Claiming Right to Health Care

Long Battles and Small Victories to Make Health Care Services Accountable

❍ **Ila Pathak**

India is notorious for its abysmal health services leading to a very high infant and maternal mortality rate. The general health profile of citizens, especially those living in rural areas, is also very poor. The following account provides a glimpse of how much effort it takes to get official health functionaries to perform their assigned duties with a minimal degree of seriousness.

Ahmedabad Women's Action Group (AWAG) has been working for the last 25 years in Gujarat to strengthen women's issues. In Radhanpur block of Patan district AWAG concentrates on the health care of rural women. The Government of Gujarat has set up an elaborate system to serve the health needs of rural people. For serving women's needs pertaining to Reproductive and Child Health (RCH) the state appointed Female Health Workers (FHWs) operate as Auxiliary Nurse Midwives (ANMs). However, these services did not reach rural women because they are often not informed that such services are available. Not only do FHWs play truant, but even when the rural women find out about these services, they often don't know how to assert their rights. In 1997I AWAG started a campaign to make rural women become aware of their rights and helped establish linkages with the state's machinery so that the health delivery system begins to respond to the needs of citizens.

Initial Interventions

A woman's health, especially among the poor and illiterate, is often neglected not just by her family but by the woman herself. She is taught not to complain and if she does then she is directed either to use condiments in the kitchen or try faith healing. The women of Radhanpur block were no exception.

We began our work by communicating to the rural women of Radhanpur block that health care provided by the state is a right of the citizens of India as per the Constitution of our country. And women should assert their right.

Awareness raising workshops were conducted and women were organized into Women's Committees or *Naari Samitis* (NSs) in each village. (In each *Naari Samiti* (NS) leading women of the village such as the members and office bearers of the Village *Panchayat*, the Integrated Child Development Scheme (ICDS) workers, the Traditional Birth Attendant (TBA), office bearers of Self Help Groups (SHGs) were included). Women were informed that if the family did not want to spend on their illness, they could access health care from nearby state dispensaries. Although the NSs were enthusiastic about what was taught during the workshops they had to prepare for the problems they would face in actually accessing the health services.

Survey by *Naari Samitis*

The next step was to get Naari Samitis to conduct a survey on the actual conditions of facilities provided by the state. They came up with the following report:

Three Primary Health Centres (PHCs) were established in the block, one each at Bandhavad, Gotarka and Nanapura.

The PHC at Bandhavad was working well. However, most people residing in nearby villages did not utilize it. Reasons: (i) They were not aware of all the facilities available there and (ii) the village was not easily accessible from neighbouring villages.

Women of Gotarka village were most active in their complaints. They said that the PHC did not open and if it was open the staff did not attend to them.

NSs were asked to bring in specific complaints. Eventually two women of Gotarka made complaints, quoting the date and time of being rejected from the PHC. In one case a child with a festering boil was taken and the health providers present at the PHC did not provide any medical help. In another a pregnant woman who had gone to the PHC suffered a similar fate.

AWAG sent a letter of complaint to the next senior officer and also approached the Medical Officer in charge of the Referral Hospital. He responded immediately and the PHC started functioning.

The next move was to request the medical officer of the PHC at Gotarka

to hold a meeting with the people of the village where he was requested to inform them of the timings of the PHC, the number of persons working there as well as the facilities available. This meeting led to a distinct improvement and the PHC started working regularly.

At Nanapura the medical officer of the PHC was reported to be drunk in the middle of working hours. So even in the daytime women were scared to approach him.

NSs of Nanapura complained about the drinking habits of the medical officer to the District Health Officer (DHO) and difficulties faced by women in approaching him. As the pressure of women's complaints increased, the Medical Officer solicited help from a local politician. At his bidding, some villagers certified that he was a good Medical Officer and need not be disturbed. The NS felt very frustrated at this.

More NSs were organized and gradually all joined in demanding accountability from the District Health Office (DHO).

Involving Village *Sarpanches*

In 2001 the male members of the village *Panchayats* were given the power to monitor the working of the PHCs, locations of sub-centers of health and non-functioning of health-centres.

Despite repeated complaints against the Medical Officer stationed at Nanapura PHC, his drinking had increased to such an extent that it was futile to approach him at any time. The office bearers and members of the *Panchayats* of the villages of Radhanpur block discussed the issue and decided to send a letter to the District Health Officer (DHO) on the subject. Accordingly a letter was dispatched with the endorsement by the then Vice President of the block *panchayat*. People waited for a positive response but nothing happened. In the next meeting the issue was again discussed and another letter was dispatched.

AWAG meeting with District Health Officals

This time the DHO took cognizance of the letter. The Medical Officer (MO) of Nanapura PHC was advised to mend his ways. Within weeks the MO's family members including two grown up daughters started living with him at Nanapura itself. This induced confidence in the women who started visiting the PHC as and when required.

Lack of Information

Many rural people did not know about the services set up for them at sub-centers by the government because they did not see any evidence of these services being provided for them. As a part of the awareness programme an exposure trip was organized to the civil hospitals at district towns. It was there that the women were informed about the specifics of various services supposed to be made available to them. This encouraged some of them to ask questions and report on the situation in their PHC. They explained that though a nurse did visit their village it was not a daily visit, nor did she go beyond a certain point in the village, and certainly did not take a round of the village. A complaint was made regarding these issues and the officer of the District Health Department spoke to the erring nurse, the Female Health Worker (FHW) on the job. After that the nurse started visiting the village Delana regularly and took rounds of the village. This story was repeatedly told to rural women and to FHWs, which brought better services to a few women in some of the villages. However, the larger problem persisted. People did not know the conditions of service of the FHWs trained as ANMs. The FHWs are aware that they have to stay in the accommodation provided to them at the sub-centre. The educated FHWs took advantage of the ignorance of the people and continued to fool them. They made a show of doing their duty by providing nominal services.

In a meeting, held on June 20,2003, between the members and office bearers of village *Panchayats* and the DHO, a request was made to ensure that the village sub-centre should start functioning. He promised that once a month a medical officer would open one or the other sub-centre in rotation. Such irregular services are

not of much help to the rural people. On his part he could not promise more, since everywhere in Gujarat the FHWs do not stay at their allotted centres. Even medical officers are usually absent from workplaces allotted to them. The system had deteriorated to such an extent that any order given by the District Officer was not likely to be heeded.

In two subsequent meetings on September 15 and 16 2004 the members and office bearers of village *Panchayats* insisted that the sub-centres must be started as soon as possible. The DHO who attended the meeting agreed and stated that he would do his best. It was common knowledge that the sub-centres would start functioning only if FHWs stayed in the villages assigned to them. FHWs had formed the habit of living in nearby towns. Hence it was going to be difficult to change their ways. Yet, since this was the only block where people demanded the services the medical officers had become somewhat regular and responsive. The district officers, however, were still hesitant about asking the women medical staff to start living in the village and so AWAG offered to help.

A joint survey of sub-centres was undertaken by AWAG and NS .It was found that only one FHW stayed at the sub-centre. As the survey proceeded, four more started staying at sub-centres. But the majority of FHWs, 21, refused to shift their residence. They considered requests made by AWAG or NSs unreasonable because their employers had not asked them to do so.

Duties of FHWs

The work expected from a Female Health Worker is as follows:

- To live in the village allotted to her and run a Sub-centre with medicines and other necessities provided to her at the Sub-centre.
- To provide First Aid.
- To look after RCH specifically and assist in regular health checkups of the pregnant women and during the delivery.
- To look after the immunization of children.
- To educate young mothers in childcare.
- To provide information about spacing childbirth and use of contraceptives.
- To undertake activities with reference to malaria.
- To educate villagers about nutritious food.
- To inform people about infectious diseases.
- To upgrade the skills of the Traditional Birth Attendants (TBA).
- To help in preventive and curative activities.
- To participate in National Health programmes.
- To keep records and reports of the health profiles of patients and treatment administered to them.

A FHW is appointed to look after a population of 5000 persons. If villages are small, she is asked to cover two or more villages. She could have her headquarters at one place and go to the other villages. If she is assigned more than one village, each village has to be visited at least twice a week depending upon her assignment.

Her accessibility at village level is crucial to the efficient functioning of the entire system.

It was common knowledge that most of the FHWs lived in the Block town and went to the assigned village in the morning to return by afternoon. Some went to the assigned village only once a week, opened 'a dispensary' somewhere (an open platform / somebody's house / a space in the local school) and operated from there for four hours. They would then leave the village only to return the next week.

So with the consent of the Commissioner, Health and Family Welfare, a two-day workshop was organized on 4th and 5th December 2004. The Commissioner, Amarjit Singh, inaugurated the workshop with a message that the health staff was expected to serve the rural population and should do so as per the letter of their appointment. DHO Makwana reiterated the same message the next morning. Some members of NSs were present. They put across their demand for health services at their villages. They also stated that they would help the FHWs at their village base if they faced any problems.

On the second day of the workshop, the FHWs were asked for their decision about the date by which they would shift to their villages. They responded unanimously saying they would not shift to the villages. After that, a session of cajoling, persuading, offering assistance etc. was undertaken by both AWAG personnel and RCH specialist Dr.Maheshwari and Mr. Jagdish Bhavsar, in-charge of the Nursing staff at the District office. In the end 13 women consented to start living at their sub-centres by the end of two months. Five FHWs stated that they would go to their villages if their living quarters were repaired. One FHW resolutely refused to reconsider her initial 'no' and said that she would petition higher authorities to exempt her from living in the village.

The FHWs acknowledged that they spent around Rs. 1,000 on rent and were spending Rs.200 to Rs. 500 on transport. If they lived in the villages allotted to them they would not incur extra expenditure. A couple of them were in any case living in nearby villages though these were not those assigned to them. They refused to divulge the real reasons for their unwillingness to stay in the assigned village. One possible reason for their reluctance was that they probably did not want to remain within calling distance of the villagers because they

did not want to be disturbed at all hours. The District Health Officer (DHO) for his part stated that the quarters would be repaired wherever repairs were required.

The FHWs then approached the local MLA, who had earlier sympathized with them. He did not support them this time because of the overwhelming majority of rural people wanting the FHWs to live in their allotted villages.

Finally the FHWs started relenting and began working as required. AWAG assisted them in finding vacant houses in villages. A case in point is Srinath where a private citizen had occupied the quarters constructed by the government on the plea that the land acquired by the state was originally owned by his forefathers. AWAG met the *panchayat* at the village and got the quarters vacated. Negotiations were also undertaken at Bhilot but the FHW is still unwilling to go and live there.

The DHO alerted the Medical Officers at PHCs and had the repairs expedited. The Health Department also wrote letters to FHWs informing them that part of their work was to run 'Health Sub-centres' and they could not ignore their responsibilities. These rural women had now clearly understood the role of the FHW in their lives and wanted them to come and live in their villages. They did all they could to cajole the FHWs to become a part of their village, including helping them with the house hunting where needed and assisted in negotiations. The District Health Office supported the move and also pressured the FHWs to take their job more seriously.

So on March 31st, 2005, 3 months and 25 days after the promises were made, 20 FHWs started staying at the villages allotted to them to run Sub-centres. Currently four are in a defiant mood, two appointments have not yet been made.

Pressuring government to do its job

Thus 80 percent of the FHWs have gone to live in the villages where sub-centres are allotted to them.

Before AWAG intervened only one FHW was providing honest service to rural people as per work allotted to them, but after nearly six years of efforts 20 accepted living in the villages where they run health Sub-centers. This could only be achieved by sustained efforts and dialogue between rural women and the service providers.

Although some FHWs tried to withdraw from the villages assigned to them to run sub-centres, the *sarpanches* of the villages protested and wrote letters to the District Health Officer.

Small Gains Matter

Our long drawn campaign has helped at least some women to consider the importance of their own health, to look around for medical assistance, to assert their right to procure services from health care providers and to pressure the state machinery to get the health service providers to do their job with a degree of seriousness.

The movement to assert Right to Health has spread to the nearby block of Saltanpur south of Radhanpur. It is now widely understood that the FHWs have to serve 5000 women. It is only when all our PHCs start functioning efficiently that timely assistance from trained personnel is likely to bring down the prevailing high MMR and CMR in the state. ❐

The author heads AWAG.