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Health in India Since Independence

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Abstract

This paper suggests that history is essential to an understanding of the challenges facing health policy in India today. Institutional trajectories matter, and the paper tries to show that a history of under-investment and poor health infrastructure in the colonial period continued to shape the conditions of possibility for health policy in India after independence. The focus of the paper is on the insights intellectual history may bring to our understanding of deeply rooted features of public health in India, which continue to characterise the situation confronting policymakers in the field of health today. The ethical and intellectual origins of the Indian state's founding commitment to improve public health continue to shape a sense of the possible in public health to this day. The paper shows that a top-down, statist approach to public health was not the only option available to India in the 1940s, and that there was a powerful legacy of civic involvement and voluntary activity in the field of public health.

Keywords: India, Health policy, Development policy, Colonial legacy, Disease eradication, Malaria control

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We recognise health as an inalienable human right that every individual can justly claim. So long as wide health inequalities exist in our country and access to essential health care is not universally assured, we would fall short in both economic planning and in our moral obligation to all citizens.

Prime Minister Manmohan Singh, October 2005¹

This paper suggests that a historical perspective on health policy in independent India can help to explain a number of deeply rooted features of public health in India, which continue to characterise the situation confronting policymakers in the field of health today. These features include:

- 1) The paradox that a heavily interventionist state has never, since independence, made health a priority in public policy or in the allocation of public resources. The Indian state's conception of development has allowed little space for the importance of health and wellbeing. Conversely, the political economy of health care in India has been characterised by widespread privatisation, and the large, perhaps dominant, role of the private and informal sector in providing healthcare, even to the very poor.
- 2) Marked regional variations in health outcomes, and in the degree and the extent to which healthcare is publicly available. It is well known that between, say, Kerala and Bihar lies a huge gulf in capacity and historical experience in the field of health (as also in many other aspects of human development). These variations do not always correlate closely with differences in income.
- 3) The complex and uneven relationship between Indian democracy and public health. The language of rights, so prevalent in post-colonial India, has only at certain times and in certain conditions broadened to encompass the right to health. Health has only intermittently been the subject of political mobilisation.

India has unquestionably experienced a significant and continuous lowering of mortality and a steady increase in life expectancy since independence. Life expectation at birth was estimated at 36.7 years in 1951; by 1981 the figure stood at 54 years, and by 2000, 64.6. The infant mortality rate fell from 146 per 1,000 in 1951, to 70 per 1,000 half a century later, although the decline in infant mortality slowed or stagnated during the 1990s (Visaria, 2004).

¹ As cited in Sharma (2005).

Yet it is clear that these gains have seen a highly unequal distribution across regions, and along lines of caste and social status. The trend of declining mortality in modern India coexists with persistently high levels of ill-health and disability. The most recent National Family Health Survey shows that 45.9 percent of children under three are underweight, and that only 43.5 percent of children are fully immunised (*The Hindu*, 2007b). India has the highest number of tuberculosis cases, and probably the largest number of people suffering from HIV/AIDS, in the world (Visaria, 2004). At the same time, 'first world' illnesses—hypertension, cardio-vascular disease, cancers—are increasing rapidly (*The Hindu*, 2007b; Visaria, 2004).

The Indian government acknowledged the challenges in its most recent comprehensive National Health Policy document (Government of India, 2002):

Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide inter-state disparity implies that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate.

Detailed analyses and anecdotal evidence alike suggest that the state of India's public health services is dire. Even official sources lament that:

the presence of medical and paramedical personnel is often much less than that required by prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and, the buildings are in a dilapidated state ... the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate.

'Grossly inadequate' is a phrase that appears all too often in the report.

There is little doubt that health has not been one of the Indian state's priorities since independence. Only in the last few years has public expenditure on health in India risen above the level of 0.8 or 0.9 percent of GDP, which is India's historical average, lower than almost any other country in the world (Sen and Dreze, 2002: 202). The share of public expenditure to total health expenditure in India is around 15 percent: the average for sub-Saharan Africa is 40 percent, and for high-income European countries, over 75 percent (Sen and Dreze, 2002: 204).

This picture of failure and under-investment contrasts rather sharply with the confidence, the ambition and the sense of historic opportunity that pervaded public discourse about health around the time of India's independence. Buoyed by their acquisition of sovereignty and state power, the representatives of the Indian people set out to 'wipe a tear from every eye', as Gandhi put it. Prime Minister Manmohan Singh's commitment to

the 'right to health' has clear and distinct roots in the 1940s, but so too does the Indian State's manifest failure to live up to its promises.

This paper suggests that history is essential to an understanding of the challenges facing health policy in India today. Institutional trajectories matter, and the paper tries to show that a history of under-investment and poor health infrastructure in the colonial period continued to shape the conditions of possibility for health policy in India after independence. This will be familiar to development policymakers and institutional economists interested in 'path dependency'. However, the focus of the paper is less on institutions than on the insights intellectual history may bring to our understanding.

I argue that attention to the ethical and intellectual origins of the Indian state's founding commitment to improve public health are worthy of attention, and indeed that these moral and political arguments continue to shape a sense of the possible in public health to this day. By situating particular policies in the context of the political questions to which they emerged as a response, a historical approach can show that particular solutions adopted were chosen from a range of possibilities, greater or smaller in different circumstances; thus revisiting 'paths not taken' is one evident way in which history can inform contemporary development policy. Thus the paper shows that a top-down, statist approach to public health was not the only option available to India in the 1940s, and that there was a powerful legacy of civic involvement and voluntary activity in the field of public health. Some of these traditions may continue to shape the recent move back towards giving civil society a greater role in public health. Equally, however, taking seriously the reasons why a state-directed and technocratic approach seemed so clearly the best path for policymakers in the 1940s might direct our attention to some of the weaknesses or shortcomings of voluntary initiatives in health, often forgotten in contemporary enthusiasm for civil society's capabilities.

Furthermore, the paper aims to suggest that ideas and arguments can take on a life of their own. Ethical and constitutional commitments, for instance to the 'right to health' or more generally to social justice, are open to appropriation and re-deployment in any number of contexts. Health activists in India today invoke, repeatedly, the language of the 1940s and the Indian Constitution, in their criticisms of the state's failures; by re-deploying earlier languages of legitimacy, political actors today reinforce the power of those ideas to shape expectations and motivate change. Examining where those ideas come from, and some of the contradictions that underpin them, can help us to better understand the multiple and sometimes unexpected ways in which they live on to shape political debates about health, and may also point to their double-edged nature.

A historical perspective on the political culture of public health in India suggests that one of the most striking contrasts between the late-colonial period and the period after independence lies in the extent to which the Indian political elite concerned itself with

questions of public health. The instrumental argument, that it has not been in the 'interests' of India's elite to prioritise public health—given their easy access to high-quality, urban curative health services—is indisputable; but interests can come into being and unravel through political discourse and as a result of political mobilisation. In the first half of the 20th century, the Indian political elite was deeply concerned with questions of public health, engaging in more or less paternalistic attempts to educate, and uplift the health of, the Indian population; after independence, as responsibility for health resided increasingly with the developmental state, the culture of public discussion and voluntary activity in the field of health witnessed a rapid decline.

What was the 'colonial legacy'?

It was as a response to crisis and emergency that the colonial state in India began to develop what we might recognise as a concerted public health policy. Probably the first document of 'public health policy' in British India was the 1863 report of the Royal Commission on the sanitary state of the British army in India (Harrison, 1994). Concern about threats to the health of the Indian Army, particularly after the rebellion of 1857, motivated a wide-ranging inquiry into health conditions in the country.

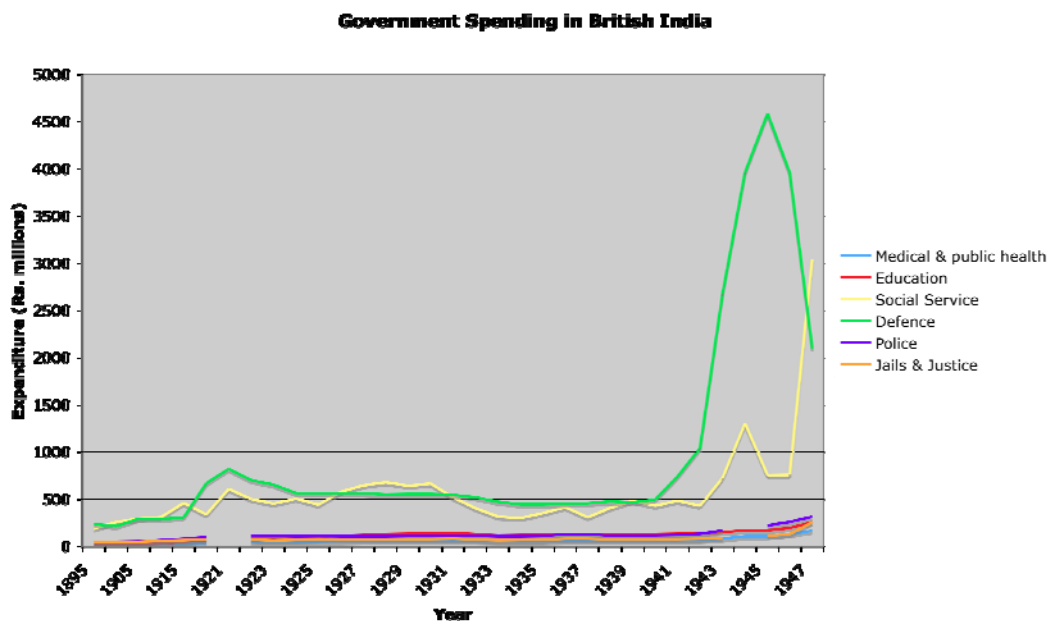
Only gradually did this interest in the health of the troops lead to a more general interest in the health of the population, and then too only as a response to immediate crises. If India did not experience the massive decimation of indigenous populations through disease and warfare that the 'New World' witnessed, there were nevertheless many episodes of sharp rises in mortality, associated with the violence and social disruption of conquest and conflict, most notably the Bengal Famine of 1770. A century later, the great famines of the 1870s and 1890s caused both mass mortality and mass migration; it was fear of unrest and social disruption that caused the colonial state, belatedly, to take some interest in famine relief and public health (Dreze, 1988; Hodges, 2004).

It was for a long time a commonplace that one of the 'benefits' of colonial rule in Asia and Africa was the advent of modern medicine. Institutions of public health—hospitals, health centres, medical research laboratories, pharmaceutical production facilities—were amongst the new colonial institutions that appeared in South Asia, along with the railways, the telegraph and new forms of land tenure and law. If some historians have subsequently allowed the pendulum to swing far in the other direction, seeing medicine as only a tool of colonial power and domination over Indian lives and bodies, this paper tends to concur with C.A. Bayly (2008), namely that what we need to understand is the ways in which Indians engaged with, appropriated, criticised and adopted colonial health institutions.

The broad set of policy shifts that began in the later 19th century, around the time of the late-Victorian famines, had lasting and important consequences for the future of public

health policy in India.² Two, perhaps contradictory, legacies of this period stand out for their significance in shaping the conditions of possibility for public health policy in India: the first is institutional, the second, ideological.

As an 'extractive' colonial state, public health and social welfare were never near the top of the Raj's priorities (Figure 1). What is most striking about the medical infrastructure that the Raj bequeathed to independent India is its weakness and its limited reach. In the hey-day of Victorian liberalism, one of the cardinal principles of British rule in India was that Indian revenues would pay for Indian expenditures, and in the late 19th century, the tax base of the colonial state grew progressively weaker.



[Compiled from Annual Reports of the Government of India (1890-1947), and from Government of India (1946).]

Colonial public health policy was inherently limited and self-limiting; it focused on keeping epidemics at bay, responding to crises and not much more. A crucial institutional innovation came in the 1880s (Jeffery, 1988), when much of the responsibility for local health and sanitation was devolved to partly elected local government bodies, a responsibility shared by the 1920s with provincial governments. This is a division of responsibility that lasts into the present day, and puts significant

² Since I am chiefly concerned here with tracing the history of institutions and the ideas underpinning them, I will take as read the argument that changes in mortality and morbidity may have owed as much to non-policy factors, including secular trends in the virulence of particular pathogens, and patterns of natural resistance within populations (Klein, 1990).

limits on the capacity to enact public health policies: then, as now, the ability of local and even provincial governments to raise resources is very limited.

Nonetheless, it was at the level of local sanitation that the most tangible improvements in public health were found in early 20th-century India. Cholera, the great scourge of India in the 19th century, saw a significant decline, as a result of the provision of clean drinking water at major sites of pilgrimage (Arnold, 1993). The establishment of panchayats with responsibility for sanitation and conservancy led to marginal, but nevertheless real, improvements in local sanitation in certain locales—inevitably those where the local elite used their new powers to enact change (Tinker, 1954).

However, Hugh Tinker's meticulous work shows how limited even these improvements could be. He showed the inadequacy of personnel, infrastructure and resources in the public health system of British India: just 56 health officers, for example, in all of the municipalities of Madras Presidency; only four serving all of rural Burma. As a result of the weakness of infrastructure, 'local authorities at best could only select the most pressing cases for relief; at worst the slender local funds were dissipated in tiny sporadic ventures from which no permanent benefit was derived' (Tinker, 1954: 287).

At many points, the colonial state justified the paucity of its expenditure on public health with reference to notions of India's 'naturally' high death rate, and by raising the spectre of Malthusian catastrophe if too much was done to reduce mortality (Arnold, 1993; Davis, 2001). Yet in the light of the terrible famines of the last quarter of the 19th century, the colonial state did make a number of commitments, which transformed the conditions of political possibility. At no point did the state commit itself to providing a certain minimum of public health. It did, however, declare in 1880 that in a 'calamity such as famine, exceptional in its nature and arising from causes wholly beyond human control', it 'becomes a paramount duty of the State to give all practicable assistance to the people in time of famine, and to devote all its available resources to this end'. The state committed itself, at least nominally, to preventing death from starvation. This commitment was open, thereafter, to expansion and interpretation. Thus, if the institutional legacy of colonialism was to constrain the public health apparatus of India, the ideological legacy was the rise, perhaps unintended, of the notion that the state would and could intervene to prevent certain kinds of suffering.³

The ambivalent nature of the colonial state's engagement with questions of public health had two particularly notable consequences. The first is that Indian elites began to take up the ideas of the colonial state in order to hold it to account. Health, that is to say, was

³ Of course, notions of the responsibility of the ruler to alleviate suffering, particularly in times of dearth or famine, long pre-dated the British, and the Mughal state had highly developed doctrines on these subjects. However, by universalising these expectations—beyond the person of a just king or ruler—the colonial commitment nevertheless marked a shift.

politicised. The early works of Indian political economy, by Dadabhai Naoroji, Romesh Dutt and others, highlighted the shortcomings in the colonial state's response to famine and epidemics, and pointed to the responsibility of high levels of taxation for the immiseration of the Indian countryside. Speaking in the colonial legislative council, Gopal Krishna Gokhale raised, time and again, the poor state of health and sanitation in India, comparing it with conditions prevailing in Britain and elsewhere. Gokhale and others mounted their critique of the state's neglect of public health by invoking the state's own promises and principles in that regard; this is a pattern that continued in India after independence.

By the 1920s, this had evolved into the argument that only a representative national government could truly care for the health of the Indian people. In the view of Dr Nil Ratan Sircar, a prominent nationalist and member of the Indian Medical Association, 'medical backwardness' was a consequence of imperialism:

An alien trusteeship of a people's life and fortune is almost a contradiction in terms. For among the governing factors in all sanitary reforms and movements are the social and economic conditions of life, the environment, material as well as moral, and above all the psychology of the people—and an alien administration, out of touch with these living realities, will either run counter to them and be brought up against a dead wall of irremovable and irremediable social facts or ... grow timid and fight shy of all social legislation, even in the best interests of the people's lives and health (Ray, 1929: 5).

The suggestion here was that the colonial administration did not possess the will, the knowledge or the confidence to intervene deeply enough in Indian society to ameliorate health conditions.

As India's modernising nationalists set their sights on power, in the 1930s, they committed themselves to precisely this kind of 'deep' intervention by the state in society. The health of the population became part of a much broader agenda of transformation from above. A healthy, productive and useful population would be put in service of an industrialising state that promised to provide welfare for the citizens of the new nation. In this way, Indian nationalists could argue not only that the colonial state had failed in its duty to care for the welfare of the population, but that they, as genuine representatives of 'the people', could and would do so, using the latest technologies of government (National Planning Committee [NPC], 1948). It will perhaps be surprising and even uncomfortable to us now to note that amongst the charges Indian nationalists levelled at the colonial state was that it was not interested enough in questions of eugenics, not bold enough to 'sterilise the unfit' (NPC, 1948).

The second important consequence of the colonial state's unwillingness to spend much money on public health was that in late-colonial India, there was much scope for 'civil society' or voluntary initiatives in health. Devolving responsibility to charities and voluntary bodies suited the colonial state, which was imbued with the ideals of Victorian liberalism, and its belief in the power of civil society to solve social problems; relying on philanthropy was cheaper, too. Many of the early health initiatives were undertaken on the initiative of Christian missionaries (Lal, 2003). However, new ideas about the importance of health and sanitation were taken up by middle-class Indians, creating a strong aspiration for change in the fields of marriage practices, child-rearing, and public sanitation. Social reform organisations, often religiously inspired, made healthy living central to their practices and interventions (Watt, 2005). New norms of healthy behaviour circulated through print, in the limited but significant public sphere which developed across India in the later 19th century (Bayly, 2008).

To cite just one example of the new breed of periodicals dedicated to questions of personal and social hygiene, there was *HEALTH*, a journal 'devoted to healthful living', founded by V. Rama Rao in 1923. The somewhat hybrid commitments of the journal are clear from its credo, advocating: 'vegetarianism, temperance, purity, simplicity and moderation in all phases of life'. The magazine invited contributions from far and wide, on 'Vital Health Care Topics—diet, nutrition, prevention of disease, care & feeding of infants ... Healthful beauty, vital statistic, etc.', in the form of 'line drawings and dramas' as much as drier articles and opinion pieces. And few people were as enthusiastic as Mahatma Gandhi in his profusion of writing about issues of health, which reached a very wide audience indeed through his periodicals and newspapers, *Young India*, and *Navajivan* (Amrith, 2006).

A number of Indian social reformers established, on a local and experimental basis, health projects of their own: model health centres, demonstration projects and educational initiatives. To extend Christopher Bayly's comments about the law (Bayly, 2008), this suggests that 'peer educators' were equally important in instilling new expectations of health, and new kinds of behaviour, limited though their reach may have been.

One of the most crucial areas in which voluntary activity flourished in the 1920s and 1930s was in the field of local sanitation; Bengal in particular witnessed the emergence of numerous local-level initiatives to improve sanitary conditions in rural areas. To take one example, the Central Co-operative Anti-Malaria Society of Bengal was established by Dr G.C. Chatterjee in 1912, and by the 1930s it had 2,000 similar bodies affiliated to it: local-level initiatives carried out by elite reformers. Through the missionary fervour of the societies, one admiring British official declared, 'the illiterate, suspicious and apathetic peasant could be moved to action' (Blunt, 1939: 382-382). Yet the income of

this valiant society, 'from the endowments collected and invested by Dr Chatterjee', was 'small in comparison with the task before it'.⁴

For its part, Rabindranath Tagore's Sriniketan rural reconstruction project adopted models and techniques from far and wide: the technique of the rural survey, new ways of collating statistics, new sanitary technologies, and modes of education. The blueprint for Sriniketan's organisation reveals the traces of diverse influences, but the dominant strain is the method of rural reconstruction pioneered in Yugoslavia (Tagore, 1938):

Organisation:

1. A detailed study of the village or villages comprising the health society, of the inhabitants, of the social and economic conditions connected with public health problems, and of the incidence of diseases.
2. Preliminary propaganda to develop people's consciousness of the need for better health and the means by which it could be obtained.
3. Constant education in the ideas of health, sanitation and hygiene, through lectures, demonstrations, exhibitions, etc.
4. Organisation of a medical establishment, with a qualified medical officer, compounder and dispensary, run on co-operative basis, each member paying an annual subscription, in cash or labour of equivalent value.
5. Arrangements for the medical examination and the keeping of the health records of all members.
6. Sanitation and preventive work carried out with the help of organised squads of young men of the village: filling up of the stagnant pools, making of roads and drains, preventing the breeding of mosquitoes, cleaning jungles and utilising waste lands for the growing of fruit and vegetable gardens, etc.

The plans envisaged the large-scale mobilisation of voluntary labour, and nothing short of a change in attitudes and aspirations on the part of the villagers—the rise of expectations of healthy life.

The comparative frame of mind, the widened awareness of other ways and other places, was evident: 'in China it has been demonstrated that even a few weeks' training, provided it is intensive, can be sufficient to produce efficient workers for rural health work', the workers of Sriniketan concluded. Taking their lead from practices elsewhere, but also from their knowledge of the local medical marketplace, leaders of the Sriniketan project developed a list, for each local project, of 'an absolute minimum' of drugs that any village dispensary ought to have (Tagore, 1938).

Indeed, one of the most notable features of the expansion and dissemination of ideas about public health in the 1930s, particularly in the context of present-day development

⁴ Central Co-operative Anti-Malaria Society, *Annual Reports* (Calcutta, 1927—1943), held at the Wellcome Contemporary Medical Archive Centre, Wellcome Library, London

policy, is the importance of international standards, information, and models. The Rockefeller Foundation, for instance, had extensive involvement in establishing small-scale health projects in India, China and beyond. The discussions of the League of Nations Health committee were widely reported in India, and the League's expert committees on minimal standards of nutrition, for instance, provided new ammunition for nationalist critiques of the colonial state (Amrith, 2006). Indeed, in the 1930s the Government of India was held to account, to some extent, by having to report to the League of Nations on the progress of health and welfare in India.

The value of health: Shaping political discourse

Development experts working in 'transitional' societies in the world today will be familiar with the openness to new ideas (often ideas from other countries, or from international organisations) that such transitions bring, for better or for worse. A historical perspective on India's political transition to independence—in particular the period between 1945 and the early 1950s—suggests that the languages of politics forged at these moments of transformation can have lasting effects. Promises made during moments of great political enthusiasm can take on a life of their own.

At the moment of India's independence, the value of public health was deeply contested. Within the thinking of the Congress Planning Committee, health was, at once, a basic human right, a tool for the improvement of the 'Indian race', making it more efficient and more governable, and health was an instrument for economic development. The need for public health stemmed from an egalitarian commitment to welfare, and from a far-from-egalitarian fear of the rising numbers of the lower classes.

Furthermore, there remained a wide gulf between aspirations for the improvement of public health, and the absence of the ability to bring this about. The serious crises of the 1940s, with the massive influx of refugees during and after Partition, revealed the fragility and weakness of India's health infrastructure. This was, essentially, the crux of the colonial legacy: the nationalist engagement with questions of health and welfare, in dialogue with and in opposition to the colonial state, had created a great sense of expectation; the long legacy of under-investment in health institutions, however, made those promises and expectations unrealistic, and almost impossible to fulfil.

As Uday Mehta has written, the 'immediate ambit' of political power in post-colonial India was 'dictated by the intensity of "mere life"'. Mass poverty and destitution put most Indians 'under the pressing dictates of their bodies'; 'and this ambit', Mehta observes, 'can have no limiting bounds. This simple logic transforms power from a traditional concern with freedom to a concern with life and its necessities' (Mehta, 2006: 26-27). Only the rationality of the state, that is to say, could reconcile the enormity of ambition with the lack of resources.

The dominant view in India was that the problems of 'life and its necessities' were so pressing that there was little time, or need, for dialogue and discussion. In the late-colonial period, as I have argued, ideas about health and healthiness circulated widely through civil society—in pamphlets and magazines, through Baby and Child associations, within particular neighbourhoods. The institution of planning, with wise experts allocating scarce resources, appeared increasingly as a substitute for that sort of social engagement with questions of health and welfare (Chatterjee, 1997). Indeed, the new leaders of India condemned as outmoded the principles of charity and sympathy that had underpinned earlier elite interventions in the field of health. 'When planned society comes fully into being, occasions for individual unorganized or sporadic charity will have no place', they declared, even if this charity was motivated by an ethic of 'service' (*seva*) or self-sacrifice. The planners envisaged a transition 'from dependence on spontaneous charity and goodwill to scientific social work', and a process whereby the state would 'institutionalise the methods of social service' (NPC, 1948). Little wonder, then, that in recent years, health activists in India have bemoaned the absence of any deep social awareness that health is a right and an entitlement of citizenship; the Indian state felt little need, after 1947, to communicate this to its citizens.

Arguably, it was a failure to justify health as an intrinsic value that paved the way for the relative weakness of public health in the broader competition for support and resources within the Indian state after independence. When, by the 1960s, external resources for population control proliferated, and the old argument re-asserted itself that population control may be a more 'cost-effective' way of achieving the same ends as public health, the level of resources devoted to public health dropped significantly (Rao, 2005), and there was surprisingly little discussion or dissent. This instrumental approach towards the various components of development policy is also responsible for some of the worst excesses of the post-colonial Indian state in the field of population policy, which reached their sordid climax in the forced sterilisations of the Emergency period (Rao, 2005). More prosaically but—as all who work in development know—crucially, ideas matter in the quest to justify expenditure and budget allocations, in mobilising the resources necessary to make policy interventions meaningful and self-sustaining. Champions of public health in post-colonial India did not make the argument strongly enough that health was intrinsically valuable. For instance, much of the legitimacy of the malaria control and eradication programme of the 1950s came from the argument that malaria control would result in demonstrable economic benefits; when those benefits proved difficult to demonstrate or quantify, support for the malaria control programme dropped off sharply.

Health in India after 1947

Malaria control: A case study

The development of malaria control policy in the 1950s encapsulates, in many ways, the political culture of public health that evolved after independence. This is, not least, because at its height, between 1959 and 1963, the National Malaria Eradication programme took up nearly 70 percent of India's budget for communicable disease control; communicable disease control itself accounting for nearly 30 percent of the overall health budget under the Second Plan (Jeffery, 1988). India quickly became the world's largest market for DDT. The malaria eradication programme was heavily dependent on outside funding: between 1952 and 1958, the US contributed more than 50 per cent of the cost of the programme, and nearly 40 per cent of the cost of the eradication programme between 1959 and 1961 (Jeffery, 1988: 200).

The National Malaria Control Programme—which subsequently set its sights on malaria eradication—epitomises the political culture of public health in the 'high-Nehruvian' era, and it points to the contradictions and the weaknesses inherent in the Indian state's approach to public health.

The success of the malaria control and eradication policies must not be under-estimated. The success was quite staggering. Malaria, perhaps the leading cause of mortality and morbidity at independence, had virtually disappeared by the late 1950s.⁵ The Indian anti-malaria campaign was undoubtedly the world's most extensive. By 1958, a total of 8,704 malaria squads were in operation—a dramatic indication of the expansion of malaria control from a few pilot projects—and the spraying of a total of 438 million houses was complete. The statistics, however problematic, tell an astonishing story. The number of recorded cases of malaria fell from 75 million in 1951 to just 50,000 in 1961. The malaria eradication programme employed 150,000 people by 1961. By that year, malaria cases accounted for less than one percent of all hospital admissions, an astonishing diminution in the burden of malaria. It is important to bear in mind that, though the eradication programme failed, with a significant resurgence of malaria in the 1960s, the incidence of the disease has never since reached the levels where it stood in the 1940s.

Yet the malaria eradication campaign did begin to falter, in the 1960s, because of the absence of health infrastructure and, in some views, because of resistance to DDT and to anti-malarial drugs. Reliance on technology (DDT) was a consequence of the weakness of India's health infrastructure at the moment of independence; DDT promised a 'magic bullet', a cheap solution to a mass problem that did not require much in the way of local health infrastructure. Yet the success of DDT, in the end, depended upon a level

⁵ In 1951, there were an estimated 75 million cases of malaria in India. After the resurgence of the 1970s, the number of cases was approximately 2.7 million in 1981, and has since stabilised at a level of around 2.2 million—however, recent years have witnessed a 50 percent increase in the incidence of the most lethal, *P. Falciparum* strain (see Government of India, 2002).

of medical surveillance that was noticeably absent in India. An active programme of 'case-finding' constituted a crucial final stage in malaria eradication; Indian conditions made this very difficult. After the initial campaign of intensive spraying, to eliminate the anopheles vector, malaria control teams needed to find all infected persons in an area and treat them with anti-malarial drugs to eliminate the human reservoir of plasmodia before the mosquitoes could return. Such was the state of rural health services that 'by the time a reasonably prompt report came that a particular individual was infected, he might have left his village or, because of a false or ambiguous identification at the local clinic, have become untraceable' (Harrison, 1978: 252).

In 1961, there were fewer than 100,000 cases of malaria in India. Between 1961 and 1965, the number of cases jumped to 150,000, and then doubled again within a few years. The Indian government itself concluded, in an investigation into the resurgence of malaria in the country, that:

We can see that in those States where the rural health services are well developed, such as Mysore and Kerala, reversions have not occurred, and the maintenance is kept under good control even in areas previously hyperendemic. In other words, the map of reverted areas can be super-imposed on those with delays or imperfections in the development of the rural health sector (Sharma and Mehrotra, 1986).

Mysore and Kerala are, in a sense, the exceptions that bring into sharp relief the prevalent political culture of health in most of India: a culture in which public health fared poorly in the competition for political attention and funding, and in which a history of infrastructural under-development stymied ambitious policies.

For the most part, the dominance of the 'vertical' malaria control apparatus throughout the 1950s led to a consequent neglect of general health services, while establishing a pattern that continues to this day. The Government of India's most recent National Health Policy reflects, honestly, on this legacy:

...the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent on reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain.

The report proceeds to suggest that such programmes may 'only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time-span' (Government of India, 2002: § 2.3.2.1), viz. smallpox, the one eradicationist success. The ultimate cost of this approach was the patient, unglamorous task of building up local health services.

As early as the 1960s, the pioneering research conducted by the National Tuberculosis Institute in Bangalore underscored the costs of neglecting local health services, showing the weakness of health services in the face of the serious problem of tuberculosis. Criticising the tendency by the Indian state and by the WHO to blame the failure of public health programmes on the 'non-compliance' of patients, a sociologist at the Bangalore institute wrote: 'the Indian villager does not need to be told in words about the tuberculosis problem, but needs a service to deal with a problem which...is only far too well known to him' (WHO, 1963). The problem did not lie in the 'ignorance' of the poor, and the solution did not lie in a simplistic form of 'health education'. The problem was deeper, and lay in the lack of confidence that many Indians' prior experiences with the public health services had engendered in them. 'People who now feel ill', Andersen continued, needed the confidence that that 'they will be taken care of as well as medical technology can currently manage', and 'people who fear that they or their dear ones might become ill' ought to have the sense that 'should catastrophe strike', that it could, and would, be cured (WHO, 1963).

It is in the gap between expectations of health and the availability of health facilities that we can look for an explanation of why, despite the centrality of the state to public health policy in India since independence, India has developed one of the most extensive, and least regulated private markets in health in the world. The medical technologies that circulated as a result of the public health campaigns of the 1950s 'were not supposed to become common commodities', but the effort to control them was 'doomed to failure' (Whyte et al, 2002). The very weakness of local health infrastructures meant that pharmaceutical technologies have circulated in an unregulated way (Sen and Dreze, 2002). 'Malaria doctors' dispensed not only anti-malarials, but also all manner of other drugs (Phadke, 1998). Powerful anti-tuberculosis agents became available from private providers, from grocery shops and 'medical stores' to private clinics and ayurvedic practitioners. Rarely, if ever, were patients able to afford to complete their courses of treatment, leading, inevitably, to the spread of drug-resistant pathogens.

A further and serious consequence of the ways in which the Indian state has engaged with public health in the period since independence—emphasising single diseases, and techno-centric interventions on a large scale—has been the neglect of quotidian, but essential questions of local sanitation. As Vijayendra Rao, Radu Ban and Monica Das Gupta have shown in recent research, environmental health outcomes in India are very poor (Rao, Ban and Das Gupta, 2008). Over several decades, this has been due to low levels of political commitment and advocacy, and a lack of public awareness of sanitation and threats to public health. As Mavalankar and Shankar (2004) put it: 'the availability of cheap antibiotics coupled with lack of visions among the public health and political leadership has meant that authorities have become complacent to poor sanitation and water supply'; they aptly label this an 'insanitation-antibiotic syndrome'.

India's state of chronic insanitation has often found representation in literature and on screen over many decades: in Phanishwar Nath Renu's description of the poverty and insanitation of rural north India in the Hindi masterpiece *Maila Anchal*; in R.K. Narayan's gentle satire of the crumbling infrastructure of his fictional village of Malgudi after Indian independence; in Satyajit Ray's memorable rendition of Ibsen's *An Enemy of the People*. To the extent that a lack of political awareness and commitment lies behind India's problem of insanitation (Rao, Ban and Das Gupta, 2008), a historical perspective would seem essential to explaining the roots of this policy failure; particularly when, as the earlier part of this essay suggested, sanitation was at the core of many earlier elite attempts at public health reform in the early 20th century.

Regional variation and political culture

This broad account of the shortcomings in national disease control policies needs some qualification, at this point, because—as indicated above—there were significant regional variations in the ways in which the national (and international) disease control campaigns affected local health services. The point here is that regional political cultures exercised a significant impact on the extent to which public health became a political priority after independence, and the extent to which the 'right to health' had any prospect of enforcement.

As is well documented, Kerala presents a history quite different to that of much of India; one in which the 'universal' campaigns of disease control and eradication were matched by a sustained, and deeply politicised, effort to build up local institutions. Health, in mid-20th century Kerala, was championed as a 'people's right', in a way almost without parallel in the region. The declaration that health was a 'fundamental right', institutionalised with the foundation of the WHO after the Second World War, took on ethical force and political meaning in Kerala, where a political culture of social reform had taken root in the 19th century, particularly in the princely states of Travancore and Cochin (Jeffrey, 1993).

The mobilisation of a well organised communist movement, first within and later outside the Congress party, led to a level of political competition unusual in post-colonial India. Of equal significance was the emergence of a broad-based People's Science Movement in the 1950s, which has remained potent and which currently has over 50,000 members: the People's Science Movement has conducted health camps, campaigned on unsafe drugs, and spread public awareness of health through its publications, *Sastragathy* and *Sastra Keralam* (Isaac, Franke and Parameswaran, 1997).

The broad politicisation of questions of public health led to a heightened awareness among the poor that 'health services were their right and not a boon conferred upon

them'. In the words of one observer, 'In Kerala, if a Primary Health Centre were unmanned for a few days, there would be a massive demonstration at the nearest collectorate led by local leftists, who would demand to be given what they knew they were entitled to' (Mencher, 1980: 1781-1782). Moreover, notions of health and wellbeing in Kerala continued to circulate widely, after independence, through a vigorous popular press—newspapers, women's magazines—in a highly literate and informationally dense society, and one in which female labour-force participation was high (Devika, 2002). Thus, the specific configuration of political society in mid-20th century Kerala served to turn national and international promises of health and welfare into claims of entitlement.

In the more recent past, the neighbouring state of Tamil Nadu has chalked up significant achievements in the field of health. Since the 1970s, Tamil Nadu has seen the largest proportionate fall in child mortality (after Kerala), as well as a significant decline in fertility (Visaria, 2000). A particularly noteworthy intervention in this case was the institution in 1982 of the Mid-Day Meals scheme, which has guaranteed one meal a day to children in government-aided schools. Twenty years later, the scheme feeds 7.8 million children a day, and is credited both with a significant reduction in malnutrition and under-nutrition, as well as an increase in school attendance (Sen and Dreze, 2002; Parikh and Yasmeen, 2004). Given India's generally appalling record in addressing the problem of malnutrition, this is a noteworthy exception. More generally, and again in contrast to the pattern across large parts of north India, local health services in Tamil Nadu are broadly of good quality, and widely accessible. Jean Dreze and Amartya Sen (2002), in making their case for Tamil Nadu's achievements, point out that 89 percent of children in the state are fully immunised, and 84 percent of births attended by a health professional.

Amongst the explanations for Tamil Nadu's relative commitment to public health (its 'political will' in the language of policy) are its long tradition of social reform, manifested in the rise of the radical anti-caste Self Respect movement in the 1920s, and the translation of this movement into a powerful regional political force after independence. Tamil Nadu's unusually competitive political system—the Congress has not ruled in the state since 1967—allowed for the politicisation of issues of public health. Described by some commentators as a form of 'populism' (Subramanian, 1999; Harriss, 2001), the competition between rival factions of the Dravidian movement in Tamil Nadu have made public health a subject of political competition, in a way that it has not been elsewhere in India (Visaria, 2000). The history of anti-Brahmin activism in Tamil Nadu translated into a widely implemented programme of affirmative action ('reservations') in the health sector, with the result that the 'social distance' between medical workers and patients is perhaps smaller in Tamil Nadu than elsewhere (Visaria, 2000).

The pioneering Mid-Day Meals Scheme, for instance, which provided a cooked meal to children in all government schools—and which has subsequently been implemented

widely in other states—was a direct initiative of the charismatic film-star-turned-Chief-Minister, M.G. Ramachandran ('MGR'). Launching the scheme in 1982, MGR declared:

This scheme is an outcome of my experience of extreme starvation at an age when I knew only to cry when I was hungry. But for the munificence of a woman next door who extended a bowl of rice gruel to us and saved us from the cruel hand of death, we would have departed this world long ago. Such merciful women folk, having great faith in me, elected me as Chief Minister of Tamil Nadu. To wipe the tears of these women I have taken up this project ... To picture lakhs and lakhs of poor children who gather to partake of nutritious meals in the thousands of hamlets and villages all over Tamil Nadu ... will be a glorious event (Harriss, 1991:10)

This is not the usual language of development policy; MGR's objectives, as Barbara Harriss pointed out, 'were political, not at all technocratic' (Harriss, 1991: 10). The hyperbole and emotionalism here may make many development policymakers very uncomfortable, yet the importance of MGR's intervention lies in his ability to translate a very specific and ambitious health intervention into the language of everyday politics. As Sudipta Kaviraj has argued (1991), it was the failure of the post-colonial state to achieve this in most fields of its endeavour that underlies a number of its failures and frustrated expectations.

Civic activism in health, too, remains strong. The Tamil Nadu Science Forum, founded in 1980, has played a role akin to the People's Science Movement in Kerala, focusing initially on literacy, but by the 1990s turning to public health. The Tamil Nadu Science Forum's health movement, the Arogya Iyakkam, has been active in 500 villages, spreading awareness and education about public health.

The 'lessons' of Tamil Nadu and Kerala, such as they are, are that political mobilisation matters, and can act as a counterweight against the tendency towards technocracy. Both examples, however briefly presented, suggest that an important factor in explaining the relative success of these states in securing improvements in health lies in the re-activation, after independence, of deep traditions of local activism, public discussion and cooperative endeavour in the field of health.

To put it another way, it seems to be the case that in those parts of India where the 'right to health' had the deepest roots and saw constant reinforcement after independence, the resultant health outcomes were more impressive. This might offer interesting insights to development policymakers contemplating the most effective strategies for communicating particular development policies to diverse publics. Yet this also, in some ways, returns us to what economists call 'path dependency'. For it is arguably only those parts of India which already possess deep traditions of civic activism in health, which are in a position to deploy the full range of political and constitutional discourses available to

them to hold the state to account. For regions much less endowed with strong civil society, the lack of a binding, legal commitment on the part of the state to provide for public health means, by and large, that it fails to do so.⁶

Conclusions

Charles Rosenberg, a leading historian of medicine, has written recently that:

Policy is always history. Events in the past define the possible and the desirable, set tasks, and define rewards, viable choices, and thus the range of possible outcomes. As we move through time those choices reconfigure themselves, trends may establish themselves—but at any point in time the ‘actionable’ options are highly structured. ... Most important, what history can and should contribute to the world of policy and politics is its fundamental sense of context and complexity, of the determined and the negotiated. (Rosenberg, 2005)

This paper has attempted to show that, in the field of health, notions of ‘the desirable’ in India were shaped by Indian interpretations, appropriations or criticisms of colonial ideas about health, nourished by an increasingly international field of debate and the international flow of information in the 1930s. By the mid-20th century, these included the notion that health was a right. Yet the institutional legacies of the colonial state, in terms of the medical infrastructure and fiscal structure of the new state, acted to constrain the extent to which the ‘desirable’ (a vast reduction in disease and human suffering) could be realised.

In the context of the mid-20th century, it is difficult to imagine that any approach could have prevailed but the highly statist, centralising and technocratic one that governed public health in India for a generation or more after 1947. The enormity of the ambition, the extent of the promises made to India’s new citizens, and the flow of policy models and technologies from abroad, all pointed in that direction. But historians would do well to highlight the element of complexity and contingency that remained: there were many other ‘capacities and capabilities’ that Indian society developed in the late colonial period, including a deep civic engagement with questions of health in the public sphere. It is perhaps some of these traditions, which the post-colonial state ignored or suppressed, that will be of particular value at a time when development policy appears to be looking for non-statist approaches to what is now called ‘global’ (no longer national) health. I conclude with three possible areas in which India’s past may provide resources, models or inspiration for development policy in the present and future.

⁶ I owe this point to David Hall-Matthews’ commentary on the original paper in Manchester.

The first lies in the stock of political ideas that originate from the debates of the 1930s and 1940s, and which remain open to reinvigoration and reinterpretation. The commitments that the Indian state made to its citizens at independence were hard-won. They were the result of political debate and political struggle, within the nationalist movement, and between the nationalist movement and the colonial state. If the subsequent history of public health policy in India after 1947 exhibited many signs of depoliticisation, the example of Kerala shows that this was not universally true. Recent years have witnessed moves by a range of groups to make health, once again, a subject of public debate. Such groups seek to turn the promise of the right to health care into a properly political demand for its provision. This is most notably the case of the Jan Swasthya Abhiyan (People's Health Movement), which declares that:

We reaffirm our inalienable right to and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum—the right to Health For All, Now!

This demand is the more powerful for drawing on precisely the language of rights and promises which the post-colonial state made to the people on the eve of its foundation. The ideas of 1947 still matter; they still provide legitimacy and force to political demands in the present. The sheer range of political commitments made in 1947—in the Constitution, and in the international agreements that the Indian state signed—may have led to frustrated expectations, but as long as they remain un-met, they provide a yardstick by which activists and civil society groups can judge the state's failures (Feher, 2007).

The second resource that India's past may provide lies in the historical importance of the engagement between India and international/transnational institutions in the field of health. In asking how India is responding, and should respond, to the globalisation of public health, it is worth recalling that the history of public health in India has always been a transnational and an international history (Amrith, 2006). International influence on India's health policy has not always been positive (Rao, 2005; Amrith, 2006), but India is nevertheless in a good position to determine what and how much to adopt, adapt or reject from the models and advice that come flooding in.

Writing of what 'global democracy' might look like in the field of administration and policymaking, Joshua Cohen and Charles Sabel (2006) point to the possibility of policymaking by 'deliberative polyarchy', in which 'the aim is not to achieve uniformity, but to pool information, identify best practices and compare solutions across locations'. Thus, forms of global connection and comparison in the field of public health would uncover 'unexplored possibilities and unintended consequences'. This is, in fact, a rather good (if surprising) characterisation of how international connections fed into thinking

about public health in India in the 1930s. A rather unlikely instance of this kind of 'deliberative polyarchy' at the interface of local, national and transnational institutions was found in the League of Nations' conference on Intensive Rural Hygiene in the Far East, held in Bandung in 1937. This was an occasion for colonial and national governments, independent scientists and even some early 'NGOs' to share ideas, information, and approaches, without trying to impose uniform policies in the way that the WHO tried to do after 1945 (Amrith, 2006).

Something of this approach seems to underpin the establishment of the Public Health Foundation of India (*The Hindu*, 2006). The Foundation's aim is to 'address the limited institutional capacity in India' by 'strengthening training, research and policy development in the area of public health' (*The Hindu*, 2007a). The Foundation has heavy state involvement, but is relatively autonomous, with academics, private foundations and civil society groups involved in its administration.⁷ The Foundation is based on 'the best of Indian and international courses'; 'the inputs might be international', director Srinath Reddy insists, 'but the context is predominantly Indian' (*The Hindu*, 2007a).

The history of public health in India since independence illustrates, above all, the complex relationship between health and democracy. Rediscovering or reinforcing some of India's traditions of democratic deliberation about health and wellbeing might help to correct some of the failings of an excessively statist, centralising approach, whilst maintaining or even reinforcing the central role that the Indian state continues to play in giving the most disadvantaged people some access to the conditions of health and wellbeing. In the context of India's vibrant democracy, its own historical commitments and promises mean that the Indian state cannot fully abdicate its responsibility for health and welfare, even if at times it may wish to do so.

⁷ Note, however, that the Foundation is criticised by K.S. Jacob for its attempt to provide 'American-style education' and its 'side-stepping of existing public health resources within medical colleges and governmental institutions and their completely separate operations' (*The Hindu*, 2007c).

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