HEALTH POLICY

AZAD JAMMU & KASHMIR

DIRECTORATE OF HEALTH SERVICES

MUZAFFARABAD

April, 1996

HEALTH POLICY ☆

AZAD GOVERNMENT OF THE STATE OF JAMMU AND KASHMIR

INTRODUCTION.

1. Numerous Health Assembly resolutions have reaffirmed that health is a basic human right and a worldwide social goal; and that is to be attained by all people by the year 2000, a level that will permit them to lead a socially and economically productive life.

2. An acceptable level of health cannot be achieved by the health sector alone. It can only be attained through national political will and the coordinated efforts of the health sector and relevant activities of other social and economic development sectors. In this way strategies for the health and social and economic sectors will be mutually supportive, and together contribute to the ultimate goals of the society.

3. There is political commitment at the highest official level for achieving the goal of health for all by the year 2000 in the Azad State of Jammu and Kashmir in order to build a healthy, confident nation, full of vigour and vitality, ready to take on the challenges that lie ahead.

4. Health policy of the Azad Government of State of Jammu and Kashmir is an expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them. It is based on the following five sets of recommendations of the Declaration of Alma-Ata (WHO- 1978) and subsequent thinking:-

   a. Health services should be effective, efficient , affordable and acceptable;
   b. Efforts to deal with health should include disease prevention, health promotion, and curative and rehabilitative services;
   c. There should be universal coverage with health services;
   d. Individuals and communities should participate in health activities that promote self reliance and reduce dependence; and
   e. Health activities should be integral to community and national development.

The Health Policy will rectify the priority areas in the short term which are identified in subsequent part of the policy and in the long term attempts to provide comprehensive health care.

☆ Health Policy was approved by the Cabinet on April 3,1996

HISTORICAL BACKGROUND.

5. In 1948 there were two hospitals with 30 beds and 11 dispensaries. After the formation of the Government of the Azad State of Jammu and Kashmir in the liberated territory, the Government as well as Pakistan Army started their devoted struggle to establish health care delivery system for the population

6. Since 1955, considerable funds were made available for the uplift of health services which resulted in expansion of health services which is reflected in the table below:-

FACILITY/HUMAN RESOURCE	1948	1955	1988	1995	FACILITY POPULATION RATIO
FACILITIES					
I) CMHs	–	2	2	2	
ii) District HQ hospitals	–	2	2	2	
iii) Teh/Civil hospital	–	2	2	2	
iv) Hospital beds.	2	–	6	8	
v) Rural health Centres	30	170	1088	1158	2280
vi) Basic Health Units	–	–	18	23	
vii) Dispensaries.	–	–	150	182	
viii) First Aid posts.	11	42	128	105	upgraded.
ix) TB hospital	–	–	49	175	
x) EPI centres	–	–	1	1	
xi) Jinnah Dental Hosp	–	–	86	86	
xii) Unani Dispensaries	–	–	–	1	
xiii) MCH centres / Services	–	10	10	11	
HUMAN RESOURCES.	–	-	74	86	2674 / WRA
xiv) Specialists including Management	–	–	61	109)	6839
xv) Doctors	–	–	207	277)	
xvi) Dental Surgeons	–	–	29	36	73,333
xvii) Nurses.	–	–	95	114	8 hosp beds (does not include RHCs)
xviii) Lady Health Visitors	–	–	86	92	5000/WAR
xiv) Village Dais/ TBAs	–	–	1928 TBAs	1938) TBAs)	1294
	–	–	211 DAIS	225) DAIS)	
xx) Female CHWs/NHWs	–	–	–	1500	

CURRENT SITUATION.

7. Current health situation in the Azad State of Jammu and Kashmir is summarized blew:

- Life expectancy at birth.	60 Years
- Crude birth rate.	3.9%
- Crude death rate.	12.
- Population growth rate.	2.7%
- Infant mortality rate.	90/1000 live births.
- Under 5 mortality rate.	180/1000
- Maternal mortality rate.	6-7/1000
- Newborns with birth weight of atleast 2500 g	70%
- Infants fully immunized.	58%
- Women immunized during pregnancy with TT	16%
- Population with safe drinking water.	46% rural 76% urban
- Population with adequate excreta disposal facilities.	38.1%
- Adult literacy rate.	43%
- Total Govt spending on health.	6.9%

8. The literacy rate in AJK is 43% with female literacy rate at only 12%, but almost all children are in primary school. Health standards are still poor. The maternal mortality rate is 600-700 per 100,000 live births, and child mortality is 130 per thousand live births. Immunization coverage is 92 percent and the population / hospital bed ratio of 1900 is worse than the national average of 1,600. Due to the difficult terrain and severe weather conditions during winter and heavy rainfall in summer, the primitive communication system breaks down, making it difficult for people to obtain health care from static facilities. About 25% of the disease burden is due to respiratory infections, and TB is more prevalent than in the rest of the country. Leprosy is still a public health problem, iodine deficiency disorders are endemic and anaemia is common. Due to the poor back up services and primitive communications, maternal mortality is higher than the national average; similarly, fatality among accident victims is common.

9. AJK, has over 500 PHC facilities ranging from Rural Health Centres to First Aid Posts. Referral services are weak and outreach services are limited with the difficult geography, providing services is expensive on a per capita basis. Almost all sanctioned staff positions are filled , but many facilities have no MCH services. Armed Forces provide some staff , drugs and medicines worth in all about Rs. 50 Million annually. Demand far exceeds the highly inadequate supply for FP services, although the FPAP operates actively throughout the State Apart from FP and leprosy and TB control , few NGOs are active in AJK. Community involvement, the private sector , and traditional medicines are limited.

10. There is an urgent need to affect a fundamental change in basic philosophy and adopt a new approach. For any real and meaningful development in the health status, improvements in health services delivery system, safe water supply , sanitation and nutrition are needed.

11. At present major problems faced by the health sector are as follows: Deficient midwifery services especially in primary health care. Existing services not operated at a reasonable level. The staff is not adequate, sanctioned positions for female cadres are not there, drugs and medicines are not sufficient. There are not enough funds to meet operating costs of vehicles/ ambulances and supervisory functions especially due to terrain first referral level services are remote and deficient in emergency care to handle obstetric emergencies and ccident emergencies. Inservice staff can not be abreast with scientific development because there is hardly any continuous training programme. Pre-service training programme are not geared to the needs of the people but are justified for the requirement of the job positions. Management is centralized and very little community participation.

OBJECTIVES.

12. The objectives of the Policy include;-

i) to make primary health care available to all citizens without discrimination which include;

- Maternal and child health care including family planning,
- Immunization against the major infectious diseases;
- Education concerning prevailing health problems and the methods of preventing and controlling them;
- Promotion of food supply and proper nutrition;
- Adequate supply of safe water and basic sanitation;
- Prevention and control of locally endemic diseases;
- Appropriate treatment of common diseases and injuries; and
- Provision of essential drugs,.

ii) To improve the referral system so that hospital care becomes available to those who actually need it.

iii) Development of health services infrastructure based on primary health care.

iv) Manpower development and reorientation towards primary health care.

v) Decentralization of the administration of health care system.

vi) Strengthening of managerial skills and information system.

vii) Community participation in health and health related programmes.

viii) Intersectoral collaboration.

-ix) Use of appropriate technology in health care system.

x) Delinkage of Army support in phased manner.

TARGETS.

13. In specific terms, the Health Policy hopes to achieve the following targets by the year 2000;-

a) To make primary health care available to the entire population.
b) To enhance nutritional status so that:-

- at least 90% of newborn infants have a birth weight of atleast 2500 grams.

- atleast 90% of children have a weight for their age that corresponds to the reference values.

c) To achieve infant mortality rate for all identifiable sub- groups to be below 50 per 1000 live births.

d) To reduce maternal mortality rate by 30%

e) To achieve life expectancy at births of well above 60 years for both sexes.

14. Some of the additional quantifiable targets to be achieved by year 2000 and 2010 appear in the following table:

TARGETS FOR YEAR 2000 AND 2010

S.NO FACILITY	1995 2.690 (POPULATION MILLION) No	FACILITY POP . ATIO	2000 2.959 (POPULATION MILLION) NO.	FACILITY POP RATIO	2010 3.780 (POPULATION MILLION) No.	FACILITY POP. ATIO
1. Hospital beds.	1158	2280	2232	1326	2800	1350
2. Primary health care facilities.	525	5028	575	5146	750	5040
3. MCH centres/ services	80	5750 WRA	197	3065 WRA	merge	with BHUs
4. LHVs.	92	5000 „	240	2959 „	600	1500 WAR
5. Nurses.	114	1:8 beds	210	1:11 beds	600	1:5 beds
6. Doctors.	386	6839	646	4580	1200	3150
7. Dentists.	36	73333	50	59180	120	31500

STRATEGIES.

15. The Government's strategy is to remedy the problems stated earlier and focus on improving the quality and coverage of primary health care while keeping a strong MCH focus. The emphasis would be on strengthening and upgrading facilities rather than construction of additional facilities. In the short run, existing extensive stock of health facilities will be brought upto a proper standard by the turn of the century, fully staffed and equipped and provided an adequate budget for medicines and other operating expenses besides recently completed non operative facilities made fully functional. In the long run emphasis would be to improve the primary and referral services and remove the imbalances in various categories of trained human resources. Steps will be taken for substantial community involvement in health care delivery and creating a partnership between communities, NGOs and the Government which would promote service delivery effectiveness and sustainability.

I)Primary Health Care in rural areas.

In addition to the existing system of providing PHC at BHUs and RHCs, a programme of female NHWs introduced to disseminate PHC to the community will be expanded to include the entire State. The female NHWs , selected by the communities will be trained and equipped adequately. They will act as a bridge between the community and the health units. BHUs/RHCs will become an integral part of the programme. It is proposed to train one female NHW for each census village.

ii) Primary Health Care in urban areas

In addition to hospitals, PHC in all urban localities will be provided by training of female NHWs in each ward represented by City Fathers.

iii) Maternal and Child Health Services in Primary Health Care.

a) At the village/Municipal Ward level, MCH Services will be provided by National Health Workers, trained Dais and Traditional Birth Attendants. These will include antenatal and postnatal care, identifying risk pregnancies, deliveries of non-risk pregnancies, nutrition, supplemental foods and nutrients, especially iron and iodine, motivation for immunization, child spacing, provision of contraceptives and treating a limited range of problems such as pneumonia and diarrhoea.

b) In the short run, a Basic Health Unit, atleast, one in a Union Council will have MCH Centre which will provide services for women especially in the reproductive age (15-49 years) and children below the age of 5 years. As a long term measure, all BHU will provide MCH Services. This Centre will provide ante-natal and post-natal care, immunization, treatment of minor illness among females and children, family planning services, nutrition education and supply micronutrients, health education, receive referrals from National Health Workers and refer high risk pregnancies and critically ill cases. The Centre will train TBAs and NHWs and will be staffed by a Lady Health Visitor (LHV) and a Dai and will have sufficient stock of drugs and medicines.

c) Each Rural Health Centre will have professional staff and beds and will provide paediatric and obstetric care except for those which require specialized care. These Centres will be able to take care of some of the obstetric emergencies:

iv)Improvement in referral system.

In order to improve referral system and bring health services closer to first contact point, all rural health facilities will be upgraded and made fully functional. Upgrading will involve availability of staff, improvement of skills of staff, blood transfusion services, operating facilities, adequate provision of equipment and ambulances, so that the health acilities are able to take care of:

a) Pregnant women with life threatening conditions;
b) Critically sick children: and
c) Stabilise trauma/burns.

v) Hospital Services.

a)All Public hospitals will act as referral units. THQ Hospitals will act as the firstreferral centres and will provide care to all emergencies and acutely ill cases except those requiring specialized care. They will be fully equipped with trained staff and necessary equipment to undertake caesarian section. District Headquarter Hospitals will provide specialized care atleast in obstetrics, paediatrics, medicine and surgery with appropriate range of diagnostic services. They will have qualified and trained specialists with adequate nursing and paramedical staff in order to provide quality care. They will be fully equipped to undertake quality operating theatre functions, transfusion service and post- operative care.

b) All public hospitals will be provided drugs according to the National Formulary for Hospitals and a drug schedule will be introduced so as to ensure availability of such drugs.

vi) **User Charges.**

In addition to the funds received from Government, all public hospitals will receive scheduled users fees for outpatient visit and inpatient stay. All hospitals will be allowed to retain the user charges collected and to disburse them on agreed priorities established by the Government.

vii) **Human Resources Development.**

a) Human Resources Development (HRD) will be institutionalised byestablishing "HRD Cell" in the Directorate General of Health which will maintain updated data-base of all categories of the health care providers.

b) The shortage of Nurses, LHVs, Health Technicians and other paramedics and enhancement of their status will be overcome. It is absolutely necessary to produce public health nurses and lady health visitors in sufficient number and to enhance the knowledge and skills of TBAs/Dais.

c) A cadre of Family Physicians will be developed and given recognition as a specialty.

d) Short term local training programmes will be organized to improve the managerial capabilities at different levels of the health system with emphasis on Primary Health Care by problem solving approach. Special incentives will be offered to those professionals who chose to be career managers.

e) Training opportunities will be provided for medical specialists, nurses and paramedical staff in Primary Health Care.

viii)**Decentralization of the Administration of Health Care System.**

Health Department will undertake a process of planned organizational development, This will be a priority as it will be a mechanism by which services will be improved. The organizational development effort will be at all levels which will aim at decentralization of managerial system and decision making. Policy will be implemented through development of district plans which will be reviewed and updated on a yearly basis.

ix) **Health Management Information System.**

Existing health information system will be replaced by newly developed HMIS based on PHC in all government managed first level care facilities.

Training of health personnel in all districts will be arranged for data collection procedures for the newly designed system.

Data processing for the new system will be computerized at appropriate levels in the health system and supervisors at all levels will receive training in the use of information for health planning and management of health services.

A simple HMIS for the hospitals will also be implemented.

HMIS will provide necessary information to monitor the implementation of this Policy.

x)**Community participation.**

People of the community will be involved at the outset in identifying their needs, choosing the sequence and in implementing and supervising the health programmes. Creation of a partnership between the health department and the people will enable

both to assume responsibility and accountability for managing the outcome of investments in the provision of health services. Therefore, this policy aims at establishing Health Committees at village, Union Council, Tehsil and District levels. These committees will be responsible for advising, implementing and monitoring health programmes. The participation of NGOs will be encouraged especially of Marie Adelaide Leprosy Centre and FPAP while other NGOs will be supported to reduce the burden on the public purse.

xi)Intersectoral collaboration.

Efforts will be made to develop an integrated mechanism which would make the primary health care approach a continuing reality in Education, Agriculture, Sanitation, Women's and youth organizations. In this regard, a package of services to meet Basic Minimum Needs will be adopted as is partly being done under Social Action Programme.

xii)Use of Appropriate Technology.

A list of Essential Drugs will be introduced to make drugs available at reasonable prices to the general public.
Drug package for treatment of common diseases will be made available in villages and BHUs/RHCs.
Unani system if medicines and Homeopathy will be recognized. The drugs and medicines of these systems will also be regulated.

xiii)Integrated Diseases Control.

Common diseases will be controlled through an integrated approach of disease control through Primary Health Care different levels of health services system. Programme activities relating to immunization, diarrhoeal diseases, acute respiratory infections, malaria, tuberculosis, leprosy, IDD Cancer, Cardiovascular diseases, AIDS, diabetes, mental disorders, dental diseases etc will be strengthened at primary health care level. Extensive health education campaigns will be launched. People will be motivated to adopt healthy life styles which will provide support to all programmes. The integration of communicable diseases control programme will be undertaken by the following approach.

xiv)**Communicable Disease Control (CDC).**

CDC programs will be merged into a broad-based CDC program to follow a health care approach in contrast to single multi-purpose independent programs which thrive at the cost of primary health care programs. This will improve efficiency by involving the community and local health manager and provides service as a component of PHC through existing health care facilities. At the community level, National Heath Workers will provide promotive and preventive services in addition to maternity and family planning services. Each BHU will have two CDC workers: One to be available at the facility and the second to provide outreach services and support NHWs. The RHCs will have adequate staff from the existing vertical programs to provide services for the CDC program and laboratory services. The District Health Officer will be assisted by the CDC officer to be made available by redesignating existing staff. At the Directorate level, an Important section of the CDC program will be created by merging existing vertical program staff and adding some additional staff. MOH is co-financing CDC programs nationwide. The Federal Ministry of Health (MOH) will provide equipment transport, vaccines, reagents cold chain equipment and insecticides for malaria control, EPI and AIDS activities. These programs will be supported by the Social Action Programme.

xv) **Other aspects of integrated disease control measure includes:**

a) ORS packets will be allowed to be sold through all commercial outlets and its availability will be ensured.

b) Iodised salt supply will 'be ensured.

c) Case finding and surveillance system will be improved.

d) Availability of essential diagnostic tools in the BHUs/ RHCs will be ensured.

e) Proper screening of blood for HIV infesctions at all blood transfusion centres will be ensured.

f) Cancer registry will be established in each hospital. All district hospitals will have early detection facilities.

xvi) **Proper Food and Nutrition.**

Special attention will be given to improve the nutritional status. Food supplements will be provided to vulnerable and malnourished groups especially lactating mothers, infants and children. Efforts will be made to improve the percentage of newborns weighing atleast 2500 grams at birth.

xvii) **Family Planning.**

Family Planning advice including performance of various procedures will be part and parcel of all MCH Centres, BHUs, RHCs and Hospitals. The female (related) health personnel will be trained in contraceptive methods.

xviii) **Nutrition.**

The Nutrition component of PHC will be strengthened by the following measures;-

a) Nearly all expectant mothers will receive proper antenatal care including nutritional assessment and PHC facilities will offer advice for micro-nutrients. Nutritional status will be monitored during subsequent visits.

b) Post natal advice will include how to maintain nutritional status of lactating mothers and their off springs.

c) CDC, ARI and immunization will facilitate in maintaining a reasonable level of nutritional status of children below 5 years of age.

d) Provision of LHVs at MCH Centres will improve the nutritional status of women in the reproductive age and children below 5 years of age. In addition to providing services mentioned in other items they will provide micronutrients and FP services.

e) For effective management of the nutritional aspects of the project, the office of the DHO is being strengthened by providing a nutrition cum health education expert and assistant Inspectress of Health Services (a senior LHV).

f) National Health Worker will have a specific slice of her work for nutritional status improvements.

xix)**Private Sector.**

The investment in tertiary care by the public sector will be selective on priority need. This would create a favourable environment for private sector's investment.

xx)**Environmental and occupational health.**

Environmental problems in AJK includes deforestation, air and water pollution and poor and hazardous wastes disposal. Efforts will be made to enforce Environmental Quality Standards approved by the National Protection Council.

xxi) Rehabilitation Services.

The programme for the disabled will focus on development of institutional facilities for disabilities prevention and rehabilitation through PHC network, hospitals and rehabilitation centres,.

xxii) Army Support

Presently army provides support in terms of manpower at District level hospitals and material support for RHCs and BHUs. This support will be gradually transferred to the civil side.

16. IMPLEMENTATION ARRANGEMENTS.

Implementation of the Policy will be kept under constant watch by an over-sight committee, which will meet every 3 months. Secretary Health will be the chair person of this committee with DG Health as Vice Chairperson and Director Planning as Secretary. All DHOs, Medical Superintendents of DHQ Hospitals will be members alongwith representatives from Planning and Finance Departments and PWD. The Policy will be largely implemented through district plans. For effective implementation of the Policy the managerial capacity of the department of health will be beefed up. This will be done by:

At the Directorate level by:

a) adding additional professional staff to develop the staff functions of planning, monitoring / information system, and research as well as improve line function programme support to communicable disease control (CDC).

b) Provide management training for all staff.

c) Provide technical assistance.

d) a few support staff.

e) office automation- computers/printers, fax, photocopiers, etc; and

f) transport.

At the District level.

a) four professional staff will be added; one Additional District Health Officer (ADHO), an Assistant Inspectress of Health (AIHS), a Planning Officer and a Health Educator.

b) Providing management training to all staff.

c) technical assistance.

d) Office automation- computers/printers, fax, photocopiers etc and

e) transport.

For monitoring purposes, coordinating functions will be entrusted to the Officer responsible for HMIS and his/her associates at the district level.