



Health and Well-being





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The *Jan Rapats* show that people recognise the close link between health and ability, health and survival, health and growth, health and livelihoods – in fact between health and life itself. Health is seen as an all-embracing concept, as a state of being able to perform a variety of functions during the cycle of life. The *Jan Rapats* speak of a wide range of factors that impact on the physical and mental well-being of people. These include the environment, the quality and access to basic services, the assistance provided by support groups of kin and community, and even social and communal harmony.

Health does not mean merely the absence of disease. Nor does health care begin only with the onset of a disease and end once it is under control. People speak of what good health means to them and the importance of being healthy. The *Jan Rapats* regard health as a resource that a person must have to be able to function and earn a living.

This chapter is divided into six main sections. The first section details the various indicators commonly used to evaluate the health profile of a population. The second section presents a comparative analysis of the status of health in the past and today; it is based largely on the people's perceptions as described in the Reports. This is followed by a discussion on the determinants of

health and access to health services, both in the public and the private sector, including traditional practitioners and healers. Two separate sections discuss issues related to women's health and mental health. The last segment discusses the emerging issues and the interventions required.

From the people

Till a man is capable of working hard and earning, he is in good health. When his body doesn't have the strength to work and he needs the support of others, he is in bad health.



District Report, Bastar

When a person gets good and nutritious food and maintains cleanliness, he is healthy. When he is both physically and mentally healthy, he is in good health.

Village Report, Matpahad, Paththalgaon Block, Jashpur

Health Indicators for Chhattisgarh

State level data as reflected in the commonly used indicators suggests that on many counts Chhattisgarh does not compare very well with the national averages.

Infant mortality rate

The infant mortality rate (IMR) for the State¹ as a whole is estimated as 77.6 per 1,000 live births,

¹ Sample Registration System, Registrar General of India, New Delhi.

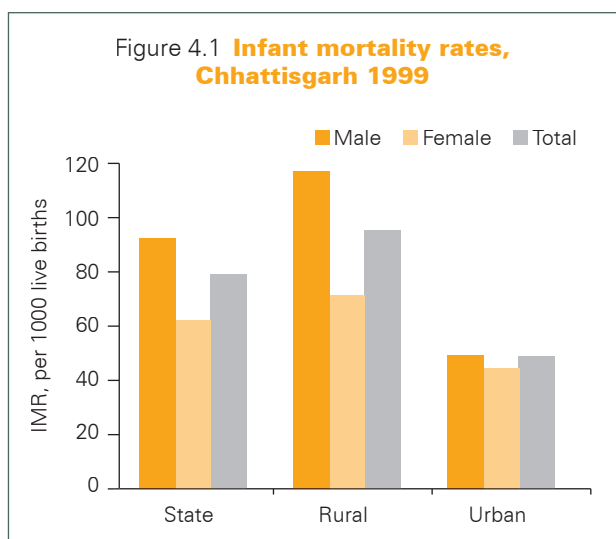
in the year 2000. As in other States, the rural IMR is significantly higher, at 94.5 per 1,000 live births, in contrast to the urban IMR, which is estimated at 47 per 1,000 live births. The high infant mortality rates suggest that urgent attention is required in reproductive health, safe delivery practices, and neonatal care. IMR for females is lower than that for males. The rural male IMR in 1999 was 116.5 per 1,000 live births compared to 71.3 per 1,000 live births, for females. This reflects the natural resilience that girl children have at birth.

Table 4.1 **Infant mortality rates in Chhattisgarh**

	IMR (per 1,000 live births) 1999			IMR 2000
	Male	Female	Total	Total
State	92.1	62.0	79.0	77.6
Rural	116.5	71.3	95.0	94.5
Urban	49.4	44.4	49.0	47.1

Source: SRS Bulletin April 2001 for data on IMR for 1999 and SRS Bulletin October 2001 for data on 2000, Registrar General of India, New Delhi.

The National Family Health Survey – 2 (NFHS-2) estimates the IMR in Chhattisgarh as 80.9 per 1,000 live births, and the under-5 mortality rate as 122.7 per 1,000 live births, in 1998/99. These figures reiterate the inadequate reproductive and child health care (RCH) services available in Chhattisgarh. Over 25 percent of births in the State are unattended. Of the births that occur with attendants, the majority (42.7 percent) are assisted by traditional birth attendants (TBS), especially in the rural areas. Diarrhoea is a major problem amongst younger children (below three years) in the State. The awareness and knowledge about the treatment of diarrhoea is limited. This, coupled with acute respiratory



illness and fever, results in high mortality among children.

Child sex ratio

The child sex ratio² is 975 females for 1,000 males in 2001³. Though this is higher than the national child sex ratio of 927 females per 1,000 males, it has declined from 985 females per 1,000 males in 1991. This points to the disturbing trend of sex selection practices before and after conception. Fertility trends suggest that son preference exists in most families⁴. This, together with the increased availability and accessibility to methods like ultrasound which can be misused for sex selection, will lead to a further decline in the sex ratio, unless urgent steps are immediately taken. This threat must be countered through preventive and regulatory measures so that the misuse of technology, both by the people and the medical community is prevented. A sincere and sustained effort for gender equality as an integral part of all development programmes needs to be initiated.

² Child sex ratio is the sex ratio for the age group 0-6. This ratio is directly associated with the pattern of mortality among children.

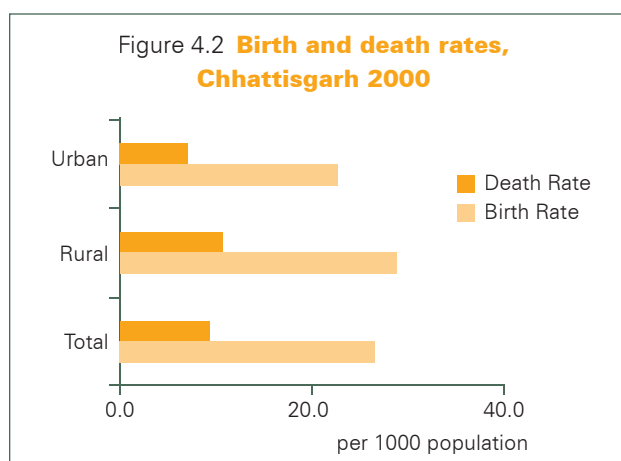
³ Census of India, 2001.

⁴ NFHS-2 reports that of the currently married women interviewed during the survey, 50.7 percent mothers preferred a male child whereas only 13.7 percent preferred a girl child, and 26.9 percent showed no preference.

Table 4.2 **Birth rate, death rate and natural growth rate, 2000**

	Total	Rural	Urban
Birth Rate (per 1,000 population)	26.7	29.2	22.8
Death Rate (per 1,000 population)	9.6	11.2	7.1
Natural Growth Rate	17.1	18	15.7

Source: SRS Bulletin, April 2001



Birth rate

The State recorded a birth rate of 26.7 births per 1,000 population in 2000, which puts it among States with high birth rates in India. It is lower than the birth rates in Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan⁵, that are all above 30 per 1,000 population, but higher than that for Jharkhand, which is 26.5 per 1,000 population. It is also higher than the national average, which is 25.8. While the birth rate remains high, there has been a perceptible decline in the growth rate of the population. The decadal population growth rate between 1991 and 2001 was 18 percent,

⁵ The respective rates are 32.8, in Uttar Pradesh, 31.9 in Bihar, and 31.2 in Madhya Pradesh and Rajasthan.

⁶ The fertility rate refers to the number of children that would be born per woman, if she were to live to the end of her child-bearing years and bear children at each stage according to the prevailing age age-specific fertility rate.

a drastic fall from 25.7 percent in the previous decade (1981-91).

Death rate

The State has one of the highest death rates in the nation, 9.6 per 1,000 in the year 2000, as compared to 8.5 for all of India. The high death rate, especially in rural Chhattisgarh, presents a challenge for the health delivery system, the supply of potable water and the availability of sanitation facilities. It also raises the issue of food security and livelihoods, that help to ensure a safe and nurturing environment.

Fertility rate

The total fertility rate⁶, in the State is 2.79 according to NFHS-2, compared to 2.85 for all India.

Table 4.3 **Fertility rate in Chhattisgarh**

Total Fertility Rate	2.79
Mean number of children ever born to all women 40 – 49	4.57
Mean ideal number of children	3.2

Source: NFHS-2 1998-99

Information from NFHS-2 shows that women in Chhattisgarh have a high awareness as far as family planning is concerned. Sterilisation as the permanent birth control method is adopted when the desired family size is achieved. There is a definite preference for a male child and till a son is born families tend to continue to have children. NFHS-2 data also suggests that there is a significant percentage of women who have an unmet need for safe contraception.

Table 4.4 **Unmet need for family planning**

	Percentage of people
Unmet need for Family Planning	13.5
Unmet need for spacing ⁷	8.0

Source: NFHS-2, 1998-99

Immunisation

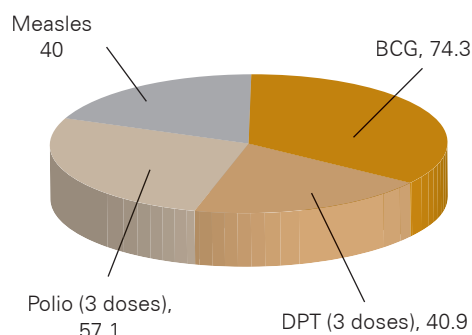
The NFHS-2 records a very low level of immunisation in the State. This is one of the primary reasons for the continued high infant mortality. Only about 22 percent of children in the State have been fully vaccinated. The reasons for this are the limited reach of vaccines and the high dropout rate, where multiple vaccines have to be administered, like those for DPT and BCG. Almost 94 percent of children received the first polio vaccine but only 57 percent received all three doses. Similarly, 68 percent of children received the first dose of DPT but only 40.9 percent children received all three doses of DPT. Immunization is considered one of the most important tools for the prevention of childhood illnesses and mortality.

The decrease in infant, child and maternal mortality in the last few decades is largely



⁷ Spacing refers to the number of years between children.

Figure 4.3 **Immunisation in Chhattisgarh – children vaccinated (%)**



attributed to increased immunisation. People use the public health centre as the main source of immunisation and most children (92 percent) receive vaccination from a public health facility.

The role of the public sector in the provision of vaccines and encouraging immunisation practices is vital in Chhattisgarh, where the infant and child mortality rates are already high.

People's Perception

Status of health – yesterday and today

The Village *Jan Rapats* record the impressions of people regarding the status of health in their villages in the past and what they perceive it to be today. People do not separate health and the quality of existence from the environment that they live in. Therefore, changes in their environment shape the perceptions that people have about their general well-being.

From all the District Reports (which are a compilation of the discussions that were held at

the village level) it is apparent that people see an overall decline in their health. This may not be based on the incidence of illness alone but in the larger context of physical and mental well-being. This perception is strongly connected to the various changes that have occurred over a period of time. The degradation of the natural environment has forced people to move away from their natural lifestyle, including types of livelihood, sources of food, eating habits and traditional practices. The Village *Jan Rapats* suggest that there is a greater level of uncertainty about health today than in the past. This arises from a sense of insecurity regarding the factors that make up health – food, environment, forests, drinking water – and this draws from a decline in the quality and quantity of these resources, as well as the sense of reduced control that people feel over these resources. The loss of control over individual health, and more importantly, its management is reflected in the general feeling of the people that they are poorer today (in terms of health) than they were before.

An analysis of the data collated from the Village Reports shows that only 18 percent (15.1 percent plus 2.9 percent) of the reports feel that the status of health is good or very good in their villages. Another 33.9 percent categorise their health as being satisfactory, while 48.2 percent

of the Village Reports feel that the status of health is poor or unsatisfactory (40.2 percent of Reports rate it as unsatisfactory and 8 percent as poor, see table 4.5 for details).

Diseases such as smallpox, polio and plague are mentioned as illnesses that took a heavy toll of life in the past, but the incidence of such diseases has declined substantially today.⁸ People affirm that their children are in better health and vaccination is a major reason for this. The decrease in epidemics may have reduced the perception of mortality, but this is not directly related with everyday health or healthy living or even with a healthy body, free of illness. There are no mechanisms which aid full recovery after a major illness. These factors lead to the perception of a general decline in the factors affecting health. The Village *Jan Rapats* point out that modern medical systems and programmes have helped to reduce the incidence of major diseases, especially in their epidemic form. People see this as an improvement but only in the prevention of illness, and not in the context of overall health.

Common diseases

The *Jan Rapats* enumerate the more common diseases that affect the villages. While these major diseases have regional and seasonal patterns, they

Table 4.5 **Status of health in the villages**
(percentage of Village Reports selected for perception analysis⁹)

Regions of Chhattisgarh	Very good	Good	Satisfactory	Not satisfactory	Poor
Northern region	3.9	14.3	22.1	56.1	3.6
Central plains	2.4	11.1	48.3	29.1	9.1
Southern region	2.4	19.8	31.3	35.3	11.2
State	2.9	15.1	33.9	40.2	8.0

Source: *Jan Rapats* Part III

⁸ Smallpox is reported to be totally eradicated from Chhattisgarh and India.

⁹ The perception analysis in this chapter refers to the 2,869 villages, identified as a representative sample for the purpose of this Report.

From the people



Earlier we used to eat a lot of roots and tubers. Our grain was produced without the use of chemical fertilisers. Now all kinds of chemicals are used. This makes the body weak and we are always troubled by illness.

Panchayat Village Report, Surguja

The lack of pure drinking water, the cutting of trees, the lack of health education, superstitions, *basi* (stale) food, all of these have an influence on health. Earlier, health was something that we always had ... and we worked all 12 months of the year. Now we fall ill easily and have to give special attention to our health.

District Report, Rajnandgaon

Earlier, people did not get fever often because they would work, sleep and rise at appropriate times. They would work hard and de-husk the rice and cook it in mud pots before eating it. They would remain clean. The environment was clean and pure, as there were no machines. People would bathe in the water of wells, lakes, rivers and streams and wash their clothes with ash. They ate roots, fruits, vegetables and other tubers to survive. If they got fever, they called a traditional physician for treatment. The use of medicinal plants led to a long life. They also gave special importance to prayers.

Discussions with Uraon tribe, Sagibhavan village, Kasbil block, Jashpur

related diseases, cholera, leprosy, skin infections and tuberculosis. Some reports also mention jaundice, typhoid, pneumonia and diabetes. Medical emergencies like complications during pregnancy and delivery, snakebites and bites from scorpions and other poisonous insects, minor and major injuries, also find repeated mention, as situations often become life threatening due to the lack of medical services. The reports speak of problems of health that arise from socio-economic reasons and are related to habitat and lifestyles, such as those related to malnutrition, anaemia and night blindness.

Diarrhoea is reported to be a major problem in more than half the *Jan Rapats* and malaria is reported in as many as 40 percent of the reports. Stomach related ailments are common in 21.5 percent of the villages, and cholera is also prevalent. A high incidence of snake bites is reported from the northern and southern forest regions.

The cycle of illness

From the *Jan Rapats* it appears that there is a cycle of illness that entraps people and due to its nature, where one thing leads to the other, it is almost impossible to be rid of it. This cycle is illustrated below in Figure 4.4.

occur frequently in all the districts. Among the more common illnesses are diarrhoea, malaria, stomach

Table 4.6 **Incidence of major diseases**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Malaria	Diarrhoea	Leprosy	Tuberculosis	Skin disease	Stomach related ailments	Head-ache	Cholera	Snake-bite ¹⁰
Northern region	43.1	49.3	1.1	2.3	3.5	21.2	6.1	13.2	15.1
Central plains	31.5	55.1	0.9	1.7	2.6	26	2.6	18	6
Southern region	45.9	57.2	2.1	1.9	3.3	17.5	7.04	14.9	21.2
State	40.2	53.9	1.2	1.96	3.1	21.5	5.25	15.2	14.1

Note: Names of the diseases have emerged from Part III of the Village Reports
Source: Village *Jan Rapats*, Part III

¹⁰ While a snake bite is not a disease, it is a common occurrence and requires medical attention. Similarly, headaches and stomach problems are symptomatic ailments described in the *Jan Rapats*.

Each successive cycle makes the person weaker and more susceptible to future illness; it harbours the seeds for the next round of illness.

Many of the more common diseases are closely associated with seasons, when both pre-disposing factors as well as problems of treatment are accentuated.

From the people

People associate the occurrence of diseases with particular times of the year. During the monsoon, diarrhoea and other infectious diseases are common. Malaria is common in November and December. In the period from March to June, skin infections are common. In August and September, illnesses due to dampness are common. The monsoon is the most difficult period, as there are a number of diseases that flourish in this season and access to health services become difficult or even impossible, due to problems of communication and transport. Some villages become virtual islands during the rains.

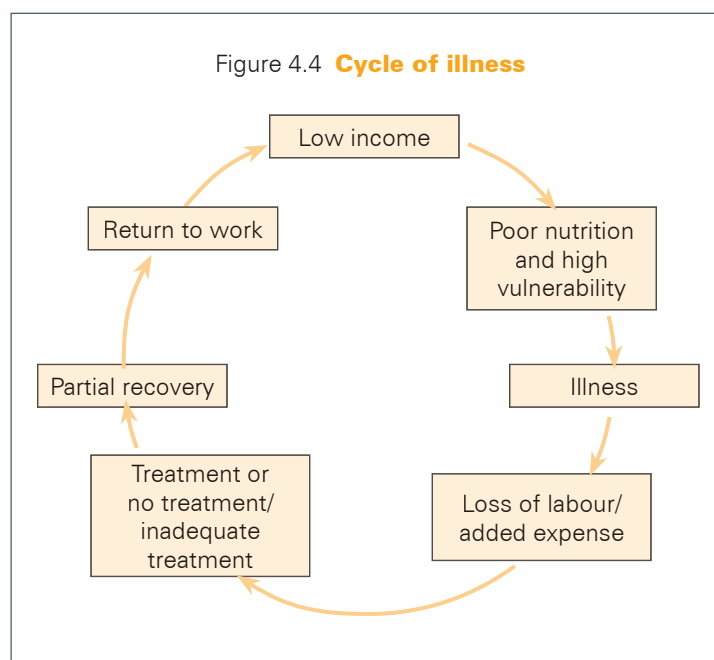


District Report, Korba

Determinants of Health

Low-income levels are the prime determinant of people's health, directly or indirectly. This is especially true when we look at ailments and disease. Poverty causes people to be undernourished; they have low resistance and are vulnerable to a variety of illnesses. Their habitat exposes them to conditions that are conducive to the spread of infectious diseases. The lack of money makes access to good health care difficult.

Figure 4.4 **Cycle of illness**



Food security and nutrition

The connection of nutrition to health is strongly established, not only in terms of having a nutritious diet for good health but having adequate food to eat, for survival. Lack of adequate nutrition is cited as one of the main determinants of ill health. Being undernourished is both an illness in itself as well as a cause for other illnesses. In the Village Reports, good health is often expressed as a situation where there is enough to eat. Adequate nutrition is

From the people

In 18 percent of the villages in the district, poverty is the reason for the lack of nutritious food. The economic situation is a problem. Due to less money, we cannot even buy medicines.



District Report, Kabirdham

The priority given to food, and the struggle to obtain it, pushes the concern for health to the background. First we think of food, then of our health.

Udaipur Village, Surguja

recognised as a prerequisite for good health. Nutrition is connected to issues of livelihood, food security and distribution.

Many of the District Reports speak of poor levels of nutrition, and managing two square meals is an issue for most people. In the village and district reports, people repeatedly say that not having enough to eat is one of the most important issues for them and that the lack of adequate food is one of the biggest causes of ill health. Therefore, tackling the issue of nutrition and food security must be an integral part of the effort to improve the health status of the State.

Table 4.7 **Anaemia in women and children**
(as a percentage of the total of the subset)

Women with anaemia	68.7
Women with moderate/severe anaemia	22.6
Children (age 6-35 months) with anaemia	87.7
Children (age 6-35 months) with moderate/severe anaemia	63.8
Chronically undernourished children (stunted ¹¹)	57.9
Acutely undernourished children (wasted ¹²)	18.5
Underweight children	60.8

Source: NFHS-2, 1998-99

From the people

We see a direct connection between livelihood and health and believe that if we do not earn a living all throughout the year, we will not get suitable and adequate nutrition. Only on getting enough nutrition will our family members remain healthy else, they will be malnourished and will suffer from various illnesses. Because of this reason, we want employment all year round.



District Report, Raigarh

Prevalence of anaemia

Women and children in the State suffer from a high incidence of anaemia. Over 68 percent of the women have anaemia. Anaemia is especially relevant in the reproductive years and affects pregnant women and their children adversely. Well over half the children in the State are chronically undernourished and more than 18 percent are acutely undernourished.

Sanitation

The relationship of health with sanitary conditions and clean living environment has been made clearly in the *Jan Rapats*. The ways in which this can be achieved are equally well articulated. Lack of drains and the presence of ditches create unsanitary conditions, which contaminate water, breed mosquitoes and cause water-borne diseases. Malaria, typhoid, tuberculosis, jaundice and diarrhoea, which have been listed as common illnesses, are all connected to unsanitary living conditions.

From the people

For health, it is important that there is cleanliness. This depends on oneself, the village, the city and the country.



District Report, Mahasamund

Village Reports have clearly listed what needs to be done at the individual and at the village level and what is required to be done by the State. Keeping the village environment clean,

¹¹ Stunted refers to the condition when the height of children is less than the average height for children in a particular age group.

¹² Wasted refers to a situation when the body weight of children is less than the median weight for the height-body mass in relation to body length:Such children are considered to be too thin or wasted.

filling ditches preventing water stagnation, and waste management can be done collectively at the village level. Provision of toilets and bleaching of wells, fumigation and expenditure towards the provision of staff are responsibilities that fall on the Government. The reports also speak of the role of the *Panchayats*. The *Panchayat* needs to take a proactive role in accessing resources from Government schemes and then making rules and regulations for their implementation, to ensure the general cleanliness of the village.

From the people

The *Panchayat* should have strict rules for maintaining cleanliness around the boring made for water, and then we will all follow the rules.



Dongargaon Village, Rajnandgaon

Clean drinking water

Diarrhoea, jaundice and typhoid are among the more common illnesses that occur in Chhattisgarh. Sometimes in the monsoon season they take on epidemic proportions. These illnesses are water-borne and the people list clean drinking water as a priority. The Bastar District Report points out that 71.3 percent of the people feel that the unavailability of clean drinking water is one of the main causes of illness. The demand for the provision of drinking water, hand pumps in the villages and regular bleaching of the existing water sources emerges strongly from all the Reports.

Maintaining water sources and keeping them uncontaminated has been recognised as collective responsibility of the people and the State. Reports say that once the drinking water reaches the village, the people will take

From the people

Water is life, yet in far-flung areas of the district, people do not have access to drinking water. Even today, many villagers are forced to drink water from a *dhodhi*, *nallah* or a *turra*. The Indira Gaon Ganga Yojana has not reached the hilly and interior regions. There are no hand pumps in these areas either. In areas which are close to the road, the Indira Gaon Ganga Yojana has definitely had an impact. However, in some places, due to the lack of maintenance, its presence has not benefited the area.



In many villages, a prominent male or female health worker has been given bleaching powder to be used to keep the water source clean. However, it is not regularly used and this effort has not been fully successful.

District Report, Korea

responsibility for keeping the water clean. However, they cannot assume responsibility for industrial pollution, the unavailability of water or the pollution due to the absence of proper sanitation facilities. These areas are seen as the responsibility of the Government.

Another important point that has been made in the Village Reports is that the location of the hand pump should be a collective village decision, keeping the convenience of all groups in mind. Where water sources are available in the villages, universal access should be ensured.

Factors that affect health

The relationship between environment and health is clearly articulated in report after report. The *Jan Rapats* highlight the main factors that impact on health and point out the deterioration in these factors. The main factors which are listed are:

- The quality of drinking water (listed in two out of five Village Reports)
- Poor sanitation and non-availability of running water, and the resulting lack of hygiene (44.3 percent of the Village Reports, see table 4.8 for details)
- Shrinking forests and the consequent reduction in herbs and other produce accessed from the forests.

The social and economic factors that impact on health are:

- Diseases that the body has to deal with have increased
- The nutritive value in food grains has reduced, due to the increased use of pesticides.
- There are fewer inbuilt security mechanisms that ensure some food security. (This is largely due to the breakdown of the relationship between forests and people.)
- The breakup of the feudal and the *Jajmani*¹³ systems, which ensured some security

within the village for poor households, especially for those who traded their labour or service skills.

Consumption of locally brewed liquor, alcohol and tobacco

The consumption of alcohol, including traditionally brewed liquor and other addictive substances like tobacco products, also lead to ill health. Most District Reports say that locally brewed liquor (from *mahua* and *salfi*) is considered to have beneficial properties as well. The people say that while excessive consumption of the traditional brews made from *mahua* and *salfi* are intoxicating, when consumed in small quantities, they act as relaxants.

The District *Jan Rapats* of Raipur, Durg, Bilaspur and Raigarh state that the widespread

From the people

The drink made from *mahua* or that brewed from rice (*landa*) helps to repress hunger. It also intoxicates.



District Report, Bastar

Table 4.8 **Factors leading to ill health**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Polluted water	Lack of hygiene	Stale food	Alcohol	Illiteracy	Pollution	Malnutrition
Northern region	36.3	39.9	18.3	38.2	3.3	2.9	2.7
Central plains	49.3	46.3	19.3	41.1	1.9	3.8	3.5
Southern region	34.1	43.3	22.1	33.4	2.1	2.4	2.1
State	38.1	44.3	20.3	38.3	2.6	2.8	2.4

Source: Village *Jan Rapats*, Part III

¹³ The *Jajmani* system refers to the traditional system where people of the relatively disadvantaged classes work on the land of large landlords in the village. They receive customary payments in cash and/or kind.

consumption and addiction to alcohol (including liquor made from *mahua*, but specially country liquor and Indian Made Foreign Liquor) leads to ill health. Nearly two-fifths of the Village Reports say that alcohol consumption is a factor that is responsible for poor health. Excessive consumption of liquor affects the wellbeing of the entire household. It adds a burden to household expenditure and often results in the loss of wages. Women pitch in to maintain incomes. However, they are often targets of domestic violence associated with the consumption of alcohol.

There is concern about the spread of alcoholism among the young. Another related issue is the increased availability and consumption of *gutka*,¹⁴ even in the interior regions of the State. Many Village Reports demand complete prohibition of alcohol and other addictive substances.¹⁵

The problem of alcoholism among youth is more widespread in industrial and urban centres. The issue of alcoholism needs to be looked at not just in terms of de-addiction (which is important) but also in terms of the reasons that drive people to drink (unemployment, depression, the decline in channels of communication and peer pressure). Serious efforts need to be made to address these concerns.

Health Care

Health infrastructure and investment in the public sector

The health infrastructure in Chhattisgarh needs considerable upgradation, both in terms of coverage and reach and in quality of services provided. The State has a high incidence of



tuberculosis, malaria, leprosy and jaundice. There is only one TB hospital in Raipur district and two leprosy hospitals in Raipur and Dakshin Bastar - Dantewada district.

Most of the smaller districts (except Dhamtari), which have been formed recently, do not have a district hospital. The division of the districts has so far not affected the proximity of access or provisioning of medical facilities. This means that people continue to go to the hospitals located in the headquarters of the erstwhile districts. Tertiary care in Chhattisgarh is clearly less than adequate and there is an urgent need to increase the infrastructure in the State.¹⁶

Access to public health is facilitated through greater provisioning of public investments in the health sector, as well as greater access to medical facilities, both at the primary level as well as at the secondary and tertiary levels. The State has been investing in health infrastructure and technological enhancement in terms of advanced equipment and machinery. The budgetary provisions for health have been increasing over the last few years. The

¹⁴ *Gutka* is a mixture of betel nut, tobacco and other ingredients like lime. It is sold both loose and in small branded pouches.

¹⁵ In Chhattisgarh, the *Gram Sabhas* have been vested with powers to prohibit the sale of liquor in their area of jurisdiction. There are many examples of *Gram Sabhas* exercising this power. There are also reports of organised resistance by women's groups to habitual drinking.

¹⁶ See table 9 in the Appendix.

budgetary allocation for health increased from Rs.184 crore in 2000-01 to Rs. 243.62 crore in 2003-04, an increase of 32.4 percent.¹⁷

The current emphasis is on strengthening specialized medical education. Investments have also been made in private-public partnerships for specialised medical care. In the area of rural health, provision has been made for seven new Primary Health Centres (PHCs) and 31 new Community Health Centres (CHCs) but these are inadequate to meet the primary health care needs of the large rural populace of the State. Besides this, 1,400 *Anganwadi* Centres have also been sanctioned to provide supplementary nutrition and other services for women and children.

Among the new initiatives in the health sector is the *Mitanin Yojana*, which has been launched with 54,000 *mitanins* identified by the *Gram Sabhas*. Of this number, about 8,000 *mitanins* have received training and another 27,000 are under training. This scheme responds to the demand of the people that local personnel be used in the provisioning of health care.

It is apparent from the various health indicators and the perceptions of people that health care in the State requires substantial technical and financial investments.

Public health system

Health is an important responsibility of the State and the public health care system is expected to meet the health needs of the people, irrespective of their ability to pay. The role of the State in the provisioning of health services has been recognised in all Village and District *Jan Rapats*. However, there is a

Table 4.9 **Knowledge of Government programmes**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Yes	No	No response
Northern region	26.3	59.3	14.4
Central plains	37.1	49.2	13.7
Southern region	44.39	37.5	18.11
State	35.9	48.7	15.4

Source: Village *Jan Rapats*, Part III

general consensus that the services are far from adequate, both in terms of quality and reach. Various issues of utilisation, access, quality of services, adequacy of resources and performance of health providers have emerged from the reports.

The health delivery system in India is based on a three-tiered structure. At the base are the village level workers, located in every village and hamlet. Then there are Sub-Health Centres (SHC) and Primary Health Centres (PHC), and finally the Community Health Centres (CHC). While there are norms for the setting up of these centres and the staffing pattern,¹⁸ the general feeling is that these are not sufficient to meet the requirements of the villagers—both in terms of the number of centres and the services provided.

A telling commentary on the Government programmes is provided by the Village Reports, which show that only 35.9 percent of villages were aware of Government programmes, while the remaining villages, 64.1 percent, either did not know or did not say anything about this aspect.

¹⁷ The increase in the budgetary allocation in the current financial year (2003-2004) is, however, only seven percent over the previous year, which is the lowest increase compared to all other sectors.

¹⁸ See tables 10 and 11 in the Appendix for details.

Table 4.10 **Availability of health services**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Very good	Good	Satisfactory	Poor	Very poor
Northern region	2.2	9.3	26.4	53	9.2
Central plains	1.9	8.33	18	68	3.77
Southern region	4.2	14.1	24.4	49.1	8.2
State	2.8	10.6	22.9	56.7	7.1

Source: Village *Jan Rapats*, Part III

Availability and adequacy of services

The Village Reports categorise the health services as being very good, good, satisfactory, poor and very poor.

The percentage of Village Reports that categorise the health services as being very good or good is only 13.4 percent (2.8 percent plus 10.6 percent). The number of Village Reports that say that the services are poor and very poor is as high as 63.8 percent (56.7 percent plus 7.1 percent). These figures reflect the inability of the system to provide for the health needs of all. The demand for more Primary Health Centres and Sub-Health Centres and Community Health Centres is mentioned in nearly every District Report. While the data suggests that the number of PHCs and SHCs in the State as a whole are quite adequate, as per the population norms, an examination of the district level data shows that the average figure is quite misleading.¹⁹ There are many districts where the rural population being serviced by one PHC is much higher than 30,000 people. In some districts like Dhamtari and Mahasamund, this figure is as high as 50,000 people per PHC. In forested areas, while the number of people serviced by a single SHC or PHC is lower, the

¹⁹ See Appendix, Table 11, for details.

From the people

Villages feel that the health services are inadequate. The people of Kontagaon have demanded a new Sub-Health Centre.



District Report, Dantewada

The people of Wadrafnagar say they would like an increase in the number of doctors.

District Report, Surguja

People want a Primary Health Centre to be located within a radius of five kilometres of every village.

District Report, Mahasamund

The closest health centre is 20 kilometres away. In case of bigger illnesses, we have to go very far, because our own caregivers do not have medicines for these illnesses.

Maroda Village, Rajnandgaon

terrain makes access difficult. The absence of connectivity to all-weather roads in these districts makes it impossible for people to travel to any public health facility, especially in the rainy season.

While many districts do conform to the population norms set for establishing Primary Health Centres, the terrain and the resulting access problems, combined with the lower

population density (compared to the national average), which sometimes results in the PHCs being quite distant, means that villagers are unable to utilise their services. The peculiarities of low density of population in the tribal areas of the State are not adequately factored in. In Bastar, for instance, the distances and natural barriers require more SHCs and PHCs. Thus, while the Government sets up health centres as per the population serviced criteria, for people it is distance which acts as the determining factor.²⁰ Even where PHCs exist, the Village Reports suggest that they do not function optimally. Only very basic needs are met and the referral rate is very high.

Further, the reports say that there is a shortage of staff at the Health Centres. In some cases, staff has not been posted, and in others, the doctors and the nursing staff do not come to the Centres regularly. While the Centre is supposed to have a doctor on duty for 24 hours, it has been reported that doctors usually do not stay at the PHCs located in the rural areas, especially when the PHCs are in extremely remote areas. They often commute on a daily or sometimes on a weekly basis. Consequently, the setting up of a PHC and the posting of staff does not ensure that services are being provided or that the needs of villagers are being met. The *Jan Rapats* mention the critical requirement for diagnostic procedures and specialist doctors. They suggest weekly visits of specialist doctors. The Community Health Centres provide secondary level services, and are supposed to provide specialised services. There are 115 CHCs,²¹ seven of which are being upgraded to District Hospitals.

The inadequacy of the infrastructure and personnel also points to the lack of choice that people face when they require medical attention. One often forces them to turn to more expensive private health care practitioners, and leads to an increase in the economic burden and to increased indebtedness.

Issues of access

The Government health structure caters to people's needs using a number norm, while the people look at the structure in terms of reach, accessibility and whether it can service them or not. Accessibility itself has various aspects – the distance, modes of transport, timings, social and cultural accessibility, issues of alienation, and the limitations imposed by gender, caste, class, and even region – all of which determine use. Some of these are administrative issues and others stem from the system of formal medicine that is being practised, which is intrinsically biased towards dominant practices and groups.

Distance and absence of transportation facilities

For most villages which are not located on the main road or do not have direct transportation facilities to health centres or large towns, accessibility is the main hindrance in the utilization of health services. The health care providers at the village level find it difficult to visit the villages regularly, and the medical requirements of the population in such locations are neglected. For the people, a visit to the PHC means an added expense, and even if the service is free, it has a cost associated with it in terms of access – by some means of transport — it and in terms of time. Therefore, people prefer to rely on whatever services are

²⁰ The population density for Chhattisgarh is 154 persons per square kilometre compared to a density of 324 persons per square kilometre for India, in 2001.

²¹ The population norm suggests a CHC per 80,000 people in tribal areas; and a CHC per 120,000 people in other areas.

Box 4.1

Lifeline – mobile health care for remote villages

The Lifeline Project introduced by Government aims at taking expert care into remote villages through mobile units. Information provided by the Government suggests that this project has been successful in districts like Durg and Bilaspur, but the Village Reports have not said very much about the impact of this scheme.

Government of Chhattisgarh

available within the village itself. These may not be adequate or appropriate for their needs.

The issue of access is accentuated when there is a medical emergency. In such an emergency or during delivery, for example, getting the patient to the health care centre is very difficult and a burden for the patient (physical and psychological). There is the added uncertainty of whether or not the service will be available. Sometimes the sub-centre or the PHC refers the patient to the tertiary hospital located in the city. This compounds the problem and the loss of time in travel and making arrangements, or the sheer inability to reach proper medical care, is often life threatening.

Relationship with health functionaries

The people feel that health functionaries, especially the doctors at the PHCs are too far removed from them. The general attitude and behaviour of doctors, the unsatisfactory interaction with the patients, and reluctance of doctors to treat all patients with equal care and dignity are the main reasons for this. In report after report, the behaviour of the staff is reported to be unfriendly. They are insensitive to the difficulties that people face when they come into an alien environment for treatment,

and provide little or no assistance. There is a reluctance to give information, and very little regard for patients' rights in terms of explaining procedures.

However, health care workers who are 'closer' to the people maintain a more amiable relationship. The services provided by the ANMs (auxiliary nurse midwife) and the *anganwadi* workers have been commended in the *Jan Rapats*. The *anganwadi* worker is the most visible and her presence has been acknowledged as being extremely useful. The level of satisfaction reported for the work done through the *anganwadi* and *balwadis* is higher than for most other services (this includes all government services). The ANM has a prominent presence, as she is the one who provides basic primary health care in the village. Even with her limited skills, villagers find her extremely useful and often seek her help and advice. The *dai* also provides assistance and advice, especially in the area of reproductive health care and delivery. In both these cases, the cultural and contextual location of these providers works in their favour.

Access for women

The absence of women doctors not only makes access for women difficult but also affects the sensitivity and comfort with which women patients expect to be treated. The treatment of women's health primarily as a matter concerning reproductive health has made the entire health system insensitive to the requirements of women. It reduces the issue of women's health to women requiring care only in the period when they are in the active reproductive phase of their lives and completely ignores their need for medical care at other times and for other illnesses.²²

²² Problems of discharge and prolapse of the uterus, for example, often go untreated.

Box 4.2

Women's health

About 37 percent of currently married women in Chhattisgarh Report some kind of reproductive health problem, including abnormal vaginal discharge, symptoms of urinary tract infections and pain or bleeding associated with intercourse. Among women who reported problems, 68 percent have not sought any kind of medical treatment for their problems.

Source: NFHS -2, (1998-99), Chhattisgarh

The neglect of women's health is evident from the fact that it finds little mention in the Village Reports, while there is data as well as experiential work evidence to show that there are a number of diseases and problems that are widespread among women.

Access for people with special needs

Many Village Reports have reported the presence of disabled children or young adults or the very elderly, who continue to live in neglect, due to the lack of any special facilities for them. There is very little information as to who within the health care system is supposed to take care of people with special requirements.

There are some District Rehabilitation Centres situated in the cities, but they do not address the needs adequately. There is virtually no information regarding the schemes that exist and therefore people are not in any position to access these services. Again, within the family, people with special needs are the most marginalised and disempowered, and therefore most removed from access to health services.

Chunauti is a campaign launched in 1996 by the Government for the economic rehabilitation and social mainstreaming of persons afflicted by various kinds of disabilities. Social Security

From the people

Milan Ram Yadav is about 70 years old, is below the poverty line, and needs Government help.

Phulkuvanar Bai, who is about 20 years old, cannot speak and needs help.



Tilaibhat Khergadh village, Rajnandgaon

pensions are available for destitute people with disabilities and for school-going disabled children, between the age group of 6-14 years.

The *Jan Rapats* indicate that there is a section of the population whose needs are unmet. This reiterates the need for larger outreach, proper awareness, and information systems that will make people aware of the schemes and ensure that the services reach the targeted population.

Quality of services

Quality of services is one of the most serious issues in health care provisioning. The *Jan Rapats* voice strong dissatisfaction about the quality of services provided.

The main issues that have come up in the Reports are:

- The location of the service: Areas where Government health services are most vital are the remote and inaccessible areas; but these areas are also the most poorly serviced.
- Deficiency in service: Where Government health centres exist, the villagers are largely unhappy with the delivery system. The main reasons cited for this are the absence of health staff, especially doctors

From the people

Twenty percent of the villagers want free health care services.



District Report, Kabirdham

The absence of free services and medicine is a major problem.

District Report, Durg

in PHCs and CHCs, the non-availability of drugs, the lack of trained staff, and the absence of facilities that are supposed to be available. As a result, many procedures and tests, which are required, cannot be performed and the service being provided is incomplete.

- User fees: The people have voiced their discontent at the levying of user fees. There is considerable confusion about what is to be charged and what is free, and no clear information is given regarding the fee structure.

Timings of health centres

The timings of health centres limit their utilization. This is because the timings are unsuitable for the users. Most health centres function from the morning till early afternoon. This is the time that people work in the fields. A visit to the doctor means the loss of a workday and wages. Therefore, people prefer going to a private doctor at a time which is more convenient (early morning or late evening). They may even end up going to the same Government doctor, who practises privately and charges a fee for his services.

Non-availability of drugs and diagnostic procedures

The supply of medicines is another area that has received considerable attention in the *Jan*

Rapats. As many as 80 to 90 percent of reports across districts say that drugs are not supplied to them by the Health Centres and that these have to be procured from private drug stores. This happens in spite of the fact that the State has a list of essential medicines, which are to be provided through the three-tier health system – the PHC, SHC and depot holder at the village level. The reports have also pointed out that some of the drugs dispensed are of poor quality and ineffective. This is a serious issue and there is a need for more investigation into the drug procurement and dispensation problem. Certain diagnostic procedures like X-rays, blood and urine tests are also supposed to be conducted at the Public Health Centres. However, these are not done because of lack of staff or equipment, and the people have to go to another public service, often at the next higher level (which may not be accessible) or to a private laboratory.

Systems of monitoring and control

The departmental system of monitoring and the non-accountability of the service providers to the receivers means that there is a huge deficiency in the service. People have little control over the service and the way in which it is delivered. There are no mechanisms that allow people to register their grievances, and the general feeling both among the service providers and the people who receive it is that they have to be satisfied with what they get. For example, the non-availability of the doctors and services at the Primary Health Centres is a common complaint but the people have no mechanism to voice their dissatisfaction and to ensure that the staff (including the doctor) does their duty.

In spite of the *Panchayati Raj* system, the Department of Health retains its administrative control across most levels of functioning. People have very little information about the services that are supposed to be provided, the

allocation of resources and the distribution and supply of medicines. This makes it difficult for them to question the health centre staff.

An attempt to make the health care system more accountable to the people, led to an initiative by the Government that requires the *Sarpanch* to sanction the release of the pay cheques for the health workers. However, this measure has certain drawbacks. Even though it may ensure the presence of the worker, it does not ensure the quality of the work done. Secondly, the *Sarpanch* may decide to sign or not sign, according to his discretion. Besides, this scheme is applicable for the health workers but doctors are not covered by it. The people feel that it is the most overworked and the least paid – the community health workers, and other part time or voluntary staff – that are being targeted by the Government schemes initiated for people’s control.

From the people

In Dantewada, the people mention the initiative by the Government, which requires the *Sarpanch* to sanction the order for the salaries of health workers. However, they feel that this does not ensure the quality of the service.



District Report, Dantewada

Private health care

The health care needs of people are met by a combination of various medical systems, some formal and others informal. Though the public health sector (which follows allopathic medicine) is largely responsible for health care provisioning, a large section of health care providers are private – ranging from the traditional herbal medicine practitioners, faith healers (*guniya, baiga*), quacks, homoeopaths and *ayurvedic* doctors, to allopathic doctors.

Box 4.3

Share of public and private health services

A survey by the National Sample Survey Organisation in 1995-96 shows that of the people with ailments receiving non-hospitalised treatments (in rural areas) in undivided Madhya Pradesh, 65 percent went to private sources. For hospitalised services, 53 percent of the rural patients used Government health institutions.

Traditional medicine practitioners and faith healers:

Many indigenous forms of medicine exist in different parts of India. While *ayurveda* and *unani* medicine are quite well known, there are many less known local systems that are practised in different parts of the country. These use local herbs and locally available materials. The practitioners of these forms of treatment have been classified broadly as traditional practitioners. There are other healers who invoke supernatural powers or the faith of people to cure ailments and give some succour to their patients. Both traditional healers and faith healers have their origins in the local society and culture and form an intrinsic part of Chhattisgarh’s villages and its society.

These healers live with people, and draw their sustenance from them. This helps them to develop a relationship of trust and a dependence, which goes beyond the doctor-patient relationship. Traditional healers have been known to practise numerous ways to cure and prevent diseases and heal injuries. Much of their practice is based on local herbs, medicinal plants, and on practices that are similar to naturopathy. It is these traditional healers and the vast knowledge that they embody that the people rely on. In fact, there is much to be learnt from the systems from which these healers draw their expertise and craft.

From the people

People in the village know how to cure illnesses using medicinal plants as well as by *jhaad phook*. Jaundice can be cured by *kutki* and *chiraita*. *Baad* can be cured by *asgan*. People today have no faith in domestic remedies. In Mungeli, they go to the private practitioner. For medicines they use allopathic medicines.



Jamha village, Mungeli Block, Bilaspur

In our villages the prevalent diseases are malaria, cold, cough, loose motions, vomiting, TB, *moti jeera*, itching, *baad* and *gathiya*. These illnesses are caused due to unhygienic conditions. *Jhaad phook*, herbal medicines and the link worker cure these. The *guniya*, the *baiga*, the doctor and the untrained midwife are also helpful.

Taulipali Village, Korba Block, Korba

Faith healers also belong to the same socio-cultural milieu but they provide very different services. There is no evidence to show that they adhere to any empirically developed form of curative or preventive practices, but through their invocation, which borders on a combination of the religious and the supernatural, they provide emotional and psychological support. This explains why many people say that they go to faith healers, often even while they are following another line of treatment. An important reason why people choose to go to traditional healers and to faith healers is because the payment pattern is flexible. Payment options include part payments and payments in kind.

Apart from the traditional practitioners and faith healers, there are many other quasi-doctors, trained, untrained or ill trained, who roam the vast expanse of the State, offering medical services where none exist, at rates that people can afford, and in a manner that is accessible

and reassuring. These include quacks that practise a mix of allopathic, homeopathic and ayurvedic medicine. Most of them stay in one village and travel to villages around, and are among the main health service providers. Similarly, some people trained under the *Jan Swasthya Rakshak* Programme of the undivided State of Madhya Pradesh now practise privately and provide primary health care in areas where the Government system is particularly weak or absent. The typology, the characteristics and curing abilities of these health providers differ from district to district and region to region.

The Village Reports show that while 18.2 percent of the villages feel that traditional methods are good or very good, about a third of the villages classify these methods as being only satisfactory. These three groups add up to roughly half the Village Reports. The remaining half of the

From the people

Faith healers are referred to by various names such as *baiga*, *dewar*, *ojha*. They are mystical healers and are usually called when we feel that the illness is due to some black magic or the powers of a spirit, or even the ill wishes of a living person. Faith healers provide emotional and mental support as well as comfort, which is why we go to them.



District Report, Dantewada

The *guniya* is a healer who uses traditional medicine. Like the *vaid*, he too prescribes herbal medicine. The *guniya* diagnoses illnesses based on the symptoms that he sees. After this he gives the patient a *churna* or *satta* made of herbs and roots. In case of fractures, arthritis, headaches and stomach aches, the remedies given by him work very well. Faith healers are called *dewar*, *baiga* or *ojha*. We call them to our homes to treat people who are ill. The *dewar* takes rice in his hands, reads *mantras* and examines the mind. After this, he lights a lamp, takes some rice in a *supa* and then begins to chant, swaying and moving his hand.

District Report, Korea

Table 4.11 **Traditional methods of treatment**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Very good	Good	Satisfactory	Not satisfactory	Poor
Northern region	1.7	20.5	39.1	34.1	4.6
Central plains	0.9	12.3	22.3	45.2	19.3
Southern region	1.1	18.3	36.1	39.2	5.3
State	1.2	17.0	32.5	39.5	9.7

Source: Village *Jan Rapats*, Part III

Reports categorise traditional methods as being either unsatisfactory or poor.

Herbal home remedies: A variety of herbal remedies are made at home, from traditional knowledge that is passed down from generation to generation. The knowledge of herbal remedies is often the collated experience of society, collected and orally documented from the practices and cures offered by traditional healers. These have become a part of the living heritage of villages and all households use natural medicines, self-made, from locally available materials.

Some general remedies that are commonly known have become part of the system of curative medicine that people practise internally, more like grandmother's remedies, which are used in households all over India. Use of certain leaves and roots, which are either consumed or made into a paste and then applied to cure infection and heal injuries is a common practice. Fractures are also often treated locally, although not at home. Somebody within the village develops some expertise as a bone setter and people usually go to him.

The people have a sense of pride in the traditional herbal healing system, which emanates from

From the people

Some people in the village have considerable knowledge of wild herbs and roots. When people in the village fall ill, they go to these people first for treatment. Slowly this knowledge is disappearing. But we all know the healing properties of some herbs and plants.



District Report, Dantewada

their culture. The knowledge of cures for ailments helps them to take care of their own health, with resources which are available to them. The close link that people share with the forest and its resources is also reinforced by this dependence on herbal medicines and remedies.²³ People do not speak of herbal healing in lieu of a formal medicine system but as useful indigenous knowledge that they value and want to preserve.

The richness of this tradition is reflected in a general listing in most Village *Jan Rapats*. The healing practices range from simple remedies to complex cures for a wide range of ailments, from common colds to diabetes, from ulcers to procedures for treating fractured bones and snakebites.

²³ The more forested and the less urbanised districts rely more on traditional and herbal healing, as well as on the use of herbs for common ailments.

While there is a sense of pride in the knowledge base that the villages have, there is also concern about the decline in traditional healers and their practice in many *Jan Rapats*. One of the main explanations for this trend is the movement of people away from their natural surroundings and the resulting dilution of information. The close contact with the forest itself is under threat, which means access to many of the herbs and plants is denied and therefore it is not always possible to make a remedy, even if the ingredients themselves are known. The non-recognition of these practices by modern medicine and the State, both in terms of education and service delivery, is also seen as a discouraging factor.

The decline in these practices and the non-availability of quality care from the private or

public sector leaves people in a precarious position. Their own traditional knowledge that allows them to take care of some of their health needs is shrinking. It has been encroached upon by modern medical systems, and its practitioners are getting less and less skilled and are fewer in number. Mainstream medical care is connected to the privileges of the higher economic classes and works within a hierarchy in which the poor are always unequal receivers.

Some of the District and Village *Jan Rapats* speak not only of the urgent need to preserve traditional practices but also of their enhancement. There is a demand for Government recognition, and assistance in preservation and propagation. The people do not want this system to operate like the other systems that work within the doctor-patient hierarchy, where knowledge is privileged. They see it as an open system of knowledge that comes out of people's experiences and therefore cannot be restricted to a few. The Government's recognition and acknowledgement is crucial for the continuance of this system.

From the people

Some common remedies that are listed in the *Jan Rapats* are :

Malaria – *bhuileem/kalijiri* and *pathar neem ka kadha* (a thick stock made from the leaves of the neem tree)

Diarrhoea – *bhasm patti* (a dressing made from ash)

Fractures – paste of certain leaves like that of *har shringar*, is applied once the bone is set

Vomiting and diarrhoea – *pyaaz ka ras* (juice of onions)

Joint pain – *hatul ki patti ki goli*, with crushed *gud* (jaggery)

Cuts in the hand – lime and turmeric and onion are filled into the wound

Jaundice – bark of the mango tree is eaten

Measles – *neem baths*

Anti-tetanus – juice extracted from the bark of the gign tree



Compiled from District Reports of Bastar, Korea, Korba and Dantewada

Health Seeking Patterns

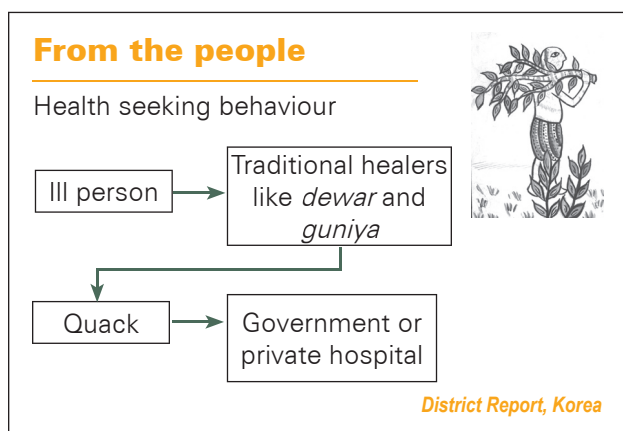
When people have a choice, they may go to different service providers for different types of treatment, depending on different decision variables like access, money, belief and faith and the type of illness. Some-times the progression from the traditional healer to the allopathic doctor is not lateral but may also be simultaneous. Often allopathic treatment is undertaken along with faith healing.

The *Jan Rapats* list the following factors, which determine the choice of the health provider:

- The availability of the health provider,

(especially the preferred one), is the single most important determinant

- The resources (cash and kind) available as against the resources required to access the health provider and his/her cure
- The type of illness. Since traditional medicine is quite effective for a range of illnesses, it is often the preferred option. For example, in an illness like jaundice, people usually go to traditional healers. Symptoms of listlessness and apathy are believed to be the effect of some supernatural force or evil design (*nazar lagna*), for which people use the services of an exorcist.
- The age, gender, importance as a wage earner, status of the patient within the family
- The inability of one practitioner to cure a particular disease may take the patient to another provider, leading to a step-by-step progression from one system to the other
- Experience – by which people learn the most efficacious treatment for different diseases



Health Expenditure

Medical treatment is one of the major expenses incurred by a household. It often leads to people selling or mortgaging possessions like utensils, jewellery, livestock, their land and house to raise money. An illness means expenses like buying medicines, paying the doctor's fees (if it is a private doctor), expenditure on visits to the doctor, and special food, if required. The loss of wages of the patient and the attendant²⁴ only compound the problem. Medical treatment even in Government hospitals is not free and the family ends up spending a lot of money. In practice, Government hospitals do not supply medicines and user fees are also levied, so people have to pay for tests and other diagnostic procedures. For more specialised services and surgeries, patients have to incur even higher expenditures.

From the people

An illness affects a person's life and family in a big way. It can impoverish the person. A person spends much more money on the treatment of the illness than he does on food. If a person falls ill, arranging money for treatment becomes impossible. The only source of money is the sale of permanent assets, which make the economic situation of the person worse.



Matsagara village, Kota Block, Bilaspur

Traditional healers, faith healers, and private doctors also mean considerable expense. The difference is that sometimes the system of payment may be flexible (in instalments) and payments can be made in kind instead of hard cash. Since illness causes an emergency-like situation, savings, if any, are usually swiftly depleted and loans at high rates of interest are

²⁴ Due to the poor nursing care in most Government hospitals, the hospitals insist on a relative as an attendant for in patient hospitalisation.

common; many families afflicted by an illness soon get into a cycle of debt.

Unethical Practices

Unethical and unnecessary treatment by health care providers often increases the expenditure on health care. Charging high fees, prescribing irrational treatment procedures and medicines,²⁵ as well as prolonging the treatment are common malpractices. It is in the largely unregulated private sector that most of these practices are more prevalent.

As people are dependent on these practitioners for treatment, they have no alternative but to comply. The lack of information, especially in the non-traditional system and to some extent even in the traditional system and the healer-patient hierarchy, encourages these practices. The Government does not have a strong regulatory system to check such practices, which leaves the people with no recourse but

From the people

Since we cannot afford the expensive treatment of the big doctors, hence, along with our deteriorating bodies, our poverty also increases.



District Report, Korba

to accept the inefficiency and dishonesty of practitioners.

Within the public sector too, incidents of corruption and unfair practices have been stated in the *Jan Rapats*. There have been complaints from villages across districts about the unavailability of doctors at the PHCs, the unavailability of drugs, and the fact that many Government doctors also indulge in private practice. Since the people have no clear redressal procedure and because they are dependent on the doctor or the health care provider, they are hesitant to register specific complaints.

Women and Health

The Village and District Reports maintain silence on health problems of women, which are not related to maternity and childcare. Apart from Reproductive and Child Health (RCH) issues, there is very little that has been said about the specific health concerns related to women.

The services provided through the State under the RCH and *anganwadi* programmes are frequently mentioned as services that the majority of the people are aware of, at least in the areas where the public health service does exist. Though the level of satisfaction with regard to quality, consistency and equal access to all people within the village may vary, these services, together

From the people

Illness results in a change in the social and economic life of a person and leads people into a debt trap.



Pebassaguda village, Bhopalpatnam Block, Dantewada

Illness causes instability both socially and economically and creates indebtedness. The people go to the *guniya* or *baiga* for the treatment of illnesses. Chicken, alcohol, rice, grain and money are spent on the same. Treatment at the Government hospital is free, but it is not available. If they visit private doctors, the poor have to give a lot of money. They have to sell their grain, *mahua* and tora for their treatment.

District Report, Korea

²⁵ Prescribing or administering unnecessary syrups, injections and intravenous saline are some common practices.

with vaccination for children, have been rated as those with the best coverage. Most of these services are being provided through the ANMs and the anganwadi workers.

According to the *Jan Rapats*, the *dais* carry out most deliveries. Though the presence of trained *dais* and the use of safe delivery methods have been reported in most district reports, some Village and District Reports point out that there is a need for such services to be located closer to their villages. This becomes especially relevant in emergency situations, when there are complications during pregnancy and childbirth, and access to the nearest health service is difficult.

From the people

The ANM comes to the village and gives pregnant women medicines for the blood (iron folic tablets) or gives them an injection. She takes their weight and gives them information on food and nutrition. She also tells them how to care for the child after its birth.



Ambikapur Block, Surguja

After childbirth, the mother is given jaggery, *kankepani* and jaipha²⁶ boiled in water for three days. On the fifth day after childbirth, which is marked by celebrations, the mother is fed *mung badi* (nutritious dried lentil balls, used in curries) and other food. Apart from regular food she is fed medicine made from dry ginger, jaggery and coconut.

Sukhri Khurd Village, Dhamdha Block, Durg

That the focus of women's health seems to be only in reproductive health and childcare is reflected in the targeted way in which most health programmes approach women's health. In Korba, in discussions held during the *Jan*

Table 4.12 **Attendance at deliveries**

Deliveries attended by	Percent
Doctor	22.3
ANM/Nurse/midwife/LHV	9.7
Traditional birth attendant (dai)	42.7

Source: NFHS-2, 1998-99, Chhattisgarh

Rapats process, women said that iron folic tablets are given free only to pregnant women and not to the others. The NFHS data reports that 67.5 percent of women in Chhattisgarh suffer from anaemia, of which 22.5 percent suffer from severe to moderate anaemia.

Women are reluctant to go to the PHC for gynaecological problems because the centres are staffed largely by male doctors. So most women rely on home and herbal remedies or do not go to a doctor till the illness becomes seriously debilitating. The NFHS data reveals that of the total number of women who reported that they had some kind of gynaecological problem, 68 percent have never sought any kind of medical treatment.

From the people

Women are considered child-producing machines.



Village Report, Madtola, Rajnandgaon

Field visits in Raipur district made during the course of the *Jan Rapat* exercise showed that one of the major programmes being pursued through the health workers is the organisation of birth control and sterilisation campaigns. However, during this aggressive campaign for birth control through the RCH programmes,

²⁶ Herbs and spices having antiseptic properties are boiled with water and given to the mother after delivery.

discussions with both the providers and the people revealed that no effort was being made to involve men in the campaign. Male sterilisation is almost negligible, while for women, sterilisation continues to be the dominant birth control method. The responsibility for birth control therefore falls largely on women.

While few district *Jan Rapats* mention the issue explicitly, discussions with health workers and local women's groups reveal that the practice of sex determination tests is spreading in the State. There are reports of diagnostic centres mushrooming in the urban centres of districts. Durg, Raipur, Bilaspur and Surguja are some of the districts where such centres are reported to have come up.

Table 4.13 **Use of contraceptives in Chhattisgarh**

Current use of contraceptives	Percent
Any method	45.0
Any modern method	42.3
Pill	0.8
IUD	1.0
Condom	2.1
Female sterilisation	35.1
Male sterilisation	3.3

Source: NFHS-2, 1998-99, Chhattisgarh

Some of the other issues that are not mentioned in the reports but became apparent in discussions during the *Jan Rapat* process are sexually transmitted diseases (STDs), reproductive tract infections (RTIs), repeated childbirths, early sterilisations, and illnesses like tuberculosis, respiratory illnesses, under-nutrition and anaemia.

Domestic violence is another area that needs to be seen as a health care issue, as it has a direct impact on women's health, because it increases both risk and vulnerability and accentuates the issue of insufficient and delayed treatment for women for all illnesses.

An important issue is that of women's participation. A large part of the work force in the public health sector and in the NGO sector are women, so it is ironic that there is still a considerable lack of awareness about women's health within the health programme, apart from the issue of maternal and child care. Even in the *Jan Rapat* exercise, despite the fact that 50 percent of the *sangwaaris* were women, many aspects of women's health have not even been mentioned²⁷.

Box 4.4

Domestic violence in Chhattisgarh

In Chhattisgarh, there is widespread acceptance amongst ever-married women that the beating of wives by husbands is justified under some circumstances. Nearly two-thirds of ever-married women (62 percent) accept at least one of six reasons as justification for a husband beating his wife. Seventeen percent of ever-married women in Chhattisgarh experienced such violence in the 12 months preceding the survey. Most of these women have been beaten or physically ill-treated by their husbands.

Source: NFHS - 2, 1998-1999, Chhattisgarh

The importance of analysing women's health within the context of their access to resources and health care, labour intensive work (both inside and outside the house), nutrition, effect of early marriage, burden of child-bearing and rearing cannot be overstated. The lack of drinking water and fuel wood, the absence

²⁷ One reason for this may be that women functionaries are often placed at the lowest level of the administrative ladder and are seldom involved in conceptualising and designing programmes.

of means of livelihood, declining access to forests, use of alcohol are all issues that directly impact women's lives and therefore need to be addressed specifically. This will only be possible if women are directly involved not just in implementing schemes but are also provided space so that they can articulate their concerns. Programmes must be sensitively designed and implemented, if they are to have any meaningful impact on women's health.

Mental Health

In the broad definition of health people define health as physical and mental well-being. However, in the *Jan Rapats* there is very little mention of mental illness, treatment patterns and facilities, either in the private or the Government sector.

The services in the psychiatric and mental health area provided by the Government are far from adequate. Psychiatric services are available only in the tertiary hospitals, situated in urban areas and big towns. Community Health Centres or secondary level hospitals do not have these services. People approach religious and faith healers for seemingly unexplained and complex problems that may be symptoms of mental illness. Many mental illnesses go undetected and untreated, due to the lack of facilities.

There is a clearly a need to examine this issue in more detail, but mental illness has always been a neglected area in community health. An assessment of the issue, the services available, and an understanding of local practices and means of strengthening them will be a positive step towards the holistic health approach that is required.

Emerging Issues

The diverse suggestions of the Village *Jan Rapats* cannot be consolidated into any one report, but an attempt is made to highlight the common issues that have emerged. The manner in which people see health and its determining factors does not match the perception of the agencies that work in the field. There are many systems and ways in which people seek to manage issues relating to their health. Their own knowledge domain is as important and relevant as the facilities offered by the State or private agents. It appears that villagers do not feel any affinity towards most systems that are trying to deal with health issues. This is because health continues to be seen within a service delivery paradigm. People look at health within the context of their struggle for survival. People who are marginalised from good health care are disadvantaged in comparison to those who are mainstreamed into health care. Issues regarding equal access, people's rights, control over services, regulation, marginalisation of communities based on class, caste, gender, religion, mode of living and livelihood and sexuality acquire significance and health assumes a political and a rights dimension.

People's participation

In the *Jan Rapats* people express the view that it is the Government's responsibility to provide adequate health facilities. The people's role should be to monitor the service provisioning and design health services in such a way that they reach the people. People see this involvement not as their contribution but as their entitlement. Just as they are entitled to quality health care, they are entitled to being involved in decision making on issues that affect them.

About a fourth of the people say that they will contribute towards the improvement of health services by volunteering services, money, shramdan (voluntary labour) for building SHCs, and construction of accommodation for the doctors and nurses. The desire to participate in health programmes, in monitoring and overseeing health functionaries (including doctors), and to contribute in ways that would help health service delivery is something that *Jan Rapats* have stated repeatedly, provided this opportunity is genuinely offered to the people.

The *Jan Rapats* are almost unanimous in their recommendation that local persons should be used for health delivery, as they are rooted in the community and will be responsive to the needs of the village. Besides, such a step will add to the human resources of the village.

Cultural alienation

The public health system is seen as being alien to the people. This is clear from many *Jan Rapats* and voiced most strongly in the Bastar *Jan Rapat*. One of the main reasons for this is that very little effort has been made to assimilate the public health system into the local context and its reach is extremely limited. The general disregard for local traditional systems in the public health system keeps sections of the population away from the services. The system is not people friendly and frightens people away. There are wide differences between the culture, language and behavioural patterns of the people and the doctors and the paramedical staff. The gap is so wide that many people try and avoid the health system for as long as possible. For these reasons a large section of the population does not utilise the services at all.

Information and awareness

Awareness of Government schemes is limited among the people, especially among those who

live in areas that are difficult to access. This is reflected in the responses that people provide in relation to specific services. The villages, which are situated near the roads and the districts or the regions that are better connected, have been able to articulate the specific lack of services, even though they also speak of not having complete information. However, in the distant parts, only the lack of services or the absence of a health care provider in emergency situations is articulated. Clearly, the villagers here do not have a complete idea of the services that the State is supposed to provide.

This leads to the non-utilisation of services and prevents people from demanding services that are supposed to be provided to them. There is very little effort by the Government to spread awareness about the various Government services and programmes.

Need for regulation

The *Jan Rapats* and discussions during the process indicate the prevalence of practices that do not fall within the domain of medical ethics. The legal, democratic and institutional mechanisms that ensure consumer rights have still not been appropriately and adequately constructed. Though there is an emerging consumer movement at the national level, it still needs to take root in the State. People are not aware of their rights as consumers.

In the absence of a strong regulatory system by the Government to check malpractices, people continue to be helpless and are forced to submit to the inefficiency and dishonesty of practitioners. Doctors employed in Government health centres are unavailable during duty hours and are often not available to treat patients. This in itself is serious dereliction of duty and should invoke strong disciplinary action. The widespread private practice by Government doctors adds

Table 4.14 **Expectations voiced in the Village Reports**
(percentage of Village Reports selected for the perception analysis)

Regions of Chhattisgarh	Awareness and information	Sympathetic health worker	Support from Government	Approachable Health Centre	Availability of medicine	Financial support to poor
Northern region	25.8	16.3	59.3	57.5	9.5	13.2
Central plains	34.3	24.2	51.5	61.2	13.2	11.5
Southern region	22.1	10.7	50.7	52.8	8.1	9.2
State	26.3	18.2	51.6	55.3	11.2	10.6

Source: Village *Jan Rapats*, Part III

to this problem. There is anecdotal evidence to show that patients are encouraged to meet Government doctors at their private clinics.

Within the administrative system there are no clear, people-friendly and empowering redressal procedures. The doctors have created a strong lobby for themselves within the health care system, to the extent that even law enforcing, administrative and political authorities are subverted and undermined. The lack of information and the existing healer-patient hierarchy effectively disempowers the patient.

The Village Reports say that more than half the villages want an approachable health centre. (see Table 4.14) They also feel that health care must be supported by the Government. More than a quarter of the Village Reports expect better awareness and information of Government health programmes. Sympathetic health workers, availability of medicines and financial support for the poor are among the benefits that the people expect the public health care system to provide.

Suggestions for Intervention

The *Jan Rapats* show that public health care is an area where the people want proactive intervention

by the Government. Providing universal access to public health care is a challenge, which will require considerable reorientation by the State and a restructuring of its system so that it is transparent and accountable.

Improving the public health delivery system

Numerous suggestions have been made by the people to improve the system. These range from improving access, introducing more suitable timings and evening clinics, to preventive medicine and better awareness and information. Easily accessible hospitals, availability of doctors, regular presence of health workers and an improvement in the quality of services are the most widespread suggestions which emerge from the Village Reports. Availability of medicines and modern treatment facilities are other suggestions which have been made in the Village Reports.

There is a sense of unease regarding user fees. There is confusion about these fees, and therefore one of the most urgent needs is to have effective and prominent communication mechanisms to convey the idea of user fees to consumers, wherever they are applicable. There is also discontent on the increasing costs of public health, and there is wariness about the new trend to charge for services by

Table 4. 15 **Suggestions for improvement from the Village Reports**
(percentage of Village Reports selected for perception analysis)

Regions of Chhattisgarh	Improvement in quality of health services	Regular presence of health worker	Approachable hospital	Availability of modern treatment facilities	Availability of doctors	Availability of medicines
Northern region	18.6	49.5	41.1	8.4	19.6	17
Central plains	46.3	36.3	21.3	29.3	41.2	21.3
Southern region	33.4	17.91	25.1	14.6	28.7	12.5
State	31.6	33.9	31.3	18.1	31.2	17.0

Source: Village *Jan Rapats*, Part III

the State. There is a clear demand in the *Jan Rapats* that basic health should be provided free of cost to the people. A call to continue with the existing public health system emerges from every report.

Preserving and integrating the traditional systems with the modern

Traditional forms of medicine are quite popular and can be relied upon for a large variety of common illnesses. Unfortunately these systems are not documented and therefore there is scepticism about their effectiveness in mainstream medical culture. Ignorance and lack of knowledge has not allowed an acceptance or proper appreciation of these systems. Yet, their efficacy in certain cases cannot be denied. There is an urgent need to study, learn and research these systems, objectively. It is evident that unless this traditional knowledge is documented, a vast body of knowledge will be gradually lost. An integration of these systems of knowledge into the other more popular, modern, medical systems would help people benefit from the strengths of both.

Health from a people's perspective

People have not alienated health from their living environment. Issues of livelihood, control

over resources, their relationship with forest and its produce, issues of nutrition and clean drinking water, as well as the social and cultural systems are seen as being closely connected to health.

The health delivery system itself needs to be more inclusive. There is some recognition in the Government of the inter-dependence of health, sanitation and clean drinking water, as well as of the close link between nutrition and health. The *Jan Rapats* recognise this association and endorse the need for a comprehensive approach to the issue of health.

Conclusion

In terms of the usual health indicators Chhattisgarh is one of the most disadvantaged states. The modern medical system has not been able to overcome the challenges of distance, remote location, and the economic and social conditions of the people. Compounding this is a general deterioration of the natural environment and other factors that impact health. Many traditional forms of medicine exist, but these seem to be weakening with the changing way of life and the gradual loss of control over natural resources. This has led to some disquiet among the people.

The State's health apparatus has made a dent in areas like immunisation and the reduction of epidemics, but the highly technology-centric approach of modern medicine has externalised health. Another constraint apparent from the *Jan Rapats* is the attitudinal make-up of the modern health care provider. The manner and approach of the doctors at the higher levels of the health care system is intimidating for common people and prevents them from using Government services.

Along with illness and disease, the people find themselves contending with inadequate services, non-availability of drugs, apathetic and unsympathetic health care providers. The health system clearly needs special efforts on a number of fronts to make health services comprehensive, accessible, and people-centric. An integrated approach to health issues is called for, so that there is a visible and lasting impact.