Demands of Ground Level Panellists in the context of the National Health Policy

Compilation of findings of Ground level Panels on Health Facilitated by Praxis in 2017

Part of By the People, a project facilitated by Oxfam India, Centre for Social Equity and Inclusion and Praxis- Institute for Participatory Practices supported by European Union
1. Context of the Project and Ground Level Panels

The project By The People: Civil Society Organisation Led By Members Of Marginalized Communities Influencing Governance Processes For Inclusive Development aims at enhancing the leadership capacity of individuals from the most marginalised sections of society in six states of India. Oxfam India, Centre for Social Equity and Inclusion (CSEI) and Praxis-Institute for Participatory Practices have partnered together and with funding from the European Union, they support 55 Community Led Organisations (CLOs) in Bihar, Chhattisgarh, Delhi, Jharkhand, Odisha and Uttar Pradesh, which are spearheaded by motivated leaders from Dalit, Tribal and Muslim communities to advocate for an equitable and inclusive society. The four themes that the project focuses on are education, food and nutrition, health and forest rights.

While capacity building across a series of organisational development areas is on-going with the CLOs, one of the project activities is organising ground level panels (GLPs). A Ground Level Panel (GLP) is an inversion of the traditional High level Panel of experts and academicians. Community Led Organisations (CLOs) develop and facilitate a GLP in order to promote the Community’s Evidence Based Advocacy (CEBA) in order to address a key issue identified by the CLOs that is impacting the concerned community. It is a forum to bring together marginalised identities that have the lived experience of an issue, and in that capacity are ‘experts’ on that issue. The main purpose of any GLP is to analyse provisions of the policies from the lens of lived experience. The organising and formation of the GLP is a means of collecting, analysing and formalising community issues in a planned step which is completely led by community leaders and taken forward to larger Civil Society Organisations (CSOs) and stakeholders including government in the form of policy advocacy. Through these processes, the excluded communities not only got an opportunity to raise the issues but also discussed ways and means to resolve them through local advocacy initiatives including charter of demands submitted to the line authorities.

During the year 2017, 14 GLPs were organised in which more than 787 community leaders from Dalit, Muslim and Tribal communities actively participated reaching out to representatives from CSOs, networks, government representatives, individuals, etc. has set the tone for thematic advocacy process. Of the 14, there were four GLPs conducted on health with people from marginalised communities, in Bihar, Delhi, Jharkhand and Uttar Pradesh.

2. Background to the National Health Policy 2017

The 2017 National Health Policy (NHP) was presented as an attempt to respond to a number of different issues that had become more critical since the 2002 Policy was launched. The introduction to the Policy references soaring levels of healthcare expenditure as affecting many households, as well as increases in certain non-communicable and infectious diseases. It also mentions the rapid growth of the healthcare industry, as well as a rising economic growth which contributes to a larger fiscal capacity.

The NHP claims that its key aim is to “inform, clarify, strengthen and prioritise the role of the Government in shaping health systems in all its dimensions.” It references the Government’s role in terms of organising services, enabling access to technologies, strengthening financial protection strategies and health assurance.

With the National Health Protection scheme set to be announced on August 15th 2018, to cover more than 10 crore poor and vulnerable families (around 50 crore beneficiaries) it is timely to consider some
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of the issues that it will need to address in order to be successful. Clearly, the scheme’s engine must be the adequately resourced, good quality, accessible and effective services that the NHP sets out to achieve: since an assurance scheme without such services will simply not run.

3. Ground Level Panels on Health

Set against this backdrop, the need for a dialogue between different stakeholders becomes important to understand the grass-root level situations and fill in gaps for meaningful implementation of the NHP and related measures. In order to provide a platform for dialogues and to hear the experiences of people from marginalised communities, four Ground Level Panels were conducted in 2017.

The panels, during the conception and preparation phase, had two sets of aims. Related to the overall policy environment, one aim was to generate statements on what is required to ensure the health rights of marginalised people. Another was to contribute to the argument and the discourse on a right to health in India, whilst illuminating ways in which government policies can be better implemented to reach the most excluded.

Related to broader processes of democratisation and empowerment, the purposes of the GLP were to support socially excluded people, and people living in poverty, to become agents of awareness-generation and of change within their own communities: through critical reflection on their own experiences. By involving local service providers in discussions, the GLPs also provided a platform for liasoning with government agencies.

Thematically, there included a focus on certain critical health issues, including sexual and reproductive health of adolescent girls and women; and health care providers; and health as a right.

Some key characteristics of the panellists are detailed in the image below:

- A young man who works with a local CBO on a range of health-related issues
- Children pursuing education
- People with experience of being patients at government hospitals
- Mainly female, including adolescent girls
- People living in rural areas
- Health service providers
- A young man who volunteers with a local CBO and supports migrant labourers with their health-related issues
- People from dalit and tribal communities
- Members of religious minority communities, including Muslims
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Participants joining the GLPs in the various areas brought different sets of experiences and strengths. In some cases, the process itself appeared to lead to considerably raised awareness levels among community members, including the conscientisation of some members around key issues related to health.

In Patna, a total of 15 people from three different districts of Bihar – Buxar, Patna and Nalanda – came together as representatives of 700 villagers. 100 adolescents have asked the Governor and Health Minister to meet the demands of the panel. The panel has conducted awareness campaigns in 5 villages and also undertaken village resource mapping and a case study.

In Ranchi, the panellists learning about malnutrition has led to commitments to raise awareness among women and children of target villages in relation to health, hygiene, sanitation and nutrition in their villages. The panellist also committed to promote the practice of kitchen gardening.

In Bahraich, the diverse group arrived from various towns and villages. All the panellists fall within the age group of 20 to 35. They all mentioned the problem of non-maintenance of cleanliness and hygiene. They shared that it is very important to implement the schemes and policies governing health and sanitation, in order to ensure a healthy living. They observed that in their locality, lack of cleanliness has been one of the key reasons for illness.

In New Delhi, the group was a socially diverse group accessing private and government hospitals. Economically, the group was disadvantaged. A number of the participants reside in bastis. There are also a number of migrant labourers among them.
4. Findings of Ground Level Panels
4.1 Perspectives on various aspects of health and healthcare

- There should be an emphasis on proper implementation of the health policy, and sound delivery of healthcare provisions.
- Discriminatory practices by healthcare providers should be stopped.
- People should use clean drinking water as it prevents 75% of diseases.
- There should be different kinds of health services, appropriate to community needs.
- Community practices such as superstitious beliefs that serve to worsen nutritional status should be challenged, and there should be efforts to bring change, in which male members should also participate.

Those in positions of responsibility with whom adolescent girls interact should be provided with sanitary napkins and oriented to distribute them to girls free of cost.

Husbands and partners should also be engaged on these issues and encouraged to participate in the struggle against GBV, so that there is a positive change within the society.

We should also be careful to use clean drinking water so we don’t fall ill.

People in positions of responsibility with whom adolescent girls interact should be provided with sanitary napkins and oriented to distribute them to girls free of cost.

Community people should be informed about the health provisions that they are entitled to.

Community people should be informed about health provisions that they are entitled to.
### 4.2 SDG Mapping

The discussions of the panellists were also mapped against the Sustainable Development Goals.

<table>
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<tr>
<th>SDG Goal</th>
<th>SDGs and Targets</th>
<th>Problems Identified and Inferred</th>
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| 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture | **2.1** By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round  
**2.2** By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons | - Some infants are not being breastfed  
- Some women are not receiving nutritive food  
- Many children are still malnourished  
- There are some community practices such as superstitious beliefs that serve to worsen nutritional status |
| 3. Ensure healthy lives and promote well-being for all at all ages | **3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births  
**3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes  
**3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | - Some children die because they are not able to access health services in the village  
- Some communities are not able to access health services  
- Healthcare providers are following discriminatory practices, especially towards dalits, muslims, and other marginalized groups  
- Some socio-economically disadvantaged groups are not able to access government health services because they cannot pay bribes |
| 5. Achieve gender equality and empower all women and girls | **5.1** End all forms of discrimination against all women and girls everywhere  
**5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of | - Women and adolescent girls (when married, or in the context of a sexual relationship) do not have sufficient decision-making power in terms of when conceiving, how many children to conceive etc.  
- Many adolescent girls do not have access to sanitary |
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<td></td>
<td>their review conferences</td>
<td>napkins or know how to use them</td>
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<td>▪ Many young people are not aware about sexual and reproductive health</td>
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<td>6. Ensure access to water and sanitation for all</td>
<td>6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all</td>
<td>▪ People in certain communities are still not able to access clean drinking water. This leads to a lot of health problems.</td>
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<td></td>
<td>6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations</td>
<td>▪ Areas surrounding where people live, work and access services are insanitary</td>
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<td>▪ Many sanitation workers do not have the proper equipment they need to keep the surroundings sanitary (by cleaning drains etc)</td>
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<td>▪ Many homes do not have toilets</td>
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<td>16. Promote just, peaceful and inclusive societies</td>
<td>16.5 Substantially reduce corruption and bribery in all their forms</td>
<td>▪ Bribery exists in certain government hospitals</td>
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4.3 NATIONAL HEALTH POLICY 2018: An overview

The NHP sets out its goal as: “the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all development policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery. The policy recognises the pivotal importance of the Sustainable Development Goals (SDGs).”

The NHP also seeks to integrate a number of key principles (see Annexure 2) as well as objectives, and targets that detail a wide range of intended impact areas.

The thrust areas of the NHP include adequate investment, preventive and promotive health, organisation of public health care delivery, primary care services and continuity of care, secondary care services, the re-orientation of public hospitals, urban health care, child and adolescent health, nutrition, immunisation, communicable and non-communicable diseases, mental health and population stabilisation. An additional set of issues, including women’s health and gender mainstreaming, and gender based violence, also attended to within the policy framework.
4.4 NATIONAL HEALTH POLICY 2018: Perspectives from the ground level panel members

As all GLP members are from marginalised communities, and all are service users speaking from lived experience of the healthcare system, their perspectives are especially helpful in illuminating challenges for implementation, as well as ways in which the policy can be better implemented on the ground. Whilst the GLPs were not designed to comment on all aspects of NHP, a number of areas that speak directly to implementers were covered during the sessions.

The participant reflections are presented below under relevant sections of the policy:

NHP Section 3.2 Preventive and Promotive Health

The policy institutionalises inter-sectoral coordination, nationally and sub-nationally. Coordinated action on seven priority areas for improving the environment for health will be delivered through Swachh Bharat Abhiyan; healthy diets and regular exercise; addressing abuse of intoxicants; preventing deaths due to rail and road traffic accidents; action against gender violence; lower stress and improved safety in the workplace; lowering indoor and outdoor pollution. The policy identifies the need for development of strategies and institutional mechanisms in each of these areas, in order to create Swasth Nagrik Abhiyan – a social movement for health.

The policy recommendations include coordinated action on seven priority areas for improving the environment for health:

- The Swachh Bharat Abhiyan
- Balanced, healthy diets and regular exercises
- Addressing tobacco, alcohol and substance abuse
- YatriSuraksha – preventing deaths due to rail and road traffic accidents
- Nirbhaya Nari – action against gender violence
- Reduced stress and improved safety in the workplace
- Reducing indoor and outdoor air pollution

Reflections of the participants: According to some participants, due to lack of toilets inside houses they go for open defecation due to which there is high vulnerability to catch different kinds of diseases. Children die because of the lack of timely treatment in the village. It is very important to keep the surroundings clean so that we don’t fall ill. Further, so as to decrease the mortality rate among children and women it is very important for the children to be breastfed and for the women to have nutritious food. There should be encouragement of a balanced, healthy, and hygienic diet, including meals at regular intervals.

Cleanliness should be properly maintained within the households and waste disposed in the right place. Due to lack of toilets inside houses they go for open defecation, due to which there is high vulnerability to catch different kinds of diseases. There should be toilets in each household. To promote sanitation, the environment, especially that surrounding where people live, work, and access services, should be kept clean to prevent illnesses. Clean drinking water should be ensured and there should be facilities available to enable access to it. Overall, sanitation and hygiene should be given a high priority. Measures should be taken to ensure cleanliness at the household level, including proper management and disposal of waste. Toilets should be provided inside homes to prevent the spread of disease through open defecation. There should be special measures taken to ensure that sanitation workers (those who clean drains etc.) have the equipment they need to be healthy and hygienic.

The policy recommendations also include strengthening Village Health, Sanitation and Nutrition
Committee (VHSNCs) and its equivalent in the urban areas.

**Reflections from GLP participants:** With respect to VHSNCs, it is important that meetings are held as per the rules. There is a range of ways in which VHSNCs should be strengthened. In quarterly reports of VHSNCs, along with income and expenditure, they should be guided to mention progress in their work, as well as minutes of meetings. VHSNCs should also be trained well in order to be able to improve and strengthen health services. Further, VHSNCs should also be supported to use modern technologies and their capacity built in order that they are able to reach out to the local community effectively and influence them. There should also be efforts to ensure that the overall environment within the local community (including various influencers and institutions) are conducive to the work of VHSNCs.

It would be good if a district level official sits on VHSNC meetings, to strengthen their work and encourage accountability. There should be district level support to ensure that schemes available through the VHSNCs are accessible and realizable for all community members. Furthermore, on Village Health and Nutrition Day, a table and curtains should be provided, so that pre-natal examinations can be undertaken. The VHSNC should also be provided with the task of identifying defective hand-pumps (for example, those that are supplying polluted water) and repairing them in a systematic way. This responsibility should be standardized and laid out in policy.

The policy recommendations include making arrangements to ensure that ASHAs are supported by other frontline workers such as health workers (male/female) to undertake preventative activities for non-communicable diseases.

The reality is that because of lack of timely treatment in the village, some children die. Primary Health Centres (PHCs) should take a proactive approach, reaching out to all community members and ensuring they are aware of services the PHCs provide, as well as relevant information concerning health promotion and illness prevention. Further, anganwadi workers should go door to door and provide women and children with proper immunization, in order to prevent illness. Special attention should be given to lactating mothers.

**NHP Section 3.3 Organisation of public health care delivery**

Seven key shifts are proposed, in primary care; secondary and tertiary care; public hospitals; infrastructure and human resource development; and in urban health.

**Reflections of participants:** One participant, after falling ill, went to a government hospital, where he saw a huge queue. But he later observed that those people who had contacts with the officers in the hospital did not have to wait in the queue and they were given the receipt quickly. However he said he was standing at the queue for a long time, when he got the receipt he had to again stand at the queue where they write the number on the receipt because of which his health was deteriorating. He said even till date such kind of discrimination persists in the government hospital. Whilst the various measures outlined in the policy might be necessary and helpful, there also needs to be focus on endemic problems such as bribery and discrimination, which prevent equitable access to healthcare.

Another participant said he was having some pain in his eyes so he went to Sardar Vallabh Bhai Patel hospital located at Patel Nagar. His eye was checked but he was not asked to use spectacles. He observed that majority of the patients in the hospital were asked to use spectacles, he was asked to visit again the next day. When he went the next day he was asked to visit after ten days, he visited after ten
days then he was not given any appointment. He says till date he does not have spectacles because of which he faces difficulties while reading and writing.

**NHP Section 3.3.1 Primary Care Services and Continuity of Care**

Health and Wellness Centres are envisaged as providing a larger package of comprehensive primary health care. To achieve the desired outcomes, every family must have a health card and this be linked to a primary health care facility, established on geographical norms. It would require human resource development, logistical support and referral backup. It would also require upgradation of existing sub-centres and the re-orienting of PHCs in order to provide comprehensive preventive, curative and rehabilitative services. It would involve access to AYUSH services and the validation of local home and community based practices, and enable research and validation of tribal medicines. Using digital technology, the policy seeks to support two way systemic linkages between various levels of care – primary, secondary, and tertiary, in order to promote continuity of care. Further, a gatekeeping mechanism is advocated at the primary level, in a phased manner, in addition to robust systems for feedback and action.

**Reflections of GLP participants:** There should be a review into the steps to be taken in order to improve public health centres. Strategies for the village should be formed on the basis of physical examinations of people and determining of their health needs. Availability of doctors in the hospital for timely treatment of patients is important. Whatever facilities are there in India related to health, they should be implemented properly.

**NHP Section 4 National Health Programmes**

**NHP Section 4.3 Child and adolescent health**

The policy emphasises accelerated achievement of neo-natal and still-birth mortality rates, through improving neo-natal care at home and in hospitals. This is understood to mean screening and treatment of children, including pre-emptive care. Adolescents should be a key focus. School health programmes should be integrated into the curriculum and reproductive and sexual health should be addresses in a holistic way.

**Reflections of GLP participants:** There should be timely immunisation of children. Adolescent girls are trained and taught about menstrual hygiene.

**NHP Section 4.4 Interventions to Address Malnutrition and Micronutrient Deficiencies**

**Reflections of GLP participants:** Iron pills should be among the supplements made available at all government institutions. Lactating mothers should take nutritious food and children should be breastfed.

**NHP Section 6 Gender based violence (GBV)**

The policy says that women’s access to healthcare needs to be strengthened, by making public hospitals more gender inclusive, including through training of staff. Dignity of survivors of GBV is a key principle and should be promoted and enabled.

**Reflections of GLP participants:** Violence takes not only physical forms, but also emotional, including coercion. The GBV issues that healthcare practitioners should be sensitised on include child marriage, rape, marital rape, female foeticide, and dowry related violence. Healthcare practitioners should therefore be made aware of these practices and trained to identify risks among the community within which they serve. Their capacities should be built to the extent that they are able to raise their voice in
defence of vulnerable and affected women, and take preventative and remedial action on these matters, in concert with law enforcement agencies, social protection agencies, and other relevant parties.

5. Demands regarding health and healthcare

The GLP participants articulated a number of other healthcare related demands that find support within the key policy principles of the NHP, but not within the thrust areas. This means that whilst NHP has expressed commitment in terms of principles, it has not necessarily spelt out the required specific policy measures that would promote the realisation of the principles.

In order to inform future NHP cycles, necessary legislation and related policies the demands are set out below, under six relevant NHP 2018 policy principles.

I. Professionalism, Integrity and Ethics

- The practice of asking for bribes from patients has a particularly negative effect on the poorest communities, since they are less likely to be able to pay. Thus, there should be special efforts to ensure that socio-economically disadvantaged sections (including Dalits and Muslims) are never asked to pay a bribe, since this can actually mean, in many cases, that they do not get proper treatment, due to which the health of patients, or would-be patients, suffers unduly.
- Pregnant mothers were among the groups over whom particular care should be taken, since there can be considerable impacts from them not being able to access treatment, including on the health of the child yet to be born.

II. Equity

- Providers should review their practices towards Dalits, Muslims, and other marginalized groups, including all economically weaker sections.
- Providers should ensure that all patients are treated equally, respecting their full dignity and human rights, and ensure equitable access to services and good quality treatment. Respecting the Constitutional Right to Life, no person should be prevented from accessing treatment simply because they lack the required documents, or because they are unable to pay a bribe.

III. Universality

- Transport should also be provided in order to enable patients from all communities to access services.
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- There should be supply of services to meet demand. It should be ensured that there is one PHC for every 10,000 people, and one bed available for each patient.
- Doctors must be available at each PHC, along with ANM.

IV. Patient Centred and Quality of Care

- There should be a session on menstruation twice a week, especially for those girls above 9 years of age. These sessions should include ASHAs, AWWs, AWHs as well as school teachers.
- Sessions on sexual and reproductive health should be arranged with adolescent boys at PHCs.
- Sanitary napkins should be made available for free at various local institutions including PHCs and AWCs.
- There should be a helpline set up for adolescent girls.
- Primary Health Centres service provision also needs to be significantly improved. Minimum standards should include:
  - Providing all necessary medicines
  - Facility to conduct all basic diagnostic tests
  - Provision to conduct all kinds of vaccinations, particularly for children, in order to immunize populations from diseases from which they are at risk
  - Anganwadi centres should provide uniforms to children, which will have the benefit of encouraging attendance.
  - Health centres at the block level should be equipped with the necessary resources such as medicines and female doctors.

V. Accountability

- There should be monitoring of all health centres to ensure that they are delivering the right services.
- In order to make Anganwadi centres more accountable, a committee should be formed to take on this task of ensuring accountability.
- Additionally, it will be important to ensure that the EWS grievance redressal committee comprises a social worker from that community.

VI. Inclusive partnerships

- Organisations with access to and influence within the community should be informed about health issues and about healthcare facilities available to people from economically weaker sections.
- In the context of the multi-stakeholder approach advocated by the NHP, and its stated cross-sectoral goals, related to health, it should be ensured that:
  - The names of malnourished children are registered at Malnutrition Treatment Centres and Nutrition Rehabilitation Centres, and the relevant staff should be given the responsibility to take action accordingly.
  - For purposes of advocacy on malnutrition issues, a high level committee should be formed, which should meet at least once a month to investigate malnutrition status within the designated area for which it is responsible.
  - In order to check and monitor implementation of schemes related to malnutrition, a committee at district level is formed.
  - Measures should be put in place by which state governments are able to reduce the malnutrition rate in all the districts to reasonable levels, and Governments must commit to doing so as a matter of policy.
Annex 1: Names of the panellists

Bihar GLP organised by Gaurav Gramin Mahila Vikas Manch, Madad, Dashra
Panellists
1. Vibha
2. Kumari
3. Naz Praveen
4. Ranju Kumari
5. Musharat Praveen
6. Rupa Kumari
7. Asha Devi
8. Kricha Kumari
9. Priya Kumari
10. Pramila Kumari
11. Pushpa Devi
12. Khushbu Kumari
13. Savitri Devi
14. Priyanka Kumari
15. Sudha Kumari

Ranchi GLP organised by ASHA (Association for Social and Human Awareness), Lok Prema Kendra
Panellists
1. Puja Tiwari
2. Shamu Kashap
3. Karmu Mundka
4. Bahlen Mundka
5. Nirmlal Kada
6. Saraswati Devi
7. Leela Devi
8. Muni Devi
9. Meena Kashap
10. Chotu Gaom
11. Anu Kumar
12. Saroj Tiwari
13. Anita Kashap
14. Bilasi Kumari
15. Priski Lasuru
16. Sunita Hora
17. Renu Devi

Delhi GLP organised by Nai Umang Naiy Soch Society, Ideal Youth Health Welfare Society, 4 B Foundation, Labour Education Development Society, Yuva
Panellists
1. Pawan Kumar
2. Ajay Kumar
3. Pooja
4. Durgasha Devi
5. Maya Devi
6. Rubina Umar
7. Savitri Devi
8. Rekha Balraj
9. Kavita
10. Mangeeta
11. Sheetal
12. Pinki
13. Mukul
14. Rohit
15. Vipin
16. Sunil
17. Abhishek
18. Shaalu
19. Sachin
20. Priyanka

Bahraich GLP organised by Musahar Seva Sansthan, Pratinidhi, Samudayik Kalyan Evam Vikas Sansthan, Samaj Seva Sansthan
Panellists
1. Sufiyan Khan
2. Aayesha Begum
3. Gudiya Begum
4. Yasmi
5. Salma
6. Sangeeta Devi
7. Hina
8. Sheela
9. Nayma
10. Anil
11. Noorbano
12. Noorjahan
13. Vigu Gupta
14. Uma Devi
15. Leelavati Devi
16. Arjun Yadav
17. Zulfikar Ansari
18. Anita Devi
19. Sunita Kumari
Annex 2: NATIONAL HEALTH POLICY 2018 (extract)

2. Goal, Principles and Objectives

2.1 Goal

The policy envisages as its goal the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

The policy recognises the pivotal importance of Sustainable Development Goals (SDGs). An indicative list of time-bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions is detailed at the end of this section.

2.2 Key Policy Principles

I. Professionalism, Integrity and Ethics: The health policy commits itself to the highest professional standards, integrity and ethics to be maintained in the entire system of healthcare delivery in the country, supported by a credible, transparent and responsible regulatory environment.

II. Equity: Reducing inequity would mean affirmative action to reach the poorest. It would mean minimising disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers. It would imply greater investments and financial protection for the poor who suffer the largest burden of disease.

III. Affordability: As costs of care increases, affordability, as distinct from equity, requires emphasis. Catastrophic household healthcare expenditures defined as health expenditure exceeding 10% of its total monthly consumption expenditure or 40% of its monthly non-food consumption expenditure, are unacceptable.

IV. Universality: Prevention of exclusions on social, economic or on grounds of current health status. In this backdrop, systems and services are envisaged to be designed to cater to the entire population, including special groups.

V. Patient Centred & Quality of Care: Gender sensitive, effective, safe, and convenient healthcare services to be provided with dignity and confidentiality. There is need to evolve and disseminate standards and guidelines for all levels of facilities and a system to ensure that the quality of healthcare is not compromised.

VI. Accountability: Financial and performance accountability, transparency in decision making, and elimination of corruption in healthcare systems, both in public and private.

VII. Inclusive Partnerships: A multi-stakeholder approach with partnership and participation of all non- health ministries and communities. This approach would include partnerships with academic institutions, not for profit agencies and healthcare industry as well.

VIII. Pluralism: Patients who so choose and when appropriate, would have access to AYUSH care providers based on documented and validated local, home and community-based practices. These
systems, interalia, would also have Government support in research and supervision to develop and enrich their contribution to meeting the national health goals and objectives through integrative practices.

**IX. Decentralization:** Decentralisation of decision making to a level as is consistent with practical considerations and institutional capacity. Community participation in health planning processes, should be promoted side by side.

**X. Dynamism and Adaptiveness:** constantly improving dynamic organisation of healthcare based on new knowledge and evidence with learning from the communities and from national and international knowledge partners is designed.

**Objectives**

Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

**Progressively achieve Universal Health Coverage**

Assuringavailability of free and comprehensive primary healthcare services for all aspects of reproductive, maternal, child and adolescent health as well as for the most prevalent communicable, non-communicable and occupational diseases in the population. The Policy also envisages optimum use of existing manpower and infrastructure as available in the health sector and advocates collaboration with non-government sector on pro-bono basis for delivery of health care services linked to a health card to enable every family to have access to a doctor of their choice from amongst those volunteering their services.
Demands of Ground Level Panellists in the context of the National Health Policy

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