health. Priority areas for such coordination are nutrition and food supply, water and sanitation, and poverty alleviation programmes. The PRIs and their statutory social sector subcommittees would be the main institutional framework for intersectoral coordination. Cohesiveness will be ensured through detailed planning of job responsibilities of health sector staff, Mitanins, panchayat functionaries, primary school teachers, and Anganwadi workers. The Panchayats will involve civil society in monitoring the availability, access, and affordability of services and supplies. Coordination will also ensure adequate registration at the village and panchayat level of births, deaths, marriages, and pregnancies. A joint assessment of performance on different parameters and joint action plans will ensure consistent progress.

PRIORITY AREAS

Nutrition

Most of morbidity and mortality in Chhattisgarh relates to a high prevalence of malnutrition. Children, adolescents, pregnant and lactating women, and the elderly are the most vulnerable to malnutrition. The single greatest remedy for malnutrition is equitable development. Poverty-induced hunger is unacceptable in modern society. To ensure food security in the State the public distribution system will be strengthened and universalised and employment guarantees or unemployment benefits will be ensured. Reduction of child malnutrition to less than one-third of its current rates by the end of the Twelfth Five Year Plan period will be a central policy goal. To meet this objective supplementary feeding systems that reach all children through anganwadis

and school meal programmes and all vulnerable sections faced with hunger will be strengthened. Energising the ICDS (Integrated Child Development Scheme) and midday school meal programmes to play this role is a challenge that the State would attempt to meet. Innovative, flexible, and collaborative approaches will be built into the ICDS programmes for meeting the health needs of infants, pre-school children, schoolgoing children, expectant young mothers, and elderly people. Public understanding of good dietary habits as suitable to different cultural and economic contexts will be promoted through appropriate nutrition education programmes.

Social Security for Health

Recognising that the cost of healthcare even in the public sector has an adverse impact on poverty levels and that many health crises can be economically catastrophic to families of all social classes, the State will move towards compulsory social insurance and health guarantee schemes, with the State paying the premia for the poorest. The insurance schemes will initially cover all primary and secondary healthcare needs for both visible and invisible costs, and later extend to tertiary care services. In the near term, supplementary voluntary insurance programmes will be made available for tertiary care services. All public health facilities and accredited quality- and cost-regulated private healthcare facilities will act as service providers along with adequate monitoring of quality, cost, and ethical practices.

Mainstreaming Gender and Women's Empowerment

Empowering women is essential to achieve developmental objectives. In policymaking, the need to improve women's access to and control over resources and their role in decision-making will be kept in perspective. In healthcare gender barriers will be reduced by reducing economic barriers, making services responsive to women's special needs, ensuring accountability, promoting technology and skills to make services women-friendly and enhancing the availability of women healthcare providers. Wholehearted assistance will be given to the State Commission for Women in its endeavour to safeguard women's civil rights and promote their empowerment. Discrimination in any form and violence against women will be effectively dealt with. Particular attention will be given to change gender stereotyping that attributes most of the family and healthcare responsibilities only to women. Male responsibility in areas like reproductive health and childcare will be emphasised through redesigning training and BCC programmes and health service delivery programmes accordingly.

Tribal Health

Chhattisgarh State, with over 30 per cent tribal population, has a special responsibility to lead in the area of tribal health. The specific objective will be to provide an integrated quality primary healthcare service with improved coverage, accessibility, acceptability, and utilisation with the participation of the community and as part of the process of empowerment of tribal people. To achieve this content, health programmes will be made ethnic- and culture-specific. Programme designs will be informed by studies of cultural and health practices among different tribes. The wealth of knowledge inherent in tribal systems of medicine and good health practices amongst these communities will be documented and built upon even as they are provided access to all the benefits of modern medicine. The State will also develop sufficient number of referral hospitals capable of tackling emergencies in tribal areas. As a result of these measures the health status indicators gap between tribal and non-tribal areas will be closed. Special programmes will be launched to control factors responsible for the gradual extinction of some of the primitive tribal groups (PTGs). The priority is to ensure their survival by protecting their livelihood and access to natural resources while also providing access to culturally appropriate strategies of prevention

and cure of specific diseases, sanitation, hygiene, and nutritional services. The district health societies will identify and notify medically underserved areas in tribal blocks and districts. In consultation with local panchayats of these areas they will be provided with additional resources and powers to choose from a number of alternative approaches to medical and healthcare provision for these areas.

Involvement of the Private Sector

Currently, the major part of curative healthcare provision in the State is by the private sector. There is need to involve the private sector in contributing to the public health goals such as in social franchising and marketing strategies, while ensuring that healthcare provision does not adversely impact on poverty levels. For this, a basic minimum regulatory framework needs to be put in place at the earliest. This involves registration of all private healthcare providers, and adequate information available in the public domain about the services they offer and their cost and quality. These should also be linked to processes of accreditation. It needs to be ensured that cost and quality remain within fair and reasonable limits, and the poor have access, especially in emergencies, and that there is no conflict of interest in relationships between different private care providers. All these aspects need monitoring. The private sector would be encouraged to develop linkages to the public health system especially for referral and diagnostic health services, taking due care against conflict of interest. Such partnerships should supplement and not substitute existing public healthcare. They should also bring in private capital to contribute to health sector goals and should not involve transfer of public assets or resources to private hands. Above all, the mechanism of access to the poor would need to be ensured.

The State will promote a more diverse variety of services and specialities provided from the private sector and ensure better access for the poor to such services through risk pooling mechanisms and social insurance linkages.

As regards the small but important and dedicated non-profit-oriented voluntary sector in healthcare service provision, the Government will actively engage with this sector and promote a partnership where they serve as benchmarks for dedicated service and act as centres of innovation and excellence in reaching healthcare to the poor.

Involvement of Civil Society

The term civil society is understood to mean NGOs, CBOs, associations of working people, people’s movements, women’s movements, civil rights movements, etc. Civil society has the potential to play many important supportive roles to government action. Civil society organisations can increase awareness on health issues, facilitate and monitor public and private healthcare provision, provide special outreach programmes and input to vulnerable sections, contribute to health planning and innovation at all levels, and through advocacy action spur the government into more effective and accountable health policies and programme implementation.

In specific areas, especially medically underserved areas and with specific vulnerable groups NGOs may contribute by service delivery. Recognising the importance of NGOs the State will endeavour to build a climate where ethical dedicated and capable organisations are able to flourish and sustain themselves. This would require transparency and fair play in selection and payment process with clear memorandums of understanding (MoUs) and agreements binding both parties into a fair partnership. It also requires funding policies that allow such organisations the development of a corpus fund so as to promote independent initiatives and survive interruptions in funding and gaps between programmes. In the absence of such a policy

framework the whole NGO sector falls into disrepute as unethical organisations get an advantage over dedicated and accountable organisations.

INTERVENTIONS

Reproductive Health

Socio-cultural determinants of women's health and nutrition have a cumulative effect over a lifetime and even across generations. To have adequate impact on reproductive health, the emphasis will have to shift from a narrow focus on maternal health to an entire "life cycle of the woman" approach and health issues of women must be seen as a subset of women's empowerment. Commitment to life-cycle approach would include combating gender discrimination before birth in the form of sex-selective abortion or pre-conception technologies. It would mean ensuring adequate access to all social services and opportunities for the girl child, adequate nutrition and life choices in adolescence, non-discrimination in the institution of marriage, adequate access to good quality maternal care, and protection from neglect and destitution in old age. It also means an end to the various forms of violence against women. At all ages services accessed must be gender sensitive and special attention given to the entire range of reproductive healthcare, including infertility management, access to a variety of contraceptives, and prompt and effective care for reproductive tract infections. Promotion of sexual health, education regarding reproductive health issues, and women's control over decision-making with regard to their bodies can alone promote achievement of population stabilisation goals.

On reproductive health issues the Government will promote organisations and collective action by women, male and community participation. There will also be greater number of women healthcare providers and expanded facilities with convenient timings for women to access these. The build-up of women's health committees and women health volunteers (Mitanins) in every hamlet expands enormously Government's ability to strengthen these processes.

Child Health

Every child has a right to adequate nutrition, good health, good quality education, love and care and adult protection, and opportunities to grow and attain his/her full potential.

For the pre-school child, the ICDS will remain the key strategy, modified into a comprehensive early childhood care programme with improvements in quality and outreach to assure every pre-school child nutrition, pre-school education and healthcare and for every working mother daycare support for young children.

Continuing efforts will be made to reduce child mortality to levels comparable to the best-performing states of India. This will require prompt and adequate community and primary healthcare on the very first day of health need with adequate institutional referral support for the sick child. It would also require considerable reduction in child malnutrition levels and preventive measures against epidemics and recurrent infections like diarrhoea, malaria, and measles. Every section of society, especially local government bodies, would be involved in this priority of accelerating child survival.

The Government also recognises that certain categories of children, such as the handicapped child, children without adult protection, street children, etc. have special health needs and would need to develop flexible partnership-based approaches to address them.

Adolescent Health

Providing information, guidance, and counselling services to adolescents and orienting parents about the needs, issues, and constraints of adolescents is important and also needs further research to understand these issues better. Adolescent health would be integrated into routine services. Specific programmes on adolescent nutrition, anaemia, and reproductive health will be introduced along with good counselling and support systems to enable adolescents to reach their full potential. Mass screening and counselling would identify and immediately minimise anaemia caused by iron deficiency and also contribute to identifying sickle-cell diseases and traits among adolescents, leading to a reduction of the disease in the next generation.

Emphasis will also be placed on skill and ability development by the educational system keeping with the opportunities in the job market.

Population stabilisation goals such as adequate spacing and delaying age of the women at marriage and at first birth and the goals of HIV/AIDS control programmes can be achieved only in a context where adolescents are fully informed and can make responsible choices on sexual and reproductive matters. To promote this knowledge sexual health and reproductive health issues will be incorporated into the formal education curriculum as well as non-formal education and peer education approaches.

Communicable Diseases

An effective diseases surveillance system will be developed to monitor the magnitude and distribution of communicable diseases in different population groups. State- and area-specific plans and strategies will be developed and appropriate interventions will be identified incorporating new technological advances. All communicable disease control programmes will be integrated with each other and with the health system as a whole at the Gram Panchayat, Block and District levels for best results.

The emphasis will be on prevention through appropriate evidence-based, monitored strategies. Prevention approaches would recognise the centrality of community participation, intersectoral coordination, and involvement of PRIs. Massive, planned, and focused BCC campaigns would also play a pivotal role. Current State priorities will be to eliminate leprosy, polio, and yaws and reduce tuberculosis and vector-borne, water-borne, and sanitation-related diseases. The programme for control of malaria will have in place steps for early diagnosis and prompt treatment of fever cases, surveillance through blood smear examination, locally planned vector control measures with emphasis on bio-environmental methods, universal access to personal prophylaxis measures like pesticide-impregnated bed nets, and early warning and effective response to disease outbreaks. For tuberculosis the key measures would be increased awareness of their role among all healthcare providers, better communication with those affected by the disease, improved diagnostics integrated into all healthcare facilities, easy access to drugs at all times, and follow-up on treatment.

HIV/AIDS

The State will take proactive steps to create public awareness regarding HIV/AIDS as a major public health issue. Relevant health education campaigns will focus on adolescents, migrant workers, and occupational or social sectors known to have high prevalence rates. Voluntary

counselling and testing centres (VCTCs), currently established in all district hospitals, will be extended to all referral centres. Treatment to reduce trans-placental (mother-to-child) transmission will be introduced. Home-based care for people living with HIV/AIDS will be encouraged and supported. It will be ensured that there is no discrimination in providing treatment to them in any public or private sector hospital. Measures will be enforced to reduce transmission of HIV through blood transfusion and blood products. Strong advocacy and social mobilisation efforts will be made at all levels to promote collaboration between public, private and voluntary sector, all departments concerned and with citizen groups in responding to a pandemic of HIV/AIDS. The strategy to control HIV/AIDS, sexually transmitted infections (STI), reproductive tract infections (RTI), Hepatitis B, and Hepatitis C will be converged. The State will be sensitive and responsive to problems such as children with HIV/AIDS, orphaned children, abandoned patients, and legal issues arising out of an HIV pandemic.

Non-Communicable Diseases

Non-communicable diseases account for over 40 per cent of morbidity in the State. A large part of non-communicable disease morbidity and mortality can be prevented with effective primary healthcare strategies. Health education to promote healthier lifestyle approaches would be a major step, discouraging the use of tobacco, alcohol, and other addictive substances. Policies to discourage their consumption would include ban on direct and indirect advertising, sponsorship of sports and entertainment by manufacturers of tobacco and alcohol, higher taxation, sales to be permitted to persons only above the age of 25 years and sales to be barred within certain distance of educational institutions and sensitive areas. De-addiction strategies using group therapies will be supported besides individual therapy and counselling on the role of exercise for those in sedentary occupations. Reduced exposure to atmospheric pollutants and physical and mental stress would be important components of the requisite lifestyle changes. Diagnosis and treatment of non-communicable diseases will be made available at all levels. At the primary care level medical officers will provide effective primary care based on standard treatment guidelines, and rational use of diagnostics and drugs. Specialist care will be made available at secondary referral (district) and tertiary care levels.

Cancer management will be strengthened and facilities will be made available at regional levels.

A planned campaign against sickle-cell disease should significantly reduce its prevalence in the next generation.

Mental Health

The State will make systematic and sustained efforts to enhance mental health services by improving training in psychiatry and psychology in medical and paramedical courses. Psychiatric teams and services will be integrated at district hospitals and counselling services introduced at CHCs. Mental health component will also be introduced into school health services. Societal strategies to address the underlying causes of poor mental health such as violence, particularly against women, various forms of social discrimination, substance abuse, and poverty, will be supported. Institutional mechanisms will be established through which mental health services can be effectively and widely accessed.

Occupational Health and Disaster Management

A State-level unit will be established to monitor adherence to health standards both in the organised and the unorganised sector and also to ensure that all employees entrusted with task

are providing services for prompt recognition and management of occupational disease. There will be periodic health and disease surveys for occupational disease in disease-prone settings such as coal mines. Disaster management units will be set up at the State and district levels to ensure preparedness to deal with natural and man-made hazards and disasters, ensure capacity building of the health functionaries responsible for health management in disaster situations, and coordinate rescue operations and control of outbreaks.

Elderly Healthcare

Increasing age brings with it increased susceptibility to stress. Chronic illnesses and disability become more prevalent, and psychosocial crisis such as retirement, loss of income, and loss of spouse become common. The elderly need both community care and institutional care. To assist long-term managed care of the elderly geriatric nursing homes, geriatric provisions in general nursing homes, day centres, and residential housing with provision for shared geriatric support, including independent living units of the elderly, can be made use of. Health services for the elderly will be integrated with all healthcare services, and special geriatric health services will be made available at the tertiary level. Raised public awareness of the needs and care of the elderly is also an important goal.

Disability

Appropriate measures will be taken to disseminate the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. The State will adopt an inclusive approach for persons who are ‘differently abled’ with their full participation in decision-making and implementation. Prevention, early detection, and intervention will be the watchwords to minimise disability. The State will promote universal immunisation, good nutrition, accident prevention etc. to prevent disabilities, ensure timely treatment at all levels, ensure access to rehabilitation services, access to aids and appliances, and capacity building of health service providers to assist people with disabilities.

Urban Health

Chhattisgarh has a 20.09 per cent urban population which is projected to grow faster than the rural growth rate. Urban areas would also be under pressure due to migrations from rural areas both within the state and from poor areas of adjoining states. A result often is the growth of slums inhabited by an urban poor who have no social security, have poor access to social services, and who, because of their living and working conditions are even more vulnerable to ill health and disease than the rural poor.

The State will ensure basic amenities such as food security, safe drinking water, sanitation, education, and healthcare facilities for the entire urban population, irrespective of their legal status.

The State will undertake mapping of urban slums with the help of municipal corporations and municipalities. The primary healthcare services for the urban slum population will be strengthened with the participation of public, private, urban self-government bodies and NGOs. Every 5000 urban population would have access to the preventive and promotive services of a trained public health nurse, assisted by community health volunteers and peer educators. Every 100,000 urban population would have access to an urban healthcare referral centre with adequate medical officers and basic healthcare. Specific health programmes would also reach out to all the

marginalised and vulnerable sections comprising the homeless, migrants, destitutes, and mentally or physically challenged.

Emergency Health Services

The Policy commits the State to strengthening and expanding emergency health services and trauma care to include accidents, emergency obstetric care and other surgical, medical, and paediatric emergencies. The State will aim to achieve 24-hour access to comprehensive emergency obstetric services and other basic surgical services at CHC level (with a well-equipped 30-bed basic hospital) by the end of the Twelfth Plan. Referral system with adequate transport and communication arrangements will be established to reduce time of access to emergency services from any habitation to one hour.

Citizen's charter will assure emergency care in critical need in any hospital, public and private, as determined by the Supreme Court of India.

Training of first aid and life support systems will be imparted to school, college, and university students, teachers, factory workers, drivers, bus conductors, and all paramedicals. Special efforts will be made to enforce accident prevention measures such as protective gears in industry, safety belts in automobiles, and use of helmets on motorised two-wheelers for personal safety.

AYUSH/ISM&H

Chhattisgarh is a tribal State with vast herbal diversity and wide range of ethno-traditional practices. The State Policy recognises the importance of AYUSH (Ayurveda, Yoga, Unani, Sidha, Homoeopathy) system in addressing health needs. Ethno-traditional practices will be mapped and documented. It will be the State's endeavour to codify, standardise, and preserve the natural resource practices of traditional healers and the natural resource base on which they depend so as to help mainstream their knowledge into health systems. Efforts will also be made to address the gaps in existing practices of these systems to improve upon them. All possible steps would be assured to promote only validated practices. The gaps between the various systems in terms of epistemology and understanding would be narrowed through research and development and through sharing information between the systems.

The State will mainstream AYUSH for contributing to better healthcare to all. Training and orientation in primary healthcare will be provided to institutionally qualified AYUSH practitioners. Qualified practitioners of AYUSH systems will be posted in mainstream health facilities so that healthcare seekers have an option to choose their own preferred system of medicine. Community participation in AYUSH programmes and AYUSH content in BCC and community-level health processes would be used to promote a holistic understanding of health and disease.

Health Planning and Management

Health planning would ensure that the health system has a clear sense of direction and priorities, makes efficient use of resources, and is responsive to people's needs. Health planning would be ensured at the state, district, Janpad Panchayat, and Gram Panchayat level. At the Gram Panchayat and Janpad Panchayat level, published indicators of health and related sectors measured in a participatory way would guide planning. The statutory health committee of the panchayat (may be synonymous with district health society at the district level) would be the main centre of planning of the Health Department, with civil society and CBOs contributing.

District-level planning would look into raising adequate resources especially from budgetary support, efficient use of resources and resource allocation to identified priorities, human resource development, efficient stock and inventory management, and for coordination and convergence with all related sectors. The database for this exercise would be aggregation of Gram Panchayat and Block plans, inputs on disease profiles from epidemiological studies and disease surveillance systems, and inputs on service delivery from health management information systems. Feedback from the community and external evaluation studies would also contribute. All stakeholders concerned would be involved in a district-level health committee and provided the requisite technical assistance.

State-level health plan will largely be an aggregation of district plans. In addition, it will address the area of medical education and healthy human resource development, set and monitor quality standards and norms and lead on research and development issues. It will also ensure that equity concerns are addressed and uneven development within and across districts is corrected through appropriate resource allocation and technical support options. Technical resources required from the national and international levels would also be identified.

Plan implementation will depend upon four crucial aspects of good governance—

A. Institutional separation of all procurement and civil works development aspects, with transparent and efficient processes and subject to periodic public scrutiny.
B. Supportive workforce management policies.
C. Fair and merit-cum-seniority-based choice of management leadership with assured tenures and periodic assessments of performance.
D. Professionalisation of management at all levels.

Professional management implies ensuring that all health management personnel at state and district levels have appropriate skills and qualifications. Where required, management expertise and functions can be sought from or outsourced to external agencies. A corollary is a commitment to developing public health management and hospital administration training institutions in the State and ensuring that they access the best talents nationally and internationally to improve existing State-level capacities.

The State and district health societies would play the key role in planning and monitoring. They will coordinate between training institutions, technical assistance agencies, health management information system, and disease surveillance systems. Autonomous arrangement will be made for infrastructure development, procurement of drugs and supplies, and overseeing logistics. The Directorate at the State level and the Chief Medical and Health Officer’s office at the district level will act as the main implementation mechanism. Technical assistance agencies will be encouraged and facilitated at the State level to provide additional technical capacity to the State and district health societies. The State Health Resource Centre, Regional Resource Centre, UNICEF, and technical assistance agencies of development partners will be supported to play this role. Suitable NGOs with health expertise who are active in the State would also be requested and supported to provide technical assistance in areas of their expertise.

Human Resource Development

Policies and institutions will be promoted to ensure that the State generates the requisite number of quality of healthcare professionals. There is currently a shortage in human resources, worst in the areas of specialists, but extending to medical officers, nurses, midwives, and many categories of technical support staff. State planning would rest on estimating future human resource

requirements and encouraging a mix of government and private sector institutions to create this human resource. Monitoring will be an important aspect.

In each technical and professional domain the State would have at least one institution of international standards, equivalent to the best in the nation and with the ability to undertake research and development in its domain.

In promoting professional education it will be ensured that the professionals have the knowledge, skills, and attitudes necessary to serve the population of the State, especially those living in rural areas and the most vulnerable sectors. This will be a criterion in the recruitment of both faculty and students to such institutions. The State will also make a variety of skill upgradation options available for the medical professionals.

The State has adopted an in-service human resource development (HRD) policy that provides for periodic retraining and skill upgradation of all its personnel through a hierarchy of training institutions at state, regional, and district levels. Training for all public health sector staff in health management roles is a major component of this policy. The State Institute of Health and Family Welfare will be the apex training institute in charge of all in-service training and policy planning institution for HRD. A mandatory continuing medical education programme for all medical professionals will also be organised.

Health Financing

The State will increase public heath sector allocation to 6 per cent of the State budgetary allocation. The investments in primary, secondary, and tertiary care and the ratio of expenditure between rural and urban areas will be based on the norms that will be developed regarding scale of services in these sectors. In managing resource flows the focus will be on increasing health facilities in the rural areas and the vulnerable sectors.

The health budget would make allocations district-wise in accordance with district health plans. As part of State Finance Commission recommendations for more effective decentralisation to PRIs in both rural and urban areas delegation of financial resources and process to districts would be strengthened. District health planners would be aware of the resource envelope available to them, the norms for intersectoral distribution, the proportions earmarked for mandatory spending items to reflect State planning priorities and the untied fund pool.

Supplemental resource mobilisation options through donor support to hospital management committees and district health societies would be encouraged. Private sector investment for contribution to public health would also be encouraged while ensuring access to the poor and quality and rate control. Since out-of-pocket expenditure forms the major part of household expenditure on health, the State will endeavour to promote social security options to reduce the adverse impact of such household expenditure on levels of poverty and indebtedness.

Access and Rational Use of Drugs

Access to essential drugs is a basic human entitlement. The State will ensure annual increase of budgetary allocation for purchasing drugs and supplies for both in-patients and outpatients in the public health sector. An essential drugs list will be prepared and periodically updated for primary, secondary, and tertiary hospitals. Rational use of drugs as defined by the essential drugs list is essential to keep the drugs budget affordable. Procurement of drugs will be transparent and efficient. Appropriate institutional framework for procurement and distribution of drugs will be put in place. Warehouses for drugs and supplies will be constructed and storage space of

adequate standards will be created in all health institutions. Health staff will be trained in logistics management. In line with a State Drug Policy the State will ensure registration of all drugs in the market with adequate information to both consumers and to those prescribing drugs. Hazardous and banned drugs will be proscribed from the market and irrational drugs will be progressively weeded out. Prices will be regulated and quality standards maintained in coordination with Central Government institutions. Spurious drugs would be promptly uncovered and their producers and distributors given exemplary punishment.

Population Stabilisation

Population stabilisation requires social development measures like better education, improved access to quality of health services, better nutrition, good employment opportunity, higher earnings, and social security, all these contributing to improving the quality of life.

In addition to the above objectives, the State will promote the ability of the family to plan consciously when and how many children it wants to have. Family planning services will shun coercive strategies. The State recognises the importance of family planning services being made a part of life-cycle approach to reproductive health and of comprehensive primary healthcare strategies. Good-quality family welfare services and safe and effective contraceptive technologies will be promoted. The use of safe, universally accessible temporary methods to delay the age of the mother concerning her first child to 21 years and ensure at least four years spacing between two children will be promoted. Male responsibility in contraception as well as in all aspects of women's healthcare will be advocated to reduce the burden on women. The State will develop special packages for districts with highest unmet need in terms of health and family welfare services and endeavour to make them user-friendly.

POLICY IMLEMENTATION MECHANISM

A detailed operational plan will be prepared for each policy intervention. Roles and responsibilities of people/department and timeframe with outcomes will be developed. The State Health Mission will be constituted with the Chief Minister as Chairperson, the Health and Family Welfare Secretary as Member Secretary and representatives of other development departments and other sectors such as NGOs and professional bodies as members. The District Health Society will be entrusted with the responsibility of planning for monitoring and implementation of the Policy at the district level.

CONCLUSION

A State is judged by the well-being of its people, as reflected in the levels of health, nutrition, and education; by the civil and political liberties enjoyed by its citizens; by the protection guaranteed to children; and by the provisions made for the vulnerable and the disadvantaged. The people of Chhattisgarh can be its greatest asset if they are provided with the means to lead a healthy and economically productive life. Comprehensive primary healthcare and population stabilisation is a multi-sector endeavour requiring effective dialogue and coordination at all levels of government and society. The spread of literacy and education, increasing availability of primary healthcare services, convergence of service delivery at village level, participation of women together with a steady, equitable involvement in family resources will facilitate early achievement of socio-demographic goals. An improved standard of governance is a prerequisite for the success of any health and population policy. The success of the Integrated Health and Population Policy in consonance with the National Population Policy 2000 and the National Health Policy 2002 will fulfil the aspirations of the people of Chhattisgarh.