GOVERNMENT OF TRIPURA
2ND DRAFT TRIPURA PUBLIC HEALTH POLICY
2019
HEALTH & FAMILY WELFARE DEPARTMENT

1. INTRODUCTION :

Tripura has achieved good health indicators compared to other Indian states. A prime reason for this has been the stewardship role that successive governments, before and after independence ,have played. This has become even more important at a time when the state is facing the emergence and re-emergence of some of the communicable diseases along with problems resulting from the epidemiological and demographic transition. In order to navigate the sector through the multiple challenges faced in the health sector Government of Tripura needs to articulate the policy framework under which all the stakeholders can develop their strategies. This document is an attempt to address such a need.

2. FORMULATION OF HEALTH POLICY DOCUMENTS IN INDIA AN OVERVIEW

National Development Committee and Bhore Committee had developed a very broad and elaborate frame work for the Health Policy for the country even before Independence. Successive Five year plans have been the guiding documents for national policy in India. Post independence Tripura has, by and large, followed the guidelines of the national government. The state went on to achieve most of the targets set out in these documents such as population stabilization and control of communicable diseases through a network of institutions modeled on the national pattern, even though there were a few differences. The national health policy 1983 was the first articulation of a policy document at the national level. Commencement of the National Rural Health Mission in 2005 resulted in substantial augmentation of resources and modification of implementation arrangements. The National Health Policy 2017 plan document sets a target of Universal Health Coverage before the government. Since Tripura is in an unique position to achieve the targets set out in the National Health Policy 2017 document it is important to develop a policy to guide our efforts in this direction.

3. TRIPURA CURRENT SCENARIO

3.1 TRIPURA STATISTICS :

Sl.No.	*Category*	*Numbers*
1.	Districts	8
2.	Sub Division	23
3.	Panchayat Wards	1178
4.	Autonomous District Council	1
5.	Blocks	58
6.	Revenue Circles	45
7.	City Corporations	1
8.	Municipalities	13
9.	Nagar Panchayat	6
10.	Population (Census -2011)	36,73,917
11.	Male	18,74,376
12.	Female	17,99,541
13.	Urban	9,61,453
14.	Rural	27,12,464
15.	Total 0 to 6 Populations(2011 Census)	4,58,014
16.	Sex Ratio	960
17.	Density of population(per sq. km)	350
18.	Literacy Rate %	87.2
19.	Male literacy rate %	91.5
20.	Female literacy rate %	82.7

3.2 HEALTH FINANCING :

Health expenditure in the State has seen an increasing trend in the last 5 years. A large part of the expenditure on healthcare continues to be out-of-pocket which takes place at the time of illness, thus imposing a huge burden on families. This puts an undue financial burden on the population leading to catastrophic health expenditures.

The below table is showing the trend of budgetary approval of the Health & Family Welfare Department received from the State Govt. & Union Govt.

Financial Year	Directorate of Health Services (in lacs)	Directorate of Family Welfare & Preventive Medicine (in lacs)	National Health Mission (in crores)
2015-16	39719.66	51089.73	180.78
2016-17	47707.84	53589.62	218.13
2017-18	48573.39	49859.71	241.00
2018-19	52122.68	53452.42	257.88

3.3 SOCIAL DETERMINANTS OF HEALTH :

3.3.1 WATER SUPPLY: Even though Tripura gets over 3000 cm of rain in a year poor management reduces the state of near drought conditions in the period between January and May. With increased reclamation of wetlands and water bodies and persistent pollution of drinking water sources, water availability is likely to come under increased strain in future. Added to this is the failure to provide safe drinking water in hilly regions, coastal and water logged areas. Unless this is reversed and the state manages its environmental and water situation better we are likely to witness outbreaks of water borne diseases such as Cholera and Hepatitis A.

3.3.2 SANITATION: The availability of sanitary toilets has improved in most parts of the state except backward regions like hilly, tribal areas and urban slums. Problems of toilets construction in water logged areas and the absence of appropriate models for areas with water scarcity are unresolved technological issues of this field. First generation sanitary toilets were without septic tanks(with ordinary pit) contaminating the nearby drinking water sources including the wells. The increasing population density and the migrant situation further complicate this issue.

Ecological degradation and the contamination of the water bodies and ecosystem in general due to the unscientific use/misuse of pesticides pose a serious health hazard. Health problems due to occupational pollutants, asthma, allergy, chronic obstructive pulmonary disease especially in the context of raising urbanization and increase in the automobile use are other related issues to be addressed.

3.3.3 CLIMATE CHANGE AND PUBLIC HEALTH : The changing climate will inevitably affect the basic requirements for maintaining health, clean air and water, sufficient food and adequate shelter. Climate Change also brings new challenges to the control of infectious diseases. Many of the major killers are highly climate sensitive as regards to temperature and rainfall, including Cholera and the diarrheal diseases, as well as diseases including malaria, dengue and other infections carried by vectors. Also the tissues of reductions and seasonal changes in the availability of fresh water, regional drops in food production etc has the potential to force population displacement with negative health impacts. This State Health department in order to extend the benefit of the programme to the entire population has introduced the state Climate change cell in the department.

3.3.4 CANCER CARE-PREVENTION AND EARLY DETECTION: Tripura reports nearly 2500 patients newly diagnosed every year and almost 10000 are under treatment every year. But treatment in Government Sector is limited to Regional Cancer Centers at Agartala and leaving the remaining districts with no facility for Cancer treatment .The focus has to be on elimination of risk factors, increased awareness, early detection and prompt. Government proposes to establish early Cancer detection and follow of Chemotherapy centers in all districts attached in phase manner to district head quarters hospitals. In orders to control the use of tobacco and other tobacco containing products, a major cause of cancers and other NCDs, COTPA is being implemented in the State. The State aims to establish tobacco free homes, schools and workplaces.

3.3.5 WOMEN'S HEALTH : In Tripura atrocities against women, domestic violence, and other related issues are comparable to the national level. Gender based priority is given in all the hospitals . The health problems of the elderly women, widows, women workers of the traditional industries like handicrafts, tribal women, domestic women workers, agricultural workers, low paid urban based sales girls working in shops/malls etc needs to be addressed in a comprehensive manner covering the health determining sectors. Rising trends of under nutrition, anaemia, obesity, infertility etc. among women also need to be addressed. The declining child sex ratio reported in the 2011 census of India points to the possible existence of child sex selection and foeticide in some parts of the state. This has to be verified and corrected to prevent Tripura going the way of most other states in India.

3.3.6 MATERNAL HEALTH : Though the maternal mortality rate of the smaller States is better than the all India average it is unacceptably high compared to the international standards has been relatively stagnant for the past few years. Governments intense to reduce the MMR by 50% of current rate by the end of the 2021. By addressing the most common obstetrical complication like anaemia in pregnancy ,post partum hemorrhage and pregnancy induced Hypertension is to be focused to make a dent in maternal mortality in the state. From the last one decade both government and private sector Hospital are reporting a rising trend of caesarean section touching 40%, through some administrative and technical measures have to be taken up at state level . Other like early marriage and teenage pregnancy in some of the district and tribal areas also remain intractable .

Maternal and Child health indicators during the last 2 NFHS periods

(2005 -06 & 2015 -16)

Indicators	**NFHS-III 2005-06**	**NFHS - IV 2015-16**
Fully Immunized Children (%)	49.7	54.5
Under Weight Children (%)	39.6	24.1
Infant Mortality Rate	51	27
Full Antenatal Care (%)	7.4	7.6
Institutional Delivery (%)	46.9	79.9
Total Fertility Rate (TFR)	2.2	1.7

3.3.7 Child Health : While the IMR of Tripura (27 per1000) is better than most Indian state but the rate has increased for the last few years. The state to reduce the present IMR to single digits by the end of 2025. For further reducing the infant mortality , the Neonatal Intensive Care Unit (NICU), Special New Born Care Unit (SNCU) & New Born Care Corner (NBCC) and other New Born Care facilities attached to the delivery points will be further strengthened. Government attached foremost importance to prevention of disabilities among children. A new born screening programme for congenital diseases like G6 PD deficiency, adrenal, hyperplasis, hypothyroidism and phenyl ketonuria is in the pipeline of the department to start very soon. This will be further expanded to cover other conditions. Community level disability detection and management through ASHA, Anganwadi worker and health worker will be strengthened .Remedial measures in such cases will be made available free of cost by Government. Though no polio cases were reported in the state since 2000, the VPDS like diphtheria, measles and tetanus are still reported. Health Department

and social justice Department will collaborate to achieve universal immunization an nutritional monitoring.

3.3.8 Adolescent Health (ARSH): Government seeks to equip, sensitizes, and empower all adolescent of the state to realize their full potential. To this end their physical and mental health need will be addressed. Through the weekly folic acid Supplementation Programme(WIFS) health department will covered the beneficiaries in the state including adolescent girls and boys from class 6 to 12, and out of school adolescent girl from 10 to 19 yrs for anemia control. Hospital based Adolescent Friendly Health Clinics (AFHCs) have been started at all District Hospitals and selected SDHs, CHCs. Outreach sensitizations, peer leader motivation, and adolescent health promotion through the Parents Teachers meet which is started in the schools state wide. Large numbers of doctors, nurses, and field level workers will be trained in all district, to serve as the manpower for all these efforts.

3.3.9 RBSK : The modified school health programme i.e RBSK is implemented in all the school of the state. The programme aims to provide school based health support services to all the student by working collaboratively with different agencies, school teachers, parents and community members. The programme will try to establish, with the support of health and education officials, teacher, students, parents, health providers and community leaders, a school, "that constantly strengthens its capacity as a healthy setting for living, learning and working".

3.3.10 Health problems of elderly : At present the percentage of population above 60 is 12% and is expected to cross 25% by the year 2050. As in many other areas the capacity of the health sectors has to be scaled up substantially to deal with the enormity of the problem. This has taken efforts to set up Geriatric care wards with Geriatric friendly facilities at Medical College & District and Hospitals. A significant achievement has been the palliative care services in the State. Palliative care programmed which, operates in three levels, home based primary care, hospital based secondary care and major institution based tertiary care, is supported by local self Governments.

3.3.11 Mental health problems : The state aims to incorporate the mental health services with the general health care services up to the primary health centre level. This is done by establishing district mental health programs and phase wise establishment of HWCs which helps in the diagnose and prescribe medication, leaving the management in the hands of the PHC team and by having psychiatry units in District Hospitals. Rehabilitation of mentally ill persons is done as joint efforts of Health, Social Justice and local self Government Departments.

3.3.12 Health of Vulnerable Section: The health status of some tribes is worse then what exists in most parts of India. This is the party the result of political disempowerment and partly due to their remote location. Hard to reach areas suffers from diseases that result from lack of safe drinking water and sanitation. These call for long term efforts & political commitments to make a difference. Within the constraints government department will continue to provide ameliorative measures. Urban population, especially persons living in slums don't have access to primary health care centre. Urban sub centre and primary health centers has to reconfigured to provide primary care preventive and curative services

3.3.13 Health Infrastructure in Tripura :

SL.NO	*Institution*	*Number*
1.	Medical College	2
2.	State Hospital	6
3.	District Hospital	6
4.	Sub Divisional Hospital	12
5.	CHC	22
6.	PHC	107
7.	UPHC	6
8.	Ayurvedic Govt. Dispensary	35
9.	Homeopathic Govt. Dispensary	73
10.	Health Sub Center	1020

4. Overview of Health Service System of the State.

Curative service is provide by Modern medicine, Ayurveda and Homeopathy systems of medicine. Whole in general modern medicine is the preferred system and for specific conditions Ayurveda and Homeopathy are chosen by a large percentage of the population of Tripura. Government acknowledges the importance of the three system of medicine and will encourage studies of the comparative advantages of treatments under the three systems.

4.1 Tertiary care: Tertiary care in government service is provided through Medical collage hospitals. It is likely that in five years the State has AIIMS in Tripura. Each of the Hospital would be equipped for managing cases in all specialties and super specialties. Couple with a revamped primary care system, referral linkages between secondary and teaching hospitals and an ICT enabled networking of care the medical college hospital can be positioned as the manager of the health care needs of the entire State, including capacity building, quality and research. But to achieve this, capacity and standards in teaching of

medical college will have to be substantially improved and better organizational arrangements made. Diagnostic and treatments will have to be standardized at all levels and referral linkages established between hospitals at different levels. It will also mean creating closer links between institutions under the health and medical education department.

4.2 Secondary care institution: District Hospital and Sub Divisional hospital, will be strengthened to provide secondary care. Respecting the burden of non communicable disease these hospital will be equipped to handle routine cases of such diseases.

4.3 In Tripura the national pattern of one post of Gynecologist, Pediatrician, Physician, surgeon and anesthesiologist are not available in every CHCs since at present the available specialists are inadequate to meet the requirements of specialists in Districts and Sub Divisional hospital. When the primary care facilities are reworked and the health protection agency comes into being the role of the CHCs will worked out appropriately.

4.4 Primary Health Centre: Primary Health Centre were set up for health promotion activities including prevention of communicable and non communicable disease, disease surveillance, implementation of the maternal and child health programs comprising antenatal care, immunization, post natal care, adolescent health and health and implementation of other national health programmes. But the system, originally designed to address reproductive and child health issues and communicable disease, has not been reconfigured to meet the needs of a population that is way on the way through a demographic and epidemiological transition. The job description of primary care physicians will be reworked to resemble that of the family physician or General Practitioner. Each team will be responsible for a population of 30, 000 - 50,000 provide them preventive, primitive and basic curative services and help them navigate through the health system should they need higher level of services.

4.5 Sub Centre: there are 832 ANMS and 998MPW (M) in Tripura operating in 1020 Sub Centers. The role and responsibilities of the sub centers and primary health centers has come down markedly due to changes in pattern of utilization of health services. There is a need to better reorganize the functioning of the sub centers in such a manner to address the health promotion prevention and other primary health care services at the field level. With the introduction of NHM, the formation of ward level health & sanitation committee and the implementation of the ASHA scheme have also necessitated reworking of ANM/MPW job requirements.

4.6Emergancy Medical services and management of trauma: Increase in the road traffic accidents in the recent days Tripura needs an efficient system for efficient evacuation and good management of victims of road traffic accidents. The 108 Ambulance services will be started to the entire state. Since management of emergency cases and trauma a specialist cadre of doctors & nurses trained in life saving & trauma management techniques will be built up.

4.7 Tripura Clinical Establishment Act: In the state private hospitals, laboratories & other diagnostic centre play an important role in providing medical care. Fortunately there is a system for mandatory registration and monitoring of the functioning of these institutions through the above Act. The rules of the Act has to be implemented as early as possible.

4.8 Human Resource Policy in Health: Human Resource is the core building block of any health system. In order to ensure a health HR the management capabilities will be improved in all the directorates. HR policy and job description will be dynamically updated to meet changes in the sector. An HR cell and another HR Advisory Committee will be set setup to advice government on this. Adequate investments will be made to develop, manage & implement an HRMIS system that will gather & update HR related data on a regular basis. This will ensure availability of authentic information on every individual staff within the department at all levels. This will further aid in process of transfer, capacity building, HR planning etc. All directorates will have a systematic capacity building system including induction & periodic training. A performance appraisal & grievance redressed system will also be institutionalized.

4.9 Nursing Care and Nursing Education: The services of the nurse of Tripura is well appreciated all over the world, in Tripura itself the profession has not been allowed to realize its full potential. The potential of nursing cadre as an independent professional need to be identified & propagated. The role of nurses in initial work up and counseling of the patients in outpatient section, & the right to administer key drugs at times of emergencies in OP/IP sections based on a protocol would be very much helpful in improving the patient care. In time Tripura move to the concept of nurse practitioner i.e CHO which is available in all advanced health systems of the world.

4.10 Treatment protocol, referral protocols and management guidelines: The State has Standard Treatment Guidelines and management guidelines but unfortunately it is not followed in the due time. Steps will be taken to streamline the issue. Many Patients were referred to higher center which can be manage in the lower level so a referral protocol will be designed by the State.

4.11 Data Management System: Health sector generates a large amount of data. This should be analyzed & form the basis for managerial decision making in the policy formulation. Recently Tripura has began to use data from various management Information system for decision making. However there is no system to integrate this data & present it in a manner useful to managers at different levels. Tripura setup a data management Centre that can come up with identification of information needs, of managers at different levels, identify the data inputs that are needed, analyze them & provide feedback to persons inputting the data and to managers who need to use them.

4.12 Decentralization & Health: In the year 1996 the directorate is bifurcated in 2 directorates for better monitoring and supervision of the health facilities. The commissioning of public Health cadre at all may be made responsible to shoulder this responsibility though appropriate HR development.

4.13 Medical Education: Tripura has separate Directorate of Medical Education which is looking after the medical education aspects of the State. Directorate needs to be strengthened and initiation is taken to make all the registration and admission activities in the courses. One would have assumed that the banning of private practice would have led to greater research activities. But Tripura is yet to develop a sub-culture of research. Government will encourage research activities and innovation in health care delivery & management.

4.14 Private Sector: Tripura is encouraging private partners to establish Clinical Establishment in the States so in the Tripura Clinical Establishment Act 2018 the provision of period of registration is kept with extended period of registration for bigger establishment.

5. GOAL, PRINCIPLES & OBJECTIVES :

5.1 GOAL : The policy envisages as its goal the attainment of highest possible level of quality health care services for the people of the State through a promotive ,preventive ,curative and rehabilative health.

5.2 PRINCIPLES :

5.2.1 Professionalism ,Integrity & Ethics : The public Health policy of the State commits itself to maintain Professionalism ,Integrity & Ethics in the entire system of health care delivery services.

5.2.2 Equity : Health care delivery system to the people of the State is equitable for every section of people . It means it would minimizing the disparity of caste, gender, community , poverty and geographical conditions.

5.2.3 Accessibility : Health care services to the people of the State will be accessible without any barriers.

5.2.4 Affordability : Health Services will be affordable to every citizens of the State and government is committed towards it.

5.2.5 Universality : Prevention of exclusion on social ,economic or on grounds of current health status.

5.2.6 Patient Centered & Quality Care: Gender sensitive ,effective , safe and convenient health care services to be provided with dignity and confidentiality. Government has full commitment towards its people to provide quality and standard health care services.

5.2.7 Accountability : Financial and performance accountability for every service providers.

5.2.8 Pluralism : Every people has its own choice to the system of medicines selection for the treatment and Government is committed to give all provisions to the people.

6.Objective

1. To position good health as the product of development agenda including water supply, nutrition, sanitation, prevention of ecological degradation, respect for citizens' right & gender sensitivity.
2. To ensure availability of the needed financial, technical & human resources to meet health needs of the state.
3. To effectively organized provision of health care from primary to tertiary levels through referral networks managed by primary care providers to maximize efficiency and reduce costs.
4. To regulate practice in health sector to ensure quality & patient protection.

7. Plan of action:

For achieving the above objective this policy propose specific plan of action as discussed in the following sub section.

7.1 Determinants of health care: Many of the factors that determine health status of the population lie outside the purview of the health sector. These include clean drinking water, proper management of solid & liquid

waste, food safety. Many of these have been delegated to other departments to effect convergence of efforts to improve such determinants.

(i) Clean drinking water: Responsibility for provision of safe water is now DWS department. There is scarcity of drinking water in many parts of the state, leading to host of health problems. The state will continue the efforts to provide adequate drinking water of good quality in these areas. Health department will access technologies to test the quality of water being provided in times of scarcity or natural calamity.

(ii)Sanitation facilities: in addition to providing sanitary latrines in all houses Tripura has to deal with issues created by first generation toilets which have no septic tanks & the lack of scientific system for management of sewage. In the absence of such a system many agencies dump such waste in abandoned areas & water bodies causing serious public health hazard. Govt. will access & implement technologies that can treat sewage in water logged areas & high density residential areas.

(iii) Solid waste management Policy, and plan of action: the system of collection of waste without segregation and dumping them without a scientific system of management has resulted in an ecological & social crisis. By legislative means & education o the public generators of the waste, including households will be asked to assume responsibility for the waste, segregate them & participate in decentralized scientific system of management. Banning of thin plastic carry bag & other administrative, managerial & legal measures will also be enforced.

(iv) Poverty: poor persons have greater load of morbidity without the means of paying for treatment. ABPMJAY & THASP schemes have increased financial risk protection in the state. However govt. will also introduce other measure to ensure that the poor have access to services free at the point of consumption.

7.2 Progressively achieve Universal Health Coverage :

7.2.1 Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive , maternal , child and adolescent health and for the most prevalent communicable and non communicable disease in the population. The policy also envisages optimum use of existing of manpower and infrastructure as available in the health sector.

7.2.2 Ensuring improves access and affordability , of quality level of services through a combination of public hospitals and private service providers.
7.2.3 Achieving a significant reduction of Out of pocket expenditure due to health care cost.

7.3 Reinforcing trust in Public Health Care System: Strengthening the trust of the common man in public health care system by making it predictable, efficient, patient centric, affordable and effective, with a comprehensive package of services and products that meet immediate health care needs of most people.

7.4 Align the growth of private health care sector with public health goals: Influence the operation and growth of the private health care sector and medical technologies to ensure alignment with public health goals.

7.5 Specific quantitative goals & objectives:

Outlined in three broad objectives (a) health status & programme impact (b) health system performance and (c) health system strengthening. These goals and objectives are aligned to achieve sustainable development in health sector in keeping with the policy thrust.

7.5.a : Health status & programme impact :

- Life expectancy and healthy life

≠ Increase life expectancy at birth from 67.5 to 70 by 2025.
≠ Maintenance of TFR to 1.7 as per NFHS 4.
≠ Use of any family planning method to 75 % from 64.1% by 2023.

- Mortality by age and cause

≠ Reduce under five mortality to 10 from 33 by 2025.
≠ Reduce infant mortality to 24 by 2021 and to 15 by 2025.
≠ Reduce to Still birth rate to single digit by 2025.

- Reduction of disease prevalence / incidence

≠ Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS i. e,- 90% of all people living with HIV know their HIV status, - 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.

≠ Achieve and maintain elimination status of Leprosy by 2019-20.

≠To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
≠ To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels.
≠To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.
7.5.b : Health System Performance :

- Coverage of Health Services

≠ Pregnant women who had first ANC in the 1st trimester to be 95% from 66.4% by 2024.
≠ Consumption of IFA tablets 100 and more to be 70% from 13.4% by 2021.
≠ Full antenatal care services is to be more than 75% by 2025.
≠ 4 Ante natal check up to be 90% by 2025.
≠ Institutional birth to be 90% by 2022 and 95 % by 2025.
≠ Fully immunisation to be 80 % by 2020 and 98% by 2025.
≠ 100% immunisation of birth doses in all the institutional delivery cases by 2020.
≠ Acceptance of any family planning method to be 80% by 2021
≠ 80% of known hypertensive and diabetic individuals at household level maintain controlled disease status" by 2025.

- Cross Sectorals goals related to health

≠ Relative reduction in prevalence of current tobacco use by 15 % by 2021 and 30 % by 2024.
≠ Reduction of 40 % in prevalence of Stunting of under five children by 2024.
7.5.c : Health System Strengthening

- Health Finance

≠ Increase State sector health spending to > 8% of their budget by 2020.
≠ Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.
≠ Average out of pocket expenditure per delivery in public health facility to be reduce to nil from Rs 4784 by 2021.
≠ Ensuring 100% coverage under Jannani Suraksa Yojana by 2020.

- Health Infrastructure & Human Resource

≠ Ensure availability of Doctors and Paramedical in the Aspirational District by 2020.
≠ Ensure minimum essential deployment of ANM/MPW in the most affected blocks for malaria.

- Health Management Information

≠ Establishment of daily reporting system as per new HMIS portal by 2019.
≠ Creation of online web portal for reporting of monitoring visits by different levels by 2020.

7.6 Enforcement of regulations for good health:

Enforcement of enabling & preventive measures, if necessary by coercive means remains a necessary elements of public health anywhere in the word. Due to outdated laws & poor enforcement public health in Tripura has not benefited fully from such regulatory support. Govt. will revise such laws & move towards their effective enforcement relying on democratic institution in the state to prevent their abuse.

i) Food Safety: with the passing of the FSSA in India now has a legal framework for ensuring food safety. However the enforcement machinery lacks the capacity to effectively implement to provisions of the act. In addition to strengthening the commission rate of food safety Govt. will leverage capacities available on other departments for technical support (e.g. Laboratory tests) or to administer areas that fall into other areas as sanitation. To respond to increased awareness of food safety & the demand for quality food govt. will scale up the machinery to ensure safe food & beverages.

ii) Public Health Act: Govt. proposes in the draft public health Act 2018 of the GoI. The proposed health protection agency & the public health cadre will be able to implements the provisions of the act effectively.

iii) Drugs & Cosmetics : Govt. will ensure drug safety by regular inspection , monitoring and testing in the laboratories. Proposes to make an online procedure for registration of the drug liscence.

7.7 Reorganization of Government Health System: Govt. health services currently function as a conglomeration of standalone institution. This creates high degree of inefficiency. Govt. will aim to link them in a networked care system with the primary care team providing initial care & assisting individuals navigate through different levels of health system. This call a higher level of organization & management than what health services currently posses. The primary care system in Tripura has concentrated on family planning, maternal & child care ,prevention & management of communicable disease. It is now designed to respond to some of the current challenges as non communicable disease, mental health issues & geriatric care. Govt. intends to revamp the primary care provision to make them assume responsibility for population allotted to them under Ayushman Bharat to provide comprehensive primary health care.

Health Sub Center : Established in every Panchyat or ADC council area and the maximum coverage of population is ranging from 3000 to 5000. Staffing will be 1 ANM & 1 MPW (M).

Primary health centre: Staffing of primary health centers will be reworked with three teams of doctors including Ayush/ Dental & 4 nurse managing a population of 30,000 - 40,000. Only OPD, IPD & field activities will be discharge in PHCs & OPD would be managed in evening hours by turn. The job responsibility of nurses will be revised to assign more patient care

responsibilities to them. Laboratory services will be available at all PHCs. The primary care in difficult to reach will be configured differently.

Community health center: Community Health Center are the block level institutions expected to provide basic specialty services. Considering shortage in specialists such services will be provided only after the requirement s of higher level institutions are addressed. Facilities at the CHC would be utilized as coordinating centers of pain & palliative care, terminal care & community mental health programme. Community health center will be the lowest Unit of the health protection agency & public health cadre.

Sub divisional Hospital: a Hospital with all major & minor specialties, with average bed strength of 50 - 100 provides an optimal level to provide secondary care. It will have such supporting services as emergency services, laboratories, blood bank/blood storage centers & emergency OT services. Basic secondary care services, such as caesarian section and neonatal care would be made available at the least at sub-divisional level in a cluster of few blocks. To achieve this, policy therefore aims:

> To have at least two beds per thousand population distributed in such a way that it is accessible within golden hour rule. This implies an efficient emergency transport system. The policy also aims that ten categories of what are currently specialist skills be available within the district. Additionally four or at least five of these specialist skill categories be available at sub-district levels. This may be achieved by strengthening the district hospital and a well-chosen, well located set of sub-district hospital.

District Hospital: District hospital in the district will have in addition to all major & minor specialties and cover 18 specialties services including developing as Knowledge hub center.

State Hospital: State hospital will have in addition to all major & minor specialties and cover 18 specialties services including developing as Knowledge hub center.

Medical College hospital: Super specialty Services will be provided from the same roof .Act as a model center for training. They will provide the top most level of the networked care system managed by primary care providers.

7.8 Urban Health Care : National health policy prioritizes addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, and temporary migrants. Policy would also prioritize the utilization of AYUSH personnel in urban health care. Given the large presence of private sector in urban areas, policy recommends exploring the possibilities of developing sustainable models of partnership with for profit and not for profit sector for urban health care delivery. An important focus area of the

urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. These dimensions are also important components of smart cities. Healthcare needs of the people living in the peri - urban areas would also be addressed under the NUHM. Further, Non-Communicable Diseases (NCDs) like hyper tension, diabetes which are predominant in the urban areas would be addressed under NUHM, through planned early detection. Better secondary prevention would also be an integral part of the urban health strategy. Improved health seeking behavior, influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism, would also be important components of this strategy.

7.9 National Health Programmes :

7.9.1 RMNCH+A services: Maternal and child survival is a mirror that reflects the entire spectrum of social development. This policy aspires to elicit developmental action of all sectors to support Maternal and Child survival. The policy strongly recommends strengthening of general health systems to prevent and manage maternal complications, to ensure continuity of care and emergency services for maternal health. In order to comprehensively address factors affecting maternal and child survival, the policy seeks to address the social determinants through developmental action in all sectors.

7.9.2 Child and Adolescent Health: The policy endorses the national consensus on accelerated achievement of neonatal mortality targets and „single digit" stillbirth rates through improved home based and facility based management of sick newborns. District hospitals must ensure screening and treatment of growth related problems, birth defects, genetic diseases and provide palliative care for children. The policy affirms commitment to pre-emptive care (aimed at pre-empting the occurrence of diseases) to achieve optimum levels of child and adolescent health. The policy envisages school health programmes as a major focus area as also health and hygiene being made a part of the school curriculum. The policy gives special emphasis to the health challenges of adolescents and long term potential of investing in their health care. The scope of Reproductive and Sexual Health should be expanded to address issues like inadequate calorie intake, nutrition status and psychological problems interalia linked to misuse of technology, etc.

7.9.3 Interventions to Address Malnutrition and Micronutrient Deficiencies: Malnutrition, especially micronutrient deficiencies, restricts survival, growth and development of children. It contributes to morbidity and

mortality in vulnerable population, resulting in substantial diminution in productive capacity in adulthood and consequent reduction in the nation's economic growth and well-being. Recognising this, the policy declares that micronutrient deficiencies would be addressed through a well-planned strategy on micronutrient interventions. Focus would be on reducing micronutrient malnourishment and augmenting initiatives like micro nutrient supplementation, food fortification, screening for anaemia and public awareness. A systematic approach to address heterogeneity in micronutrient adequacy across regions in the country with focus on the more vulnerable sections of the population, is needed. Hence, screening for multiple micronutrient deficiencies is advocated. During the critical period of pregnancy, lactation, early childhood, adolescence and old age, the consequences of deficiencies are particularly severe and many are irreversible. While dietary diversification remains the most desirable way forward, supplementation and fortification require to be considered as short and medium term solutions to fill nutrient gaps. The present efforts of Iron Folic Acid(IFA) supplementation, calcium supplementation during pregnancy, iodized salt, Zinc and Oral Rehydration Salts/Solution(ORS), Vitamin A supplementation, needs to be intensified and increased. Sustained efforts are to be made to ensure outreach to every beneficiary, which in turn necessitates that intensive monitoring mechanisms are put in place. The policy advocates developing a strong evidence base, of the burden of collective micronutrient deficiencies, which should be correlated with disease burden and in particular for understanding the etiology of anaemia. Policy recommends exploring fortified food and micronutrient sprinkles for addressing deficiencies through Anganwadi centres and schools. Recognising the complementary role of various nutrition-sensitive interventions from different platforms, the policy calls for synergy of inputs from departments like Women and Child Development, Education, WASH, Agriculture and Food and Civil Supplies. Policy envisages that the department would take on the role of convener to monitor and ensure effective integration of both nutrition-sensitive and nutrition-specific interventions for coordinated optimal results.

7.9.4 Universal Immunization: Priority would be to further improve immunization coverage with quality and safety, improve vaccine security as per National Vaccine Policy 2011 and introduction of newer vaccines based on epidemiological considerations. The focus will be to build upon the success of Mission Indradhanush and strengthen it.

7.9.5 Communicable Diseases: The policy recognizes the interrelationship between communicable disease control programmes and public health system strengthening. For Integrated Disease Surveillance Programme, the policy advocates the need for districts to respond to the communicable disease priorities of their locality. This could be through network of well-equipped

laboratories backed by tertiary care centers and enhanced public health capacity to collect, analyze and respond to the disease outbreaks.

7.9.6 Control of Tuberculosis: The policy acknowledges HIV and TB co infection and increased incidence of drug resistant tuberculosis as key challenges in control of Tuberculosis. The policy calls for more active case detection, with a greater involvement of private sector supplemented by preventive and promotive action in the workplace and in living conditions. Access to free drugs would need to be complemented by affirmative action to ensure that the treatment is carried out, dropouts reduced and transmission of resistant strains are contained.

7.9.7 Control of HIV/AIDS: While the current emphasis on prevention continues, the policy recommends focused interventions on the high risk communities (MSM, Transgender, FSW, etc.) and prioritized geographies. There is a need to support care and treatment for people living with HIV/AIDS through inclusion of 1st, 2nd and 3rd line antiretroviral(ARV), Hep-C and other costly drugs into the essential medical list.

7.9.8 Leprosy Elimination: To carry out Leprosy elimination the proportion of grade-2 cases amongst new cases will become the measure of community awareness and health systems capacity, keeping in mind the global goal of reduction of grade 2 disability to less than 1 per million by 2020. LCDC is completed in the State for achieving the leprosy elimination stage.

7.9.9 Vector Borne Disease Control: The policy recognizes the challenge of drug resistance in Malaria, which should be dealt with by changing treatment regimens with logistics support as appropriate. Strong component of inter-sectoral collaboration is necessary for prevention and control of vector borne diseases.

7.9.10 Non-Communicable Diseases: The policy recognizes the need to halt and reverse the growing incidence of chronic diseases. The policy recommends to set-up a National Institute of Chronic Diseases including Trauma, to generate evidence for adopting cost effective approaches and to showcase best practices. This policy will support an integrated approach where screening for the most prevalent NCDs with secondary prevention would make a significant impact on reduction of morbidity and preventable mortality. This would be incorporated into the comprehensive primary health care network with linkages to specialist consultations and follow up at the primary level. Emphasis on medication and access for select chronic illness on a „round the year“ basis would be ensured. Screening for oral, breast and cervical cancer and for Chronic Obstructive Pulmonary Disease (COPD) will be focused in addition to hypertension and diabetes. The policy focus is also on research. It emphasizes developing

protocol for mainstreaming AYUSH as an integrated medical care. This has a huge potential for effective prevention and therapy, that is safe and cost-effective. Further the policy commits itself to support programmes for prevention of blindness, deafness, oral health, endemic diseases like fluorosis and sickle cell anaemia/thalassemia,etc. The National Health Policy commits itself to culturally appropriate community centered solutions to meet the health needs of the ageing community in addition to compliance with constitutional obligations as per the Maintenance and Welfare of Parents and Senior Citizens Act, 2007. The policy recognizes the growing need for palliative and rehabilitative care for all geriatric illnesses and advocates the continuity of care across all levels. The policy recognizes the critical need of meeting the growing demand of tissue and organ transplant in the country and encourages widespread public awareness to promote voluntary donations.

7.9.11 Mental Health: This policy will take into consideration the provisions of the National Mental Health Policy 2014 with simultaneous action on the following fronts:

o Increase creation of specialists through public financing and develop special rules to give preference to those willing to work in public systems.

o Create network of community members to provide psycho-social support to strengthen mental health services at primary level facilities and

o Leverage digital technology in a context where access to qualified psychiatrists is difficult.

7.9.12 Population Stabilization: The National Health Policy recognises that improved access, education and empowerment would be the basis of successful population stabilization. The policy imperative is to move away from camp based services with all its attendant problems of quality, safety and dignity of women, to a situation where these services are available on any day of the week or at least on a 14 fixed day. Other policy imperatives are to increase the proportion of male sterilization from less than 5% currently, to at least 30% and if possible much higher.

8. Women's Health & Gender Mainstreaming: There will be enhanced provisions for reproductive morbidities and health needs of women beyond the reproductive age group (40+) This would be in addition to package of services covered in the previous paragraphs**.**

9. Gender based violence (GBV): Women's access to healthcare needs to be strengthened by making public hospitals more women friendly and ensuring that the staff have orientation to gender –sensitivity issues. This policy notes with concern the serious and wide ranging consequences of GBV and recommends

that the health care to the survivors/ victims need to be provided free and with dignity in the public and private sector.

10. **Mainstreaming the Potential of AYUSH:** The policy ensures access to AYUSH remedies through co-location in public facilities. Yoga would be introduced much more widely in school and work places as part of promotion of good health as adopted in National AYUSH Mission (NAM). Further the development of sustainable livelihood systems through involving local communities and establishing forward and backward market linkages in processing of medicinal plants will also be supported by this policy. The policy seeks to strengthen steps for farming of herbal plants. Developing mechanisms for certification of prior knowledge of traditional community health care providers and engaging them in the conservation and generation of the raw materials required, as well as creating opportunities for enhancing their skills are part of this policy.

11. **Mid-Level Service Providers:** For expansion of primary care from selective care to comprehensive care, complementary human resource strategy is the development of a cadre of mid-level care providers. Equip them with skills to provide services at the sub-centre and other peripheral levels through a IGNOU certified course of 6 months.

12. **Nursing Education:** The policy recognises the need to improve regulation and quality management of nursing education.

13. **Public Health Management Cadre:** The policy proposes creation of Public Health Management Cadre in the State based on public health or related disciplines, as an entry criteria. The policy also advocates an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals.

14. **Disaster Management :** Area where collaboration with private sector would enable better outcomes especially in the areas of medical relief and post trauma counselling/treatment. A pool of human resources from private sector could be generated to act as responders during disasters. The private sector could also pool their infrastructure for quick deployment during disasters and emergencies and help in creation of a unified emergency response system. Additionally sharing information on infrastructure and services deployable for disaster management would enable development of a comprehensive information system with data on availability and utilization of services, for optimum use during golden hour and other emergencies.

15. **Anti-microbial resistance:** The problem of anti-microbial resistance calls for a rapid standardization of guidelines, regarding antibiotic use, limiting the use of antibiotics as Over-the-Counter medication, banning or restricting the use of antibiotics as growth promoters in animal livestock. Pharmaco-vigilance including prescription audit inclusive of antibiotic usage, in the hospital and community, is a must in order to enforce change in existing practices. State has to developed its own Anti Microbial policy in implementation.

16. **PMJAY** : As per Socio Economic Census data almost 5 lakhs families and approximately 20 lakhs peoples will comes under this umbrella. State will do a special drive to enrol the beneficiaries in mission mode by 2020 March.

17. **Health Survey** : State will periodically conduct health survey on the identified indicators by a special team and the result will analyse to take corrective measures .

18. **Health Research** : State will promote the research activities on the specific health issues of the State which is cleared by the Ethical committee. The result will incorporate in the planning of the implementation of the various activities.

19. **Governance :** Health is a multidimensional field and involvement of all sectors is essential for achieving good health. Involvement of public representatives in the planning process and decision making is essential to achieve the objectives.