

**ORISSA STATE INTEGRATED
HEALTH POLICY – 2002**

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1. Introduction

- 1.1 Through a planned process since 1947, there has been an expansion in infrastructure and systems for providing health care services throughout Orissa. Orissa has adopted Central Government norms, guidelines, policies and programmes for this development.
- 1.2 In recent years, there have been a number of additional statewide initiatives to enhance the reach and quality of health care to improve the health of people. These include the multi disease surveillance system; several measures towards streamlining drug procurement, distribution and rational use of drugs; total risk coverage for five major communicable diseases through the *Panchabyadhi Chikitsa Scheme*; the Infant Mortality Rate Reduction Mission; mandatory pre-post graduate placement of doctors to serve in difficult areas; establishment of district cadres for paramedical staff, among others. It is a matter of pride that in several of these areas Orissa has been a pioneer and positive results are seen. District level initiatives have piloted important components of primary health care such as community participation, improved mobility assistance for field staff, support to training and health education systems, maintenance of built assets and equipment, use of low cost construction for primary health centres and sub-centres. All these have led to improved capacity and confidence of health service providers and improved health care. The Policy and Strategic Planning Unit (PSPU) has initiated work on policy areas including health financing. These involvements have led the State Health and Family Welfare Department to develop a Vision for 2010 and to this policy statement.
- 1.3 Since the year 1947, there has been a gradual improvement in the health status of the population due to several factors including developmental and educational interventions, economic improvement and better health care services. While the Infant Mortality Rate (IMR) has declined from 135 in 1981 to 97 in 1989, it is still one of the highest in India – much above the national average of 70. The Crude Death Rate (CDR) has declined from 15.4 per 1000 population in 1971 to 13.1 in 1981 and 10.6 in 1999. Rural urban differences remain (for 1999 rural, IMR-100, urban IMR – 65; rural CDR 11.1, urban CDR 7.1). The Crude Birth Rate (CBR) has declined substantially from 34.6 per 1000 population in 1971 to 33.1 in 1981 and 24.1 in 1999 (rural 24.6, urban 20.3, all India 26.1). The gender ratio (females per 1000 males) is 972 in 2001, which has increased from 971 in 1991 and is higher than the all India level of 933 in 2001. Orissa is on its way to achieving population stabilization with an annual growth rate of 1.59% (2001 census), against the all India figure of 2.13%. The life expectancy for 1996-2001 is projected as 58.5 years for males and 58.1 years for females, up from 54.1 and 51.9 years for males and females respectively in 1981-86. Indicators of

nutritional status among women and children and burden of diseases indicate a substantial proportion of preventable morbidity and mortality. The people of Orissa experience a large number of disasters – about 40 major disasters in 50 years – that adversely affect health and development and health care services.

1.4 It is in this context that an integrated health policy statement is being articulated for the comprehensive, planned development of the entire health sector (public, voluntary, private; allopathic and Indian systems of medicine as well as homeopathy); and to address key determinants of health (nutrition, water supply, sanitation, environmental hazards); in order to improve the health of people and their access to care. This state health policy draws upon the National Health Policy 1983 and 2002. Central policies regarding specific health related issues, such as education for health sciences (1989), nutrition (1993), drug policy (1988 and 1994), pharmaceutical policy (2001), Medical Council of India guidelines (1997), blood banking (1997), the elderly (1998), Population Policy (2000) and others continue to be the guiding documents. The Orissa State Integrated Health Policy developed by the Health and Family Welfare Department, Government of Orissa, indicates directions for health improvement in a state-specific context, as health is a State subject under the Constitutional framework of India. It helps to actualise the Vision Statement for 2010 by providing a framework within which strategies and operational plans are developed, implemented and reviewed.

2. Mission Statement

*The Mission of the Health and Family Welfare Department, Government of Orissa, is to **facilitate improvement** in the health status of the people of Orissa with their participation, and to make available health care in a socially equitable, accessible and affordable manner within a reasonable timeframe, creating partnerships between the public, voluntary and private health sector and across other developmental sectors.*

Medium and long-term goals are derived from the Vision 2010, and some of the specific goals are given in Section 8.

3. Approach

The various components of the approach are outlined below:

3.1 **A participatory analytic and reflective approach** will continue to be used in achieving health goals. Involvement of communities and stakeholders in decision-making, planning and implementation increases ownership and can harness creative energies and resources – human, material and financial - towards shared goals.

3.2 **A public health and societal approach** will be used to address determinants of ill health such as nutrition, water supply and sanitation, to reduce transmission of communicable diseases, and risk factors for diseases at population levels. Public

health aims to protect, promote, restore and improve the health of all people through collective action.

3.3 **The primary health care approach** works together with public health and emphasizes principles of:

- inter-sectoral coordination at all levels, especially at the district, sub-division and village / municipal level
- community participation and social control through Panchayati Raj institutions, health committees and other institutionalized mechanisms for community feedback
- equitable distribution of good quality health care, recognizing that health is a human right and there is need for social justice in health care
- value of appropriate technology for health
- adopting an inclusive approach with equal support to local health traditions, yoga, Indian systems of medicine, and homeopathy
- referral systems and linkages between the primary, secondary and tertiary levels of health care.

3.4 **Health financing, management and administration** are critical support systems for the health sector. They will be developed through training, research and nurture.

3.5 The pro-poor approach: The co-relation between poverty and poor health is well known. It is not only the wage-loss during illness episodes or due to consequent disabilities that make the poor poorer, but also the sudden financial loss and debt-trap that make the situation worse for them. High out-of-pocket expenditure on treatment incurred by all sections of the community, as is evident from a variety of investigations in Orissa, leads to the conclusion that unless the State takes adequate care to protect the poor and the vulnerable from the adverse economic effects of diseases, any serious effort at sustainable socio-economic development will have no long-standing and favourable impact. At present, a very large portion of the public-provided services is consumed by the better-off than the worse-off for a variety of reasons. The policies and strategies therefore attempt to address this issue in every possible situation thereby indirectly helping in sustainable human development. Health improvement complements socio-economic development process by directly increasing human well-being and reducing economic risks and poverty. The policies and sector reform strategies contribute to health improvement by translating those strategies into actions that are cost-efficient in achieving health gains in the community, by reducing wasteful and inappropriate expenditure by the State as well as by the individual.

4. Core Components

4.1 Equity

The policy aims to reduce disparities on four parameters, namely region; disadvantaged groups (scheduled tribes and castes); gender; and vulnerable groups (persons with disability and elderly persons).

4.1.1 Region

The eleven KBK (Koraput-Bolangir-Kalahandi) plus districts have been identified for priority development inputs by the state. These districts are Kalahandi, Nuapada, Koraput, Nabarangpur, Malkangiri, Rayagada, Bolangir, Sonepur, Kandhamal (formerly Phulbani), Gajapati and Boudh. Greater human and financial investments for health sector development and functioning will be made to these districts and to disadvantaged pockets in other districts over the next eight years. Rural urban disparities in health indicators will be reduced. Resource mapping of public / private, civil society and donor inputs followed by integrated planning will help avoid wastage and duplication.

4.1.2 Scheduled Tribes and Castes

The scheduled tribe (ST) population in Orissa (22%) is larger than the national average of 8%. The scheduled caste (SC) population is 16%. Together they account for 38% of the population. Available disaggregated indicators point to a poorer health status among these deprived social groups. Under-nutrition, stunting of growth and underweight are higher among SCs, ST, and backward communities. Coverage of antenatal care is lower among deprived socio-economic groups. Geographic and other reasons have led to lower access and utilization of health care. Efforts have been made by the state on a priority basis to redress this. For indigenous people, a package of services will be made available and accessible. This would include nutrition services (education cum supplementation); communicable disease control especially malaria, TB, leprosy, yaws; services for specific diseases such as sickle cell anaemia and special norms for health services including training and induction of health workers and professionals from this social group into the state health services.

Persons of scheduled caste origin are spread throughout the state in all districts, while scheduled tribes are more concentrated in certain districts. Primary care, access to complete treatment, follow up and referrals to secondary and tertiary care hospitals at very subsidized rates will be assured. Local health traditions will be acknowledged and respected. Sensitization training is necessary for health providers to reduce negative social attitudes and to instill respect for human dignity.

4.1.3 Gender

Though Orissa's gender ratio is higher than many other Indian states, it has declined over the decades from 1037 females per 1000 males in 1901, to 971 in 1991 and increased nominally to 972 in 2001 (all India average 933 in 2001). However, in the critical 0-6 years age group it has declined from 967 to 950. This is a matter of serious concern. Implementation of the PNDT Act (1994) and creating awareness among the public and professionals of the harmful consequences of female feticide will be undertaken. Other reports suggest that violence against women is on the increase. Health providers will be trained to identify, record and manage such cases and initiate preventive measure through families and the community.

The NFHS 2 data indicate that women marry relatively late compared to other states and the small family norm is more accepted. However only 39% are involved in decision-making about their own health care, and only 29% who earn cash can decide independently how to spend the money they earn.

NFHS 2 also reports that based on a weight for height index 48 per cent of women in Orissa are undernourished, with serious nutritional deficits among women in rural areas and disadvantaged socio-economic groups. Prevalence of some degree of anaemia occurs in 63 per cent of women. Over 28 per cent of currently married women reported some type of reproductive health problem.

Therefore, highest priority will be given to improve women's health status and access to care. The number of women doctors and female health workers at primary care level will be increased with provision of residential facilities and personal security. Linkages with the voluntary and private sector will be encouraged. ICDS functionaries also play a critical role and their capacity will be strengthened through training. Empowerment training of women's groups for better health seeking practices will be supported. Life skills education for adolescent girls and boys will be developed in collaboration with the Department of Education.

4.1.4 Vulnerable groups

Innovative and collaborative efforts will be made to meet the health needs of persons with disability, the elderly, street children, out of school and working children, prisoners and commercial sex workers. The state will be open to learning from other parts of the country especially of participatory approaches. Resource generation from a variety of sources such as voluntary agencies, philanthropists, private sector, and the local community will be encouraged.

In summary, efforts to achieve equity for the four broad groupings above will cut across all health sector strategies in order to improve social, cultural and physical access to health care.

4.2 Quality of Care

Concurrent with the improvement of health care infrastructure, the focus during the coming five years will be to enhance quality of care and patient satisfaction. The State will set clearly defined standards of care for each level of health institution. Quality assurance mechanisms and certification will be established covering the public, voluntary and private sector. It will include accreditation, repeat registration, mandatory continuing education for all health care personnel, patient's charters, grievance redress systems and legal measures. Service product offer and the quality of service delivery will be suitably tailored to increase public awareness, confidence and service consumption. An important element towards achieving this would be to train the service givers. Good governance of the large public funded health system, by internal institutional mechanisms and through elected representatives, local bodies and civil society groups needs greater attention in order to improve quality and accountability.

4.3 Sustainability

The Health and Family Welfare Department will make efforts to:

- a) sustain the momentum of changes introduced since the 1990s;
- b) build a core group of middle level and younger multi-disciplinary health professionals;
- c) develop leadership;
- d) facilitate and be open to civil society involvement;
- e) build in financial sustainability by 2010, protecting and increasing the health budget, and increasing the range of sources of funding;
- f) continue with human resource development and personnel planning to ensure retention of a core group of highly trained and motivated staff.

4.4 Medical and Public Health Ethics

In order to protect public and patient interests and human rights, including the right to life, health and health care, the State, with the support of Universities, professional bodies, consumer groups and civil society, will

- a) promote the principles and practice of medical ethics in all health care institutions, and in all sectors and systems of medicine;
- b) promote the practice of public health ethics in decision making, resource allocation and implementation of policies and programmes;
- c) address and reduce the scourge of corrupt practices or extortions through better and transparent systems and building public support.

5. Organizational Components

5.1 Health Care Financing

In view of:

- a) the large proportion of out of pocket expenses as part of health expenditure and its adverse consequences on the poor;
- b) the linkages of chronic ill-health or hospitalization with indebtedness and poverty, and
- c) the rising costs of medical care

the State will take proactive initiatives in health care financing. The State Government spending will be gradually scaled up to achieve the national norms. Allocations will be protected and increased in a phased manner up to 2% of Gross Domestic Product and to 5- 6% of the budget depending upon the financial situation of the State. There will be complete utilization of Central Government grants under all the schemes. Spending will be equitably distributed:

- (i) between primary, secondary and tertiary levels at 55%, 35% and 10% as suggested by Government of India;
- (ii) between urban and rural areas, and
- (iii) between the worse off and better off districts. Indigenous systems of medicine and homeopathy will receive a better share of resources than what is available at present. Allocation and spending on health promotion will be enhanced.
- (iv) A greater consciousness about resources will be instilled among health providers and decision makers. Efforts will be made to reduce wastage and duplication through selection of cost-effective strategies and efficient management practices. Innovative financing schemes will be tried. Local needs-based planning and management will be encouraged, and financial management skills at the peripheral levels will be strengthened.

5.2 Strategic Planning

5.2.1 Strategic planning and management, based on sustained environmental scanning, creativity, innovation and new ways of looking at the organization to achieve its objectives and mission, will form the core element of the Policy. Based on the findings of organizational reviews conducted at least once in 5 years, adjustments in the structure, staffing and systems will be made to make the organization best suited and most efficient in achieving its operational goals.

5.2.2 A few areas were identified for long range planning by the Organizational Review, 2002 of the Health and Family Welfare Department, undertaken as part of the broader administrative and fiscal reform of the Government. Those identified areas will be further investigated, piloted, and appropriately implemented.

5.2.3 The Policy and Strategic Planning Unit (PSPU) will be an integral part of the Health and Family Welfare Department, and will comprise of internal and external experts. Using evidence obtained from studies undertaken or commissioned, and from analysis of HMIS and other surveillance systems data, it will provide strategic advise to the leadership. The unit will have a multidisciplinary team comprising of public health specialists, health administrators, economists, sociologists and anthropologists. The PSPU will keep constant watch on all critical areas of strategic concern through regular action research. The critical areas would include health care financing, decentralization, health management, quality of care, equity, primary health care, public health and health promotion.

5.3 Organizational Changes

The organizational review (referred to in Para 5.2.2 above) has brought out a number of factors affecting performance within the Health and Family Welfare Department. Changes in the systems, styles and internal structure are called for, to remove those constraining factors and improve the health care management functions. Since the successful implementation of the strategies depends on the appropriateness and strength of the organization, an all out effort will be made to improve the capacity, culture, structure, systems and processes within the organization through a set of carefully chosen strategies.

5.4 Health Management and Administration

A core group of young and middle level health professionals of different categories will be trained in health management and administration. This will help increase professionalism in management of public health, hospitals and health centres. Induction and in-service training will be conducted through the State Institute of Health and Family Welfare (SIHFW), with the involvement of outside experts and local faculty. Service and job protocols and responsibilities will be reviewed, updated, disseminated and discussed with staff.

The Health Management Information System will be suitably strengthened for timely decision-making in personnel management. Vacancy positions will be filled in a transparent manner without delays with trained personnel. Mismatch of specialists and staff will be minimized. Monthly staff position status will be provided to the leadership. Performance appraisals at institutional, district and state level will be streamlined.

Systems for engineering, construction and maintenance of infrastructure; procurement, maintenance and condemnation of equipment and transport; drug procurement and distribution will be strengthened based on the experience gained in the past few years. Contracting out of non-core activities such as the cleaning, laundry, security, dietary and gardening sections will be reviewed, and the most suitable outsourcing framework and mechanisms will be evolved after due

consultations. Conditions for adequate wages and social security of contract staff will be ensured as contractual obligations in the memorandum of understanding (MoUs).

5.5 Role of *Panchayati Raj* Institutions (PRI)

In keeping with the 73rd and 74th Constitutional Amendments and the National Health Policy 2002, the role of PRIs (rural and urban) in governance and implementation of the public health programmes will be appropriately laid down in consultation with PRIs, followed by adequate financial devolution by 2005. The Health and Family Welfare Department will take responsibility for capacity building of *Gram Panchayat* and ward members to discharge the above functions, in collaboration with Departments for Panchayati Raj and Rural and Urban Development, and with the involvement of NGOs. Experiences from States of West Bengal, Kerala, Karnataka and MP will be studied.

5.6 Inter-sectoral Coordination

Though recognized as an important component of primary health care since the Alma Ata Declaration of 1978, inter-sectoral coordination has received inadequate attention. Working linkages and joint programmes will be initiated with the Departments of Women and Child Development and Social Welfare, Education, Panchayati Raj Institutions, Rural Developments, Urban Development, Environment, Mines, Water Supply and Sewerage Boards, and Pollution Control Boards. Mechanisms of collaboration at village, block, sub-division, district and state levels will be established [in partnerships with other departments](#).

5.7 Partnerships

In the past the government, voluntary and private sectors grew and functioned in relative isolation. Through the present policy the health sector will be seen in totality, including the Indian Systems of Medicine and Homeopathy, and the informal health sector comprising of RMPs (Registered Medical Practitioners), traditional healers and local health traditions. The state will play a facilitating role building partnerships between groups, and a regulatory role to maintain standards regarding quality of care in the public interest. There will be sufficient flexibility to allow creativity of each sector to grow. Coordination will be initiated and supported particularly in the areas of disease surveillance, notification, training, and health promotion and for national health programmes will be initiated and supported. [Considering the acute shortage of medical manpower in the State, the Government will encourage establishment of medical colleges in the private sector to fill the supply–demand gap.](#)

5.8 Education for Health Personnel

The State Policy recognizes that the basic education, training, continuing education and accreditation of the entire range of health professionals, allied professionals and health workers is vitally important for access to good quality health care. Standards of education have been deteriorating with negative effects on health care. The Government, along with Universities, professional councils and associations will undertake measures to ensure high standards in teaching and examinations, with revisions of curricula to be updated and made socially relevant. Learner centered, problem solving and experiential educational methods will be encouraged. Educational units in the different colleges will be set up, for training teachers and postgraduates in pedagogy. The infrastructure, equipment and teaching aids of colleges, training institutions, associated hospitals and health centres will be improved in accordance with norms laid down by national councils. Staffing with required number of qualified teaching personnel, selected on merit will be ensured.

The annual and five-year financial and other resource requirements will be worked out for and by each institution, within a stipulated time. Plans will be made to assure resources from different sources. Fund raising bodies will be established for each major institution, involving well-known personalities from the public and private sector.

Research will be encouraged to provide good academic ethos and to address important, locally relevant medical and health problems. Library and Information technology facilities will be upgraded. Teaching and training institutions will adopt primary health centres (and associated sub-centres); community health centres and district hospitals so that students learn in varied health care settings, with teachers also working in these institutions.

The State Institute of Health and Family Welfare will be developed into a high quality centre for induction and in-service training, and integrated continuing education for various grades of health personnel. It will be organizationally linked to the district training centres and other health worker training institutions. The necessary infrastructure and staffing will be made available. Faculty development will be encouraged through attending conferences, seminars, and short courses and through writing professional papers. Good performance will be mandatory with annual reviews.

Each teaching institution will bring out annual reports highlighting their academic, training, service and research activities, as well as the financial and administrative aspects.

5.9 Rational Drug Policy

There are over 60,000 formulations of medicinal drugs in the open market. The essential drug list (EDL) of the World Health Organization lists about 300 drugs necessary for secondary care and 50 – 60 drugs for primary health care. There is an abundant over production of vitamins, tonics, health drinks, cough and cold preparations, over the counter preparations, tranquilizers, antacids and a range of other formulations. The production, sale and prescription of irrational and hazardous drugs constitute a major area of concern.

The State has already introduced an essential drug list, and measures regarding pooled drug procurement, quality assurance and distribution for its own health institutions. These will be sustained and further developed. It will regularly review and update the essential drug list, drug policy and therapeutic guidelines, rate contract lists, registration and re-registration, drug selection, pooled procurement, quality assurance systems, and drug management systems, all with transparent procedures through established bodies and with the participation of professionals, consumer groups and the public. Use of generic prescribing will be promoted. Drug donation guidelines will be developed and implemented.

The State will continue its responsibility to ensure that all people can obtain drugs (including vaccines immunologicals and blood products) that they need, at affordable prices assuring safety, efficacy and quality. Hazardous drugs will be withdrawn from the market. List of banned drugs and their formulations, with trade names will be widely publicized in the consumer interest.

Education of medical professionals and pharmacists with periodic information dissemination regarding rational therapeutics will be encouraged and supported. The right to information will be respected and protected. Information about harmful, hazardous and irrational drugs will be made public. Adverse drug reaction monitoring will be piloted and developed through medical and pharmacy colleges and councils. Drug package labeling and inserts will carry unbiased drug information, with necessary warnings in Oriya and English in print large enough to read.

The Drug Control system will be strengthened with necessary qualified staff and support laboratories. Quality tests and inspection for good manufacturing practices (GMP) will be regularly done. The rational drug use unit will hold workshops and training programs, publish newsletters and updates, conduct prescription audits and studies and other activities for the wider promotion and practice of rational therapeutics. Drug pricing of new drugs following the new patent laws will be studied in the context of access to antiretroviral drugs for HIV/AIDS, psychiatric drugs, newer antibiotics etc. Linkages will be made with national and other bodies in this regard to explore compulsory licensing and methods to procure drugs at low cost to meet public health needs.

Rational drug policies for the Indian Systems of Medicine and Homeopathy will be introduced, following discussions with their councils and experts.

Functioning of blood banks will follow national guidelines, ensuring availability and distribution in rural areas. Rationalization of blood use, and preparation and utilization of blood components will be promoted.

6. Public Health and Medical Care

6.1 Nutrition, Water Supply and Sanitation

Analysis of recent data on nutritional status and data from the multi-disease surveillance system indicates high levels of under-nutrition and anemia especially among women and children and a large burden of diseases due to water and sanitation related causes. It is evident that unless people have access to basic determinants of health such as adequate food and nutrition, potable water supply and sanitation facilities, the health status of the community will not improve.

While action is called for through different departments, the specific role of the Health and Family Welfare Department is important. The following steps will be promoted towards better nutrition: nutrition education of mothers and families through health workers in collaboration with ICDS functionaries; improvement in nutritional content of supplementary feeding using low cost locally available food through self help groups; improved training of health professionals regarding nutrition; nutrition and growth monitoring with trend analysis; vitamin A, iron and folic acid supplements for women and children, under supervision; early detection and treatment of childhood illnesses to prevent deterioration of nutritional status; and de-worming. These are indicative, and the department will support any action by local communities towards promotion of nutritional status.

Regarding water supply and sanitation, the specific role of the department will be limited, such as testing of water quality through its laboratories, health promotion regarding water and sanitation related problems and how they can be prevented, outbreak investigation, regular chlorination and water purification. However, efforts will be made at better inter-sectoral linkages to achieve synergy in action and outputs towards this goal.

6.2 Environmental and Occupational Health

The workplace and environment have important effects on health. Of particular concern are exposures of people in mining areas, impact of pesticide use; and water pollution. There is increasing pollution of air, water and soil due to rapid, often unplanned industrialization; inadequate compliance with pollution control regulations and poor monitoring. Increased chemical pesticide use, including of

banned products, has affected the food chain. Research undertaken by universities, research groups and NGOs will be studied carefully and necessary action initiated. Health and environment impact assessment of developmental projects, industrial and power plants, dams and mines etc. will be undertaken. Government will ensure that adequate measures are taken by public and private owners regarding occupational health and safety.

The health sector will work in collaboration with the concerned agencies to improve drainage and sullage systems, and solid waste management in keeping with Supreme Court guidelines. The Government will also give priority to proper hospital and health care waste management in the public and private sector.

6.3 Population Stabilization

The National Population Policy 2002 forms the context for efforts by the State towards population stabilization. Data suggest that the small family norm has been largely accepted. The Total Fertility Rate (TFR) in Orissa was estimated by NFHS2 at 2.5. The state is expected to reach the replacement level of TFR of 2.1 during 2011 – 2016. The decadal growth rate is declining and was 15.9 percent in 1991 – 2001, significantly lower than the national growth rate. The age of marriage at 19.8 is higher than the national average. However the momentum of population growth will continue due to the young age distribution of the population. Thus the focus of the policy will be on providing good quality contraceptive care and increased access to spacing methods. This will be achieved through integration with the general health services. The vertical programme approach will be broadened. Reduced maternal and infant mortality, improved reproductive health care for women and men, and life-skills education will receive support (refer Para 6.8). Public campaigns and professional education against son preference and sex selection will be undertaken. Gender equity with reproductive rights will be one of the core thrust areas of the Policy. Appropriate steps such as training, application of community needs assessment, treatment of RTIs and STDs, women's health empowerment training, male involvement, and attention to the population growth of primitive tribes, will be taken.

6.4 Communicable Diseases / Infectious Diseases

These are still a major cause of morbidity and mortality in Orissa. Communicable disease control will therefore be given high priority, particularly malaria, diarrhea, acute respiratory infections, tuberculosis, leprosy, filaria, HIV/AIDS, STD/RTIs, and measles.

Capacity will be built for early detection and complete treatment at primary health centres, the health institutions closest to homes of people. Efforts will be made to reduce transmission through provision of safe water and sanitation facilities; integrated vector control including use of bioenvironmental methods; immunization and health promotion. The multi-disease surveillance system (MDSS) will be further consolidated, covering all government facilities, private

and voluntary facilities and ISM& H dispensaries. It will be expanded into a public health surveillance system in a phased manner. The laboratory services will be strengthened at PHC, block, district and state level. Uninterrupted drug supplies will be ensured. Recording and reporting systems will be improved. The information technology base and network will be expanded. An understanding of these disease, their spread and methods of control will be given priority in professional education and community health education. In order to make time bound gains in communicable disease control, besides technical and financial support, attention will be paid to leadership, governance, management and administration of these programmes, with community involvement. The respective national health programmes will function as an integrated part of primary health care. Close supervision will be provided in the field by district and state programme officers. Performance reviews will be conducted at a higher level, learning from the field realities to fine-tune the operational strategies. A geographic and time trend analysis, through epidemiological units, will support control interventions. The MDSS will feed into the National Disease Surveillance Network.

6.5 Mental Health

The burden of suffering from mental illness is large enough to make it an issue of public health importance. Two percent of the population suffers from severe mental morbidity at any point of time and ten percent from neurosis, alcohol and drug addictions and personality problems. About 20 – 25% of outpatients at primary care centres come with psychosomatic symptoms. Currently more effective treatment, counseling and management methods for persons with mental illnesses are available. In keeping with the Mental Health Act of 1986 the state will develop its mental health services by sending young staff members for training in psychiatry, clinical psychology, psychiatric nursing, counseling, psychiatric social work etc. Non-institutional, community based, innovative methods of mental health care will be encouraged. The mental health component in the training of all health professionals will be strengthened. The medical colleges will be supported to develop their departments of psychiatry. Provisions in the national mental health programmes will be utilized to initiate district mental health programmes. Adequate supply of drugs for psychiatry and epilepsy will be made available at district and peripheral health institutions.

6.6 Non-Communicable Diseases (NCD)

Orissa, as in India, carries the double burden of pre and post-epidemiological transition disease patterns. Non-communicable diseases such as cardiovascular diseases, cancer, diabetes, accidents and injuries, blood disorders and newer environment-related disorders are on the increase. They will increase with rising life expectancy. The state will adopt a two-pronged approach to address NCDs:

- a) Public health strategies to reduce risk factors and health education:

It will initiate policies to reduce use of tobacco as is being done by several countries and states in India, following WHO guidelines. These include bans on sponsorship of sports and entertainment; bans on direct and indirect advertising; higher taxation; barring sales within certain distances of educational institutions; public education regarding health effects of smoked and chewed tobacco especially for children and youth; banning smoking in public places; and education of health personnel. Steps to reduce alcohol abuse will also be initiated, some of which will be similar as for tobacco.

- b) Facilities for diagnosis and treatment for non-communicable diseases will be improved at district and CHC level. Training updates for PHC doctors will be done as part of the integrated in-service continuing education. Over time the recording and reporting of NCDs as per the International Classification of Diseases will be introduced into the disease surveillance system, after necessary training, preparation and pilot testing.

6.7 Health Promotion

Information, Education and Communication (IEC) activities are fragmented, being linked to different programmes. Health promotion will be developed in an integrated and more professional way with feedback loops from the community and youth. It will shift focus from merely communicating information towards participatory change and empowerment. It will enable people to increase control over and participate actively in improving their own health. Different groups such as school children, youth, women, workers and farmers will be addressed appropriately, and the use of local folk media will be encouraged. The State Institute of Health & Family Welfare will lead this function. Pooling of resources from different programmes and from the community will be done. School health programmes will be implemented.

6.8 Health of Women

This is a high priority in the State (refer Para 4.1.3 and 6.3). The policy components for women's health will be in synergy with the Women's Policy, which is being formulated. The entire range of women's health problems for all age groups will be addressed, in the overall context of improving their social status under a gender perspective. There will be enough focus on nutrition, maternal and reproductive health care, mental health, self-esteem, and access to general health care preferably with women health professionals wherever possible. Many health problems of women have social roots, and therefore, interventions will have psychosocial, community health and medical components. Sensitization of health providers to these components will be part of their integrated training and continuing education.

6.9 Health of Children

Investing in the health and wellbeing of children is investing in the future. The state already has several health interventions for children through the RCH programme, the IMR reduction strategy, and the ICDS. The state is distressed about the high Infant Mortality Rate, widespread under-nutrition and anaemia in children, leading to stunted growth and development, and other health problems.

The State will ensure better functioning of all programmes directed at improving health of the children. The coverage and quality of the Integrated Child Development Services (ICDS) with regard to nutrition and health care will be expanded and improved, in collaboration with other departments. School Health programmes will be supported and developed further in partnership with the community, NGOs and the private sector. School age children comprise about 25% of the population and are at a very receptive and vulnerable stage in life. Innovative efforts to reach out of school children, working children and street children will be made through Self help groups, NGOs, women's groups and children's groups. Health care and education of adolescent girls and boys will be supported.

6.10 Disability Reduction and Management

Persons with disability constitute 3 – 4% of the population of India. The 2001 census will provide state-specific information for Orissa. The health services will help minimize preventable disability through immunizations, genetic counseling and reduction of injuries. Medical rehabilitation services at district level will be established using national programme and external resources. The range of services will be expanded. Community based rehabilitation services will be encouraged through community health programmes. The provisions of the “Persons with Disabilities Act, 1995” will be implemented.

6.11 Oral Health (including Dental Health)

Though oral and dental health has an impact on general health, this has been a neglected area in policy and service provision. Preventive oral health will be encouraged through school health and health promotional programmes. Services at district and sub-divisional hospitals and gradually in CHCs will be improved, through provision of equipment and staff. Services of paramedical personnel as dental hygienists will be used. All dentists' posts will be filled and the number of positions gradually expanded.

6.12 Indian Systems of Medicine and Homeopathy (ISM&H)

Services of these systems though popular among people function in relative isolation and receive inadequate financial support and little policy attention. Shifts will be made with greater resource allocation, and involvement in decision making, health planning and service provision. This will increase the choices for the community. Establishment of ISM&H units in the same premises of the district hospitals will be attempted to enable sharing of infrastructure, diagnostics and nursing care, and better access by public. ISM&H medical colleges will be

strengthened and continuing education promoted for public and private practitioners.

6.13 Medical Industry and Technology

Technological up-gradation will be undertaken in pathology, microbiology, virology and clinical biochemistry departments in secondary and tertiary hospitals, including medical colleges. Specialized departments of plastic surgery, burns, trauma care, oncology, cardiology, cardio-thoracic surgery, neurology, neuro-surgery, immunology, genetic studies and others will also be developed. The procurement, maintenance and insurance of costly medical equipment and health accessories will be regulated through a specialized body, which will be established with government, private and voluntary sector professionals, and NGO and consumer representatives. Criteria will include need, quality, cost-effectiveness, safety, and patient and consumer interests.

6.14 Disaster Preparedness

Following a series of major disasters, the Government established the Orissa State Disaster Mitigation Authority (OSDMA). The department will continue to work on comprehensive health system preparedness and planning for disaster response at state and district levels.

Institutional capacity building for the health sector will be facilitated. Emergency response and comprehensive follow-up services that include medical, public health, psychosocial and rehabilitative components will be strengthened. Coordination, networking, communication and building community preparedness for rapid response during disasters will be undertaken systematically.

7. Conclusion

The Policy document is a guiding document providing a framework for the integral development of the health sector in Orissa to meet its stated social goals and objectives. The Policy is a working document, which will evolve and change over time in response to emerging needs and challenges. The strategic planning mechanism built into the Policy will take care of that function. Through this Policy statement, the Health and Family Welfare Department, Government of Orissa, hopes to make a positive change in health and health care within a definite timeframe. Medium term strategies and action points have been developed using a participatory approach. The Strategy sections may be referred to, for a detailed understanding of how the issues contained in this Policy paper are addressed. Annual plans of action will be developed at the appropriate time identifying details of how, by whom and when, interim goals and objectives will be met. Reviews will be inbuilt with the strategic planning process. In conclusion, the Health and Family Welfare Department reiterates its commitment to improve the health of the people of Orissa and to work in partnership with all who share similar goals.

8. Goals to be Achieved

Sl. No.	Issue	Time Frame
1.	Eradicate polio and yaws	2005
2.	Eliminate leprosy	2005
3.	Eliminate lymphatic filariasis	2015
4.	Achieve zero level growth of HIV/AIDS	2007
5.	Reduce mortality by 50% of on account of TB, malaria, other vector and water borne diseases	2010
6.	Reduce prevalence of blindness to 0.5%	2010
7.	Reduce IMR to 45/1000 and MMR to 100 / 100,000	2010
8.	Increase utilization of public health facilities from current level of <20% to > 75%	2010
9.	Establish an integrated system of disease surveillance, national health accounts and health statistics	2005
10.	Increase share of central grants to constitute at least 25% of total health spending	2010
11.	Increase state sector health spending from 3% to 5% of budget	2005
12.	Further increase this to 6%	2010
13.	Increase extra-budgetary health allocation and spending from alternative sources.	2005
14.	Establish networks between public, voluntary and private sectors at state, district and local levels.	2005
15.	Introduce mechanisms for community feedback and participation.	2005
16.	Incremental measurable achievement of equity goals	2005
17.	Establish training and mechanisms for involvement f Panchayati Raj Institutions at district and gram/ward panchayati levels	2005
18.	Create adequate infrastructure for the public health system with maintenance and management systems	2010

8.1 Priority Outcomes

While the State will pursue all the above mentioned goals, it will take up the following 7 items on priority basis :

1. Eradicate polio and yaws
2. Eliminate leprosy
3. Reduce mortality due to malaria by 50%
4. Reduce IMR and MMR
5. Increase utilisation of public health facilities from current level of <20% to >75%
6. Establish networks between public, voluntary and private sectors at state, district and local levels
7. Create adequate infrastructure for the public health system with maintenance and management systems.