The total population of Chhattisgarh according to the 2001 Census, is 2.08 crore. Of this, 80 percent of the people live in rural areas and 20 percent live in urban areas. Almost a third of the population belongs to Scheduled Tribes (STs). The health status of this marginalised section of the state is dismal. (See Box below)

### Health Status of Tribal population in Chhattisgarh 2005-06
- 91 ST children in the state, out of every 1000 children born alive, die before their first birthday every year (even for scheduled castes it is 63)
- 78% children below 5 years of age are suffering from anemia (for upper caste it is 53.5; for scheduled castes it is 69.3)
- Only 18% of deliveries of ST women were assisted by health personnel (for upper caste it is 70.1; for scheduled castes it is 50.5%).
- Only 28% of ST children below 2 years had a vaccination card (for upper caste it is 59.5; for scheduled castes it is 27.3%).
- 74 percent of ST women are weak with anemia. (for upper caste it is 42.4; for scheduled castes it is 51.9)

Over 25 percent of births in Chhattisgarh are unattended. Of the births that occur with attendants, the majority (42.7%) are assisted by traditional birth attendants (TBS), especially in the rural areas. Diarrhea is a major problem amongst younger tribal children (below three years) in the state. The awareness and knowledge about the treatment of diarrhea is limited. This coupled with acute respiratory illness and fever, results in high mortality among children. Adult tribal population of the state suffers from illnesses like malaria, cholera, leprosy and tuberculosis. 1 The doctor-population ratio of the state is 1:3100. 2

Since the formation of the Chhattisgarh as a separate state in 2000, the Government has initiated specific programmes like Mitanin, to address the health services need of the tribal population in the state. Mitanin programme is a major link between past experience at national and state levels with community health worker (CHW) programmes, and the future of ASHA (Accredited Social Health Activists), the programme espoused by the National Rural Health Mission. The Mitanin programme is widely credited with bringing down the rural Infant Mortality Rate (IMR) in Chhattisgarh from 85 deaths per 1,000 live births in 2002 (the second highest in the country) to 65 in 2005, much the same as the national rural IMR of 64. 3 Similar improvements were also noticed with relation to child health and immunisation coverage.

The formulation of the Integrated Health and Population Policy (IHPP) by the Government of Chhattisgarh (GOC) in 2006 is seen as yet another initiative to improve the health of the people of the state especially the disadvantaged. It acknowledges and recognises the pivotal contribution of

---

1 National Family Health Survey (NFHS – 3) Chhattisgarh
2 Bulletin on Rural Health Statistics in India, 2005
socio-economic determinants of health, an important aspect in improving tribal health. The Policy document provides a comprehensive framework for strengthening the public health systems and health care delivery. Before analysing further, let us look at the key features of the Policy.

MAIN FEATURES OF THE INTEGRATED HEALTH AND POPULATION POLICY 2006

The Chhattisgarh State Integrated Health and Population Policy 2006 talks of the commitment of the State to promote health for all and to provide quality health care services, especially to those in remote and difficult areas. 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.

The policy objectives are as follows:
1. To ensure universal access to comprehensive primary health care
2. To ensure equity in delivery of quality health care services
3. To ensure adequacy of health infrastructure and health systems and to develop human resources for health care.
4. To achieve population stabilisation through vigorous implementation of quality reproductive health care including family planning and other relevant social development measures by adopting an inter sectoral strategy

Strategic Directions
For achieving its objectives the Policy identified certain strategic action points:
- Decentralized planning and implementation - The policy suggests delegating charge to Panchayati Raj Institutions of all health facilities and functionaries in their areas and ensuring participation of women in decision making.
- Community Participation - Promotion of Village health committees, self help groups, youth clubs and their involvement in problem identification, planning, implementing and monitoring of health care programmes is suggested.
- Comprehensive Primary Health care - Access to preventive and curative care services through a trained health volunteer in every habitation and access to hospitals within 2 hours is proposed.
- Equity in Health care - This approach would also aim at gender equity and endeavor to provide highest quality of reproductive health as a part of life cycle approach and seek active partnership with NGOs to reach out to underserved sections.
- Improved Quality and Standards of Care - The policy proposes to develop parameters for different levels of health care in consultation with health professionals which would be upgraded periodically to ensure health outcomes and patient satisfaction. Appropriate legislation to guarantee and make these above means into health rights would be adopted.
- Behaviour Change Communication (BCC) – Societal change with regard to behavioural norms on health by locally relevant BCC programmes is suggested.
- Inter sectoral Coordination – To address the social determinants of health; priority areas are nutrition, water, sanitation, poverty alleviation programmes.

Strategy (priority areas)
The Policy also identified areas which it thought should be given special focus. They are as follows:
• Nutrition – Energizing ICDS (Integrated Child Development Scheme), mid-day meal programmes and nutritional education programmes.
• Social Security for Health – Compulsory social insurance and health guarantee schemes covering all primary and secondary health care needs.
• Mainstreaming Gender and Women’s Empowerment – Improving women’s access to and control over resources and increase their role in decision making and collaborate with State Commission for Women for safeguarding their civil rights.
• Tribal Health – Programme designed keeping in mind the cultural and health practices among the different tribes in addition to protecting their livelihood and access to natural resources as over 30% of the population is tribal.
• Involvement of Private Sector and Civil Society – Promote public private partnerships (PPP) in a variety of services and specialties and ensure better access for the medically underserved and vulnerable groups to these services.

INTEGRATED HEALTH AND POPULATION POLICY: HAS IT BENEFITTED THE ADIVASIS?

As stated above the Policy makes special mention of ‘tribal health’ as priority areas needing special attention. The Policy, talks about accessible integrated quality primary health care services for tribal people. Most importantly it speaks of launching special programmes for improving the health situation of the Particularly Vulnerable Tribal Groups (PTGs).

The Policy is a statement of commendable ideas and Government intent. The intent does not appear to be backed by sufficient political will as evident/manifest in the tardy/uneven implementation of these ideas. The state has made little progress in terms of improving health care in under-served tribal areas since the formulation of the Policy.

We now specifically look at few aspects of health services to ascertain whether the Policy directives have ensured or have tried to ensure affordable quality health services to the adivasis of the state.

Medical infrastructure

The Policy instructed the district health societies “to identify and notify medically underserved areas in tribal blocks and districts”. Though it has been 3 years since the formulation of the Policy, the health infrastructure in the state, especially in the tribal areas is far from satisfactory, much needs to be done also in terms of service delivery and in quality of services provided. The tertiary, secondary and primary heath care services in tribal areas of Chhattisgarh needs considerable upgradation, both in terms of coverage and reach. Though with the initiation of NRHM programme, some concrete steps has been taken to establish first care contact with the tribal people of the state, but more needs to be done.
For instance if we take the case of ANC registration (as per the Policy document it is as low as 26.7) which is mostly done by ANM as part of outreach services, but there exists a large number of vacancy in ANM recruitment. (as per the state Health department data there are 770 vacant post for ANM and 2270 for MPWs as of 2008-09).

Moreover with the increase of violence in tribal areas of the state in the last few years, provision of health service delivery has been negatively affected. According to Jan Swasthya Abhiyan (JSA) state convenor, Sulakshana Nandi “the level of health care provisioning in conflict ridden areas (most of which are in tribal belt) has worsened over the last three year periods.”

Availability of health providers in tribal areas

Health Secretary of Chhattisgarh, R S Vishwakarma in June 2008 said that “Providing health facilities in the rural areas is a major challenge because of the shortage of doctors in the state”.

Chhattisgarh Government has formulated an action plan to provide special allowances, insurance cover and other perks to medical professionals so as to motivate them to serve in remote villages. Under the National Rural Health Mission, Rs 4.57 crore has already been allocated for the plan, to be known as Chhattisgarh Rural Medical Core. Another initiative of the government has been posting of Rural Medical Assistants (three year course graduates) in remote areas.

These are welcome initiatives. However, much more needs to be done to ensure the success of these initiatives. Many studies have established that government doctors do not take up their postings in rural areas and find ways and means to stay away; and that several engage in private practice instead of attending to patients at the primary health centres; or divert these patients to their private clinics sometimes even on the same premises as the PHC. Tribal people are thus unable to access the free government services meant for them and at the same time with their very small disposable income are unable to access the private medical care offered by these doctors. If and when they do, it is at a great cost to them. They are forced to seek the services of traditional healers known as guniya, whose service also does not come free.

The Policy suggests that AYUSH (Ayurveda, Yoga, Unani, Sidha, Homeo) systems could be utilized/relied

---

4 Joseph John, Screen India National Network; Posted: Jun 30, 2008
5 The state health department has issued an advertisement to fill up 859 posts of Rural Medical Assistants to work under the National Health Mission. Those who have passed the three-year medical course, now known as ‘Practitioner in Modern and Holistic Medicine’, are eligible to apply. Source: http://www.indianexpress.com/news/3yr-medical-graduates-to-fill-rural-posts/500445/
upon to address the health care needs of the tribal population. But the Policy is silent on the issue of traditional healers, who caters to health care needs of tribal people in the state in an important way. It is very important to understand the cultural practices of health seeking behaviour of tribal people while formulating health care needs for them and develop these traditional systems in a more systematic way.

**Affordable health services**

Medical treatment is one of the major expenses incurred by a household. Studies have shown that it is major factor in indebtedness of poor/rural households. A study done by IFAD’s Tribal Development Project in three tribal districts of Surguja, Jashpur and Raigarh in 2006 found that close to 40% of households were indebted, and health was the main reason for indebtedness. The Policy acknowledges the adverse impact of the cost of health care.

After a long period of neglect, availability of essential drugs at village level has seen some improvement very recently. The availability of anti-venom and anti-rabies injections has improved in the PHCs and CHCs but the poor still have to pay to access them.

The Policy proposes compulsory social insurance and health guarantee schemes, where the poorest would have their premium paid by the state. In December 2008, the state government announced that the government will cover nearly 3.5 poverty-hit families across all the 18 districts under a health insurance plan in a phased manner. How far the recently announced health insurance scheme would be able to provide affordable health services to the tribal people needs to be seen.

**Transport**

Most tribal villages in Chhattisgarh, do not have proper transportation facilities to health centres. The health care providers at the village level find it difficult to visit the villages regularly and the medical requirements of the tribal population thus gets neglected. Proper transportation is an essential part in referral health care. If the Chhattisgarh government wants to decrease infant and maternal mortality rates then it needs to improve transport facilities. But instead of investing in this aspect, the state government have cut budgets and dismantled state transport corporations, overlooking their role in providing equity of access to essential services. This type of practices will go against the Policy aim of providing accessible quality care to all.

**Role of civil society**

---

6 Source: www.solution exchange-un.net.in (Maternal and Child Health Community)

7 www.janswasthya sahyog…
According to Himanshu Kumar, noted social activist based in Dantewada (South Bastar) and heading a grassroot organisation 'Vanvasi Chetna Ashram', "Lack of genuine participation of NGO and community for deliverance of health services is evident, contrary to the provision of the Policy. NGOs those who are committed and working sincerely among adivasi and their health needs are excluded deliberately from the committees and Jeevandeep society." This type of practices where credible groups have been deliberately kept out from Jeevandeep societies had resulted in taking anti-poor decisions like increasing user charges in many places says Jan Swasthya Abhiyan (JSA) state convenor, Sulakshana Nandi.

CONCLUSION

So far the Chhattisgarh Health department has not been able to overcome the challenges of poor quality health services in the state. Compounding this is a general deterioration of the natural environment, the economic and social conditions of the people and other factors that impact health. Traditional forms of medicine used by the tribals seem to be weakening with the changing way of life and the gradual loss of control over natural resources. Therefore, in order to make an impact in improving tribal health care and health status, concerted effort needs to be undertaken.

The intentions listed in the Policy needs to be backed by appropriate and detailed plans. For the Policy to actually succeed and realize its objectives greater political will is necessary, otherwise the Integrated Health and Population Policy 2006 will remain a mere lip service. There have to be strong peoples movements monitoring the health services and demanding the right to health and forcing to create a political will for provision of all entitlements including serious action on social determinants of health.

THINGS TO BE UNDERTAKEN BY THE HEALTH DEPARTMENT OF CHHATTISGARH

- Increase budget on health (for the present year budget on family welfare and medical and public health together is only 4% of the total budget) so that the required health infrastructure and personnel can be put in place in tribal areas.
- On priority basis initiate activities in tribal areas to implement the proposed state health guarantee scheme.
- Start initiatives to make the proposed monitoring bodies at various levels functional and make it accountable to people.
- Initiate activities to eliminate leprosy, tuberculosis, and other vector borne diseases as priority as per the Policy.
- Constitute the State Health Mission as stated in the Policy.
- Formulate a state act on health (stated in the policy document (strategic directions) about such an intent) to provide the citizens’ of the state ‘Right to Health and Health Care’.