14 Changing Avatars of Social Medicine in the Indian Subcontinent

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Much of scholarly writing on the concept of social medicine traces its roots to Western Europe of the early twentieth century.[1] The core concerns that underpinned this concept were social and health inequalities, normative concerns of social justice, and equity. In order to realize these objectives, centrality was given to the role of the state to ensure access to health services and address the social determinants of health. The South Asian region, consisting of India, Pakistan, Bangladesh, Nepal, and Sri Lanka, share a common history of British colonial rule and so a common approach to several policy issues. Most of these countries gained independence during the 1940s and faced similar challenges of nation building as postcolonial states. With respect to health service development, Western European ideas of social medicine found considerable resonance. However, through the process of anti-colonial struggle there were a plurality of ideas on the relationship between society, medicine, and health. These included the world view of practitioners of indigenous systems of medicine; sections of the leadership of the nationalist movement; the communist movement that drew inspiration from the Soviet Union and later China; and radical elements within the medical community and society at large. I call this diversity of approaches as the many "avatars" of social medicine.[2]

The leadership of the social medicine movement during this period was among several physicians from Western Europe and the United States. Prominent among them were Henry Siegrist, John Ryle, John Grant, Andrew Russell, George Newman, and John Gunn, to name a few, who formed an epistemic community of doctors who advocated the idea and practice of social medicine. They were associated with institutions that included the

[1] George Rosen, *A History of Public Health* (Baltimore: Johns Hopkins University Press, 1993).

[2] I use the metaphor of Avatar which means descent in Hindu philosophy to denote the different ideas of social medicine that were in circulation in pre and post independent India. The term social medicine has been informed by varied ideological positions and its practice and therefore the metaphor "avatar" tries to capture the many strands of the same. The term avatar has evolved from a religious connotation to a broader idea of transformation or embodiment of ideas. In this chapter we use avatar in social medicine to elaborate on the transformation and embodiment within a historical context in south Asia.

International Health Division of the Rockefeller Foundation, Johns Hopkins University, Harvard School of Public Health, and others who were engaging with China, India, and several countries in Latin America. They contributed significantly to the debates on how to structure and organize health services in developed and developing countries. As Milton I. Roemer observes, there were debates around the importance of the integration between preventive and curative medicine by setting up health centers as the primary level of care.[3] Circulation of the ideas of social medicine had a far-reaching influence on postcolonial societies both from the West and the Soviet model of social medicine. Several postcolonial countries, including India, were founders of the Non-Aligned Movement (NAM) and thereby did not align fully with the United States or the Soviet Union. The former tried to wield their influence through economic, scientific, technological, and cultural domains, while the latter left an imprint on planned approach to the economy and health development in post-independent India.

British Colonial Rule and Social Medicine

European and American ideas of social medicine in circulation in the early twentieth century influenced health service development in India during the pre-independence period. Western concepts spread through allopathic medical institutions set up from the early eighteenth century. These institutions initially treated Europeans in India but later were opened to native population. The institutionalization of hospitals, dispensaries, and medical colleges during the colonial period was continued by the leadership of the national movement after independence. Colonial health policies were dominated by curative medicine, laboratory science, control of infectious disease, and sanitary measures. The idea of European social medicine did not find a place in the overall strategy of health services development during the colonial period since the policies were more focused on disease control and sanitary policies.[4]

Health Service Development for Independent India

The Joseph Bhore Committee on Health Survey and Development, set up in 1943 by Government of India, provided the blueprint for health services

[3] R. Roemer, "Milton I. Roemer, 1916–2001," *Bulletin of the World Health Organization* 79 no. 5 (2001): 481, World Health Organization, at: https://iris.who.int/handle/10665/268338.

[4] Muhammad Umair Mushtaq, "Public Health in British India: A Brief Account of the History of Medical Services and Disease Prevention in Colonial India," *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine* 34, no. 1 (January 2009): 6–14, Doi: 10.4103/0970-0218.45369.

development in independent India. The influence of social medicine was visible with the representation of international experts who were its strong advocates. These included John Ryle, Henry Siegrist, and John Grant, who played an important role in contributing to the deliberations of the committee. One would argue that the influence of European social medicine was an important avatar in shaping policy for the development of health services in independent India. Sunil Amrith elaborates on the liberal and left positions that were present in the Bhore Committee that advocated strong ideas of social medicine in its deliberations.[5] The Bhore Committee advocated for a three-tier structure with a well-worked-out referral system. The design of the health services was similar to Yugoslavia and China during the 1930s. However, the investments required for a strong state-supported healthcare were inadequate and the emphasis was on curative hospital-based care. While curative medicine was dominant, several preventive programs had elements of the idea of social medicine through state-supported disease control and population -control programs. Several civil-society organizations also furthered ideas of social medicine by partnering with the government for national health programs.

Plurality of the Ideas of Social Medicine in the Indian Subcontinent

The nationalist movement was a coalition of differing ideological persuasions. Certain sections of the nationalist movement were supportive of heavy industrialization, while others presented alternate visions of development. There were four documents that represented the differing ideological positions on the future of India's development. These were the Bombay Plan representing big business; the Congress Plan that was elaborated in the National Planning Committee Report; the People's Plan representing socialist ideas; and the Gandhian Plan that was for small-scale industrialization with a focus on the needs of village India. One would argue that the very idea of development was represented by different ideological avatars. Despite the differences, there was a consensus among the various actors to bring an end to colonial rule.

The National Planning Committee that was set up in 1938 elaborated on the importance of addressing inequality, poverty, and unemployment. The vision was for a state-led development in the economy and for health, it emphasized how:

> Planning must aim at liquidating illiteracy, eliminating epidemics, expanding health facilities and raising the average life span. A rational population policy would have to be framed to enable economic growth to improve the standard of living of an average

[5] Sunil Amrith, Rockefeller Foundation and Postwar Public Health in India, 2009, Rockefeller Archive Center, at: www.issuelab.org/resources/27992/27992.pdf.

Indian. Labour must be assured better and hygienic conditions of work and protection from sickness and accidents. Unemployment insurance and minimum wages must be provided statutorily.[6]

The Bombay Plan, authored by leading Indian industrialists, pro-actively sought state intervention for capitalist development.[7] Their vision included a central role for the state in the economy and social sectors. The acceptance of allopathy as rational and scientific resonated with the Nehruvian emphasis on industrial development and promotion of a scientific temper. On the other hand, the People's Plan, which was drafted by M. N. Roy, a communist leader, gave primacy to agriculture and advocated for the nationalization of agriculture and all production activities. Unlike the advocates of the Bombay Plan and members of the National Planning Committee, Gandhi was skeptical of Western ideas of development and modernity. The Gandhian Plan articulated a decentralized economic structure for India, with self-contained villages. Unlike the National Planning Committee and the Bombay Plan, the Gandhian Plan emphasized agriculture and stressed cottage and village industries.

In the case of health, Gandhi drew upon local traditions, indigenous systems, and naturopathy that had a sophisticated understanding of the relationship between the environment, society, and the individual body. This holistic understanding engaged in the complexity of the physical, social, economic, and psychological aspects of health and well-being. Gandhi was critical of the reductionism of biomedicine and emphasized the cultural rootedness of understanding health. In many of the indigenous systems, there was a great deal of emphasis on the relationship between food and health; detailed knowledge of flora for enhancing well-being and also curing illness; and individual and societal interrelationships was also given importance as determinants of health. It is interesting to note that while Gandhi engaged in folk and indigenous systems of healing, Nehru was skeptical about their value. Given the dominance of allopathy, indigenous systems were given a secondary position within the health services. Apart from the socialist influence, ideas of Gandhi's Swaraj also played an important role in shaping ideas of social medicine where the role of the state was critiqued for its inadequacy and local self-government and engagement with indigenous knowledge systems gained ground.

Babasaheb Ambedkar who was the author of the Indian Constitution and a key intellectual on the question of caste and inequality in Hinduism, was

[6] Girish Mishra, "Nehru and Planning in India," *Mainstream Weekly* 52, no. 47 (November 15, 2014), at: www.mainstreamweekly.net/article5320.html.

[7] Sanjaya Baru and Meghnad Desai, *The Bombay Plan: Blueprint for Economic Resurgence* (New Delhi: Rupa Publications, 2018).

an important influence for development and its implication for health.[8] His views on health are critical because he questioned and rejected the Hindu caste system, which he saw as the cause of persisting social inequalities. Keeping inequalities at its core, Ambedkar recognized how it mirrored unequal life chances, access to basic needs, health inequalities, and access to health services. Some of his ideas resonated with the ideas of Western social medicine but went beyond the importance of the state's role in public health. There was emphasis on the structural determinants of health and therefore went beyond health services or advocating particular medical interventions against diseases. Babasaheb Ambedkar argued that the state's role was to improve the social determinants of health, such as ensuring access to nutritious food, a stable income, and access to clean drinking water, the lack of which caused ill-health. In addition, Babasaheb Ambedkar argued that the removal of caste and class inequalities in access, not only to medical institutions, but to the determinants of health, was an essential responsibility of the state. Health required not just medicines and hospitals, but a grappling with India's grossly unequal social reality. As Mahanand observes:

> Babasaheb's ideas on social security and public health sought to address these social realities through state efforts that could help bridge the inequalities that are deeply embedded in Indian society. His idea of a democracy emphasised a state that would intervene to break down structural divisions. His conception of public goods – such as health and education – were inclusive and equitable, seeking an equal distribution of and access to public health and social security, in order to ensure the overall well-being of the masses.[9]

Geopolitical Order and Postcolonial Societies in Twentieth-Century Asia

From the early part of the twentieth century, the rise of the Soviet Union resulted in a bipolar world. Most postcolonial societies asserted their independence by largely taking a position of non-alignment and asserting self-reliant development. This essentially meant that they were in a position to articulate and resist pressures from both the capitalist and socialist blocks. There was diversity in the politics of the Indian subcontinent during the 1940s. A stark

[8] Dr. Babasaheb Bhimrao Ambedkar is one of the architects of the Indian Constitution. Dr. Ambedkar fought for the rights of Dalits and other mistreated classes and to eradicate untouchability perpetuated by the upper castes in India). The caste system is a hierarchical system of socioeconomic order that is determined by birth. The Brahmins occupy the uppermost rung and the lowest rung is occupied by the Dalits. Ambedkar, B. R. (Bhimrao Ramji, 1891–1956), *Annihilation of Caste: An Undelivered Speech* (New Delhi: Arnold Publishers, 1990).

[9] Jadumani Mahanand, "India's Pandemic Response Needed Ambedkar's Vision of Social Security and Public Health," *The Caravan*, August 24, 2020, at: https://caravanmagazine.in/policy/indias-pandemic-response-needed-ambedkars-vision-of-social-security-and-public-health.

contrast in approaches to socioeconomic development was seen between India and Sri Lanka during the 1940s and 1950s.

While the leadership of the Indian nationalist movement was informed by a democratic and socialist ideology, Sri Lanka's leadership in the early years was influenced more by communism. Differences in political ideology influenced public policies both in the economic and social sectors. As observed by Rosenburg et al., "By the time Sri Lanka gained independence in 1948, government policy required health facilities to accept any patient who sought admission. In 1951, the government abolished all user fees. The idea was 'welfare first, then growth.'" Welfare, in addition to health, included investment in food subsidies, free education, and subsidized transportation. Public sector services were offered without consideration for the income or other status of beneficiaries.[10]

The approach to building welfare was shaped by differential ideologies in India and Sri Lanka. India was essentially an interventionist state, while the latter guaranteed employment, food security, health, and education. Thus, the extent of state support for welfarism varied in the South Asian region. The weakness of an interventionist welfare state in India was reflected in the underfunding of the public sector that had consequences for inequities in access to services across regions, caste, class, and gender.[11] The inadequacies of the public sector in India gave rise to diverse approaches to ensure equitable access to health services and addressing the social determinants of health by civil society groups. Another important fallout of a weak public sector was the expansion for markets in healthcare from the late 1970s.[12]

Social Medicine and the Role of Civil Society during the 1960s and 1970s

By the 1960s, social medicine acquired many avatars. American influence came through partnerships with the Rockefeller Foundation and with public health experts from the Harvard School of Public Health and Johns Hopkins University, who collaborated with the Christian Medical College in Ludhiana,

[10] Julie Rosenberg, Tristan Dreisbach, Claire Donovan, and Rebecca Weintraub, "Positive Outlier: Sri Lanka's Health Outcomes over Time," Harvard Business Publishing, 2018, Global Health Delivery Project, at: www.globalhealthdelivery.org/publications/positive-outlier-sri-lanka%E2%80%99s-health-outcomes-over-time-0.

[11] Niraja Gopa Jayal, "The Gentle Leviathan: Welfare and the Indian State," in Mohan Rao (ed.), *Disinvesting in Health: The World Bank's Prescriptions for Health* (New Delhi: Sage Publications,1999), 39–48; Rama Baru, Arnab Acharya, Sanghmitra Acharya, A. K. Shiva Kumar, and K. Nagaraj, "Inequities in Access to Health Services in India: Caste, Class and Region," *Economic and Political Weekly* 45, no.38 (September 18–24, 2010): 49–58.

[12] Rama V. Baru, *Private Health Care in India: Social Characteristics and Trends* (New Delhi: Sage Publications, 1998).

Punjab. The two projects, Khanna and Narangwal, were partnerships between the Rockefeller Foundation, Harvard School of Public Health, and Johns Hopkins. Rebecca Williams has documented the American influence through the Khanna and Narangwal studies in the Punjab that focused on primary healthcare and population control. The International Health Division of the Rockefeller Foundation had close links with the Harvard School of Public Health that was engaged in human ecology and population problems in developing countries. She argues that:

Gordon had been working alongside two of his MPH students, medical missionaries Carl Taylor and John Wyon, on plans for a population study as part of a broader series of epidemiological studies in the Ludhiana district of Punjab. The geographical setting was chosen for the practical reason that Taylor was set to take up a position as head of the newly-formed Department of Preventive Medicine at the Ludhiana Christian Medical College. Taylor, a medical missionary with the American Presbyterian mission, was already well known to the RF. He had been in a class of doctors that had been trained by the RF on behalf of the U.S. Army during the Second World War. In 1950 the RF awarded him a fellowship which allowed him to study at the HSPH, and in March 1952, they offered Taylor a position as head of the Department of Preventive Medicine at the RF-funded Vellore Christian Medical College in South India. Taylor declined the proposal on the basis that he was morally and mentally committed "to returning to Ludhiana. Taylor was born in North India to medical missionary parents, already spoke Hindi and Urdu fluently and was familiar with Punjab village life," and therefore wanted to work in the region.[13]

In 1961, the Narangwal study, which was similar to the Khanna Study of the 1950s, was initiated in Ludhiana under the aegis of the Christian Medical Colleges. As Chakrabarti states:

The Narangwal and the Khanna rural health-care projects, which attracted global attention, show that population control often operated as part of rural primary health-care initiatives that had started in India in the post-independence period. The Narangwal Rural Health Research Centre in three community development blocks of the Ludhiana district in the Punjab was established in 1961 and had similarities with the Khanna project of 1952 and rural health projects in other countries during the mid-20th century, such as in Danfa, Ghana, and Lampang, Thailand. Narangwal was a complex operation that established some of the basic modes of community participation in rural primary healthcare in India. The centre had its primary health clinics run by the Christian Medical College of Ludhiana.

Chakraborti describes the focus of these surveys as:

The medical team and the resident social scientists also undertook surveys on diet, nutrition, and child and maternal health. Crucially, the project also trained and

[13] Rebecca Williams, Rockefeller Foundation Support to the Khanna Study: Population Policy and the Construction of Demographic Knowledge, 1945–1953, Rockefeller Archive Centre Collection Home (January 1, 2011), at: www.issuelab.org/resources/28011/28011.pdf, p. 16.

employed nurses, midwives, and other community health workers. The family health workers, who were mostly women, had previous training as auxiliary nurse midwives and catered for various primary health concerns of the villages, including assisting in childbirth.[14]

This avatar of social medicine influenced the preventive and social medicine departments in medical colleges in India during this period. The circulation of the Americanized version of social medicine influenced the shaping of departments of preventive and social medicine in the medical colleges from the mid 1950s to the 1960s. One could argue that this version of preventive and social medicine departments in medical colleges privileged allopathic interventions and "desocialized" social medicine.

Another important avatar was that of critical social medicine from China, Latin America, and Africa that influenced several community health projects in India. Critical social medicine was heavily influenced by Marxian ideology and praxis that gave more importance to the structural factors that shape health outcomes and highlighted the limits to medicine. Several civil society movements in India in the late 1960s and 1970s were inspired by these country experiences. Social deficits in India energized non-partisan social movements around sociopolitical, living, working, and environmental conditions, with a demand to recognize that, "the struggle for liberation (was) not just from alien rule but also from internal decay."[15] These movements stimulated grassroots community health projects across different Indian states that connected health with larger social concerns and with a claim for social justice and local democratic control. These ideas, with those from other regions, had some influence in the comprehensive framing of Alma-Ata Declaration.

In the 1970s, social movements challenged the state in addressing inequality and poverty and implemented innovations at grassroots level, including community health projects. They reflected Gandhian, Christian, Marxist, and feminist ideas, most often a hybrid of the three. The Chinese idea of barefoot doctors changed the idea about a "health worker" and resonated with the Gandhian idea of "Arogya Swaraj,"[16] or "peoples' health in people's hands," a popular slogan that influenced many community health organizations that focused on social determinants of health and health systems. These social movements were of the view that only an equitable, sustainable, and just society can ensure

[14] Pratik Chakrabarti, "Health as Activism: Rethinking Social Medicine in India," *The Lancet* 399, no. 10341 (June 2022): 2096–7, Doi: 10.1016/S0140-6736(22)00979-5. P.2097.

[15] Rajni Kothari, "Party and State in our Times: The Rise of Non-party Political Formations," *Alternatives* 9, no. 4 (October 1984): 541–64, doi.org/10.1177/030437548400900404.

[16] Arogya Swaraj is inspired by Gandhi's ideals and it includes understanding of oneself, including one's mind, body, conscience, and conduct. It includes the idea that an individual must reduce dependency on doctors and drug manufacturers. Therefore it translates to the idea of People's Health in People's Hands.

health for all. Health action was seen to call for a struggle against harms such as pollution, poor living, dietary and psychosocial conditions, and for the promotion of an alternative, healthier pattern of development. While many actions for this lie outside the healthcare system, they saw the health system as the most visible determinant of health, calling for a public system that would be responsive to people's needs and be socially accountable. They rejected blame placed on poor people, women, and other marginalized groups for their own ill-health, seeing this as a consequence of elite dominance in decision-making, in and beyond the health sector.

These ideas resonated with (and contributed to) the principles and design of comprehensive Primary Health Care (PHC) in the 1978 Alma Ata-Declaration. While they were implemented in limited local settings, alliances were formed on specific issues in the 1980s and 1990s that gave them stronger policy visibility and influence. Diverse networks, women's and consumer movements, doctors, and social activists converged on issues such as the promotion of essential medicines, breastfeeding, local traditional farming and food security, and on the protection of medicinal plants and traditional therapies. As examples, the Medico Friends Circle (MFC) formed in 1974 by a group of doctors and social activists who broadly subscribed to Gandhian and socialist ideologies to critique technology-determined disease-control programs.[17] One of the civil society coalitions in western India led a campaign on the "right to food" through school-feeding programs, universal preschool childcare, employment, and food security for vulnerable social groups. The women's movement engaged in a diverse set of health issues like hazardous contraceptives such as EP drugs, Net En, Norplant, Depo-Provera, sex-selective abortions, and coercive state population-control policies, as well as domestic and state-sponsored violence against women.

Comprehensive PHC and rights-based approaches to health were further advanced by social movements, especially by the Indian Peoples' Health Movement (PHM), termed Jan Swasthya Abhiyan (JSA), which was formed in 2000. JSA is a coalition of about twenty national networks and more than a thousand local organizations across India working on health, science, women's issues, and development. It has opposed commercialization of medical care and argued for pro-people changes in the health sector. It has taken up research, advocacy, legal action, and alliances on the right to health and social determinants of health. It has highlighted inequities in health outcomes and access to health services, pointing also to a social gradient that has led some parts of the middle class to equally experience declining health outcomes.

[17] N. B. Sarojini et al., *Women's Right to Health, National Human Rights Commission* (New Delhi: National Human Rights Commission, 2006), at: http://dev.ecoguineafoundation.com/uploads/5/4/1/5/5415260/womens-health_rights.pdf.

Following the 2008 World Health Organization (WHO) Commission on Social Determinants on Health Report, JSA energized PHM branches in Asia to form a South–South alliance in order to draw attention to the inadequacy of state policies on social determinants, with different networks covering issues such as equitable social development, migrant health, pesticide safety, and the determinants of HIV.

Several of the health NGO initiatives were led by doctors and allied professionals who provided leadership to these projects, drawing from diverse ideological moorings – Marxist, feminist, populist – that broadly subscribed to the critiques of capitalist development. During this period, several resistance movements led by organized and unorganized working class, women, Dalits, Tribal, and religious minorities also had ideas of social medicine as a part of their understanding. Several of these movements highlighted social inequalities and the limits of allopathy in addressing well-being and health. This in essence formed the rubric of the radical ideology that included the organized left, Gandhian and Ambedkarites, feminist, Catholic and Christian health networks. The diverse ideological positions focused on inequality, poverty, and the unmet needs of marginalized groups. They were critical of the bureaucratic and top down approaches of the public sector and emphasized the importance of a people-centered health services, recognition and legitimization of folk practices and indigenous systems of medicine, and going beyond to address the social determinants of health.

Thus, the idea and practice of social medicine in its various avatars remained vibrant among social movements and civil society organizations in the Indian subcontinent. The influence of these various avatars remained largely outside the purview of state-sponsored medicine. However, there have been certain periods when some of the practices in community health projects were translated into mainstream health policy.

Community Health Projects

There were several community health projects that experimented with training community health workers for basic care, demystified medicine and engaged in traditional medicine in its various forms. A few of these were initiated by missionaries in remote parts of the country, where they engaged in women's health, empowerment, and education. Others were inspired by Gandhian ideology to demystify Western medicine. As Iyengar observes:

> Gandhi was critical of biomedical approaches, but also and saw limitations in traditional healing systems. He saw hospitals as a "symptom of decay," and called for more focus on prevention of diseases and on mental, physical and spiritual health. Rather than the top-down application of technological approaches, he perceived that achieving health depended on living healthy lives, starting at the village level, as a form of a

social determinants approach. He advocated for community health workers, or *Arogya Samrakshan Samiti* and for primary health centers that promote healthy lifestyles and family care, advise on diets and production of healthy foods, promote safe water and sanitation and apply herbal therapies based on the available biodiversity.[18]

This approach made the community and primary level of care as two important pillars for health services and healthy societies. The Gandhian paradigm was taken up by many grassroots groups and movements in the 1980s and 1990s. This led to the rise of several coalitions around specific issues of human rights, responsible development, health, and social rights. The constituents of these coalitions consisted of political parties, leftist trade unions, Gandhian, Dalit, Adivasi, and feminist groups.

It is interesting to note that elements of the American ideas of community medicine were adapted by a generation of doctors who founded a few health projects in rural India. Furthermore, the leadership of several of these community health projects were in the hands of doctors who had done their Masters in Public Health at Johns Hopkins. There was much variety in ideology, praxis, and innovations in the practice of social medicine through the 1970s and 1980s among such doctors who chose to return to India. One could argue that these projects combined the diverse avatars of social medicine in their praxis. There was uptake of these diverse experiences of community health projects that was translated into national health policy with the introduction of the Community Health Workers (CHWs) scheme in 1977. The government scheme drew inspiration from the barefoot doctor scheme in China and several community health projects in India that resonated with the Gandhian ideas of strengthening people's health in people's hands.

There are some well-known examples of community health projects that had introduced health workers and also tried to address some aspect of social determinants of health. These projects were primarily located in rural areas.[19] Several of the community health projects were initiated by clinicians. Prominent among these are the Comprehensive Rural Health (CRPH) project and Society for Education, Action and Research in Community Health (SEARCH) in Maharashtra. The former was founded by Drs. Raj and Mabelle

[18] Sudarshan Iyengar, "Health Care: The Gandhian Way," 13th HM Patel Memorial Lecture, Karamsad, Anand, Gujarat, 2017, at: www.charutarhealth.org/sites/default/files/13thhm_patel_memorial_lecture_text_new_0.pdf.

[19] Saroj Pachauri, *Reaching India's Poor: Non-governmental Approaches to Community Health* (New Delhi: Sage Publications, 1994). The Community Health Workers of Jamkhed; the village health workers of the Indo Dutch Project; the lay first aiders of VHS-Adyar; the link workers on the tea gardens in South India; the Family care volunteers and Health Aides of RUHSA; the MCH workers of CINI-Calcutta; the Swasthya Mithras of Banaras Hindu University-Varanasi; the Sanyojaks of Banwasi Seva Ashram, Uttar Pradesh; CHW course of St. John's Medical College – Bangalore; the Rehbar-e-sehat scheme of Kashmir government; the CHVs of Sewa Rural and the Community Health Guides of many other projects.

Arole and the latter by Drs. Abhay and Rani Bang. Both the couples had their medical education in India and later gained their Masters in Public Health from Johns Hopkins University. The Aroles set up their project in the 1970s, with a vision of providing primary healthcare services using appropriate technology. Health services were integrated within a multisectoral approach to address social inequalities and ill-health, poverty, poor women's status, and the caste system. An important contribution toward upscaling the project was their training programs for community health workers in Non-Government Organizations (NGOs) from different parts of the country. SEARCH was established in a tribal area, Gadchiroli, that had one of the poorest health indicators. The Schedule Tribe communities in India are among the most marginalized and in some cases their socioeconomic and health status is even worse than Dalits. The focus of their work was on maternal and child health in the tribal areas that did not have functional health services.

An overview of these CHWs in the non-government sector showed that frontline workers were predominantly women volunteers belonging to the lower socioeconomic groups. They were trained to use strategies to empower and represent marginalized communities across different states in India. Some of the community initiatives by NGOs were translated and upscaled into state-supported programs. An example of these are the Women's Development program in Rajasthan and the Mahila Samakhya program in 1988 by the Central government. Both of these were government-led programs in partnership with NGOs. There were specific initiatives within this program to address women's education, empowerment, health, and specifically reproductive health.

Alliances for Promotion of Social Medicine from the South Asian Region

The Non-Aligned Movement of the postcolonial societies and leadership of clinicians, public health, and civil society organizations formed alliances for the promotion of social medicine. Drawing inspiration from the Bandung Conference on Rural Hygiene in August 1937, the importance of state-funded health services and addressing intersectoral action for health was foregrounded. The ideas of the Bandung Conference were instrumental in shaping the Primary Healthcare approach in 1978.[20] The Conference drew attention to the relationship between high levels of poverty and ill-health across developed and developing countries. This was much higher in the rural as compared to urban populations. The poor bore the burden of

[20] Imrana Qadeer and Rama Baru, "Shrinking Spaces for the 'Public' in Contemporary Public Health," *Development and Change* 47, no. 4 (June 6, 2016): 760–81, at: https:/10.1111/dech.12246.

morbidity and mortality of communicable diseases with limited access to food, work, housing, and medical care.

The idea of social medicine was kept alive by several prominent physicians and practitioners in public health in the South Asian region. Deeply committed to the principles of equity and rational care, many formed alliances across the south to question Western dominance. Broadly, the NAM engaged in self-reliance and the need to push back on the dominance of multinationals in the economy and social sectors. Many of the ideas on rural hygiene that were discussed at the Bandung Conference in 1937 strengthened the practice of social medicine through the next few decades and many of these ideas were resurrected in the Alma-Ata Declaration for Primary Health Care in 1978.

There were discussions on how to organize health services at a population level and examples were drawn upon from Eastern Europe and later John Grant's attempts to apply the same principles in rural China. The emphasis on state intervention for comprehensive health services with a well-worked-out referral system was accepted and practiced by the advocates of social medicine.

The 1970s saw the coming together of leadership from the south of professionals within a political climate of heightened radicalism. The leadership for radical reform in an important subsystem of the health service system, namely pharmaceuticals, came from Sri Lanka during the early 1970s. It was the dominance of Left politics that provided spaces for nationalization of the pharmaceutical industry and curbing multinational corporations. Dr. Seneka Bibilie, who was a clinician and supporter of the Left parties, envisioned the Sri Lankan National Drug policy. As Perera observes:

> Professor Bibile's principle of developing a rational pharmaceutical policy intended to ensure that people would get reasonable drugs at an affordable price, was based on ensuring that doctors prescribe the minimum required drugs to treat the patient's illness. This policy was used with enormous benefit to Third World countries as a model for expansion of policies based on rational pharmaceutical use in other countries as well by the WHO, the United Nations Conference on Trade and Development (UNCTAD) and NAM. Due to the far reaching effects of his proposals and policies, he has been called the "greatest medical benefactor of humanity that Sri Lanka has hitherto produced." UNCTAD, in fact scrutinized the Sri Lankan practice, concluding that an examination of the Sri Lankan model could give other third-world countries an insight into ways of devising, developing and executing integrated national medicinal drugs policies.[21]

The Sri Lankan experience found global resonance that gave rise to a number of networks in India and later Bangladesh. Dr. K. Balasubramaniam, who was Bibilie's student and protégé, became part of Health Action International (HAI).

[21] K. K. S. Perera, "Dr. Senaka Bibile's 'Drug Price Policy' Was Feared by Transnational Pharmaceutical Industry Known as 'Big Pharma,'" Posted by Administrator on November 26, 2016, 1:21 a.m., at: https://dbsjeyaraj.com/dbsj/archives/49865.

HAI was formed with clinicians and public health persons from both the developed and developing countries, who strongly advocated for a rational drug policy as an important aspect of social medicine. Dr. Zafarullah Chowdhury from the Gonashasthya Kendra in Bangladesh and the All India Drug Action Network (AIDAN) in India are examples of South Asian partnerships with HAI for accountability on pharmaceutical products, rational drug policies, and essential drugs. In addition, several of these movements focused on banning pesticides, banned and restricted products, and hazardous waste exports.

Institutionalization and Practice of the Many Avatars of Social Medicine

The many avatars of social medicine and its practice is seen in several community health projects and also addressed by health movements across India. In this section, I present vignettes of efforts to institutionalize the idea of critical social medicine in a university and of a network of medical practitioners, social scientists, and activists who had diverse institutional affiliations called the Medico Friends Circle.

A unique effort to institutionalize the theory and practice of social medicine as an academic discipline was the establishment of the Centre of Social Medicine and Community Health in the Jawaharlal Nehru University, New Delhi, during the 1970s. In a radical departure, the Centre was located in the School of Social Sciences in the university and not attached to a medical college. The committee that endorsed this saw the need to go beyond curative medicine and engage with the relationship between society and health. The committee was critical of the curriculum of the Preventive and Social Medicine or Community Medicine departments in medical colleges and sought to expand the scope to include the social determination of health. There was a view that innovation in approaches, curriculum, and pedagogy would be possible only outside the confines of the medical college with greater interaction with social sciences.

The Centre was founded by a public health clinician, Dr. D. Banerji,[22] who had worked in community health projects and had engaged in a study of the National Tuberculosis Institute that informed the Indian TB program. Instead of a vertically driven program, this study advocated for strengthening the general health services to address the felt needs of people suffering from TB in a community. This collaborative study of Indian scientists with the WHO was a departure from the vertical programing for controlling communicable diseases globally in the 1960s. Subsequently, Dr. Imrana Qadeer, a pediatrician by training and deeply engaged in the Medico Friends Circle and several community

[22] Debabar Banerji, *Health and Family Planning Services in India* (New Delhi: Lok Paksh, 1985), 174–252.

health projects, joined the Centre. Over the years, the composition of the faculty drawn from medical and social sciences for interdisciplinary approach engaged with students from diverse disciplinary backgrounds. The curriculum for the master's and doctoral programs have an interdisciplinary approach to Indian health problems. The core concerns addressed were inequality, poverty, and an intersectoral approach for health and well-being. This Centre is one of its kind in South Asia because the concerns are derived from an understanding of the relationship between society and health.

Medico Friends Circle

Many health activists from the 1970s to the 1990s were either involved in or closely followed the discussions of the MFC *Bulletin*. The exchange of mail between two young barefoot doctors, coping with the difficulties of providing rural healthcare is often credited with the formation of MFC. The first meetings of MFC in the early 1970s was a discussion group of ten to twenty persons who were keen to discuss and debate rural work and health services, rather than to institutionalize their work into more formal organizations. The group refused any external funding. This emerged as a platform for academics, practicing doctors, and civil society organizations who engaged in ideas of social medicine by emphasizing politics of health, giving priority to the health of the poor, and concerns regarding social inequalities. The membership of MFC intersected with AIDAN, HAI, and several networks of Christian and Catholic medical missions. This was a period of growth of civil society groups setting up community health projects taking an anti-state stance but campaigning, advocating, and practicing social medicine in local contexts. Several of these actors later came together to form the peoples' health movement globally and the Indian Jan Swasthya Abhiyan.

In addition to publishing the journal and carrying out studies, activists in the movement helped to create alternative hospitals whose particularity was to be co-managed by several stakeholders. These health centers could, for instance, be run by unions, workers, and civil society groups, the most famous being the Shaheed Hospital, built in 1983 in Madhya Pradesh, with the support of Dr. Binayak Sen. In doing so, they chose to bridge the cultural and epistemic boundaries between the expert doctor and the impoverished patient: all of them had to be involved on an equal footing in the construction and organization of work in health centers.

Neoliberalism, Commercialization, and Social Medicine

With the introduction of liberalization policies in the 1990s, the spaces for critical social medicine started shrinking in the Indian subcontinent. The erstwhile

radical politics that informed civil society discourse were marginalized with the introduction of the Structural Adjustment Program (SAP) of the World Bank that privileges privatization. The neoliberal agenda was antithetical to social medicine perspectives and the Alma-Ata Declaration that emphasized the important role of the state to ensure redistributive justice, health as a right, and going beyond health services to address the structural determinants. On the other hand, neoliberal health reforms believes that the private sector is more efficient than the public sector. The clear demarcation in roles of the public and private sector undermined the comprehensiveness of health services as espoused by the principles of social medicine and primary healthcare approach. The private sector is responsible for the provisioning of curative services in order to ensure cost efficiency of delivery of services, freedom of consumer choice, and the promotion of competition among private entities. While the "for-profit" sector was privileged, the "non-profit" sector was seen as an important player in public–private partnerships for preventive and promotive services. This was seen in several externally funded disease-control programs for tuberculosis, HIV, malaria and blindness control.[23] Apart from existing NGOs and external funding from multilateral organizations like the World Bank in partnership with bilateral organizations, several new NGOs emerged in the health sector. These newer organizations were influenced by market models of service delivery. As a result, complex partnerships involving public, non-profit, and for-profit entities emerged.[24]

Alliances of some civil society actors against the SAP continued to pressure the state by providing evidence on rising inequities in access to health services, weaknesses of public provisioning, and the pitfalls of rampant commercialization of services. In 2004, when the United Progressive Alliance consisting of a coalition of the Congress and left-wing parties was voted to power, there was once again an opportunity for civil society to engage in policy. In health, the National Rural Health Mission (NRHM) provided a limited opportunity to restructure rural health services. Many ideas of community health volunteers as a link worker between the community and formal health services, communitization, decentralization to local levels, and so on became part of the design of the NRHM. Several civil society actors were engaged in the planning,

[23] Rama V. Baru and Madhurima Nundy, "Blurring of Boundaries: Public–Private Partnerships in Health Services in India," *Economic and Political Weekly* 43, no.4 (January 2008): 62–71, at: www.epw.in/journal/2008/04/special-articles/blurring-boundaries-public-private-partnerships-health-services. These complex partnerships were seen in the Reproductive and Child Health program wherein social franchising was introduced. The case of Janani in Bihar where a partnership between financing company and local actors was cited as an innovate partnership. Similar partnerships were also seen in the tuberculosis program.

[24] Rama V. Baru and Anuj Kapilashrami, "Unpackaging the Private Sector in Health Policy and Services," in Anuj Kapilashrami and Rama V. Baru (eds) and Madhurima Nundy (eds.), *Global Health Governance and Commercialisation of Public Health in India* (London: Routledge, 2018), 117–35.

training, and monitoring of innovative interventions.[25] The process of mobilization of several small and large community health projects of diverse ideological persuasions to engage with the NRHM was painstaking and commendable. However, these initiatives could not reverse commercialization that had gained a prominent place in the Indian health services. One could argue that commercialization had fragmented comprehensive health services broadly along the lines of "public" and private goods. The for-profit sector dominated the health services and reduced the role of the state to providing preventive services.

The Structural Adjustment Program of the 1990s, with its funding for select disease control programs like HIV, malaria, tuberculosis, and blindness, promoted public–private partnerships with NGOs and "for-profit" organizations. The external funding of the World Bank flowed to state governments and NGOs for these select programs with the introduction of parastatal institutions. The disease-specific funding resulted in several older health NGOs shifting their priorities to attract available funds from multilateral, bilateral, and American foundations. The funding was tied to conditionalities with the broad agenda of privatization.

Another important area of influence of the World Bank and American schools of public health was in education. In the 1990s, several private institutions offering Masters in Public Health were set up. Prominent among them was the Public Health Foundation of India that was a public–private partnership with corporate funding from global and Indian companies, in partnership with the government. Much of the curriculum was influenced by the American schools of public health. This was broadly the trend followed by other schools of public health across the country. The many avatars of social medicine that were in circulation from the 1970s onward had become peripheral and there was a tendency for homogenization and globalization of mainstream public health curricula. This is not something that is peculiar to the Indian subcontinent and is seen in parts of Africa and Latin America, too.[26]

With the change in government in 2014 and the emergence of the right-wing Bhartiya Janata Party, the spaces for critical engagement by civil society

[25] Kaveri Gill, "A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan," Planning Commission of India, Government of India (June 2009), at: http://environmentportal.in/files/wrkp_1_09.pdf2009.

[26] Eric D. Carter, "Social Medicine and International Expert Networks in Latin America, 1930–1945," *Global Public Health* 14, nos. 6–7 (June–July 2019): 791–802, doi.org/10.1080/17441692.2017.1418902. Rene Loewenson, Eugenio Villar, Rama Baru, and Robert Marten, "Achieving Healthy Societies – Ideas and Learning from Diverse Regions for Shared Futures," Training and Research Support Centre, Alliance for Health Policy and Health Systems Research (November 2020), at: www.tarsc.org/publications/documents/Healthy%20societies%20paper%202020%20final.pdf; Erasmus D. Prinsloo, "A Comparison between Medicine from an African (Ubuntu) and Western Philosophy." *Curationis* 24, no. 1 (March 2001): 58–65, Doi: 10.4102/curationis.v24i1.802.

organizations started shrinking.[27] Several NGOs that were engaged in human and civil rights, health, women's issues, and aligned with social movements and political parties struggling for the marginalized, came under scrutiny. Many of them who were critical of the government were labelled as "anti-national." They had to face various forms of harassment by the government, including imprisonment of civil liberty activists. There were several efforts to curb the activities of NGOs receiving foreign funding by introducing amendments to the Foreign Contributions (Regulation) Act. Several civil society organizations that were questioning state power came under scrutiny and their sources of funding from foreign organizations were restricted. This resulted in further shrinking of spaces for strengthening ideas of social medicine.

Covid-19 and the Re-emergence of Social Medicine and Its Distortion

The Covid-19 pandemic brought back the importance of social medicine and comprehensive primary healthcare for public health. There was much debate on the need to strengthen the role of the state for health services and the social determinants of health. There was a broad agreement that public-health-strengthening was important. However, in the Indian subcontinent, this did not translate into increased public investments in health nor for addressing the economic and social disruptions for the working and middle classes. Ironically, the government advocated for greater privatization of curative services and medical education during this period. There was no effort to address the private sector that largely did not respond to the humanitarian tragedy. As Baru and Bisht observed:

> The preparedness of private hospitals in dealing with the COVID-19 epidemic and the extremely variable quality of services in the poorly regulated private sector is now becoming apparent. Even internationally accredited hospitals in Mumbai and Delhi were ill-prepared to deal with the outbreak of coronavirus. A large number of health workers in these hospitals tested positive since they did not have adequate Personal Protection Equipment (PPEs) for doctors, nurses and other staff members. Once the positive cases were identified, some of these hospitals shut down.[28]

The Covid-19 pandemic has resulted in economic and political instability, especially in Sri Lanka. The rise of right-wing politics in the region has deeply

[27] Ajay Gudavarthy and G. Vijay, "Social Policy and Political Mobilization in India: Producing Hierarchical Fraternity and Polarized Differences," *Development and Change* 51, no. 2 (February 2020): 463–84.

[28] Rama V. Baru and Ramilla Bisht, "Government Must Stop Appeasing the Private Healthcare Sector," *The Wire* (April 25, 2020), at: https://thewire.in/government/coronavirus-private-hospitals.

compromised democratic spaces. These tendencies go against the ethical and moral imperatives that underline the many avatars of social medicine.

In conclusion, this chapter has tried to capture the ideological diversity that characterized the many avatars of social medicine. It elaborated on the global, national, and local avatars engaged in the idea of social medicine in the public sector and civil society organizations. It has argued that since the 1990s, neoliberal ideas and policies constituted a major setback for the idea of social medicine, both globally and in India. This led to a shrinking of the space for public health.