

**ADVOCACY FOR RIGHT TO HEALTH CARE**  
**Experiences of organising a health initiative in a tribal people organisation**

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This paper is an attempt to describe and draw some preliminary lessons from the experience of a health programme initiated in a people's organisation, with one of the objectives as taken up the issue of right to health care. The experience described is related to the on going health activities in the context of the people's organisation Kashtakari Sanghatna, in Thane District of Maharashtra. These activities have been organised by the activist team of the Sanghatna mainly over the last three and a half years.

The initial actions on issue which could be called 'Right to Health Care', in the context of the Sanghatna were spontaneous. These incidents took place in the period before I started working with the organisation. These were people's spontaneous response to negligence or maltreatment by the primary health care staff in the area. For example, in one case a patient died in one of the primary health centers due to what was apparently negligence by the doctor. Also no vehicle was available to transport the patient to a referral center. After this the people spontaneously gheraoed the PHC for several hours, until taluka level health authorities came and assured the people that a vehicle would be made available permanently at the PHC to transport serious cases. Since then a jeep with a driver has been posted at the PHC which is available to transport patients. Such incident-based responses were part of the process of people's involvement in various militant movements of the Sanghatna.

**ACCESSING PUBLIC HEALTH RESOURCES**

In July 1995, a health programme based on trained health workers was initiated in selected Sanghatna villages (Ten hamlets to begin with). Our energies in the initial one-year were concentrated on forming health societies, training and follow up training of the health workers and helping these workers to become functional. There was initially a tendency of trying to handle every thing at the village level and rely only on people's resources. However, we realised that we should also make use of resources available from the formal health care system. Our first step in this direction was in the form of accessing PHC drugs for use by our health workers. In April 1996, we approached the district health authorities and explained to them about our health worker programme, and invited them to one of our trainings where they interacted with our health workers and were reasonable impressed. We have been able to easily obtain certain supplies for PHC from the government health system for regular use by our health workers, in which the background strength of the Sanghatna also played a role. We have also been able to access supplies of Sodium Hypochlorite for water disinfecting, for distribution by our health workers.

**DECENTRALISED SURVEILLANCE AND ADVOCACY FOR PREVENTIVE MEASURES**

Another issue, which had been of concern, was the occurrence of outbreaks of malaria and diarrhea during the monsoon. For this we have organised a system of decentralised surveillance by our health workers. The health workers maintain records of case of malaria in the village, which are compiled fortnightly. If an excessively high number of cases is seen in any hamlet, then measures can be initiated to take preventive action. In June 1997, we detected a very high number of cases of fever appearing to be malaria from one hamlet. No insecticidal spraying had been performed till late Jun even though this is normally initiated in April. Initial representation to the taluka level authorities did not lead to concrete results. So a demonstration was carried out at the Block Development office demanding that insecticidal spraying be started immediately, otherwise the focal outbreak might develop into a regional epidemic. Within two days spraying was initiated and subsequently less fever cases were seen.

We realised that the specter of an epidemic was something on which the authorities were extremely sensitive. At the same time our Decentralised surveillance was instrumental in making the problem visible at an early stage.

### **AN INCIDENT REGARDING AN EXPLOITATIVE PRIVATE**

Another incident took place regarding an exploitative private practitioner who had newly started his practice in one of the larger market villages. He was charging exorbitant fees and many people reported his giving unnecessary injection and saline infusions, and then charging heavily for these 'services'. This 'Doctor' did not have any recognised medical qualification. One of the activists of the Sanghatna lodged a police complaint against him and because of pressure from the Sanghatna he was forced to move away from the area. This experience of moving against a private doctor was however mixed, some people later complained that the Sanghatna had chased away a doctor who though he charged did give some services in that remote area. Also, it was the fact that he did not have a recognised qualification that made him vulnerable, which might not have applied to other, equally exploitative but qualified' practitioners.

### **DEMONSTRATING FOR QUALITY HEALTH SERVICES AND PARTICIPATION IN DECISION MAKING**

Subsequently, we decided to take up a range of issues relating to the Government health system in a concerted way. In December 1997, a large demonstration was organised at the Rural Hospital at Kasa, the main hospital-serving people in the area covered by the health programme. The following main issues were outlined in a memorandum.

- ▶ Poor availability of drugs at both the RH and the PHC Information regarding availability of drugs was asked for.
- ▶ Taking of bribes by staff at the RH and maltreatment of Adivasis.
- ▶ Non-function of peripheral health center during the monsoon period.
- ▶ Extremely inadequate and patchy insecticidal spraying in the past season.
- ▶ Not giving adequate attention to patients referred by Health workers.
- ▶ Banning of black jaggery (used for making country liquor).
- ▶ People's participation in management of the Hospital / PHC.

This memorandum was read out before the people and staff of the PHC and the staff was made to answer each of the questions, one by one. We were able to get a list of drugs available, and made the doctors to commit that they would treat patients as far as possible without sending them to the Medical Store. Key supplies were identified which are often in short supply. Key supplies were identified which are often in short supply. In a rather dramatic fashion, several local people related how a particular attendant had forced them to pay for certain services in the hospital. This person was called before the people and he publicly apologised, promising not to do so in the future. Another junior doctor also confessed to taking money from people for giving injections. The issue of taking bribes or 'service fees' by the government health staff was brought to light and people's reaction was forcefully registered.

The issue of insecticidal spraying was again discussed and a list of villages where spraying had not taken place or had been partial, was presented. A commitment was obtained that patients referred by our health workers would be given proper attention by the hospital staff. Finally it was agreed that meetings between the Govt. health staff and representatives of the Sanghatna health programme would be held from time to time to resolve such issues and follow up what had been committed. This was followed by the meeting between government health staff and Sanghatna health representatives in December 1997, itself. Several of the issues raised in the

demonstration were thrashed to in further detail and a framework was established for regular dialogue.

### **AROGYA YATRA-A CAMPAIGN FOR HEALTH**

The next step linked with advocacy was the Arogya Yatra, (18-23 Jan 1998) organised to develop a campaign for health awareness and health rights. The Yatra visited 11 villages and was attended by people from more than 25 hamlets in this campaign. The attendance in each programme was 200-400 people and so a total of about 3000 people were involved in the health campaign. Over 1100 signatures / thumb impressions were collected on a petition demanding that the Sanghatna health workers be recognised as link workers by the government health services.

The team of the Yatra consisted of about a dozen-health activist of the Sanghatna who demonstrated the various exhibits for health awareness. There were poster exhibitions on important health issues including right to health care; improvements in living conditions necessary for health for all; community initiatives for health; ill effects of alcohol and tobacco addiction; women's health including social aspects (e.g. stigma relating to menstruation, sterility); medical exploitation and malpractice (e.g. misuse of injections); high cost of medications and the alternative to this. High cost of medications and the alternative to this. Three printed posters were published which were available for sale, which dealt with (i) Health care rights (ii) Community initiatives for health and (iii) Healthy living conditions to be strived for.

Besides this there was a complete exhibition of actual human organs (both healthy and diseased) and a life size model of the dissected human body showing all organs and stems. A microscope was used to show live microorganisms, thus demonstrating how infections may be caused, especially waterborne infections. Human cells were also shown under the microscope. Slide shows were shown for special groups of women on women's health and also on topics like immunisation and nutrition. Video programmes were shown on the importance of clean drinking water, immunisation and on the women's antiliquor movement in Andhra Pradesh. The most popular video programme dealt with the story of an alcoholic, showing how alcoholism damages both health and family, and how an alcoholic can get rid of his addiction with social support.

During each programme, after the people had seen the various exhibits, a village meeting was held to discuss key issues relating to health. During this meeting mainly the issue of medical exploitation was discussed (high costs of medications charged by private doctors vs. actual low cost of bulk drugs; unnecessary, expensive, hazardous and overuse of injections and intravenous saline by private doctors; apathy and unavailability of drugs in government health centers). The logical alternative of forming health societies and having their own health workers was discussed. In most villages, people decided to pool contributions, form their health societies, select women as health worker and thus build their alternative health system. At the same time concrete strategies to put pressure on the government health system were also discussed. As a consequence of the Arogya Yatra eight new hamlets subsequently formed health societies and have joined the health programme.

### **DEMONSTRATION AGAINST CORRUPTION IN A PRIMARY HEALTH CENTER**

Another major campaign taken up recently concerns the corruption in one of the local Primary Health Center. Under a scheme sponsored by UNICEF, all pregnant women were to be given a sum of Rs. 800/- by the PHC to assist the women for pregnancy and delivery related expenses. However, several pregnant women were given only Rs. 50/- from the PHC. They discussed this among themselves and with Sanghatna activists and it was decided to hold a demonstration and find out about the actual situation from the PHC doctor. In September 1998, a large

demonstration was organised at the PHC, at which time the concerned doctor was absconding. However, a visit of a District level official took place at the same time and various irregularities came to light. As a result, the relevant doctor was suspended; however the women are yet to get the money due to them.

### **AGITATION AGAINST FATAL NEGLIGENCE BY A PIRATE DOCTOR**

As part of the campaign against medical exploitation, the health programme of the Sanghatna had brought out a poster in 1996 highlighting the fact that injections are not necessary for most ordinary illnesses. It was sought to be emphasised that people should not ask for injections from the doctor, as this is one major means by which private doctors extract money from patients.

The potential threat of adverse outcomes from unnecessary injection came to light in October 98 when a young man with mild fever approached a private doctor (a homeopath) in the area and was given an injection which was most likely unwarranted. The person died after about two days, with major swelling in the region of the body where the injection had been given, probably as a sequel to the injection. The Sanghatna took up the case of the person and a demonstration was organised demanding compensation to the family of the victim. Simultaneously steps were initiated to ensure an enquiry into the matter. An enquiry by taluka level authorities is under way in which the Sanghatna is assisting the victim's family and attempts are on to ensure punishment to the doctor if found guilty. This could be a basis for reducing the currently widespread, irrational and exploitative practice of giving unwarranted injections by many private doctors.

### **DISCUSSION**

Some issues have emerged in the course of our limited experience of the last three years. It would be illustrative to compare these with other parallel experiences and analyse the dynamics of working for health rights.

*Firstly*, it is comparatively more feasible to take up the issue of right to health care or right to health services compared to the much broader issue of right to health. Though we realise that health services form only a small part of the determinants for health, yet issues like right to clean drinking water or nutrition have not been taken up systematically. Probably these need to be addressed, as issues in their own right, and subsequently linked to a broader vision of health. We can also think creatively of how to link the existing health initiative with such issues. Health workers could collect data on waterborne diseases / malnutrition and then use this as a basis for generating pressure regarding issues of clean drinking water nutrition. Indirectly, by strengthening the Sanghatna's base, the health initiative can help the process of improving socio-economic conditions, which are perhaps the most important determinants of health.

*Secondly*, it is clear that a meaningful movement for health rights has to be rooted in a health initiative of the people themselves. The community health worker programme not only cuts down on medical exploitation and provides a channel for affordable first contact care, but also leads to a level of initiative and awareness on health. This leads to a situation where people can also try to access public health resources and address health related deprivation and exploitation on a large scale. In other words, some sort of community based health programme seems to be a pre-requisite for sustained movement on health, if one is to move from purely reactive to pro-active demands.

*Thirdly*, it is comparatively easy to raise quantitative demands like supply of drugs, implementation of preventive measures etc. but much more difficult to address qualitative issues like quality of care given at Govt. health centers or rationality of care by private doctors.

A greater degree of health awareness and knowledge would be required to carry out such monitoring. But the question arises as to whether we should put in energy into monitoring someone else's system or try to develop and strengthen our own?

*Fourthly*, we have experienced the difficulties involved in pressurising the private health sector even though it may be far more exploitative than the public health system. Ultimately the government regulatory machinery will have to be pressurised into exerting some control over at least the 'bogus' doctors. We can hold the Public health system accountable to a much larger extent than the private health sector. The second strategy could be to 'selectively' boycott or pressurise the most exploitative doctors and make use of the contradictions among the section.

*Fifthly*, we are increasingly feeling that the powers determining even simple issues like drug supplies to the local PHC or implementation of preventive measures are not easily amendable to local pressure alone. We need to build broader alliances with other pro-people groups to address such issues and build pressure at, say, the District level. We also need support from the media and middle class sections on the issue of disease outbreaks and inadequate public health measures. At the same time there is a definite need for more information, for example, on District level health expenditure, health finances, supplies etc. In the absence of such information it is difficult to formulate strategies to access resources.

*Finally*, there is a need to formulate the concept of minimum health services, which should be available to every citizen of the country. A much broader campaign is required to demand this as a basic, judicable right. This would specify the range of services and supplies, which should be available to the people at every sub-center. Primary Health Center and Community Health Center in the country. At the same time, we could ask for a modified health worker scheme (on the lines of the recent education for all schemes in MP). Under this, any fifty households could undertake to select a health worker from their community and then the State health services would be legally bound to train this person, give basic supplies to him / her, and referral back up. A basic honorarium to this person could be given by the village Panchayat. We need to think of a broader coalition of people's movements, NGOs, political groups and citizen's organisations to take up these issues and convert the light to health care from a slogan into reality.

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