

Rockefeller Foundation and Postwar Public Health in India

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I

I undertook research at the Rockefeller Archive Center in December 2003, as part of my doctoral research on the history of international health. I became interested in the Rockefeller Foundation's records as a potential means of shedding light on some of the controversies and difficulties faced during and immediately after the Second World War, when the field of international health was still being defined and its boundaries debated. In writing an international history of public health, one of my main areas of interest has been the connections forged between individuals, institutions, and ideas within an increasingly global field of public health. Much work has been done on the role of the Rockefeller Foundation (RF) as a conduit for this kind of international exchange of ideas and personnel in the inter-war years. The major part of my dissertation, however, focuses on the 1950s, a period in which the foundation had scaled back its involvement in public health. Yet I found that for this period, too, the foundation's archives are an important source. The diaries of the RF officers in Asia, in particular, provide the perspective of "informed outsiders" on the complex, often tortured, negotiations between the UN agencies and national governments. This kind of source material is particularly valuable given the paucity of post-independence archival material which I was allowed to see in India and elsewhere in Southeast Asia.

I have made most extensive use of the Rockefeller Archive Center's materials in the early part of my dissertation, which considers the international currents of thought out

of which the World Health Organization (WHO) was born, and which shaped the agenda of global public health into the early 1950s. The extract that follows focuses upon the Rockefeller-funded committee of experts that advised the Indian Health Survey and Development Committee on the form, and the values, of a post-war public health service, in 1944-1945. I use this material in the dissertation to highlight the ways in which social medicine provided a shared language and shared set of assumptions in the field of public health planning. The dissertation then proceeds to relate the debates outlined here to the formation of the WHO in 1946-1948.

II

By virtue of their imprisonment after launching the Quit India movement in 1942, leading Indian nationalists were unable to play a role in the wartime planning for the future of India's health. Notwithstanding Gyan Chand's proviso that only a free India would be capable of planning for its future, the colonial Government of India took up the challenge of planning for India's future health services and, perhaps surprisingly, the committee was of distinctly progressive complexion. The Health Survey and Development Committee were appointed by the Viceroy in early 1944, under the chairmanship of Sir Joseph Bhore, a leading member of the Indian Civil Service. The Bhore committee was nothing less than a global exercise in social medical planning, involving, amongst others, John Ryle.

John Ryle was given a significant opportunity to develop his thinking, and to put it into practice, when he travelled to India in 1944 as an expert adviser to the Bhore committee. His views echo many of the themes that Gyan Chand had raised in his pamphlet on *The Problem of Population*. His journey to India had given him the chance

of “seeing and hearing at first hand something of India’s immensely complex problem,” Ryle wrote, in his *Changing Disciplines*. He concluded that “no narrow or unrelated planning in the fields of medicine and hygiene and no considered population policy can be expected to affect the situation in the near future. Political, social, agricultural, industrial, and economic developments and educational and political progress are all as urgently necessary as sanitation and medicine to the people’s health.” He suggested that “time must be allowed for historical growth, for self-determination, and for the percolation of what is best and most applicable in the ideas derived from the experience of other nations.”¹ This visit to India, sponsored by the Rockefeller Foundation,² brought Ryle and his Oxford colleague Janet Vaughan³ together with two other leading proponents of social medicine during the war: John B. Grant of the Rockefeller Foundation’s International Health Division, and Henry E. Sigerist, of Johns Hopkins medical school.

Within this group, Grant represented the American variant of social medicine, interested less in inequality and more in efficiency; his was a managerial social medicine.⁴ A career Rockefeller officer, and the son of a missionary, Grant spent much of the 1930s in China. During the war, Grant headed the All-India Institute of Hygiene and Public Health in Calcutta. Despite his extensive experience in public health in poor rural areas, Grant later told an audience in New York, “India shocked me. I knew the Asiatic countries, and all of them had features way ahead of India. Medically it is the most

¹ Ryle, *Changing Disciplines*. p. 85.

² Rockefeller Archive Center, Pocantico Hills, New York [Henceforth RAC]. Records of the Rockefeller Foundation [RF] Record Group 2—General Correspondence, 1945, Series 464. Box 306, Folder 2076.

³ Janet Vaughan, a trained pathologist, managed the blood banks during the Blitz, and took a particular interest in industrial medicine.

⁴ See, for example, his article: “Public Health as a Social Service,” *Science and Culture*, 6, 5, (1940), pp. 296-300.

backward country in the world.”⁵ In private and in public, Grant was deeply critical of the Government of India; its inefficiency was particularly galling to him. “Another excellent illustration of the difficulty in India to obtain action and results is seen in the delays attending upon the special measures taken ... to cope with famine, particularly the control of the cholera, smallpox and malaria epidemics,” he wrote in his diary in early 1944. Whereas military relief, belated though it was, was “quickly and successfully established, the preventive programme requiring collaboration of the civil government is three months behind schedule ... an illustration of the complete inefficiency of provincial government.”⁶

Another of the international advisers to the Bhoire committee, Henry E. Sigerist was, unlike Grant, avowedly on the left. Born in Paris, and educated in medicine at Zurich University, Sigerist arrived in the United States in 1931, taking up the directorship of the Institute for the History of Medicine at the Johns Hopkins School of Public Health in 1932. Sigerist’s diaries and correspondence provide a clear indication of the sense of opportunity, and the flourishing of communication, engendered by the worldwide planning for the future of public health. Sigerist’s wartime interest in India was, in fact, stimulated by his chance friendship with a young Indian doctor named Kamala Ghosh. Their fleeting correspondence is symptomatic of the depth of shared ideas about health during the 1940s.

Ghosh had written to Sigerist at Johns Hopkins in early 1941, introducing herself as “an Indian (Hindu) woman doctor” who had been “working for 8 years in India, as a member of the Women’s Medical Service, being in charge of small (45-65 bed) hospitals

⁵ Vellore Christian Medical College (North American Board), Luncheon Meeting, December 11, 1945, New York City: John B. Grant’s address. RAC, RF, RG2—1945, 464, Box 307, Folder 2083.

⁶ RAC, RF, RG 12.1: John B. Grant Diaries, 1944-1945 (Volume 1), entry for Jan 1-19, 1944, Calcutta.

for women and children in different parts of the country.”⁷ Ghosh, the daughter of a former Justice of the Calcutta High Court,⁸ happened to be in the United States on leave. She was moved to contact Sigerist, she wrote, “because, reading your book on ‘Socialised Medicine’ a few weeks ago, all the problems in public health and education that I have been facing, were presented in an entirely new aspect and became suddenly capable of solution.”⁹ Sigerist invited Ghosh to visit him at Johns Hopkins, which she did, and in their subsequent correspondence, she expressed a desire to return to India to play a part in medical relief and planning for the future. Unable to secure a passage home on an ordinary ship, Ghosh took the position of medical officer on an oil tanker: a radio broadcast about her heroic journey described her as a “small, dynamic, charming woman, under thirty, she insists that she is first and foremost a doctor and refuses to say anything about her adventures.”¹⁰ On board the oil tanker, traversing the North Atlantic, Ghosh wrote to Sigerist again: “I have been reading some books on the Chinese industrial co-operatives, and a surgeon’s book on the experiences of the ... medical services during the Spanish War, and also have your little ‘Medicine and Human Welfare’ with me to dip into for a tonic at low moments.”¹¹ A more evocative idyll of social medicine in the 1940s would be hard to find. Tragically, Kamala Ghosh died at sea. The oil tanker was attacked and destroyed by enemy fire. “It is really terrible,” Sigerist wrote to Charlotte Silverman, “I am more upset than I can tell.”¹²

⁷ Sterling Memorial Library, Yale University. Henry E. Sigerist papers (No. 788), Box 5, folder 176: “Kamala Ghosh 1941-43.” Ghosh to Sigerist, March 23, 1941.

⁸ “Indian Woman Doctor’s Courage,” London 13 January 1943. Typescript of Broadcast, Sigerist Papers, Box 5, Folder 176: Kamala Ghosh.

⁹ Ghosh to Sigerist, March 23, 1941.

¹⁰ “Indian Woman Doctor’s Courage,” 13 January 1943.

¹¹ Sigerist Papers, Box 5, Folder 176: Ghosh to Sigerist, October 19, 1942.

¹² Sigerist Papers, Box 5, Folder 176: Sigerist to Charlotte Silverman, US Department of Labor, June 15 1943.

The following year, Sigerist received an invitation from the Government of India to join the tour of international experts studying India's health problems and advising the Health Survey and Development Committee. Noting that his fellow international experts included John Ryle, Sigerist concluded that "I think the choice is interesting. It shows that liberal forces are involved."¹³ In Sigerist's mind, this was a symptom of the flourishing of progressive and radical thinking about health in the 1940s, which—more than anyone—his late friend Kamala Ghosh epitomised. "I think Kamala Ghosh prepared the ground," he wrote, movingly, in his diary.¹⁴

The thinking of Ryle, Grant and Sigerist found echoes, and a receptive audience, in India. The Bhore commission was composed of leading Indian civil servants and public health specialists. The chairman, Sir Joseph Bhore, was a lawyer and a "master in the art of compromise."¹⁵ Dr K.C.K.E. Raja, a statistician from the All-India Institute of Hygiene and Public Health in Calcutta, did much of the work. The most flamboyant member of the committee was the Diwan Bahadur Dr. A. Lakshmanaswami Mudaliar, who would later occupy a leading position in the World Health Organization. A gynecologist by training, he was, at the time of the Bhore survey, the vice-chancellor of Madras University. Sigerist described him in a confidential letter as a "highly cultured man, a clear thinker, and an ardent patriot who, however, is willing to cooperate with any government for the benefit of his people."¹⁶ The latter point referred to the ambivalent position of the committee—appointed by the colonial Government of India whilst most

¹³ Diary entries for 16 August 1944, and October 7, 1944, in Henry E. Sigerist, *Autobiographical Writings*, [selected and translated by Nora Sigerist Beeson], (Montreal: McGill University Press, 1966), p. 188, p. 190.

¹⁴ Diary entry, 16 August 1944, in Sigerist, *Autobiographical Writings*, p. 188.

¹⁵ Sigerist Papers. Series II. Box 35, Folder 74, "Report on India," typescripts from *On the Sociology of Medicine*, p. 2.

¹⁶ Sigerist, "Report on India," p. 3.

leading Indian nationalist politicians languished in jail. The perceived taint of collaboration was a sensitive issue. Others, however, found Mudaliar's idiosyncrasies wearing, particularly the secretary of the committee, K.C.K.E. Raja.¹⁷ Sigerist suggested, in the same confidential report to the president of Johns Hopkins medical school, that Grant played a crucial facilitating role in the committee: "he is equally liked by the British and Indians and has their full confidence. He is a brilliant man of wide experience, an excellent teacher and administrator who very tactfully succeeded in inspiring and steering the committee. The best and most progressive recommendations of the Committee are his."¹⁸

The Committee based itself at the Grand Hotel in Simla, where the first round of meetings was held in July 1944. The hotel was "taken over as a government hostel, which provided opportunity for numerous off-the-record exchanges of opinion." There was a strong sense, in the corridors of the Grand Hotel, that "officials have been confronted for the first time with the necessity of seriously educating themselves as to the trends in other parts of the world." Many were "beginning to realize the backwardness of India" in public health.¹⁹ Over the following months, these impressions were strengthened by a series of tours around India, inspecting health conditions and facilities—this was a part of the broader trend of survey and investigation during the war. In August 1944, a group from the Bhole Committee toured Agra, Delhi, and Lucknow (where the United Provinces were thought to possess a governor "particularly interested in medical and

¹⁷ RAC, RF, RG 2—1945, 464. Box 306, Folder 2075: K.C.K.E. Raja to J.B. Grant, 24 December 1944. Amongst other things, Mudaliar "categorically refused to attend meetings after the middle of May on the ground that it will be too hot to travel." RAC, RF, RG 12.1. John B. Grant Diaries, 1944-1945 (vol. 1), entry for January 20, 1944.

¹⁸ Sigerist, "Report on India," p. 3.

¹⁹ Grant Diaries, 1944-45, Volume 1. Entry for July 1944.

public health” work).²⁰ In November, the international visitors arrived, and were taken on a five-week tour around the country.²¹

The Bhore report, finally published only in 1946, was consciously comparative in its approach. The report illustrates the internationalisation of health which began in the 1930s and advanced during the Second World War. An examination of the report from the perspective of international, rather than national, history thus seems justified.²² Lest it be argued that the Bhore commission represented only the views of the Indian civil service and a small group of international experts, it is worth reading alongside the Indian National Congress’ National Planning Committee’s own report on health. The latter was largely the product of pre-war meetings of the Planning Committee, but the final report was not issued until 1947, revised to incorporate plentiful references to the Bhore report.²³ Planning for post-war reconstruction in India was undertaken with broader international developments firmly in mind; at the same time, I have already suggested above, currents in international thinking about health exercised a considerable influence on nationalism in India and elsewhere.²⁴

²⁰ RAC, RF, RG 12—John B. Grant Diaries, 1944-45 (vol. 1), August 1944.

²¹ Sigerist’s impressions, and his analysis of the Indian situation, are detailed in his “Report on India,” which begins: “As everyone knows, health conditions in India are appalling. Two hundred years of Western rule have hardly improved them. General and infantile mortality rates are extremely high ... Millions of people die every year from preventable diseases (malaria, smallpox, cholera, plague, typhoid, dysentery, etc.) Malnutrition is general, and there is a constant threat of famine,” p. 1.

²² Even within the context of writing the history of independent India’s health services, the Bhore report has received little attention. An incisive, if brief, analysis can be found in R. Jeffery, *The Politics of Health in India* (Berkeley and Los Angeles: University of California Press, 1988).

²³ National Planning Committee, *National Health: Report of the Sub-Committee*, (Bombay, 1947) [henceforth *Sokhey Report*].

²⁴ The similarity with the 1944 National Health Service Commission in South Africa, for example, is striking. The Commission’s brief was to “inquire into, report and advise upon the provision of an organized National Health Service in conformity with the modern conception of ‘health.’” The report has been described by historians as “wide-ranging and remarkably innovative”: Marks and Andersson, “1944 Health Commission in South Africa,” pp. 154-60.

Both of the essential documents planning the future of India's health services espouse the fundamental tenet of social medicine: that patterns of disease are inextricably associated with social and economic conditions. The Bhore report expressed its interest in widening the "conception of disease ... by the inclusion of social, economic and environmental factors which play an equally important part in the production of sickness." It went on to associate public health firmly with plans for economic development, suggesting that "unemployment and poverty produce their adverse effect on health through the operation of such factors as inadequate nutrition, unsatisfactory housing and clothing and lack of proper medical care during periods of illness."²⁵

The Congress Planning Committee report, too, places great emphasis on the social and economic roots of India's high prevalence of sickness. The report opens with a stirring extract from Jawaharlal Nehru's autobiography: "India is a country whose people are poor beyond compare, short lived and incapable of resisting disease and epidemics, illiteracy rampant, vast areas devoid of all sanitary or medical provision, unemployment on a prodigious scale." As the report's authors point out, "the above quotation tersely describes the present health conditions of the country and their causes. The poverty of the people is proverbial."²⁶ Thus the Planning Committee held that the "root cause of disease, debility, low vitality, and short span of life is to be found in the poverty—almost destitution—of the people."²⁷

The Bhore committee report and the Congress party's Planning Committee were united, secondly, in their global view of what constituted a "modern" health service. The

²⁵ Government of India, *Report of the Health Survey and Development Committee*, 4 vols, (New Delhi, 1946) [henceforth *Bhore Report*], vol. 1, p. 17.

²⁶ *Sokhey Report*, p. 37.

²⁷ *Sokhey Report*, p.18.

Bhore committee cast its net wide, examining, in detail, plans for post-war health services in Britain, the United States, Canada, Australia and New Zealand, as well as making frequent reference to Henry Sigerist's admiring (and somewhat uncritical) account of the development of Soviet health services in the 1930s.²⁸ Based upon this comparative view, the Bhore Commission suggested that "the comprehensive conception of what a community health service should undertake has led to the development of modern health administration, in which the State makes itself responsible for the establishment and maintenance of the different organisations required for providing the community with health protection."²⁹ The Congress party concurred: "It has begun to be increasingly realized" that the State had the responsibility to "provide not only the necessary means of curing disease when it occurs, but also for preventing it by bringing about an environment and conditions of living which would prevent the germs of disease taking hold." Above all, health was no longer a matter for "spasmodic charity," but "a matter of right to the individual through an organised public service."³⁰

At the center of the Bhore committee's proposals for the Indian health services was their "Three Million Plan." The plan was based around an "arbitrarily chosen" figure of three million people to represent a district. It was proposed that each district would have a District Health Center, a core from which primary and secondary health centers were to be built up. The committee envisaged each primary unit serving a population of between 10,000 and 20,000 people, with 15-25 primary units constituting a secondary unit which would be better equipped with curative and specialist services. The primary health centers were designed to integrate preventive and curative work. Nurses in the

²⁸ H. Sigerist, *Socialised Medicine in the Soviet Union* (London, Victor Gollancz, 1937).

²⁹ *Bhore Report*, vol. 1, p. 21.

³⁰ *Sokhey Report*, pp. 26-7.

health centers would “go to the homes of the people,” focusing on “the health of school children, the welfare of mothers and children [and] tuberculosis work”: social medicine to its core. At least two of the medical staff in each primary unit, the committee suggested, ought to be women; ideally, at least 50 per cent of doctors in the national health service would be women.

Taking up the concerns of the League of Nations conference on Rural Hygiene, the Bhore committee paid attention to the creation of a “new class of worker known as ‘Health Assistant.’” The workers would receive simplified medical training, and be left in charge of medical statistics, water purification, and the “spray killing of mosquitoes.” In keeping with the transformative, almost missionary, aims of social medicine, the Committee declared that a “social outlook should be developed in every health worker.” The “woman who, through lack of knowledge of mothercraft, feeds, bathes, clothes, or nurses her baby improperly, the tuberculosis patient who, through ignorance, disseminates infection by indiscriminate spitting or coughing,” each of them required the “technical knowledge and skill that the doctor, the nurse and the social worker can make available to them.” However, they also needed “understanding and sympathy, tact and patience.”³¹

The practitioners of indigenous medicine in India, it seems, possessed none of these virtues. The Bhore committee turned its face firmly against making use of India’s indigenous medical traditions of *Ayurveda* or *Unani*. “We can say with truth that 95% of the total corpus of knowledge with regard to the working of the human body has been obtained within the lifetime of men who are still with us,” the committee declared emphatically, “science is one and indivisible.” Certainly, these systems of medicine “in

³¹ *Bhore Report*, Vol. 2, p. 32.

the long distant past” had influenced the “development of medicine and surgery” around the world, and this “naturally engendered a feeling of patriotic pride.” However, “we would feel that it would be unfair and unjust merely because some other method of treatment is said to be cheaper, to deny to any one in this country the benefit of the scientific system.” The committee noted with approbation the move towards abolishing indigenous systems of medicine in Japan and the Soviet Union.³² Yet, the problem was not in any way resolved. As John Grant noted in his diary, “the question of the place of indigenous systems of medicine is constituting a very real problem, so filled with political complexities that a recommendation is being made for Government to appoint a special committee.”³³ Palmed off to another committee, the question remained unresolved. Having launched a strong attack on indigenous medicine, the Bhore committee prevaricated, stating that “we feel it should be left to the Provincial Governments to decide what part, if any, should be played by the indigenous systems.”³⁴ The place of traditional indigenous practices within “modern” international medicine would confront the Indian government repeatedly over the following decades, and, later, the World Health Organization as well.

A second area of disagreement amongst the planners of India’s health services concerned the extent to which public health ought to be concerned with the question of population control. This unresolved debate, too, would take on great international significance in shaping the WHO in the 1950s. The Congress party’s planning committee, as has already been shown, took a keen interest in population control, as did modernizing

³² RAC, RF, RG 2—1945, 464. Box 306, Folder 2076, “India—Bhore Committee Reports, 1,” p. 3.

³³ RAC, RF, RG 12—John B. Grant Diaries, 1944-45 (vol. 1). July 1944, Grand Hotel, Simla.

³⁴ RAC, RF, RG 2—1945, 464, “India—Bhore Committee Reports, 1,” p. 3.

intellectuals like Gyan Chand.³⁵ The Bhore committee, on the other hand, took an uncharacteristically reactionary view: “the deliberate dissemination of knowledge regarding birth control will remove one of the major deterrents to promiscuity,” they declared. “Conduct divorced from responsibility injures the individual and the community.” Worse still, in their view, and “fraught with serious consequences to the national welfare,” was the fact that “contraceptive practices are ... more likely to be used by the more successful and intelligent sections of the community than by those who are improvident and mentally weak.”³⁶

This is to suggest, then, that the discourse of hygiene and social medicine from the inter-war years, inflected with eugenic thought, concerned with population, with rural health, and with education, had a long half-life. It persisted, indeed, well into the post-colonial era, and in the work of the World Health Organization.

III

I found my research at the Rockefeller Archive Center immensely valuable. At a later point in the dissertation, where I discuss the practical workings of international health campaigns in Southeast Asia during the 1950s, I draw, once again, on my research at the RAC. The diaries of Rockefeller Officers, for example, offer many clues as to the issues at stake as the WHO attempted to establish itself as the pre-eminent international health organization.

³⁵ National Planning Committee, *Population* (1947)

³⁶ RAC, RF, RG 2—1945, 464, Box 306, Folder 1078, “Bhore Committee Reports, 3,” pp. 14-16.