Q7(a)

Critically examine existing paradigms of holistic health for the marginalized sections of society drawing inferences from COVID-19 pandemic.

UPSC Civil Services Mains 2024 · Anthropology GS 2 · 20 marks · Evolution of the Indian Culture and Civilization

1.1 Evolution of the Indian Culture and Civilization-Prehistoric (Palaeolithic, Mesolithic, Neolithic and Neolithic-Chalcolithic), Protohistoric (Indus Civilization). Pre-Harappan, Harappan and post-Harappan cultures. Contributions of the tribal cultures to Indian civilization.

Core demand of the question

- State what holistic health means in anthropology
- Review biomedical, public-health, AYUSH, community and rights paradigms for the marginalised
- **Use COVID-19:** migrants, tribals, nutrition, vaccine, stigma
- Be critical of each paradigm's gaps

Revision summary

Holistic health means body, household, ecology and inequality together.

Paradigms include hospitals, Alma-Ata primary care, AYUSH/ethnomedicine, and rights-based social determinants.

COVID-19 exposed migrant invisibility, weak tribal PHCs, vaccine distrust and nutrition shock.

Vertical hospital care without food and housing failed the poor.

Assemble PHC, PDS, FRA livelihoods and non-discriminatory biomedical care; do not stop at a wellness slogan.

Introduction

Holistic health treats illness as **body, household, ecology and inequality** together. For marginalised sections - ST, SC, slum, migrant, PVTG - no single clinic model is enough. **COVID-19** made that visible when the virus followed crowding, transport and distrust rather than a random medical map.

Body

Existing paradigms

Biomedical hospital care saves acute lives (oxygen, ICU) but is distant from hamlets and costly. During COVID-19, tertiary hospitals filled while tribal PHCs lacked oxygen and staff. **Alma-Ata primary health care** (1978) and India's **NRHM/NHM**, ASHA and anganwadi are the public-health paradigm: prevention, immunisation, nutrition. They work when the worker is local and paid; they failed when migrants were invisible on lists.

AYUSH and tribal medicine are living systems (**Elwin** noted local healing; ethnomedicine is a syllabus topic). They can support care and meaning; they cannot replace oxygen. A holistic paradigm **includes** them without abandoning epidemiology.

Rights and structural paradigms (**Xaxa, social determinants: land, food, water, caste clinic discrimination) say TB and stunting are political. WHO** social determinants and **Amartya Sen**'s capability talk belong here. **ICDS, PDS, POSHAN, PM-JANMAN** are this paradigm in scheme form.

Community and PESA Gram Sabha health would make the hamlet the unit: quarantine decided with consent, MFP cash as nutrition, local language information. This was rare in 2020.

Inferences from COVID-19

- **Migrant Adivasi and OBC workers walked home when industry shut: livelihood is health**. Quarantine centres that ignored food taboos and menstrual needs failed. **Vaccine** uptake lagged where rumours met a history of coercive camps; trust is a clinical resource. Excess death in the poor was a **class and crowding** fact. Forest villages sometimes had fewer early cases (distance) then worse second-wave outcomes (no beds). Sickle-cell and TB co-morbidity in tribal belts were under-managed.

Holistic talk that only adds a yoga module to a corporate hospital is not holistic. Holistic health for the marginalised is **PHC plus food plus FRA income plus non-discriminatory wards plus epidemic information in Ho, Santali, Gondi, Kui**. COVID-19 showed that **vertical disease control** without social protection collapses.

Critical close

Do not romanticise "tribal immunity" or blame "superstition" as the main death cause. The paradigm that survived the pandemic is **primary care + social determinants + respectful biomedical surge**. Anthropology's job is to keep the household and the hamlet in the protocol.

Flow diagram

Biomedical surge -> Holistic health

PHC nutrition PDS -> Holistic health

Land FRA no stigma -> Holistic health

COVID migrants -> Gap in assembly

Conclusion

Holistic health for the marginalised joins clinic, food, land and trust. COVID-19 proved that hospital modernity without migrant housing and hamlet PHCs is not holistic. Existing schemes name the parts; the pandemic showed they were not assembled.

Facts & figures

Alma-Ata 1978

WHO/UNICEF declaration of primary health care as the main path to health for all, still the public-health baseline.

ASHA / NHM

Community health volunteers and the National Health Mission are India's primary-care infrastructure, uneven in ST hamlets.

Xaxa 2014

Linked tribal health failure to land, displacement and staffing, a structural paradigm confirmed in the pandemic.