

# Universal Health Coverage:

## A Community Perspective from Northeast India

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### Report of a Regional Consultation on Universal Health Coverage held in Shillong, Meghalaya

July 16 – 17, 2019

Organised by:

North East Network, Shillong; Public Health Foundation of India, Delhi; Self-Employed Women's Association, Ahmedabad; Indian Institute of Public Health, Shillong, with support of the World Health Organisation, India office.

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Disclaimer: The opinions, views and ideas expressed in this Report are based on the deliberations at the Shillong Consultation and do not necessarily reflect the official position of the World Health Organization.

# Report of Shillong Consultation on Universal Health Coverage (UHC)

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## **Executive Summary:**

The Shillong consultation on Universal Health Coverage (UHC) -- focused on India's Northeast (NE) states -- saw civil society and grass root groups from the region calling for renewal of public health care that was responsive to the special needs and circumstances of communities living in the region.

The inaugural speakers in the workshop emphasized that UHC entailed a strong government role in ensuring provision of quality health services. They also stressed a reduction in Out Of Pocket Expenditure (OOPE) of households and individuals and presented a model by which this could be achieved. OOPE accounts for 60 per cent of total health expenditure in India. A key issue in UHC is of ensuring that no one is left behind in the access to public health care.

Speakers in the various sessions explained that official data from the NE states revealed that substance abuse – alcohol, narcotic drugs and tobacco – was one of the main challenges affecting health in the NE. The need for primary health care with services for treatment and rehabilitation of addicts was an urgent community priority, participants stressed. They identified alcoholics, drug and tobacco addicts, physical or mentally disabled and single mothers as the most socially marginalised groups in the NE.

Although many of the NE states has amongst the highest health spending in the country, the outcomes on basic health indicators showed a mixed picture in terms of improvement. These indicators -- which showed State variation within the NE region -- related to data on mortality amongst infants and children under-five years of age, maternal deaths, imbalance in sex ratio, poor access to health services and high malnutrition rates.

NE participants stressed the need for accurate official data based on an understanding and assessment of ground realities. These needed to take into account the social factors that explained why communities did not benefit from health programmes and services.

The Consultation highlighted the linkages between cash-strapped communities and the absence of livelihood security, to deteriorating nutrition and health indices. The link between balanced agriculture practices, where the move towards cash crop cultivation was nuanced with a concern for nutrition and local food self-sufficiency, was stressed.

The limited government investment in public health services had led to the growth of corporate and private sector medical services in some states like Assam. Participants shared their view that these providers were driven by the profit motive, and had no commitment to health promotion and encouraging life-style change. Inaccessible terrain, lack of transportation, absence of basic primary health facilities and untrained and insensitive health personnel further compounded the reach of public health care.

Several NE groups had, however, demonstrated pioneering initiatives that were a model for the rest of the country, and shared these approaches and efforts during the Consultation. The Meghalaya Health Insurance Scheme of the State government is one such example. A programme of mental health counseling and standardised treatment at the community level in Bodoland, Assam, by an NGO, was another effort to meet community needs.

The Consultation saw a strong demand for the inclusion of traditional healers and medicines that have long been a part of NE health experience and faith. NE participants emphasised how the rich gene pool of the region had enabled food from the daily diet to also work as medicine that ensured health. Concerned by fast changing life-style influences, participants said there was need to reinforce this wisdom and knowledge through public education.

Discussion on the way forward, at the end of the deliberations, saw representatives of the six states chalking out plans for what they would do to make UHC part of a strong social movement that institutionalizes dialogue, action and monitoring of public health programmes, with partnerships between local people, communities and government.

### **Summary of existing and emerging health issues in the NE states:**

1. Drug/substance abuse (alcohol, tobacco) are not being addressed by the health system and are major public health issues.
2. Traditional medicine and healers need to be included in the health system of the NE states.
3. Meghalaya's health insurance system is an example of good practice, but it should include suicide and alcoholism in its coverage.
4. Skewed sex ratios in several states of the NE: Nagaland, Sikkim and Arunachal Pradesh have to be addressed.
5. Young people's/adolescents health issues especially sexual and reproductive health issues require attention.
6. Malnutrition is still a serious issue in the NE though it was a rich biodiversity region with long tradition of healthy food practices. Processed foods and obesity was becoming an issue also.
7. Lack of awareness on health is widespread. There is a need for health education and information.
8. Pradhan Mantri Jan Arogya Yojna, PMJAY, part of the new Ayushman Bharat programme is not universal; there are enrolment and renewal issues that need to be addressed.
9. TB continues to be a serious health issue in the region.
10. Social Determinants of Health (SDH) need more attention, especially livelihoods, nutrition, water and sanitation and gender equality.
11. The NE states face repeated and devastating disasters like floods and landslides. The public health system needs to be more alert to this reality and plan accordingly.

## **Public Health System Issues to be addressed:**

1. While there is better health infrastructure (buildings), there is still a gap in human resources for health. Doctor availability continues to be an issue, and the terrain poses challenges for health workers.
2. Regular supplies of medicines and equipment, as well as diagnostic tests are major issues--there continue to be gaps in supply.
3. Wastage of medical supplies needs proper attention and management interventions.
4. The working conditions of local ASHA health workers need attention---especially timely payment of their remuneration and the amount itself, given all that they do for their communities.
5. Data on diseases and on some health issues is not reliable. Authentic data for proper planning and management is needed.
6. Immunization in some states needs to be improved, through better public awareness and timely availability of vaccines.
7. Transport---for patient referrals and for delivery of timely medical supplies---continues to be a challenge, especially because of the terrain.
8. People have lost faith in the public health system in some states due to the insensitivity of health care providers. Women, in particular, face insensitivity and lack of caring during child-birth.
9. In some states like Assam, competition from the private sector was weakening an already weak public health system.
10. Local human resources, especially front-line healers like traditional birth attendants and herbal healers, needed integration into the public health system.



## Consultation on Universal Health Coverage in Northeast India



Participants at the Shillong Consultation on UHC

### The Shillong Consultation: Leaving no one behind

A Consultation on Universal Health Coverage (UHC) focusing on Northeast India assumed significance for its discussions on the needs and priorities of people living in the eight states of this region. Given their unique history, culture and geography the Consultation underlined a nuanced approach to their special circumstances, realities and needs.

Extending strong support to the Government of India's policy commitment on Universal Health Coverage (UHC), Northeast civil society groups said it was an important step forward for the region. The core concept of UHC – ensuring that no one was left behind – was of special relevance in this region composed of myriad tribes, races and linguistic groups.

Although government data showed that states here spend more per capita on public health than the rest of the country, its impact would be better felt through a decentralized approach. Rather than a 'top down approach', government policies needed to respond to community voices deciding their own health needs and priorities. Ensuring a process facilitating community dialogue, as also consultation between civil society and state governments was key to ensuring positive outcomes through UHC, participants said.

Held in Meghalaya, the 'abode of the clouds', the capital city Shillong, saw a gathering of over 70 civil society and grass root workers on July 16 and 17, 2019, from six of the eight Northeast states: Meghalaya, Assam, Nagaland, Tripura, Mizoram and Manipur. It also included some public health specialists who were invited from other parts of the country.

The event was organised by the Northeast Network (NEN), Self-Employed Women's Association (SEWA) and Indian Institute of Public Health—Shillong, (a part of the Public Health Foundation of India-PHFI), with technical support from the World Health Organisation (WHO) country office, India.

Public health experts at the Shillong Consultation provided an understanding of the concepts and goals of UHC. They highlighted international and regional experience on how UHC was being implemented and the lessons to be drawn. Official data was used to explain key health issues affecting the Northeast (NE) region. There was a sharing of experiences and perceptions by civil society groups from within the NE about their realities. Also presented were several examples from the region that demonstrated pioneering health care and delivery models that the rest of India could learn from.

The Consultation also focused on connecting the dots to understand how social factors determined good health. These dots linked nutrition to agriculture policy and public education on the role of food in ensuring health. It stressed public health infrastructure that supported disease cure and prevention interventions. It highlighted the need for livelihood that enabled purchasing power and access to health.

### **Inaugural Session:**



### **Universal Health Coverage in India: The way forward**

At the time of Indian independence, India had a philosophical commitment to ensure public health services, but it was “gross under-resourcing” that led to a decline in public health, said Dr. Srinath Reddy, President, Public Health Foundation of India in his inaugural address. The gap in health services was then filled by private providers, and with liberalization in the 1990's, there was the growth of corporate hospitals.

This inadequate investment in public health had today led to the impoverishment of an estimated 60 million Indians, Dr. Reddy said. He explained that Out of Pocket (OOP) expenditure accounts for about 60 per cent of health expenditure. In contrast, 85 per cent of health expenditure in the UK was from public financing. Even in the U.S.A. with its large private health care industry, it was 48-50 per cent. Universal Health Coverage (UHC) was hence required to prevent impoverishment through access to quality, comprehensive, public health care services with no financial hardship, he stressed.

“Provisioning for health care has to balance out the issue of maximizing population coverage, which is what politicians would press for; the best service coverage, which health professionals would advocate for and costs and budgets, which economists would stress on. Equity is an important consideration for achieving the balance. People need to speak up on how much money is spent and on what”, he added.

Dr. Reddy emphasized the importance of primary health care in UHC, with back-up secondary and tertiary care. The contours of UHC in India would include:

- Health financing which would be tax-based. Insurance alone was not enough. As far as insurance was concerned, India needs one large risk pool where the rich subsidised the poor, the healthy subsidised the sick and the young--the old.
- A trained and motivated health provider force—there are shortages of human resources for health especially in the Northeastern states.
- Access to drugs--and essential ones free of cost.
- Good Management Information Systems.
- Good governance.
- Community action for health.
- Action programme to be based on the social determinants of health.

“Northeast communities have traditionally operated in a culture of solidarity”, Dr. Reddy noted. “We need a social movement for UHC that respects the spirit of social solidarity. It is critical that community perspectives and voices determine how much money is allocated and on what it is spent. The movement for UHC here will also inspire other states to take this approach. If it does not happen, India’s health indices will remain poor and hold back our country’s development”, he said.

### **UHC: Learning from Other Countries:**

UHC had three core themes, explained Dr. Hilde de Graeve, Team Leader, Health Systems, WHO:

- It left no one behind. It enabled the poor, elderly, the minorities and the disabled – who were amongst the most vulnerable and left out of the health care map – to gain access.
- It ensured progressive access to a range of services that were of high quality.
- It eliminated financial hardship among the users of health care services.



UHC had a local understanding of health needs and offered high quality treatment. It gave importance to rehabilitation, pain relief and palliative care. Health promotion was its corner stone. It identified services that were not being provided – such as ambulatory transportation or medicines – in neglected areas that most needed help.

UHC sought to reduce out of pocket expenditure by individuals and households. This was achieved through implementation of preferably tax-based finance policies that provided access to quality health services at low cost. This was important as globally it was estimated that more than 800 million people spent at least 10% of their household budgets on health expenses, while 180 million or more spent 25% of their household budget on this. 100 million people worldwide were pushed into poverty because of health expenditure.

We should think of UHC as a direction and not a destination, Dr. de Graeve explained. We can learn from the experiences of other countries that have already moved along the path to UHC. There are some common characteristics of such countries:

- Political commitment and will.
- Strong emphasis on primary health care.
- They addressed the social determinants of health.
- Defined essential health benefit packages.
- Increased government spending on health.
- Initiated policies to reduce OOP through access to medicines and diagnostics.
- Provided access to health insurance.

Key actions to be initiated towards these goals were:

1. Ensuring that policies were actually implemented.
2. Investing in a health systems that was inclusive and respectful of people's cultures and traditions; there would be a special focus on primary health care.
3. Investing in public health.

Civil society representative to the UHC 2030 deliberations at the global level, Dr Santosh Giri, explained the link between UHC and universal human rights. She stressed the importance of civil society in leading a people's movement for UHC. "We must take responsibility for monitoring UHC in our country and ensure that we reach out to all, especially the most vulnerable and excluded like the LGBT community, so that truly no one is left behind".

## **Session 1: UHC in the Northeast (NE)**

### **The Social Determinants of Health in the Northeast (NE) region:**

Key tenets of public health policy are like a four-leg stool, said Rupa Chinai, a journalist and author who had spent three decades investigating health, development and social issues in the NE states. These legs are: Nutrition, Education, Health Infrastructure and Socio-Economic Conditions. In combination and without imbalance, these four approaches shaped good community health and the concept of 'social determinants of health'.

Sharing her investigations into NE health, Ms. Chinai spoke of government abdication of responsibility in providing public health care and subsidized food through the public distribution system, in areas such as Assam. Dependence on the private sector, which had no commitment to preventive health, had led to abysmal health conditions and deaths amongst tea garden workers. In other areas the absence of a strong public health care base, falsely manufactured data and diversion of health workers into activities supporting stand-alone, vertical programmes, undermined the success of comprehensive primary health care service delivery.

The Revised National TB Control Programme was an example of how an expensive and well-conceived programme could better achieve its goals if its linkage to the social factors that affect health, was acted upon. Instead of viewing it from the prism of technology delivery alone, there was need for patients to access nutritious food that was cheap, seasonal and local, during the course of treatment. This ensured efficacy of the drugs. Studies further showed that health workers needed to reach out to marginalised groups such as drug addicts, diabetics and alcoholics, who often remained beyond the reach of the health system, but were also inflicted by TB.

Highlighting the link between agriculture and people's health, Ms. Chinai said the growing emphasis on cash crop cultivation in the NE was changing agriculture practices and causing an imbalance. There was loss of local food self-sufficiency and increased dependence on import of staples like rice, eggs and vegetables from outside the region. Decreasing cultivation of traditionally grown crops was impacting crop diversity that withstood climate change. The loss of nutrition security – earlier sustained by foraging of wild vegetables and fruits within the rich gene pool of NE forest areas and cultivation of unique strains of rice and millets -- was resulting in micro-nutrient deficiencies. The over emphasis on calories and lower access to micronutrients adversely affected health quality and immune system response. Onset of disease then led to the inevitable consequence of indebtedness and impoverishment.

Speaking of how globalization had impacted NE villages long before they had heard of this term, Ms. Chinai cited the example of Khonoma village in Nagaland, which had turned to cardamom cultivation, a valuable cash crop. When world prices of cardamom crashed, the farmers here bore the brunt of this event and incurred huge losses. Such instances, similar to

what was experienced by sub-Saharan African countries in the process of the Structural Adjustment Programme, warned of how such far reaching changes in agriculture-dominated countries could adversely affect community health, local food self-sufficiency and national sovereignty, she said.

She reminded participants that the NE had a strong community culture and all land belonged to indigenous NE communities as per the special protections promised by the Indian Constitution. Hence people of this region should trust in their own knowledge and traditions and determine their own 'master plan' for sustainable development.

### **Ayushman Bharat in Meghalaya**

A pioneering initiative of the Meghalaya Government was its 'Meghalaya Health Insurance Scheme'. Currently implemented in four phases since 2012, the scheme was reported to be growing in enrolment. It was also a step ahead of the nationally implemented Pradhan Mantri Jan Arogya Yojana (PMJAY) also known as Ayushman Bharat insurance scheme, initiated in 2018.

A striking feature of the Meghalaya Health Insurance Scheme was that it sought to strengthen and put back money into the state's public institutions. It empanelled all its public hospitals to provide services under this scheme. It also assured insurance cover of Rs.5 lakhs to all permanent residents of Meghalaya (barring government servants), irrespective of their income levels and place of origin

The centrally sponsored PMJAY empanelled private hospitals, as well as public ones, provided Rs. five lakhs coverage to Below Poverty Line (BPL) patients covering 40 per cent of the country's population. The higher rates offered by the Scheme, enabled hospitals to offer better quality of care, said Steven Bareh, lead claims officer, Meghalaya Health Insurance Scheme.

Each patient registered with the Scheme was given a smart card and money came to the hospital when the card was used. Money flow had enabled an improvement in the quality of instruments, diagnostic tools; availability of drugs in primary and community health centres as also its outreach in disease prevention services, he claimed. Targeting coverage of 7.6 lakh households in Meghalaya – of which 3.9 lakhs are categorized under the Social Economic Caste Census – it inflicted no cap on family size. (See annexure on Meghalaya Health Insurance Scheme).

Participants agreed that the Meghalaya Health Insurance Scheme was a good programme, but pointed out that its main drawback was its exclusion of suicide and alcoholism, both of which need to be included in the scheme. With regard to PMJAY, several participants said that there was a need to understand this better, and that the fact that it was not universal was a problem. Finally they said that there are enrolment and renewal issues which need to be addressed.

## Session 2: Overview of health in the NE states of India



Key issues in the health of NE communities were high morbidity and mortality due to malaria, substance abuse including high tobacco usage and its association with cancer, said Badondor Shylla, epidemiologist at the Indian Institute of Public Health, Shillong. Alcohol and drug abuse were linked to high incidence of diseases such as HIV/AIDS and tuberculosis, as well as malnutrition, he added. (*See annexure*). Data used from the National Family Health Survey (NFHS-4, 2015-'16) meanwhile showed that Assam's indices were amongst the worst in the country: Infant mortality rate was 48 per 1000 live births, as against all India average of 41. Under-five mortality rate was 56 per 1000 live births as against the Indian average of 50.

Assam also recorded maternal mortality rate of 300 as against the national average of 130. None of the other NE states showed data on maternal mortality.

Interestingly, Assam, like all the other NE states, committed the highest amount of health spending in the country. The per capita expenditure and percentage of Gross State Domestic Product allocated for health was higher than the national average, data from the National Health Accounts Cell, Ministry of Health and Family Welfare revealed.

The practice of exclusive breast-feeding of babies less than six months of age was poor in Meghalaya, Nagaland and Sikkim where indices fell below the national average. Meanwhile on this parameter at least, Manipur, Tripura, Assam, Mizoram and Arunachal Pradesh soared above the national average.

Malnutrition in the NE was a sad irony in this fertile region rich in its agriculture and horticulture produce. Although Arunachal, Assam, Tripura and Meghalaya did better than the national average, here too children under five years of age showed wasting (poor weight for height) according to NFHS-4.

Similarly stunting (poor height for age) of children below five years of age -- also an indicator of malnutrition – found Meghalaya faring poorly (43.8 as against national average of 38.4) as per NFHS-4.

The evidence of such poor childhood indices was a sensitive indicator of poor health and well-being within the general population. Malnutrition lowered the immune status and made people vulnerable to disease onslaught.

Data indicated a skewed sex ratio in Assam (993 against national average of 991) followed by Nagaland (968), Arunachal Pradesh (958) and Sikkim (942), according to Population Census of 2011. Reflecting on why Tripura's sex ratio appeared to look better, in comparison to other NE states, Dr. Srilekha Ray of Voluntary Health Association of Tripura said the State's sex ratio being above the national average was to the credit of the tribal population. The urban population, dominated by the Bengali Hindu community, was not free of the scourge of sex-selective abortion and early child marriage.

### **Incomplete and Unreliable Data:**

Responding to the sessions highlighting official policies and data on the NE states, participants said that the approach of 'one size fits all' did not consider the nuances of each of the NE states and their diverse realities. There were cases of incorrect or 'cooked' data that led to a huge gap between the ground reality, based on people's knowledge and actual needs and what government policies and programmes -- based on poorly managed data sets -- set out to do.

Inadequate implementation of public health policies was also highlighted. In many NE states, – policies and programmes were not implemented as per plan.

Pointing to unreliable data from Nagaland, for instance, an IIPH Report stated that the mentoring and monitoring protocols were not in place. This led to poor quality of data affecting its accuracy and timely updating of records in the Health Management Information System.



“In our Tamenglong district of Manipur, official state data claimed there were no infant deaths! It would indicate that we are the healthiest population in the world!” says Helam Haokip, of the Kuki tribe, who is the Manipur-based, Chief Functionary of Integrated Rural Management Association.



Rupa Chinai also highlighted such evidence of incorrect data from qualitative health studies that she conducted in Assam and Nagaland, and published in her recent book *'Understanding India's Northeast – A Reporter's Journal'*.

Dr. Mintu Moni Sarma of Action Northeast Trust (The Ant) in Assam revealed that while the State government data showed a rise in institutional deliveries, the ground reality was different. Despite the government pressure for institutional admission, tribal women preferred to deliver their babies at home. They then registered themselves at the hospital to avail of financial benefits, a birth certificate and baby kit. Health workers were happy because they could show they had fulfilled targets and could claim their incentive money. In this scenario high risk cases fell through the cracks and maternal and infant mortality rates saw no dent.

### **State Presentations: Grassroots perspectives on priorities for UHC:**

The Consultation saw a rich discourse based on grass-root realities and perspectives. In fact, understanding what had gone wrong in this most marginalised and developmentally neglected area of India, provided key insights into how and why national health policy failed and what lessons it offered for the NE and also the rest of India, public health experts said.

A key demand by Northeast participants was official recognition to traditional healers and medicinal practices. NE communities knew the value of food as medicine, facilitated by the rich bio-diversity gene pool of the region. Changing lifestyle and environmental depletion must be tackled through community awareness on issues of nutrition and lifestyle change, they asserted.

### **Traditional healers and medicines:**

Reiterating the role of traditional healers and their medicines, NE participants said there was no need for the official system to see this as an 'either/or issue'. The community needed allopathic services in a health crisis, while holding on to its faith in traditional healing and medicines at other times.

Dr. Melari Nongrun, executive director of North East Slow Food and Agro-biodiversity Society said, "Our experience at the primary health centre shows that in the absence of trained health workers, traditional healers and nutritionists are key care givers in the community. This human resource should not be neglected. They provide a reliable and high quality service in areas where the villages are in hilly, inaccessible areas. For the villagers, the effort of reaching the PHC or referral centres involves high transportation costs. The worst affected are the disabled, the elderly, single mothers and the destitute. No one reaches out to them with awareness programmes about government schemes. Such social determinants of health must not be neglected", she asserted.

Indigenous medicines in the NE were not a part of the government's AYUSH programme. In fact, many of the NE states had no tradition of Ayurveda based AYUSH, so incorporating these in the public health system of these states had limited value. Instead, some studies in Meghalaya had identified who were the traditional healers and where they were located. They operated from their homes and therefore needed access to infrastructure. Health policies needed to entitle these healers and give them their due place, said Sandra Albert, Director, Indian Institute of Public Health, Shillong.

Traditional wisdom of the NE highlighted food as medicine. It treated every ailment through naturally grown food that also had medicinal properties, said Mayfreeen Ryntathiang of Grassroots, a Meghalaya NGO.

"We need to educate communities about the nutritive value of locally available, naturally grown food that is unique to the NE. This food is also our medicine in preventing disease and ensuring good health", added Imchawati Kichu, Director, Care and Support Society, Mokokchung, Nagaland.

Fast changing lifestyles were seeing packaged, refined and junk food being served even in remote village eateries. It had a negative lifestyle impact on the youth. Loss of nutritious food practices was seeing early onset of blood pressure and diabetes. "We need to find creative ways of reviving the taste for jackfruit and bananas, which proliferate in our areas", Mr. Kichu said.

Although there was no history of famine in the Northeast, malnutrition was evident. Food habits focused on fish and rice amongst Bengali Muslims, for instance, revealed the absence of vegetables in the diet, resulting in micronutrient deficiency. Anemia was rampant amongst Northeast women and children, causing complaints of chronic weakness and tiredness.

The knowledge of foraging myriad varieties of wild fruits and jungle vegetables was disappearing with the loss of natural forests and their replacement with monoculture rubber or teak plantations. Tea garden tribes consumed excessive salt resulting in high incidence of hypertension and stroke.

### **Substance Abuse:**

The Consultation identified substance abuse – alcohol and tobacco - as the prime health challenge faced by NE communities. It called upon the health system to urgently offer access to treatment and rehabilitation services that were based on local or state-specific designs of treatment within the primary health care system. It identified alcoholics, drug addicts, disabled and single mothers as amongst the most marginalised within a community.

"Why does the health care system not provide counseling and rehabilitation for substance abuse and mental health problems? Why is government turning a blind eye to its huge contribution to illness, death and social disruption", asked Batskhem Lyngkhai, an outreach worker with Northeast Network, Meghalaya.

Alcohol and drugs use in the NE needed to be discouraged through policy interventions too, participants stressed. New wine shops were regularly coming up near hospitals and at the village level. The NE was losing its current and next generation to this scourge, they reported.

Data on tobacco use in seven NE states pointed to its alarming impact with scores higher than the national average. High rates of smokeless tobacco abuse were seeing an increase in cancer. Tripura had the highest rate of referrals to other states, said Dr. Sreelekha Ray of Voluntary Health Association of Tripura.

“Flights out of Tripura are full of patients going outside the state. Many seek cancer treatment in southern Indian states or Bangladesh. There is no local treatment centre or specialist help for cancer. Neither is there counseling and rehabilitation for tobacco addicts”, Dr. Ray said

Delegates from Manipur and Tripura spoke of the uncontrolled growth of poppy for opium cultivation and marijuana production. In their desperate need for economic survival, cash-strapped communities were turning to this means of cash crop cultivation. The NE was both a source and transit point for drugs coming into India from Myanmar and Bangladesh.

### **Health infrastructure and service delivery:**

The story of neglected public health services in the NE followed the pattern in the rest of the country. However, its impact in these long neglected peripheries had been even starker. Rural, tribal and minority areas have been especially marginalised in the face of government withdrawal and abdication of responsibility to the private sector. The plight of Assam’s tea garden tribes in upper Assam, the plains tribals in Bodoland, or the Bengali Muslims living on the char islands of the Brahmaputra provided relevant case studies.

The current public health measures remained limited. “We are now seeing growing investment in big hospitals but the primary health base remains neglected. Although buildings are coming up for local health centres, there is nothing functioning within them” said Dr. Mintu Moni Sarma.

Some common issues across NE states revealed that health centres were filled with machines and equipment that did not work and lay unutilized and rusting. There was a paucity of basic testing kits and mortality from treatable illnesses remained high.

The need for free diagnostics and medicines for poor patients was highlighted. While procuring and making medicines available was vital, there was also wastage due to improper management of supplies leading to their therapeutic expiry. “I have personally seen how iron tablets from the Reproductive and Child Health Programme in Tripura had come with only 15 days left before expiry. This is often the case”, said Dr. Sreelekha Ray.

Neito Koza, lawyer at Human Rights Law Network, Nagaland, spoke of women’s lack of awareness about government programmes and hence its poor implementation. “While schemes such as Janani Shishu Suraksha stress 100 per cent free benefit to pregnant women,

the reality shows that reimbursement came to them only after High Court cases were filed by us”, she said.

A Report of the Indian Institute of Public Health highlights the poor levels of primary health services in Nagaland. “A ranking of the NE states on key maternal and child health indicators often places Nagaland at the bottom of the list...When compared to other NE states and all India average, Nagaland fares badly in terms of primary healthcare services utilization. It has the lowest proportion of pregnant women (2.4 per cent) who have received full antenatal care”, it stated.

A major issue highlighted by all participants, most of whom came from hilly and inaccessible areas of the NE, was the absence of transportation connecting the isolated rural villages to the local primary health centre and its referral points.

Grassroot NGO workers spoke of the need to strengthen public health care services through trained and motivated, local level health workers who were mobile and adequately compensated. Patients had difficulty negotiating their way through the unfriendly environment of referral and tertiary hospitals. There was no single information window guiding them through the departmental maze.

While the privileged class went to private or corporate hospitals the poor had to avail of public health facilities that increasingly charged user fees and forced loss of daily wage work. In these circumstances, often the poor had little choice but to do what they could for their loved ones while incurring huge debt burden. It also resulted in poor health outcomes and death of people in this region.

Doctors, especially in the remote hilly areas were often insensitive and gender blind, caring nothing about privacy for women. Health centre staff were poorly trained, lacked motivation and subjected poor women to abuse and scolding. This saw resistance to indoor admission in hospitals with women saying, ‘Have we come here to hear their insults and be treated like this?’

Such insensitive attitudes also drove away adolescent cases of pregnancy that feared social stigma. This contributed to low birth weight babies, infant and maternal mortality. Scandal around such pregnancies prevented access to health centres and reportage of such cases in official data. Meghalaya had 27 per cent single mothers, who were especially vulnerable to neglect from the health system.

Thus key issues in these discussions highlighted the increasing competition from the for-profit private and corporate sectors and an already weakened public health system unable to offer an alternative to the poor. To rectify this situation, health workers had to be better trained and supported; there was need for regular supply of medicines, diagnostic testing kits and the generation of reliable health data. The public health system needed to address issues of adolescents, with sexual and reproductive health issues needing special attention.

## **Session 3: Non-Communicable Diseases in the NE:**

### **Mental Health and Cancer**

There were several initiatives in the NE – both in the government and NGO sector. Two of these – mental health counseling and treatment and referral services for cancer were presented, along with some grassroots experiences of organizing women for mental health by SEWA in Gujarat, by trained local health workers.

Two case studies of NGO initiatives, Action Northeast Trust (The Ant) in Bodoland, Assam, and that of SEWA in Gujarat, respectively revealed interventions in mental health care and doorstep counseling in diabetes prevention at the community level. This was making a difference because of its decentralized approach. In Gujarat, local health workers who enjoyed the trust of their communities led the awareness programme. Camps held by The Ant, used a standardized treatment protocol in delivery of mental health counseling linked with primary care. This had resulted in positive outcomes in the mental health of people in the area. (See annexure).

An on-going issue in the NE, including Assam, that affected the mental health and well-being of people, was disasters that were both natural and human-made. Calamities like floods and landslides were a permanent feature of the NE states. The latter related to the conflicts that erupted and were ongoing between tribes and between different communities of the NE.

The Consultation participants were educated on the impact of cancer in the NE region by Dr. Caleb Harris, oncologist at the Shillong based NEGRIMS (North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences). Focusing on awareness building and prevention of the disease, Dr. Harris said more than 65 per cent of cancers here were due to personal habits like chewing tobacco, and 70 per cent of patients were in an advanced stage when they sought medical help. Meghalaya and Assam had the highest incidence of esophageal cancer. He stressed three key factors for cancer causation and prevention: Alcohol, tobacco and low intake of fruits and vegetables.



## **Presentations from Group Work and the Way Forward**



Participants at the consultation spoke of the need for community awareness, knowledge and skills building so that the local people could assert their own health priorities and ensure better coordination with government programmes. They called for regular consultations between civil society groups locally and regionally and dialogue with the state governments of the region.

Their action plan saw strategies to convert available Information, Education and Communication (IEC) materials into local dialects to spread awareness of government messages and schemes.

Some groups sought building of community capacities in how to assess local health needs. This would also help ensure delivery and monitoring of government services.

Information and knowledge sharing between NE states and learning from national and international experience in health was an issue of interest for future such consultations, participants said. There was a need to understand the social factors that determined good health and disseminate that knowledge within their community.

Having learnt about the linkages between nutrition to agriculture policy and public education; the role of food in ensuring health, many said they would reach out to young people in their communities with these messages. The group action plans stressed the need for public health infrastructure that supported disease cure and prevention policies. They simultaneously highlighted the need for livelihood that enabled purchasing power and access to health.

The need to lobby for mental health counseling and rehabilitation for substance abuse, through the public health system, would be taken up with government. Official recognition for the role of traditional healers and medicines and creating space for them within the health system was also on the agenda. Equally important was strengthening front-line, local health workers like ASHAs -- increasing their numbers, training, responsibilities and remuneration.

Finally, several participants expressed the need for similar workshops on UHC in their states to draw in more people's organisations and civil society groups. Participants from Nagaland and Manipur offered to take up the responsibility of organizing such state-level consultations with NEN, IIPH-Shillong and SEWA.

All took back with them the message that their first task was to bring more civil society and people's organisations in their states to share the main messages on UHC imbibed from the workshop. With a clear understanding of the key principle – that no one is left behind -- they would ensure that their state moves forward steadily on the road to UHC. Once people were organized and equipped with more health-related information, then local, community action for health, as a first step towards UHC, would be undertaken, according to local needs and priorities.

Based on her long years of experience in grassroots level organizing on public health issues, and with a women worker-centered focus, Mirai Chatterjee, Director, SEWA Social Security Team, outlined possible community-level action that participants could take on the road to UHC in their own states.



“There will be no UHC without community action. Things change when we organize—that is come together, unite and push the health system and others to respond to our needs and demands, while taking some health action ourselves,” she said.

Some of the health actions she suggested were:

1. Organise---bring all in our communities together, ensuring that no one, especially the most vulnerable like women workers of the informal economy, are left out. We can do this by holding area meetings in our villages and towns, and sharing first of all, what we have learned in this workshop. Such meetings will also bring out the needs and priorities of local people, especially informal workers.
2. Undertake small local health actions:
  - a) Work with PHCs for health camps for early diagnosis, screening and prevention.
  - b) Link with the health system---to help mobilise local people. Assist in health campaigns for immunization, malnutrition and other such health issues, and also for strengthening the local health committees like Village Health Sanitation and Nutrition Committees (VHSNCs) and Mahila Arogya Samitis (MASs).
  - c) Monitor public health services at the local level. Give feedback to public health providers.
  - d) Bring out neglected and invisible health issues like substance abuse, mental and occupational health to the attention of the public health authorities.
  - e) Empower ourselves with information and help local people to get access to benefits and entitlements under the various health schemes. Setting up local information and servicing centres with the public health system would help to increase outreach.
  - f) Consider setting up local pharmacies---for selling allopathic and traditional medicines--through your own Self-Help Groups (SHGs) and cooperatives.





## Annexure :

### Programme of the Shillong Consultation



**INDIAN  
INSTITUTE OF  
PUBLIC HEALTH  
SHILLONG**



#### **REGIONAL CONSULTATION ON UNIVERSAL HEALTH CARE A COMMUNITY PERSPECTIVE**

**July 16 & 17, 2019  
Shillong, Meghalaya**

DAY 1: 16 <sup>th</sup> JULY, 2019		
10:00 – 10:30AM	Registration	
10:30 – 11:40AM	Inaugural Session Welcome address  UHC in India: the way forward  UHC : Learning from other countries  UHC in Meghalaya	MC: Uniquey Mawrie Joy Syiem, Programme Manager, NEN  Dr Srinath Reddy, President, PHFI  Dr Hilde de Graeve, Team Leader, Health Systems, WHO India Country Office Shri Pravin Bakshi, IAS, Secretary, Health
11:40 – 12:00 PM	Tea Break and Group Photo	
12:00 – 1:00 PM	Session 1: UHC in the North-East  The Social Determinants of Health in the North-Eastern States  Ayushman Bharat – Meghalaya chapter  Open discussion	Moderator: Dr Sandra Albert(SA), Director, IIPH-Shillong  Rupa Chinai  Representative from MHIS
1:00– 2:00PM	LUNCH BREAK	
2:00– 3:30 PM	Session 2:  Overview of Health in North East India  State presentations: Grassroot Perspectives on Priorities for UHC	Moderator: Joy Syiem (JS)  Badondor Shylla, IIPH Shillong  NGO Representatives from different NE States
3:30– 4:00 PM	TEA BREAK	
4:00 – 5:30 PM	Session 2: Overview of Health in North East India (continued) State presentations continue	Moderator: SA

DAY 2: 17th JULY, 2019		
9:30 – 10:30 AM	Recap from discussions of Day 1  Synthesis of State Presentations	Moderator: Mirai Chatterjee, Director, SEWA Social Security Dr Chandrakant Laheriya, WHO
10:30 – 11:30 AM	Session 3: NCDs in the North-East: Mental Health & Cancer Mental Health in the North-East Cancers in the North-East Community-based approach to NCDs: some experiences of SEWA  Discussion	Dr Mentu, ANT, Assam Dr Caleb Harris, NEIGRIHMS  Susan Thomas, National Coordinator, SEWA
10:30 – 11:30 AM	Session 3: NCDs in the North-East: Mental Health & Cancer Mental Health in the North-East Cancers in the North-East Community-based approach to NCDs: some experiences of SEWA  Discussion	Dr Mentu, ANT, Assam Dr Caleb Harris, NEIGRIHMS  Susan Thomas, National Coordinator, SEWA
11:30 – 12:00 PM	TEA BREAK	
12:00 PM– 1:00 PM	Session 4: Group Work  Developing Action Plans on UHC, improve awareness, undertake local action	Moderator: JS
1:PM – 2:00 PM	LUNCH BREAK	
2:00 – 2:30 PM	Group work continues	Moderator: Susan Thomas
2:30 – 4:00 PM	Presentations of Action Plans	Moderator: SA
4:00 – 4:30 PM	The Way Forward & Vote of Thanks	SA, JS, MC.



# REGIONAL CONSULTATION ON UNIVERSAL HEALTH COVERAGE

16th and 17th July, 2019

Shillong, Meghalaya

## INTRODUCTION

The 65<sup>th</sup> World Health Assembly held in Geneva identified *Universal Health Coverage (UHC)* as an essential component towards which countries could work to advance global health. In an effort to achieve 'Health for All', this year's World Health Day theme was '*Universal health Coverage: everyone, everywhere.*' Although health was declared a human right in 1948, we still have a long way to go to deliver on the promise of Health for All.



In 2012 nations agreed to provide universal health coverage (UHC) to their populations in a resolution of the United Nations (UN) General Assembly. By committing themselves to provide good-quality health care to everyone without exacerbating users' risk of financial ruin or impoverishment, states made a promise which the then Director-General of WHO, observed as "the single most powerful concept that public health has to offer" and the "ultimate expression of fairness. This idea was reinforced by the current Director General, WHO stated: "In the Sustainable Development Goals, all countries have committed to achieving universal health coverage (UHC) by 2030. To meet that target, we need to see 1 billion people benefitting from UHC in the next 5 years. This is not an unattainable dream, nor will it require billions of dollars to implement. UHC is achievable, right here, right now, for all of us. Health for all is possible even with health systems that are less than perfect – countries at many different income levels are making progress with the resources they have."

Universal healthcare (also called universal health coverage, universal coverage, or universal care) is a health care system that provides health care and financial protection to all residents of a particular country or region. It is organized around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes.

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of

sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UHC embodies three related objectives:

- A. Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
- B. The quality of health services should be good enough to improve the health of those receiving services; and
- C. People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

Universal healthcare does not imply coverage for all people for everything, only that all people have access to healthcare. Some universal healthcare systems are government funded, while others are based on a requirement that all citizens purchase private health insurance. It is described by the World Health Organization as a situation where citizens can access health services without incurring financial hardship. The Director General of WHO describes universal health coverage as the “single most powerful concept that public health has to offer” since it unifies “services and delivers them in a comprehensive and integrated way”. One of the goals with universal healthcare is to create a system of protection which provides equality of opportunity for people to enjoy the highest possible level of health.

As part of Sustainable Development Goals, United Nations member states have agreed to work toward worldwide universal health coverage by 2030.

More than 50 organizations across India have been working towards building up a people’s movement for Universal Health Care for all, especially informal women workers. We have had national and regional consultations with organizations working at the grassroots level on public health. This has resulted in a national campaign for universal health care. The campaign’s Steering Committee is focusing on education and awareness around UHC. It has also prepared recommendations which have been unanimously accepted by all participants in the campaign. The recommendations that emerged from the grassroot level interactions have been sent to all political parties as well for their manifestos, and some have included them in these.

It is necessary to spread awareness on UHC and especially how this can be implemented at the grassroot level in different states, with flexibility and adaptation to suit local contexts. One region of India that has not always been included in UHC discussions is the North-East of India. Therefore, in consultation with organisations there, it is felt that a special workshop needs to be organized there to bring in the views, perspectives and approaches of the people of this area and also to create awareness on UHC, as a first step towards a people’s movement.

Northeast India or the North Eastern Region of India(NER) is the easternmost region of India representing both a geographic and political administrative division of the country. **It**

**comprises eight states – Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, and Tripura**

### **OBJECTIVES of THE NORTH EAST WORKSHOP 2019**

- To develop an understanding of Universal Health Care (UHC) in India and its orientation to the NER.
- To improve understanding of the special needs of people of the North-Eastern states for UHC.
- To understand the latest developments in public health in India at the national and state levels, especially the Ayushman Bharat and National Health Mission.
- To share the innovations of the North-Eastern states with regard to community action for health.
- To share some technical information of relevance to people of the North East like on NCDs and on making health a people's and policy priority.
- To develop an action plan on how to build a public health understanding with community involvement in the North-East, and an understanding on UHC. Also, how to mobilise communities to avail of existing services and demand that these reach in a transparent manner.

50 to 70 participants from all 8 states representing both health and non-health organizations (women's organisations, farmers clubs, cooperatives, unions etc) and some state government representatives will be invited to participate and share the unique perspectives of the North-Eastern states. We will also invite some resource persons to speak on UHC, the social determinants of health in the NE states, on NCDs and on the Right to Health and developing a people's movement for UHC. There will be some field visits also to government primary health care centres and district hospitals.

#### **Key deliverables:**

1. Report on the NE regional workshop, including short notes on the state of public health in each state---a grassroot view. There will also be actual case studies of experiences of women and families with regard to accessing health care.
2. Photographs and videos on the workshop and participants views in particular.
3. Follow-up plans for awareness generation on UHC, Ayushman Bharat and primary health care more generally (including especially NCDs). The plans will outline how to build up a people's movement for UHC in the NE region.

**Photographs of Field Visit:**

[https://drive.google.com/drive/folders/1\\_ftRx82tuFlThPoQpgHgVwC6PLLQ4hun](https://drive.google.com/drive/folders/1_ftRx82tuFlThPoQpgHgVwC6PLLQ4hun)

**Other Photographs**

[https://drive.google.com/drive/folders/1H8LyrEN9A5Jh\\_WBx84eMJcvMpXguBXQ5](https://drive.google.com/drive/folders/1H8LyrEN9A5Jh_WBx84eMJcvMpXguBXQ5)

**Video:**

<https://drive.google.com/file/d/17uN6E-GoY1aJlTyV6XpuaaE-7FkAcisc/view?ts=5d5667b8>