Developing an Alternative Strategy for Achieving Health for All

achieving health for all

The ICSSR/ICMR Model- The FRCH Experience

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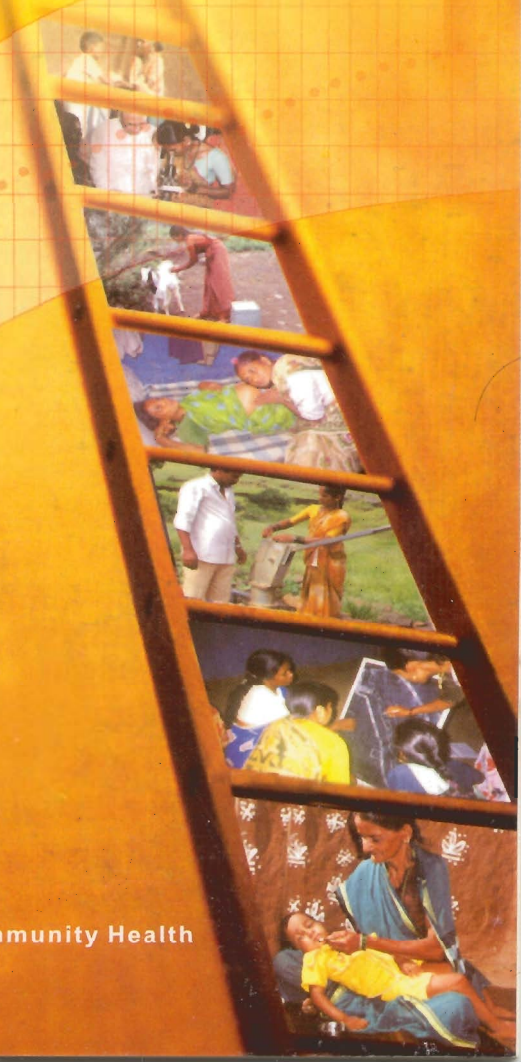

frch
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About FRCH

The Foundation was established in 1975 as a non-profit voluntary organisation to promote the concept of health care rather than the mere care of illness. This entails the study of health in its wider perspective in order to improve the health of our people. The emphasis is on the problems of the underprivileged sections of our society, especially women and children.

***Our staff** from various disciplines are engaged in conducting both conceptual research as well as field studies into the problems faced in achieving Health for All. This is to help in devising alternate models of health and medical care in keeping with the social, economic and cultural reality of the country. The aim is to influence government policy and sensitize the people at all levels to the problems and possibility of achieving good health at affordable cost.*

FRCH believes that health is a reflection of the overall quality of life: In fact, 80 percent of the diseases in India are the diseases of poverty and true health can exist only when there is a positive improvement in the socio-economic scenario of the country. This can only be achieved through the people's own efforts. Hence, FRCH aims to create a People's Health Movement by demystifying medicine and increasing public awareness on health, especially at the grassroots level, and by strengthening the age old health culture of our people based on our own systems of health and medical care. This is to be achieved, by publishing and disseminating information on all aspects of health and related subjects, and also by conducting participatory training and interacting with the community.

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Their foresight in supporting this lateral concept of a people based form of health care in its early stages has provided strength and confidence to our work. The personal participation of Shri Naoroji P. Godrej, FRCH, Trustee and visionary industrialist in the development of the Mandwa Project is especially remembered.

Abbreviations

ANM	Auxiliary Nurse Midwife(ves)
AVI	Accredited Vocational Institute
CHC	Community Health Centre
CHCS	Community Health Care System
DOTS	Directly Observed Treatment, Short Course
FRCH	Foundation for Research in Community Health
GDP	Gross Domestic Product
ICSSR	Indian Council of Social Science and Research
ICMR	Indian Council of Medical Research
MCH	Maternal and Child Health
NGO	Non Governmental Organization
NIOS	National Institute of Open Schooling
PHC	Primary Health Centre
PRI	Panchayati Raj Institution(s)
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Programme
SYMPMED	Symptomatic Medicine
TB	Tuberculosis
VHF	Village Health Functionary
WHO	World Health Organization

Glossary of Indian Terms

Ayurveda	Alternative system of medicine derived from or modified in and practised in India.
Bharat	Another name for India
Dharmashala	Temporary staying arrangements in the proximity of the People's Hospital in the CHCS for patients and relatives for which token payment is accepted.
Gram Panchayat	Executive council of local self-government at village level. Constitutes the first level of governance in the Panchayati Raj system.
Gram Sabha	A body consisting of all persons registered in the electoral rolls of the village.
Gramsakhi	A full-time female Village Health Functionary in the CHCS serving a population of 250.
Gujarati	Language of the people of Gujarat
Hindi	National language of India used more predominantly in the north of the country.
Homeopathy	Alternative system of medicine derived from Germany and practised in India.
Khelwadi	Playgroup
Marathi	Language of the people of Maharashtra
Panchayati Raj	Local self-government

Panchayati Samiti	Rural local self-government institution at the block/sub-district level of approximately 100,000 population. Constitutes the second tier of governance in the Panchayati Raj system.
Raj	A term independently used refers to post 1857 British rule in India.
Sahyogini	An extensively trained local female functionary in the CHCS serving a population of 5000. She bridges the functional gap between the village and the block/taluka level health care facilities.
Shramdaan	Volunteered labour for community benefit for which payment is not accepted.
Tai	Village elder sister(s)
Taluka	Administrative unit for revenue collection covering population of approximately 100,000.

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The maintenance of physical health and mental well being is probably the most cherished of human requirements. Hence, like preachers and teachers, healers have been the most respected, though not most affluent, members of society. Their remuneration has been the respect and job-satisfaction they have enjoyed. They have provided a personalized service with love and compassion to all regardless of other considerations.

In more modern times, this role has undergone a change. The personalized method of health care has been replaced by a more impersonalized and less effective one. Led by the World Health Organization (WHO), packaged programmes are delivered to people via the health ministries of WHO affiliated countries. This is regardless of the fact that the problems of health and disease vary not only from country to country, but also from region to region and even from village to village. The majority of health problems primarily concern the individual, the family and the local community. Yet the modern system of health care has converted this personalized activity into a commodity to be 'delivered' by an impersonal government, or as a profit-oriented privatized service.

The healing profession has been co-opted by the pharmaceutical and medical industry which sees it as a lucrative business in a field where consumer resistance is at its lowest.

In the process, curative medicine, the money-spinner, has overtaken the far more important preventive and promotive aspects of medicine.

In post-colonial societies, this new form of economic re-colonization has pauperized the masses resulting not only in the regression of people's health but also in the resurgence of communicable diseases - the diseases of poverty.

ALMA ATA AND AFTER

In 1978, at a landmark WHO-sponsored conference in Alma Ata an international declaration that promised 'Health for All' was adopted[1]. It was a strategy of integrated health and medical care for the 'need based' countries, including India, that were signatories to the declaration. Over the years, though, the integrated approach advocated in Alma Ata was converted into a series of vertical programmes based on the bio-mechanical, so called 'scientific' Cartesian concept of life, including health, which provides no space either for spiritualism or altruism, neither of which can be quantified. This approach also disregarded the fact that disease patterns are different in different parts of the world, and that some countries have their own well established, readily accessible, acceptable and cost-effective health culture, practices, and systems of health and medical care.

Privatized, lucrative, western style curative health services, which are increasingly becoming the norm, serve an affluent minority, but ignore basic health and medical care for the majority. This has come about due to excessive pressures of

the pharmaceutical and medical instrumentation industry, which has co-opted the medical profession. This has been forced on developing countries through the Structural Adjustment Policy dictated by the World Bank and the International Monetary Fund.

The major western donors of the World Health Organization, who dominated the world and its resources, co-opted the new leaders of developing countries into the economic strategy of globalization, liberalization and privatization. This widened the gap between developed and developing countries and also between the rich and poor within developing countries.

This has further distorted the health scenario in developing countries where we now have, here in India, the ludicrous situation where five-star hospitals vie with each other to attract 'medical tourists' from the West, even as 85 per cent of the local rural and urban slum population do not have access to basic health and medical care![2] The Indian government promotes and encourages this development arguing that it is a way of earning foreign exchange; but the money earned never trickles down to strengthening the public health service.

As the cost of health care in affluent urban enclaves in our country has increased hugely as a consequence of the above-mentioned policies, a new medical business termed 'health insurance' is now being promoted. Since the way in which insurance works is little understood, few people realize that what claims to make health care affordable can end up further increasing costs[3].