INDIA’S COMMUNITY HEALTH WORKERS SCHEME:
A SOCIOLOGICAL ANALYSIS

CHARLES LESLIE

Centre for science and Culture, University of Delaware, Newark,
Delaware 19711, United States of America

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ABSTRACT: The author discusses in this paper India’s massive Community Health workers scheme launched in 1977, and analyses its merits and demerits minutely here.

An ambitious and controversial program to train village people as Community Health Workers was initiated by the government of India in 1977. During the first year 774 out of the 5400 Primary Health Centres in the country set out to train 110,000 workers. The goal was to have one worker for every 1000 people in rural areas by 1981, and this would require training at least 580,000 villagers. Communities would nominate candidates to the Medical officers of Primary Health centres, who were to select trainees after consulting community members and outsiders, such as Block Development Officers and Multiple Purpose /Workers. Candidates should be literate, physically active, service oriented, and capable of devoting several hours a day to voluntary work. While they could be either male or female, preference should be given to candidates who were under 30 years of age, who had at least six years of schooling, who already practiced some form of medicine, and who belonged to scheduled castes. They would receive a stipend of 200 rupees a month during a three month course of training and then they would spend two or three hours a day on health care in their home communities. To assist this activity the government would give them a supply of medicines and 50 rupees a month, but they were not to have the status of government employees.

Although community Health Workers would know how and when to refer villagers to clinics, their work would not be classified as a job in the supervisory hierarchy of the health service bureaucracy. Their performance would be evaluated as voluntary work by the people in their own communities. Also, their primary work would be within the regular system of village occupations. From the perspective of health care planners, an important function of community Health Workers would be to serve as cultural brokers between villagers...
and the state system of professionalized health care.

The scheme resembled the one for barefoot doctors in China. The training of Community Health Workers was to emphasize preventive medicine, supplemented by simple curative practices drawn from both indigenous and cosmopolitan medicine. Newspapers referred to the Chinese system in describing the Indian program, and officials in the Ministry of Health like Dr. B.C Ghosal resorted to an unmistakable rhetoric:

Among the changes that have been brought about in health delivery in the People’s Republic of India, the introduction of community Health workers scheme has been one of the most important ..(it) is a concrete manifestation of the ideological principles of following the mass line and being self reliant. (Ghosal 1978:41)

Dr. Ghosal acknowledged “misgivings about the scheme” within the medical profession, particularly its use, and therefore its sanction of indigenous medicine, and its creation of a category of health care provider outside the occupational structure controlled by doctors. One may guess that the “misgivings” could have been described more vividly as furious skepticism and opposition. Dr. Ghosal wrote that these critics expressed “fear the community Health workers would turn to be quacks.” (ibid).

The question is, “What caused this massive program?” we could ask about how it works, but to ask about causes is better suited to our concern throughout this essay with the rhetoric of motives. I will illustrate what this means by comparing stories that describe the way the program began. To paraphrase Marx, people do not construct history any way that they wish, they make it to convince themselves and others that it is true. Self-deception is a fundamental aspect of policy making. I will conclude the essay from this melancholy perspective, discussing works by T.N. Madan, D. Banerji and others that help define the context in which the program was formulated and implemented.

I heard about the community Health worker scheme in 1977 from a western physician who had recently been to New Delhi. The story was told at a dinner party, and since an Islamic revolution in Iran was then much in the news, it was told in the topical vein of the Ayotolla-is-a-madman. In this case the “Ayotolla” was Raj Narian, the Minister of Health in the new government headed by Moraji Desai who wanted to start the scheme immediately on a nation-wide scale. My informant said that all of the responsible people in the medical community were trying to stop him, but he was hard to influence because he was an irresponsible and head-strong man who was almost totally ignorant concerning medical institutions and the problems of health care planning. Physicians in the Ministry hoped to divert him from the full-scale program by arguing the necessity of first setting up pilot projects to test the feasibility of various components of the scheme. The sane approach was for a few medical schools in different parts of the country to design pilot studies by consulting foreign experts like my informant, and by coordinating their experimental work with on-going projects of the world Health
Organization, and with other programs at institutions abroad. Although the scheme called for villagers to be trained in indigenous as well as cosmopolitan medicine, my informant thought that one of the pilot studies would involve Ayurvedic and Yunani colleges. As an allopathic physician and skeptic about indigenous medicine, he did not think that this was odd. With practically the whole medical establishment against Raj Narian’s impetuous scheme, he was hopeful that reason would prevail, and he was pleased by the prospect for international collaboration.

A few months after this conversation took place the Community Health Worker scheme was inaugurated, apparently as Raj Narian wished. The following year I visited India and had an opportunity to ask about the program. Dr. D. Banerji was one of the experts I talked to in January 1979. A physician with a graduate degree in anthropology from Cornell University, he is professor of social Medicine at Jawaharlal Nehru University. I expected him to favour the program because he had for many years criticized the urban bias and elite character of health care planning in India.

Dr. Banerji maintained that the program was fraudulent. He said that the government adopted it to give the appearance of acting for the welfare of the masses while in fact it did nothing to correct the inequities of the political economy. Raj Narian in his opinion was an unknowing and self-deceived mouthpiece of the ruling elite, offering a placebo medical reform in place of genuine change. Banerji’s language shifted Narian’s role from that of a willful, hare-brained actor to that of a puppet of reactionary social forces who perceived his situation only dimly, if at all. Although the idea of the program was a good one, and the occasion of its inauguration created an opportunity for progressive change, Dr. Banerji said that it was jeopardized from the outset by conceptual errors. In the first place, the planners ignored the social organization of rural communities, and made no provision to keep the people who dominate these communities from turning the program to their selfish uses. Secondly, the planners ignored the structure and world view of the medical profession. The people that they expected to implement the scheme were the same ones who had failed for thirty years to work effectively in rural areas. Their professional training and social status made them unsympathetic to the program’s goal of “People’s health in people’s lands.” They could not utilize indigenous medical traditions in the way that the program envisioned because they lacked both the commitment and the skills that this would require. Finally, while the scheme exhorted the masses to accept a rudimentary mixture of indigenous and cosmopolitan medicine, the ruling classes would continue to demand for themselves sophisticated professional care using expensive technology. This double standard, with “one standard for the classes’ and another for the ‘Masses,’ ‘compromised the claim that the program would achieve greater justice in health care. Dr. Banerji elaborated these points in a mimeographed background paper for a press conference held in connection with an Earthscan seminar on Primary Health care in London (Banerji 1978).
Another person I talked to in 1979 was Dr. K.N Udupa, who would soon retire from his job as director of the Institute of Medical sciences at Banaras Hindu University. Dr. Udupa had studied at B.H.U. when training there was in an Ayurvedic college with an “integrated curriculum.” He also studied surgery at the University of Michigan, and later spent a year in research at Harvard. He returned to B.H.U in 1960 to administer the transformation of the Ayurvedic college into an allopathic medical school, and eventually into an institute that conducts research and awards post-graduate degrees in Ayurveda and in cosmopolitan medicine.

Dr. Udupa told me that he had been a personal physician to Raj Narian, and when Narian became Minister of Health they went to a hill station together to work through the ideas of the community Health Worker scheme. The publicity about Chinese accomplishments in public health, the new arguments for “appropriate technology” in various fields of development, and Ivan Illich’s Medical Nemesis had created a stir in New Delhi. At the urging of leading physicians, including the Director of the All-India Institute for Medical science, Dr. V. Ramalingaswami, the previous government had appointed a committee headed by the director General of Health Services, Dr. J.B Shrivastava. The shrivastava committee Report (Ministry of Health 1975) has recommended a program similar to the community Health worker scheme. Starting from this background, Raj Narain consulted Udupa because he had experience as a WHO consultant in Geneva, and a long career in health administration, where he was especially knowledgeable about the problems of utilizing indigenous medical resources. In his account, Narain was an autonomous and intelligent man who felt responsible as Minister of Health to devise a program that would genuinely improve the delivery of health care to village people. Although he was strongminded he was not off his bean in the manner suggested by the foreign expert, and he certainly was not the unconscious instrument of politicians and social classes who intended to use a medical placebo to sustain a system of exploitation.

These stories were told by leaders in health care research, planning and administration. They were credible on-the-ground accounts of a kinds that field workers value. The discrepancies between them jog the imagination. They caused me to recall a passage in War and Peace. Tolstoy had shown military officers arguing about strategies as they laid their plans in detail before combat, but once the battle began the observer saw that no one was in control and that a leaders role was to act as if he knew what was happening and had the power to affect the course of events. The acclaimed “realism” in Tolstoy’s work is achieved largely by irony.

That Indian society is open to study is apparent in the variety of work sponsored by the Indian Council of social science research, and in the extensive data available for public scrutiny in governmental publications. It also appears in the freedom with which politicians and bureaucrats criticize their own institutions. When one compares the literature upon which the present essay is based, the amount and reliability of information about India are
impressive. Also the critical statements by officials are astonishing. For example, Dr. Ghosal wrote in a Ministry of Health publication:

The existing ... there is little coordination between the various sectors, which makes it difficult to establish priorities and to plan programmes and expenditure accordingly. The system is, therefore, inefficient and uneconomic and often leads to duplication of service in some areas and their complete absence in others. (Ghosal 1978:5)

In democratic bureaucracies declarations of chaos are as much a rhetoric as a description of fact, for they are necessary to justify the competition to plan, order and improve, that engages officials. They also justify the social sciences, whose very existence assumes that people can use the knowledge gained by studying themselves to better govern their affairs.

One of the remarkable things about the community Health worker scheme is that it was subjected to extensive sociological evaluation. Six institutes in different parts of the country collaborated to design survey research for this purpose, publishing their first report within the first ear of the program an their second report at the end of the second year. Health care is a function of state governments, and the researchers noted “apathy to the scheme” among state officials, who they quoted as typically saying, “We are Government servants and hence have to do whatever we are asked to do. But, if you ask about our honest opinion, then we do not agree with the scheme”. (NIHFW 1978:18) The instructors at the Primary Health Centres and other training locations were often themselves untrained in the goals and methods of the program, and they frequently did not use the training manual or distribute it to their students. After their training the Community Health Workers showed very little comprehension of the public health measures and the preventive medicine they were supposed to have learned, or the knowledge they should have acquire to know when to refer a patient to the primary Health centre. They had a better grasp of the curative allopathic medicine taught in the program. While training always included the allopathic component, the instruction in Ayurveda was omitted about half of the time, and by the second year, the Yunani and siddha components were largely ignored. The most vulnerable members of the population were women and children who would be most affectively served by woman workers but over 90% of the community Health Workers were men. In the second year researchers reported that “pre-school children and woman constitute a small percentage of the users of the services of CHVs” (NIHFW 1979:38) Despite these findings, the studies showed that village leaders welcomed the program and were satisfied with the selection of trainees; the community Health workers were regularly engaged in health care by the second year of the program, and the villagers who used their services were largely satisfied by their treatment.

My purpose is to give an impression of this work, rather than to summarize it. Thus, I have left out a great deal, including the variations between states. In Uttar Pradesh,
Haryana, Rajasthan and Madhya Pradesh, for example, less than 1% of the trainees in the first study were women (NIHFW 1978: Appendix Vb), while in the Punjab 35% were women (Vohra, Ramaiah et al 1978:16) and this rose to 54%). Evaluation research is a book keeping enterprise to measure the discrepancies between plans and performance. It uses documentary records and survey questionnaires that assume a nonproblematic reality, whereas our concern is with the way that reality is variously constructed by different people. In Part I we described the development of ethnographic studies in which conceptions of historical continuity or discontinuity lead to different interpretations of health care concepts and traditions. In part 2 we analysed conflicting perspectives on the utility of indigenous and cosmopolitan medicine, and in this concluding section we are examining different conceptions of reality in policy research.

In fact, the reality that the evaluation studies describe is often problematic. Let me illustrate the point. The pan called for a third Medical Officer to be appointed to the Primary Health Centres, and since the indigenous medical traditions were to be included in the training and practice of Community Health Workers, preference was to be given to physicians trained in one of these systems. The researchers wrote:

While indigenous systems of medicine were expected to be taught, qualified trainers in these subjects were hardly available. Further, 45.6 per cent of the posts of the third MOs filled so far were of Ayurveda system of medicine and only 14.2 per cent of them were filled by those belonging to modern system of medicine. Many of these posts were not even created in many of the states. On the other hand, there was high degree of preference on the part of community for modern system of medicine. (NIHFW 1978:128)

Since 273,645 physicians were registered to practice the indigenous systems in 1978, compared to only 235,631 physicians registered to practice cosmopolitan medicine, and 106 colleges taught the indigenous systems, compared to the same number of allopathic colleges (Ramalingaswami 1980: A-9, A-11), was it really a fact that few if any people were available to teach the indigenous systems to Community Health workers? Who decided who was “qualified,” and on what grounds? And what did “community preference” mean with reference to the allopathic an indigenous systems? A table showing such preferences by states asserts 98.5% preference for allopathy in Andhra Pradesh, with 1.5% for Ayurveda; 88.5% for allopathy in Gujarat, with 14.4% for Ayurveda; and so on (NIHFW 1978: Appendix VIb). Did the questionnaire assume a fictitious open market conception of medicine, so that it assumed villagers would imagine themselves to have equal access to different services and products, and the freedom to act like individualistic consumers? Were villagers in effect asked which products and services they would like to receive free of charge, the ones that were normally high priced in the market place, or the ones that were cheaper? Were the choices the questionnaire asked them to make congruent with the ways that they
normally thought about and engaged in hand, did villagers agree to the answers that they though such people wanted?

We described the relative demand for cosmopolitan and indigenous medicine in parts 1 and 2 of this essay. Marriott, Khare and others reported the prestige of cosmopolitan medicine among villagers years ago, and subsequently everyone who has attended to the pluralistic character of practice has observed it, my own research demonstrated that this was not new. Vaids and Hakims in the 19th century used “English medicines” to enhance practice, and in the first quarter of the present century Ayurvedic revivalists bitterly complained that they were compelled by client demand to prescribe allopathic medicines.

The evaluation surveys of the community Health Worker scheme exaggerated village preference for cosmopolitan medicine, and then misinterpreted it as evidence that the program should give less attention to the indigenous systems. Policy makers demand the appearance of “hard data,” and the market categories of evaluation research produce numerical tables that satisfy this demand. The categories dissolve, however, when one knows more about the reality they refer too. They dissolve in this case when one knows that the concepts and technology of cosmopolitan medicine are understood and used in a humoral manner at all levels of south Asian Society. Obeyesekere (1976) and Tabor (1981) describe how Ayurvedic physicians do this, but since we discussed their work in Part 1 of this essay I will illustrate how laymen make humoral translations of cosmopolitan medicine by quoting two passages from one of Mark Nichter’s articles on South kanara villages.

The concept of abhiyasa, habitude, is a counterpart to the concept of body constitution to he concept of body constitution, prakriti... According to the concept of abhiyasa for the body to take to a new food or type of medicine it must first adjust to its properties. Thus, a South Kanara mother feeds a young child minute quantities of food prior to weaning so that the child will later be able to digest the food. In the case of medicine, a young child regularly receives herbal preventive medicine for a number of culturally defined illnesses. Cosmopolitan medicine is generally not administered unless a crisis occurs. A breastfeeding mother avoids the extensive use of cosmopolitan medicine herself, least it be transferred to the child through breast milk... Children over three are gradually introduced to cosmopolitan medicine through crisis involving illnesses which the villager believes to be managed faster by “English” medicine. Thus, the young lose their habituation to herbal medicine and gain habituation to cosmopolitan medicine. But at what cost?... Many villagers think that English medicine offers a quick cure but eventually harms the overall integrity of one’s health. This concept is expressed by the statement that “English” medicine is heating and its continued use leads to bloodlessness and weakness... in developing an abhiyasa to “English” medicine, the villager enters into a dependency relationship. A sense of understanding the body is forfeited, resulting in weakness and loss of control. This is not to say that one cannot regain an abhiyasa.
This possibility is entertained by patients who undertake a medicinal rite de passage characterized by blood purifiers, purgatives and diuretics. Patients who have an ailment which cosmopolitan medicine has failed to cure use these substances, and so do people who seek realignment with herbal (folk, Ayurvedic) medicine as a symbol of identity... Some villagers frequent ayurvedic/folk practitioners weeks or even months after taking cosmopolitan therapy for medicines to cool the body and processes which powerful medicine has disrupted. (Nichter 1980:227-229)

Dr. Banerji the physician anthropologist and critic of Raj Narian, interprets ethnographic descriptions of humoral concepts as an effort to “blame the victim” for ineffective health care. If Mark Nichter, or other authors who describe traditional beliefs, claimed that humoral concepts caused unhealthy practices or prevented villagers from using accessible and good quality cosmopolitan medicine, Banerji would be correct, but on the contrary, the younger ethnologists like the older ones describe the functional character of traditional culture, the prestige of cosmopolitan medicine, and the demand for it that causes indigenous practitioners to purchase stethoscopes and to administer injections. From the early work of Marriott and carsstairs, social anthropologists have agreed that governmental efforts to improve health care delivery not fail because laymen use traditional concepts, they fail because the services themselves are inappropriate and inadequate. For over twenty years ethnologists have commented on the rude manners of health professionals toward poor and rural people, the long waits for brief and unsatisfying consultations, and the shortage at government dispensaries which causes patients to be turned away with inappropriate medications, or with prescriptions for drugs that they cannot afford to buy.

Dr. Banerji describes the discovery early in his career that government dispensaries often gave villagers with tuberculosis useless cough syrup as a turning point in his understanding of the system (Banerji 1964). In his view, cosmopolitan medicine is dominated by a self-serving elite that perpetuates the colonial pattern of exploitation in South Asian society. I want to summarize this perspective because it address head-on problems that medical researchers have largely ignored.

Colonialism upset the ecological balance of South Asian civilization, Banerji asserts, and under British rule malnutrition and infectious diseases increased. Even though the health of the population was declining the British withheld support from Ayurveda and Yunani medicine, causing these already stagnant systems to give way entirely to “forces of superstition” and the “infiltration of various kinds of quacks” (Banerji 1975). The foreign rulers did introduce western medicine, but only to serve their own interest, so that the benefits of this system were denied to the masses. To staff the lower positions of the colonial health service they trained Indian physicians whose attitudes towards their own society made them “brown Englishman.” These physicians took over at Independence, and since the health services were rapidly expanding they flourished in “a virtual
glorification of mediocrity”. Knowing themselves to be inadequate to the tasks before them, however, they sought the advice of foreign experts who came “to play a dominant role in almost every facet of the health services system.” (ibid) The consequence has been a continuation of colonial dependency. Alienated from the Indian masses, the “brown Englishmen” set out to promote their own interests by expanding urban services and by building medical schools to give the same training as those in Europe and America. Rather than training a ‘Basic doctor” for the comprehensive system of rural health care that had been recommended at Independence, they have replicated themselves. Immulating the so-called “standards” of western societies, they train physicians in hospital oriented high technology medicine whose ambitions are to an elite urban practice, to go abroad for advanced training or to immigrate entirely.

Dr. Banerji compares the physicians who run the Indian health service to army colonels because they like “to launch military style campaigns’ for population control or against specific diseases such as malaria or tuberculosis. He says that ‘the rural population raises I the minds of these decision makers the spectre of difficult accessibility, dust and dirt, and superstitious, ignorant, ill-mannered and illiterate people,” (ibid) and that they favour single issue campaigns because they can be administered without attending directly to the care of rural people or to the political and economic causes of their suffering. They also provide opportunities for the colonels to make alliances with foreign experts, and to travel abroad or to fly around the country for consultations, workshops and conferences.

To legitimate their view of rural society, Dr. Banerji claims that the “brown Englishmen” in charge of the health services have recruited “eminent social scientists from the west” ad their “Indian disciples” to write studies about the forces that “mitigate against acceptance of modern medical practices in the mostly tradition bound, caste ridden, rigidly hierarchical, illiterate and superstitious rural communities of India.” (ibid) Our summary of Banerji’s perspective began by refuting this charge that other anthropologists have characteristically blamed the victims for their suffering.

To counteract the ideologically misleading work of other social scientists. Dr. Banerji has directed a project in which six field assistants studied 19 villages in 8 states. Primary Health Centres were located in 11 villages, and 6 other villages were within a few kilometers of such centres. A preliminary publication reports that villagers almost universally had a low opinion of the centres, and when interviewers discussed their complaints with center personnel “on more than one occasion the interview was enough to trigger off a spontaneous outpouring ... on the very dismal state of affairs in these institutions” (Banerji 1979: Appendix 1:8) when state officials were confident of anonymity, they sometimes told interviewers that “the ideal of the primary health centre exists only in name,” and that “the medicine have not only failed to bring about the expected social orientation of medical education, but in the bargain, they
have also lost their grasp over practical community health issues.” (op. Cit.:13)

Health educators throughout India agree that social medicine has low prestige. Dr. Prabha Ramalingaswami, who is Dr. Banerji’s colleague at Jawaharlal Nehru University, found in 1971 that when the interns at the All – India Institute of Medical Sciences were asked to rank 18 specialties they gave the lowest position to preventive and social medicine, and in a recent study of 533 senior students at 10 medical colleges in different parts of India she found that students do not have any understanding of the concept of Primary Health care ... 54.4% of them even called it bad... The basic aspects of the Community Health Workers scheme such as description, selection process, and training aspects are know to a small number of students (11.63%, 12.75%, and 10.32% respectively)... (and) 26.82% have no idea at all about this scheme... The students in general could not describe adequately the interaction between the insanitary conditions prevailing in the villages, the poverty and under-nutrition, and health problems. (Ramalingaswami and Shyam 1980: passim)

Social medicine everywhere fails to meet the aspirations of its advocates, and this is particularly the case in developing countries. One expert recently described the “unqualified, unrespected, and uninspiring staff; lack-luster and tedious teaching programs and unimaginative and generally useless research, if any, and ostracism by the rest of the university and disdain by the students.” (Lathem 1979: 26) In this matter south Asian problems are part of a world pattern of medical education and practice. Dr. Banerji wants to place the Indian profession in historical context, but rather than studying the profession in the context of the world system so which it belongs, he has concentrated on village studies.

A few people have studied cosmopolitan medicine in South Asia, but so far no one has published a major historical work grounded in modern scholarship. Among the sociological studies of hospitals, medical schools and the health professions cited in Part I of this essay, T.N. Madan’s research is outstanding. He began a contrasting the “soft” professions of law, art and religion with the “hard” professions of engineering, medicine and science, he reasoned that the latter were “strongly influential in raising productivity and generally modernizing society.” (Madan and Verma 1971:47) To compliment this work he studied the 37 resident allopathic physicians in Ghaziabad, an industrial city of about 100,000 people 20 kilometers from Delhi. 67.6% of these doctors were in private practice, and all but one of those who were employed in government hospitals and dispensaries supplemented their salaries by free-for – service practice. They thought of medical practice primarily as a way to earn a living. They were little interested in talks by specialists at local meetings of the medical society, and almost never referred patients to specialists or discussed interesting cases with each other. They were not interested in nutrition, preventive medicine, family planning, or in explaining the nature of their illnesses to the patients who consulted them. The fact that they conceived of their role as physicians narrowly “I terms of the
treatment of particular episodes of illness .. (prevented) them from playing a leading role as agents of modernization.” The practice of medicine emerges as a kind of business. Though most respondent denied this, and the first concern of a doctor is to enhance his earnings.” (Madan 1972:94)

In 1974 Madan initiated a project to study the medical elite. Observing that “many developing countries have created ‘Pyramids of health care,’ based on grassroots level health centres, including intermediate level institution such as district hospitals, and culminating in a national level teaching-research-medical care complex” his original plan for the Unesco sponsored project was to study physicians in “Iran, Afghanistan, India, Sri Lanka and Malaysia. (Madan 1980:5) The studies in Iran and Afghanistan were not completed, and we will put aside those on Sri Lanka by Malsiri Das and on Malaysia by Paul Wiebe and A. Graham Said, and limit our discussion to Madan’s study of physicians on the faculty of the All India Institute of Medical Sciences in New Delhi.

The Institute was founded in 1956 to achieve the highest international standards for advanced training and research. It was to be a model that would raise standards for medical institutions throughout the country, doing in India what johns Hopkins had done for scientific medicine in the United States. Shortly before Madan’s study began in 1975 the Institute had revised its undergraduate program so that approximately one half of every student’s clinical training would be integrated through work outside the hospital in a rural and a suburban community. Influenced by Ivan Illich and other critics of high technology medicine, and by the avalanche of publicity about Chinese accomplishments, the director of the Institute, Dr. V. Ramalingaswami, had become a leading advocate in India of reforms to adopt medical education to the needs of the country. Madan cites an address that he gave in 1976 in which he argued that the profession should turn from “the over-professionalized over-centralized, over-fragmented, over-mystified, over-sized, and capital intensive system and seek out alternatives which were cheap and yet scientific and nearer the people” (1980: 103). A journalist who described this conference wrote, “the symbolic absurdity of smart, suit-clad, urban doctors from prestigious institutes calling for the de-professionalisation, de-institutionalisation, and de-mystification of medical services was manifest but went unnoticed” (Economic and Political Weekly, January 24, 1976:96). Nevertheless, at the World Health Organization in Geneva that year the Institute Director was awarded the Leon Bernard foundation Medal and Prize. Among other accomplishments his work on the Srivastava Committee prepared the way for Raj Narian to initiate the Community Health Worker scheme in 1977. Thus, the Director of an institute created to achieve national self-sufficiency in advanced scientific medicine assumed leadership in reforms to emphasize ordinary health care problems and the cost-effective methodology of community medicine. Madan’s account of disagreements within the All India Institute of Medical Sciences about this reform avoids epithets like
“brown Englishman”, yet he analyzes distortions of the medical profession that originated in the colonial period.

Madan writes that his study took place “during a period of change and doubt” in which the goals of the Institute were thrown into question by “a new emphasis on social relevance” and “a new perception of the place of medicine in national development” (1980:105) Critics of the changes that promoted community medicine outnumber their advocates, and when he excluded those who were “directly involved in ... programmes connected with community health, it was out clear impression that most of the interviewees representing other specialties were out clear impression that most of the interviewees representing other specialties were doubtful about the... emphasis on it” (1980: 94-95) They argued that India needed and could afford an elite institution that offered high quality medical care. The faculty praised teaching and research activities, and would acknowledge the importance of social and preventive medicine, “but only after the primary role of the ‘healer’ of sick people had been mentioned.” This caused Madan to comment that they “seemed almost fixated on the image of the doctor as a person who treats patients: this, then, is he key role which legitimizes whatever else a doctor may do I society.” (1980:67) Critics asserted that only second-rate students specialized in preventive and social medicine, and that the community-based instruction wasted the talent of people who would b better employed in the clinics and laboratories of the Institute. Some of them charged that the program was a political maneuver to placate “outside forces” and advance individual careers. Such charges of bad faith are commonly made in bureaucratic conflicts. Madan recorded them in an even-handed manner, though his analysis shows the need for reform.

In his conclusion Madan regrets the “negative character of the relationship between doctors and society that seems to emerge from our case studies,” and he cautions the reader that the doctors he and his colleagues studied in India, Sri Lanka and Malaya were “doing professionally competent and socially useful work”. He writes that it would be ‘absurd to treat them as the scapegoats” for failures which they share with numerous other middle and upper class people in their societies. (1980: 302) He writes that

An outstanding characteristic of the members of the professional classes today seems to be their self-centredness, the overriding concern with their own ambitions and frustrations. They suffer from a high degree of ‘need for achievement’, but this is merely ‘acquisitive achievement’... the mainsprings for the work of these classes --- whether we consider doctors, lawyers, architects, or any other profession – are .. money or power or prestige. Modern doctors in Asian countries are prevented by their social background, professional training, career goals and life-style ambitions for themselves and their children to relate to people in general in the same manner in which they are able to relate to their own class. Their involvement in community affairs is limited... the y are a
class which reproduces itself and safe guards its own privileges. By its very nature, therefore, it plays only an indirect modernizing role in society... one could describe (doctors) as “modernists” rather than as “modernizers”. (1980:296)

Conclusion

A patina of the 1960s and 1970s affects the world Health Organization slogan, “Health for all the year 2000.” It recalls a benevolent image of chairman Mao, the cultural revolution, and barefoot doctors working to serve the people. In those days newspaper stories and photographs of acupuncture anesthesia during open heart surgery testified to the powerful new combination of traditional medicine with modern technology. Barefoot doctors using a humble version of this “integrated system” exemplified a people who were lifting themselves up by their own bootstraps. The Chinese model was an act of levitation, a magical act that renewed the faith of those in social and preventive medicine who felt they had been fighting a losing battle in developing countries. Faith and reason are not incompatible, an they used the model as a new argument against the incorporation of hospital oriented high technology medicine by poor an largely rural societies.

Every historical change creates a mythology. I do not want to denigrate the utility of the Chinese model for the primary health care movement, which is an episode in the scientific and democratic revolution of modern times. Yet as the movement flags, the image tarnished of compliant Chinese patients clutching little red books, and its corps discouraged by new efforts that seem to produce small changes, then India and the other countries of south Asia have a long and instructive tradition of integrated practices. Furthermore, the Indian example need not be mythic, for it has been and continues to be subjected to critical social research.

The notion of using indigenous cultural resources in governmental reforms of primary care not gained the voluntary consent of physicians trained in cosmopolitan medicine in any country. Except for rare individuals, critical social though has no place in the education of health professionals, and the physicians who formulate and guide the movement to extend primary care almost uniformly proceed in ethnographic ignorance of the systems that they want to reform. Stimulated by a trip to India, the editor of the JOURNAL OF TROPICAL MEDICINE AND HYGIENE in 1981 challenged this ignorance. He wrote that the workers on tea plantations in north India failed to use antenatal and well-baby clinics, or the other health services available to them. Even sick workers “do not come until it is far too late to do anything useful.” (Mackay 1982:89) Rejecting “the conventional answer of health education,” he asked, “Do you spend money on creating facilities that people do not want and probably will not use, just so that you can educate people slowly to begin to use them?” instead, he urged planners to “face up to the gap between what we think are needs and what are felt to be needs at the grass roots level.” (ibid) the trouble is that this highly respected physician accepted the descriptions of the plantation medical officers at face value, and he defined the
problem in the current style of establishment leaders in western medicine as one of knowledge and cultural understanding, rather than one of social conflict grounded in historical inequities, where roles are rehearsed and perspectives shift between castes, occupations and social classes. “the grass roots level” in this context is a myth of the populist conception plain folks living in an undifferentiated society.

Social research has defined coexisting traditions of health care and the problems of understanding their relationships to each other. These relationships constitute an historical structure of learned and folk traditions, indigenous, imported and indigenized, scientific and religious, that are maintained by various social institutions. Health planning has made almost no use of this research and it is neglected in the education of the medical elite. It is probably better known in the universities of Europe and America than in the medical schools of India, yet the first line of responsibility for the injustices and irrationalities that it ponders is the profession of cosmopolitan medicine in India and the social class that it represents, the long effort beginning in the 19th century to modernize and up-grade Ayurveda and Yunani practices continues to be sabotaged, ignored or treated contemptuously by members of the profession that dominates health policies. The leaders of professional Ayurvedic and Yunani institutions share the urban middle class career goals of allopathic doctors, and except for a brief period during he independence movement, they have failed to project ideas about designing a culturally appropriate system of health services. They have concentrated on problems in curative medicine and on reinterpretations of ancient theories, neglecting the problems create a national system of social and preventive care. The ecological character of humoral tradition could have made this their strongest point.

The burden of history weighs on South Asia, but the resources for change are vast. Those who recognize and seize them can make a better society, but they cannot act autonomously, for South Asia is one thread in the fabric of a world civilization.

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