Chapter 1
Palimpsests of 'Social Determinants of Health'—From Historical Conceptions to Contemporary Practice in Global and Indian Public Health

Devaki Nambiar

> Health is a function, not only of medical care, but of the overall integrated development of society – cultural, economic, educational, social and political. … Health also depends on a number of supportive services – nutrition, improvement in the environment and education; and the influence of these services on health status is far greater than that of medical care. The major programmes which will improve health are thus outside the realm of health care proper. These were comparatively neglected in the last 30 years …this error should not be repeated [1].

Abstract Policy attention to the Social Determinants of Health (SDH) has waxed and waned over the years, both in the international and national arena. From famine to plagues, malnutrition to outbreaks, food and hygiene are 'determinants' in that they have motivated the very evolution of public health in India and the globe—albeit stochastically. Moving from colonial to nationalist to neoliberal imperatives, a coherent and abiding vision of social determinants, globally or within India for that matter, has neither endured nor arisen. This vacillation reflects the truly political nature of public health, and also of policymaking on SDH. Following deliberations held in 2013 on an Indian "Health Equity Watch" in which academicians, activists and officials participated, it was acknowledged that for India, there is in fact a substantial literature on SDH that does not explicitly reference the term SDH per se. Thus, this volume seeks to explore two interrelated questions: first, how is action around SDH conceptualized by key stakeholders in our country, and second, what are the themes that bring these conceptualizations together? We have compiled the views of academics and practitioners in both public and private not-for-profit settings to expand upon this issue, supplemented by short commentaries from individuals who reviewed individual chapters and who are involved with the project of health equity in India. From these contributions, we note that there are various vocabularies used to talk about SDH, as well as contestations,

D. Nambiar (✉)
The George Institute for Global Health, New Delhi, Delhi, India
e-mail: devaki.nambiar@gmail.com

© Springer Nature Singapore Pte Ltd. 2017

D. Nambiar and A. Muralidharan (eds.), *The Social Determinants of Health in India*, https://doi.org/10.1007/978-981-10-5999-5_1

various stakeholders, scales and types of activities. Detailing and showcasing this diversity is the contribution of this volume.

Keywords Health equity · Commission on Social Determinants of Health India · Global health

It has long been recognized that health has to do with far more than medical care. Sadly, the complaint that not enough is done in these other domains outside of health is, similarly, long-standing. The quote above comes from the 1981 *Health for All report*, the culmination of an unprecedented, five-year transdisciplinary collaboration between two premier institutions in India—the Indian Council for Medical Research (ICMR) and the Indian Council for Social Science Research (ICSSR) [1]. This important report was released in India in the wake of the 1978 Alma Ata Declaration, which had invigorated international attention around Primary Health Care, reflecting an ambitious, revolutionary agenda for health until the turn of the century, involving the widespread transformation of society beyond the health sector alone.

The idea that health is determined by factors beyond the health system, in popular and public health parlance today, is encapsulated in the notion of Social Determinants of Health, or SDH. The concept received global traction due to the work between 2003 and 2008 of the World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH). In its final report, the Commission defined SDH as 'the conditions in which people are born, grow, live, work and age, including the health system' [1, 2]. As we argue in this volume, SDH include interlinkages of ascriptive dimensions of identity (gender, religion, ethnicity, and others), material circumstances that shape our lives and well-being (like housing, sanitation, water supply), and socioeconomic opportunities (education, employment), all shaped by larger concatenations of power and ideology in the functioning of the world. Quite simply, SDH include who we are, where we are, what we do, and how things work in relation to health.

So what was the need to coin this set of ideas, this notion of SDH—at the particular time? And what does it allow us to do? What does it preclude?

Social Determinants of Health: A Palimpsest of History

The seeds for the notion of SDH were sown in the very foundation of modern public health [3–7]. As the Industrial Revolution widened the scale of impact on the health of populations across Europe and the Americas, consideration of the determinants of health grew (motivated by a desire to sustain technological progress and increase productivity). At the turn of the nineteenth century, a bevy of public health and welfarist pioneers including Rudolf Virchow, Robert Koch and Oswaldo Cruz, Louis-Rene Villerme, Edwin Chadwick, John Snow, Thomas McKeown, and

Friedrich Engels sought to broaden understandings around various determinants of health [3, 8]. Far from holding aligned views, these scholars contributed to long-standing debates on the causes of ill health [3]. Of these, 'Virchowian social medicine has long played an important part in international public health efforts and continues to inspire "public health's biggest idea"—its inextricable intertwining with the politics of social justice' [3].

The mid-nineteenth century also saw the genesis of multipartite development cooperation in health via International Sanitary Conferences held between 1851 and 1892 [9]. Staples notes that there was dissent about the nature of epidemic disease, and the creation and evolution of international sanitary codes and regulations had served to resolve these differences. Much of the emphasis at this time was geographically in Europe (through the Office of Public Health in Paris) and the Americas (through the Pan American Sanitary Bureau) and topically on water pollution and purification as determinants, owing to the toll of vector-borne illnesses in these locations. In the early twentieth century, the Rockefeller Foundation also convened regional conferences on hygiene, sanitation education and engineering, and funded a number of field projects in India and China. Social reform movements were at their zenith in both these countries during this period, adding to the ferment of nationalism [10].

Urged by Rockefeller, delegates from erstwhile British India attended meetings hosted by the Office of Public Health, and were tasked with formulating and enforcing sanitary regulations [11]. The colony was also heavily affected by cholera mortality (data on this was only systematically collected after the epidemic of 1865, though cholera is reported as far back as 1817 in what is now Bangladesh) [5]. Motivated by bouts of plague, colonial authorities devolved responsibility for public health and social welfare to 'Improvement Trusts' in cities, which were tasked with reducing overcrowding, removing insanitary dwellings, and improving ventilation [12]. The Bombay Improvement Trust, established two years after the 1896 plague was the first such body established, followed by similar institutions in the ensuing decades.[1] This devolution of power, shared with provincial governments, led to substantial improvements in local sanitation, and also set a precedent for the design and functioning of urban health systems in India.[2]

In the interwar period, from 1919 onwards, when the League of Nations came to be formed, India was still under British colonial domination, but was given membership citing extraordinary circumstances (although the terms of its participation were vexed and contested). The League possessed a Health Organization

[1]The very next Improvement Trust was formed in Mysore (1903), followed by Calcutta (1919), and various other cities under the United Provinces Improvement Act of 1919, which was amended to include Delhi in 1937. Decades later, these trusts were to evolve into Municipal Corporations with dedicated officers overseeing a range of social determinants in urban areas (see Ganesan et al. in this volume, for more). Examining how SDH are viewed in these documents was beyond the scope of our work but remains a key area of further study.

[2]As Amrith points out, this devolution circumscribed the social welfare policymaking abilities of municipal and state governments alike because of their inability to raise resources [10].

under its aegis, which had a narrow, biomedical preoccupation covering epidemic control (more than prevention), medical education, and medical product standard-setting [13]. Further, wider goals were likely subordinated under the circumscribed ambit of the League of Nations—which had limited membership.

Following the Second World War, when the World Health Organization was formed, its core function included that of improving 'nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene' [14]. Independent India's first major policy exercise—aptly termed the Health Survey and Development (Bhore) Committee, was influenced by these developments in health across the world [15, 16]. The Bhore Committee noted that 'public health requires the fulfilment of certain fundamental conditions, which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection, preventive and curative, to all members of the community irrespective of their ability to pay for it and the active co-operation of the people in [their] own health' [17]. The Committee held the state squarely responsible for providing 'health protection' to its people, reflecting the nationalist imperative that had seen health as part of its agenda for Indian independence and also drew inspiration from welfare states in Europe, the Soviet Union and New Zealand [10].

Under the newly drafted Indian Constitution, the protection and promotion of health and nutrition were placed in the Directive Principles for State Policy. During the 1950s, a number of achievements were made in reducing mortality and morbidity, with an initial emphasis on immunization and then malaria eradication. Though these efforts were described with great fervour and optimism, the responsibility of public health had begun to be placed squarely on the shoulders of the citizen, even as commensurate improvements in health services infrastructure were neglected in relative terms. Meanwhile, starting with India's first Five Year Plan, population control became a major priority, further eclipsing the attention needed for health services and other key determinants. In 1967, in what could be regarded as the apotheosis of Malthusianism in Indian policymaking, a hegemonic paradigm was set in motion for family planning and population control, deflecting attention away from health, particularly among the vulnerable [18]. As Amrith points out, this shift 'was immanent in the political culture of public health; in the sexual, racial and caste-based anxieties underlying the Indian nationalist movement's discussions of health, and in its privileging of the centralised state as the prime instrument of change' [15].

It was around this time that the national trend began to contrast significantly with the deeply politicised, mass-based, and institution-focussed efforts under way in the southern Indian state of Kerala, which would stand out in the coming decades. In states like Kerala, as elsewhere on the globe, following more than a decade of emphasis on vertical disease eradication programmes, the 1960s and early 1970s saw attention begin to re-center on the social, economic and political dimensions of health. Meanwhile, the Indian Planning Commission in 1975 initiated a Minimum Needs Programme which sought to improve the living standards, particularly the underprivileged and underserved Indian masses by catering to the following needs: (a) Rural Heath; (b) Rural Water Supply; (c) Rural Electrification; (d) Elementary

Education; (e) Adult Education; (f) Nutrition; (g) Environmental improvement of Urban Slums; and (h) Houses for landless laborers [19, 20].

At the global level, the WHO, under the leadership of Halfdan Mahler, sought to crystallize developmental experiences and lessons from other nations, which were then put together in the WHO's 1978 Alma Ata Declaration on Primary Health Care. The Declaration states that 'in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all these sectors' [21]. Working groups were created in a special bespoke unit on Intersectoral Action for Health at the WHO across many of these categories.[3] Various governments included this feature in their health policies, and systematic research on health inequalities was launched in many countries (the Black report in the UK, and similar efforts in other Western European countries) [4].

In India, the landmark report mentioned at the outset of this chapter tried to set the tone for research on SDH in India. It was authored by two leading Indian Institutions, the Indian Council for Medical Research—with V. Ramalingaswami at its helm—and the Indian Council for Social Science Research—guided by J.P. Naik in a truly unprecedented and heralded collaboration. Building on Alma Ata, Naik and Ramalingaswami proposed an alternative strategy for *Health For All*, which also served as a precursor to the National Health Policy of 1983 [22]. The main SDH identified were: full-scale employment; improvement in the status of women; adult and universal elementary education; welfare of scheduled castes and tribes; creation of a democratic participatory form of government; organization of the poor and underprivileged groups. The report called for '(i) integrated plans for health and development including family planning; (ii) reorientation of existing priorities so that bulk of the funds can be spent on programmes on nutrition, improvement of environment, immunization and education rather than on curative services, and on basic community services at the bottom than super-specialities at the top; and (iii) replacement of the existing model of health care with an alternative model which integrated promotive, preventive and curative services and is community-based, participatory, decentralized, and democratic' [22].

Shaped by the ICMR/ICSSR report, India sought to mirror the WHO's governance arrangement to address health determinants. The 1983 National Health Policy states that 'all health and human development must ultimately constitute an integral component of the overall socioeconomic developmental process in the country. It is thus of vital importance to ensure effective coordination between health and related sectors. This may require setting up standing mechanisms, at the Centre and in the States, for securing inter-sectoral coordination of the various efforts in the fields of health and family planning, medical education and research, drugs and pharmaceuticals, agriculture and food, water supply and drainage, housing, education and

[3]The most crucial areas were adequate food intake/nutrition, and women's education, identified in Rockefeller's famous report on 'Good Health at Low Cost' [45].

social welfare and rural development' [23]. This policy called for the creation of standing mechanisms—and went on to suggest coordination and review committees.

Sadly, however, efforts such as did not prove either consistent or sustained but episodic and short-lived, foreclosed on the one hand by intragovernmental rivalries where health held a relatively weak position across ministries, and on the other hand, by the ever-present challenges posed to intersectoral action of coordination across donors and competition across ministries. An additional critical negative factor was the active promotion of a 'pragmatic, financially palatable and politically unthreatening alternative to comprehensive primary care' propounded by the Rockefeller Foundation, the Ford Foundation, the World Bank, and the US Agency for International Development [4]. Much like the New International Economic Order [24], the movement for comprehensive primary health care including intersectoral action for health was vitiated almost immediately after it was proclaimed. Moreover, India's financial dependence on international donor aid, meant that it was rendered pliable to their preference for vertical, technology-driven disease control programmes [25]. This compartmentalized and fragmented health into packages of care increasingly paid for out of people's pockets.

As Irwin and Scala point out, the resultant compartmentalization and fragmentation were only set to increase [4]. The Washington Consensus, linked to the rise of neoliberal, conservative governments in donor countries including the US, UK, and Germany, and buttressed by the waning of the Cold War led to the ascendance of neoliberal ideology in both national and international development policy [24]. Social sector reform agendas were promoted in the area of health, but also in many of its determinants such as nutrition, housing, water and sanitation, social protection which involved increasing the presence of the private sector, the splitting of financing, purchasing and service provision, unregulated and poorly stewarded decentralization, and the creation of a split between efficiency and equity [4]. As a result, not only did health spending decrease, but also spending on its determinants, leading to soaring out of pocket health payments, with little (or no) long-term gains expected from the reform measures. Around this time, the World Bank began playing more of a role in global health, to some extent displacing the authority of the World Health Organisation [4, 26, 27].

By the late 1990s, the deleterious impact of these approaches began to become clear, and while the World Bank sought to reform its strategies, the WHO—under the leadership of Gro Harlem Brundtland—tried to resurrect the Alma Ata Health for All agenda and intersectoral action for health, linking it to the pragmatics of financing. In 2000, the WHO launched the Global Commission on Macroeconomics and Health, setting a precedent for extensive international research on health inequalities, particularly in relation to income and spending [4].

Overall, while there were extensive research efforts during the early naughties (2000s) in Europe and Oceania, evidence on SDH was scant in most low- and middle-income settings. In India, the Second National Health Policy acknowledged that 'public health indicators/disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector,

covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc.' [28]. On the other hand, it also took the stand that 'policy aspects relating to inter-connected sectors, which, while crucial, fall outside the domain of the health sector, will not be covered by specific recommendations in this Policy document. Needless to say, the future attainment of the various goals set out in this policy assumes a reasonable complementary performance in these inter-connected sectors' [28]. Later on in the document, the following clarification is given: 'This is not to say that other items contributing to the disease burden of the country will be ignored; but only that the resources, as also the principal focus of the public health administration, will recognize certain relative priorities. It is unnecessary to labor the point that under the umbrella of the macro-policy prescriptions in this document, governments and private sector programme planners will have to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribal and other socioeconomically under-served sections. An adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities' [28]. As evident in the lack of policy articulation here in India, it became hard at this point to envision a role for the state in intersectoral action on health. Indeed, from this point onward, there has been a divergence of views on what the breadth and depth of engagement there can be from within the health sector on this issue.

In 2004, upon winning the election, India's United Progressive Alliance resurrected the Common Minimum Programme, committing to an ambitious package of health determinants that would be guaranteed to the population including employment, housing, health, education, sanitation, roads, electricity and water supply [20]. In addition to this, a National Commission on Macroeconomics and Health (NCMH) in 2005 helped reintroduce ideas relating to SDH. This followed on from the global effort, which used the frame of investment and cost-effectiveness, so as to be pragmatic [4]. In India, the NCMH was operating at the time when a number of forces were conspiring in the domain of health in general, and rural health in particular.

A new government was in power, and the People's Health Movement, having declared its Charter in 2000, put pressure on the government to adopt welfarist policies. Jan Swasthya Abhiyan 'reaffirm[ed] 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!' [29]. The People's Health Movement drew attention also to political, financial, agricultural and industrial policies as well as the negative impacts of the processes of economic globalization, liberalization, privatization, and financialization that were creating systemic inequality, foreclosing possibilities for people's participation, and ignoring if not abetting corporate malfeasance on a grand scale. To reverse these processes, the movement demanded greater strengthening of the public sector.

The government itself was comprised of a coalition including Leftist parties that placed greater emphasis on such policies. This resulted in the launching of the

National Rural Health Mission (NRHM). The NRHM Mission Document (2005–2012) states plainly that it 'adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water' [30]. It sees this as being operationalized through district planning, which itself is an 'amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition' governed at the national level by a Mission Steering Group comprising representation from the Health and Family Welfare, Local Self Government (Panchayati Raj), Rural Development and Human Resource Development ministries, as well as the erstwhile Planning Commission [30]. In fact, the term 'social determinants of health' made its first appearance in the 2005 NRHM framework document.

This was, indeed, most fitting, as the coinage of SDH emerged at the turn of the millennium. The WHO Commission on SDH was appointed in 2003 by the newly incumbent Director General, Dr. Lee Jong-Wook. It sought in part to advance and resolve the debates launched from 2000 onwards following the Global Commission on Macroeconomics and Health, which set a precedent for extensive international research on health inequalities, particularly (some would argue narrowly) in relation to income and spending [4]. The CSDH, building upon Chairman Michael Marmot's work in Whitehall, England, highlighted the social gradient in health, emphasizing economic inequalities. In addition, mnemonically and strategically, looking at social determinants afforded an opportunity to think of health in broader terms than merely an economic one. The many knowledge networks created in connection with the CSDH, on gender, globalization, urban health, measurement and evaluation, and others, sought to create a much wider social understanding of the determinants of health and an agenda for action that lay ahead. Finally, the CSDH drew global attention to the 'unequal distribution of power, income, goods, and services, globally and nationally, [and] the consequent unfairness in the immediate, visible circumstances of people's lives' [2].

Meanwhile, in India, the buzzword of choice has been 'convergence' seeking very much to envision responses to the clearly manifest inequalities and hierarchies that are quite blatantly affecting health and well-being. NRHM has been a platform for convergence in health, along with other welfarist measures like the National Rural Employment Guarantee Act, as well as other rights-based campaigns including the Right to Education, the Right to Information and the Right to Food [31, 32]. In 2008, the thirtieth anniversary of Alma Ata was marked by efforts to redraw attention to Primary Health Care—although the vocabulary for reform began to shift to the concept of Universal Health Coverage [33].

In 2010, India's Planning Commission appointed a High Level Expert Group (HLEG) on Universal Health Coverage, chaired by Prof K. Srinath Reddy. Joining him were a number of individuals closely involved with the CSDH process, including Dr. Mirai Chatterjee, a WHO Commissioner on SDH and Dr. Gita Sen, convenor of the Knowledge Network on Women and Gender Equity. Critically, the Expert Group highlighted the SDH as part of its agenda for Universal Health Coverage reform, noting that in India, it was possible to build on the momentum generated and experience amalgamated by civil society groups and academia, as

well as government stakeholders, in various contexts and through myriad approaches.

In doing this, the Expert Group proposed no single framework to understand or act upon SDH [34, 35]. Rather, members converged upon illustrative domains of action: Nutrition and Food Security; Water and Sanitation; Social Exclusion (on the basis of gender, caste, religion, tribal status, geography, etc.); and Work (In) Security, Occupational Health and Disasters [34]. They called for greater thought and deliberation upon what India's approach to the social determinants of health ought to be. They also called for the adoption of some kind of monitoring framework on health equity that would link to SDH.

At the global level, a World Conference on Social Determinants of Health was convened by WHO and the Government of Brazil in 2011, resulting in the Rio Political Declaration on Social Determinants of Health, ratified at the 2012 World Health Assembly. This declaration articulated political will to 'improve public health, and reduce health inequities through action on the social determinants of health. The focus is on addressing the challenges of eradicating hunger and poverty; ensuring food security; enabling access to healthcare and affordable medicines; and improving daily living conditions through provision of safe drinking-water and sanitation, employment opportunities and social protection; protecting environments and delivering equitable economic growth' [36]. The Declaration has been critiqued as being depoliticized (unlike the Alma Ata Declaration) [13]—with SDH always manifesting as a familiar (re)listing of determinants in various policy pronouncements.

The National Urban Health Mission Framework document, released in 2013, made a commitment to 'systematically work towards meeting the regulatory, reformatory, and developmental public health priorities of urban local bodies. It will promote convergent and community action in partnership with all other urban area initiatives. Vector control, environmental health, water, sanitation, housing, all require a public health thrust. NUHM will provide resources that enable communitization of such processes. It will provide resources that strengthen the capacity of urban local bodies to meet public health challenges' [37]. The document noted that 'there was a lack of effective coordination among the departments that lead to inadequate focus on critical aspects of public health such as access to clean drinking water, environmental sanitation and nutrition' while adding that community efforts played an important role in improving access to drinking water, sanitation, nutrition services and livelihood. It also talks about convergence with programmes from four other ministries and within its own programmatic areas.[4]

[4]Convergence is proposed in the NUHM framework document with (a) the Ministry of Urban Development and Ministry of Housing and Urban Poverty Alleviation for (i) the Basic Services to the Urban Poor sub-mission of the Jawaharlal Nehru National Urban Renewal Mission of, which has a seven point charter including land tenure, affordable shelter, water, sanitation, education, health, and social security—all coordinated through a City Development Plan; (ii) Rajiv Awas Yojana to integrate slums into the formal system; (iii) the Swarn Jayanti Shahri Rozgar Yojana to federate existing Development of Women and Children in Urban Areas (DWCUA) and

As can be seen in this historical account, policy attention to the determinants of health has waxed and waned repeatedly over the years, both in the international and national arena. What we now have is a palimpsest, where some themes have been recurrent and others have emerged and evolved. From famine to plagues, malnutrition to outbreaks of disease, challenges of food and hygiene are 'determinants' in the sense that they have motivated the very evolution of public health in India and around the globe—albeit stochastically. More broadly, however, the plurality of vocabularies and rationales in the SDH discourse, reflect the highly political and context-sensitive nature of this topic in international and national development.

India's particular history of SDH may be periodized into four major phases. First, we have colonial rationales for Improvement Trusts, which sought to contain disease and control famine, albeit for narrow purposes and exclusive (colonial expatriate) populations. Then, we have nationalist visions of Bhore and the First National Health Policy that were part of the ferment of Alma Ata. Strong attention was paid here to SDH. This was followed in the late 1980s onwards, by neoliberal imperatives represented in the Second National Health Policy, where the state's role in health and its determinants was purposively enfeebled. The policy framework for the National Rural Health Mission inaugurated a fourth phase, encapsulated by an attempt to bridge and reconcile the second and third phases. This is evident in the inclusion of, but also the generality in, pronouncements related to SDH, evident in the High Level Expert Group on Universal Health Coverage [35], the Draft 2015 National Health Policy and the 2017 National Health Policy. The last of these seems to relegate SDH to ecological factors like pollution, as well as risk factors like diet and exercise [38] while according far less attention to the larger political and economic frames and distributions of power that affect health and action on health more broadly. In a sense, the latest National Health Policy makes no major departure from these earlier listings and categorizations, even as it doesn't necessarily reconcile or resolve them.

A Vision for SDH?

Unsurprisingly, a coherent and abiding vision of social determinants, globally or within India for that matter, has not endured or arisen. What we have instead is a palimpsest, where some themes have been recurrent and others have emerged and

---

(Footnote 4 continued)

Neighbourhood Committees groups into Mahila Arogya Samitis; (b) the Ministry of Women and Child Development for local coordination with Anganwadi Centres and Anganwadi Workers for Community Health and Nutrition day and other health promotion activities; and (c) the Ministry of Minority Affairs through convergence with the Multi Sectoral Development Programme underway in 90 minority districts which includes semi-urban areas, by developing district-specific plans for provision of infrastructure for education, sanitation, housing, drinking water, electricity supply, and income generation; (d) within the health ministry, school health programmes as well as adolescent health programmes are also seen as nodal points for convergence, as well as inclusion of specific programming to map, reach, and attend to the special needs of vulnerable groups [37].

evolved, and some have been forgotten altogether. From famine to plagues, malnutrition to outbreaks of disease, challenges of food and hygiene are 'determinants' in the sense that they have motivated the very evolution of public health in India and the globe—albeit stochastically. This reflects the truly political nature of public health, and indeed also of policymaking on its determinants. In addition to this, ascriptive determinants, like gender, ethnicity, caste, and religious affiliation that describe one's position in societal hierarchies and conjugate the determinants of food and hygiene, have also emerged as social determinants. And evocatively and iteratively argued by thinkers on inequality—from Marx to the CSDH—are the socioeconomic determinants of education and class. The palimpsest reflects variegated attention across these categories to these determinants in relation to the health of populations, and indeed of the health systems themselves.

Throughout all this, as scholars have pointed out, overtly political agendas in the international arena have been subject to sabotage, and consensus has usually meant deeply problematic compromise [4, 39]. Further, existing frameworks can at times be challenging for action on SDH—not merely in their profusion (which poses problems of which criteria may be used to choose one thing and reject others), but also their importation or adaptation outside of the contexts in which they were conceived [4]. The actual 'work' of action on SDH can therefore become siloed in academic and conceptual discourses, ripe for analysis, with interpretation prior to adaptation, and yet can be segmented and separated from what already exists on the ground.

For many, this goes against the very idea of the 'social' in SDH. We see a recurrent yearning for popular revolution, an uprising of people's ownership of and demand for improvement in social determinants [40]. In India, this was articulated first by the Bhore Committee: 'No measures designed to improve existing conditions can produce lasting success unless the people are aroused from their apathy to tolerate the insanitary conditions around them and the large amount of sickness that prevails, can be overcome […] In the programme of health development, which we put forward, the need for securing the active co-operation of the people in the day to day functioning of the health organisation should be prominently kept in view' [17]. The most recent (re)iteration of this is India's 2017 National Health Policy, which calls for the 'development of strategies and institutional mechanisms […] popularised as the Swasth Nagrik Abhyan—a social movement for health' [41]. What wasn't to become in Bhore may yet (not) arise six decades on, but clearly there is extensive policy precedent and at least de jure a discourse on SDH in India. Throughout, there has been a persistent suggestion—call it hope—that a people's movement for health and its determinants may help melt the glacial pace of health reform in India.

Policy documents tend to be aspirational and declarative, offering an incomplete picture of what is de facto the reality of SDH in India. Given that health is a state subject while other determinants are often not, and moreover, given the country's

profound diversity, what warrants a closer examination is what has been happening at subnational levels in the realms of both thinking and action in this area, that both instantiates and challenges these larger trends. As others have articulated, we have also felt that what is needed is an 'in depth understanding of the unique interplay between local, national and global SDH in a local setting, gathered by ethnographic research, is needed to be able to address structural SD in the local setting and decrease health inequity' [4].

In the summer of 2013, we had the opportunity to bring thinking and action perspectives together to participate in a national, WHO-sponsored consultative workshop on health equity. A range of stakeholders from three countries and eight Indian states attended the workshop, including the Central Bureau of Health Intelligence (CBHI), Delhi's Ministry of Women and Child Development (MWCD), the National Health Systems Resource Centre (NHSRC), civil society and grassroots organisations including the People's Health Movement/Jan Swasthya Abhiyan (JSA), the Society for Nutrition Education and Health (SNEHA), the Self Employed Women's Association (SEWA), the Child in Need Institute (CINI), a variety of research institutions including the International Institute of Population Sciences (IIPS), Institute of Public Health (IPH), Anveshi Research Centre for Women's Studies, and Azim Premji University (APU), as well as senior technical resource persons from Brazil and from the headquarters of the World Health Organization.

Presenters described in enthusiastic detail how action on SDH and health equity was being incorporated in state-wide missions, schemes and programmes, as well as private interventions and mobilizations supporting the poor [42]. In each case, elements converged around a unifying pivot, but across cases, the pivot itself was variable: administrative reform to provide multiple services through one delivery window, deliberation around myriad village development issues on one decision-making platform, legal, police, and medical action around one salient health issue, or fulfilling a charter of residential improvements for one population group [43]. Here again, we did not arrive at a single model or framework for SDH. This got us thinking—do we just not have a unified framework on SDH in India? Do we need one?

It follows that, for India, there is in fact a substantial literature on SDH that does not explicitly reference the term SDH per se (for example, there are many studies from the 1990s onwards on health inequalities [44]). Why is this? As this book argues, there may in fact be historical, contextual, and political reasons why the SDH framework itself may not apply ubiquitously in the Indian context. We explore this complex issue by bringing together multiple understandings and experiences from the Indian context.

About This Volume

This volume seeks to explore two interrelated questions: first, how is action around SDH conceptualized by key stakeholders in our country, and second, what are the themes that bring these conceptualizations together?

We have compiled the views of academics and practitioners in both public and private not-for-profit settings to expand upon this issue, supplemented by short commentaries from individuals who reviewed individual chapters and who are involved with the project of health equity in India. It was not difficult to identify these individuals, but to make demands on their time was difficult indeed. Yet, what we have here is, we hope, a set of provocations that reflect the range and depth of thinking on this issue.

We begin with Dr. Mishra’s critical appraisal of the social determinants of health concept, exploring what conceptions and methodologies are assumed (problematically) in its application. Dr. Yumnam and Dr. Dasgupta draw on international literature to propose conflict as a social determinant of health, adding reflections from the impact of continuing insecurity in the north-east Indian state of Manipur. Dr. Chatterjee introduces us to domains and categories of study in India that may be drawn upon to advance this nascent work. Dr. Bhan’s piece on the urban transition takes apart the notion of the ‘urban,’ reflecting on how one may ‘measure’ such a fluid and dynamic construct. This is paired with Ms. Nandi’s reflections on the medicalization of the urban and the challenge that befell the National Urban Health Mission in India. Dr. Chakravarthi reflects on the lack of research on distal SDH, using as examples the conspicuously small canon of conceptual thinking and empirical work on labor conditions as an SDH, as well the varied influences of corporations—factors often ignored in mainstream discourses given their highly political nature and the methodological complexity involved in studying them.

Ms. Goswami describes the process of identifying forms of vulnerability and areas of priority for action as part of a task force on women’s labor in the informal economy in Bihar. This is complemented with a historiography of feminist research on labor in India by Dr. Swaminathan. Supplementing an extensive field appraisal as part of the National Urban Health Mission’s Technical Resource Group with historiography, Dr. Ganesan, Dr. Nambiar and Dr. Sundararaman describe the institution of the urban Municipal Health Officer, which brought health and its determinants into a unified ambit, albeit enfeebled in various patterns across tiers of Indian cities. Dr. Desai tackles the complex but essential question of scaling up action on SDH, reflecting on efforts of the Self Employed Women’s Association to address priority determinants that share informal women workers’ health and well-being in different states. The need, on the one hand, for a unified approach, but also for customization and flexibility towards local understandings and idioms of action are underscored by them.

Two chapters describe the use of SDH indicators in particular. Dr. Muralidharan describes a collaborative process of developing intersectoral indicators related to menstrual health and hygiene management at the national scale in India.

Contextualizing and politicizing this domain is Ms. Dasgupta's reflection on the social dynamics and cultural frame in which such a process is nested. Mr. Garg describes the Chhattisgarh Swasthya Panchayat Survey experience, which involved the creation of a registry of indicators to be monitored regularly by village committees, allowing the creation of action plans at the local level to address SDH. Dr. Ved's reflection on this highlights the contributions that this work represents, both in terms of generating priorities for local action at the village level and the possibility of simplifying mortality into a count-based monitoring activity, again with great local relevance and the potential for broader and more complex forms of analysis.

Ms. Marathe and Dr. Shukla reflect on efforts to monitor nutrition and health services in Maharashtra, demonstrating how accountability is a necessary and achievable goal for action on SDH. Ms. Khanna and Dr. Subha sri present a bespoke social autopsy methodology to understand maternal deaths using an SDH lens, taking into account individual attributes, family and peer influences, as well as intermediary determinants (health services, community context), and structural determinants (related to governance and policies, as well as cultural and social values).

As these rich contributions came in, we sought to use them as a springboard for further reflection and debate on the individual topics, and on SDH more generally. Reviewers were chosen for each chapter, based on their prior work in these areas, and subject to their availability. Apart from giving comments and inputs to authors, many reviewers also submitted commentaries of their own, adding richness and depth to the writing exercise, and to our understandings as well. Six such valuable contributions came in from senior academics and practitioners in government and civil society and enrich this volume.

From these contributions, we note that there are various vocabularies used to talk about social determinants. While some talk about human development, others use the notion of convergence. Within topical areas, there are contestations, for instance between 'labor' and 'work' in the context of women in the informal sector, between urbanization and health and urban health. Actors who are implicated in this work also constitute a panoply—from various government departments to non-governmental organizations to local committees, unions, and technical agencies. Sometimes actors are also beneficiary populations/populations of interest—informal workers, adolescent girls, young children, people living in conflict—and sometimes not. Scales of operation have also varied greatly in this volume, ranging from the scale of the village, to that of the urban, national and international. We have great richness and diversity in the areas of focus—in all cases, multiple determinants or axes are considered together, ranging from nutrition to labor, and sanitation to conflict. The types of activities reflected upon are also variable—monitoring, research, practices of inclusion, planning, and policy implementation. All in all, we have far surpassed our goal of rendering the diversity of views and experiences on SDH in these pages, to the extent of challenging the concept itself.

References

1. Study Group Set up by the Indian Council of Social Science Research and the Indian Council of Medical Research. Health for All: An Alternative Strategy New Delhi: Indian Council of Social Science Research and the Indian Council of Medical Research; 1981.
2. World Health Organisation Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health Final Report of the Commission on Social Determinants of Health. Geneva; World Health Organisation; 2008.
3. Birn A. Historicising, politicising, and ‘futurising’ closing the gap in a generation. In: Bhattacharya S, Messenger S, Overy C, editors. Social determinants of health: assessing theory, policy, and practice. 1st ed. Hyderabad: Orient Blackswan; 2010. p. 76–113.
4. Irwin A, Scali E. Action on the social determinants of health: a historical perspective. Glob Public Health Int J Res Policy Pract. 2007;2(3):235–56.
5. Dasgupta R. Urbanising cholera: the social determinants of its re-emergence. New Delhi: Orient Blackswan; 2012.
6. Bhattacharya S, Messenger S, Overy C, editors. Social determinants of health: assessing theory, policy, and practice. Bangalore: Orient Blackswan; 2010.
7. Cook HJ, Bhattacharya S, Hardy A, editors. History of the social determinants of health: global histories, contemporary debates. 1st ed. Hyderabad: Orient Blackswan; 2009.
8. Krech R. Social determinants of health: practical solutions to deal with a well-recognised issue. Bull World Health Organ. 2011;89:703.
9. Staples ALS. Constructing international identity: the World Bank, food and agriculture organisation, and World Health Organisation, 1945–1965. Ph.D. Dissertation. Columbus, OH: Ohio State University; 1998.
10. Amrith SS. Health in India since independence. London: Brooks World Poverty Institute Working Paper 79; 2009.
11. Legg S. An international anomaly? Sovereignty, the League of Nations and India’s princely geographies. J Hist Geogr. 2014;1(43):96–110.
12. Singh KN. Urban development in India. New Delhi: Abhinav Publications; 1978.
13. Global Health Watch 3: An alternative world health report. London: Peoples Health Movement; Medact; Medicos International; Health Action International; Third World Network. 2011.
14. United Nations. Constitution of the World Health Organisation. Geneva: United Nations; 1946.
15. Amrith S. Political culture of health in India: a historical perspective. Econ Polit Wkly 2007;42:114–21.
16. Murthy P, Sarin A, Jain S, Jain S. International advisors to the Bhore Committee: perceptions and visions for healthcare. Econ Polit Wkly 2013; XLVIII(10):71–7.
17. Government of India. [Bhore Commission] Report of the health survey and development committee, vol. 4. New Delhi: Government of India; 1946.
18. Rao M. From population control to reproductive health: Malthusian arithmetic. New Delhi: Sage Publications; 2004.
19. Vaz LS, Agrawal S, Dudeja P, Jindal AK. Section 3c—health policy and health care systems—public health administration and community health care in India. In: Bhalwar R, Vaidya R, Tilak R, Gupta R, Kunte R, editors. Text book of public health and community medicine Pune: department of community medicine. Armed Forces Medical College/World Health Organisation; 2009.

20. Qadeer I. Political and economic determinants of health: the case of India. In: Cook HJ, Bhattacharya S, Hardy A, editors. A history of the social determinants of health: global histories, contemporary debates. Hyderabad: Orient BlackSwan; 2009. p. 228–48.
21. Declaration of Alma-Ata. International conference on primary health care (6–12 Sept 1978). Geneva: World Health Organisation; 1978.
22. Nayar KR. Three decades of ICSSR-ICMR Committee Report & the re-assertion of social determinants of health. Indian J Med Res. 2012;136(4):540–3.
23. Government of India. National health policy. New Delhi: Ministry of Health and Family Welfare; 1983.
24. Prashad V. The poorer nations: a possible history of the global south. New York: Verso; 2013.
25. Banerji D. Landmarks in the development of health services in India. In: Qadeer I, Sen K, Nayar KR, editors. Public health and the poverty of reforms: the south Asian predicament. New Delhi: Sage Publications; 2001. p. 37–50.
26. Youde J. The relationships between foreign aid, HIV and government health spending. Health Policy Plann. 2010;25(6):523–8.
27. Nambiar D, Rajbangshi PR, Mayra K. The World Health Organization in the South East Asia region: decision-maker perceptions. London: Royal Institute of International Affairs/Chatham House; 2014;101632714.
28. Government of India. National health policy. New Delhi: Ministry of Health and Family Welfare; 2002.
29. People's Health Movement. People's charter for health. New Delhi: People's Health Movement; 2000.
30. National Rural Health Mission [NRHM]. National Rural Health Mission (2005–2012) mission document. New Delhi: Ministry of Health and Family Welfare; 2005.
31. Prasad AM, Chakraborty G, Yadav SS, Bhatia S. Addressing the social determinants of health through health system strengthening and inter-sectoral convergence: the case of the Indian National Rural Health Mission. Glob Health Action. 2013;1(6):1–11.
32. Sharma AL. Mainstreaming of resource convergence in policymaking, programme design and execution. New Delhi: United Nations Development Programme; 2013.
33. World Health Organisation [WHO]. World health report—primary care, now more than ever. Geneva: World Health Organisation; 2008.
34. High Level Expert Group on Universal Health Coverage. Recommendations of the high level expert group on universal health coverage. New Delhi: Planning Commission; 2011.
35. Nambiar D. India's, "tryst" with universal health coverage: reflections on ethnography in Indian health policymaking. Soc Sci Med. 2013;99:135–42.
36. World Conference on Social Determinants of Health. Rio political declaration on social determinants of health (World Conference on Social Determinants of Health). Rio: World Health Organisation; 2011.
37. Ministry of Health and Family Welfare, Government of India. National Urban Health Mission: framework for implementation. New Delhi: Ministry of Health and Family Welfare; 2013.
38. Government of India. National health policy. New Delhi: Ministry of Health and Family Welfare; 2017.
39. Taylor C, Jolly R. The straw men of primary health care. Soc Sci Med. 1988;26(9):971–7.
40. Dreze J, Sen A. An uncertain glory: India and its contradictions. Princeton, NJ: Princeton University Press; 2013.
41. Government of India. Draft national health policy. New Delhi: Ministry of Health and Family Welfare; 2015.

42. Public Health Foundation of India, World Health Organisation—India Country Office. PHFI/WHO consultative workshop on an Indian ‘health equity watch’: a report of proceedings. New Delhi: Public Health Foundation of India; 2013.
43. Nambiar D, Muralidharan A, Garg S, Daruwalla N, Ganesan P. Analysing implementer narratives on addressing health inequity through convergent action on the social determinants of health in India. Int J Equity Health 2015;14(1):133-015-0267-7.
44. Bhan N, Rao KD, Kachwaha S. Health inequalities research in India: a review of trends and themes in the literature since the 1990s. Int J Equity Health. 2016;15(1):166.
45. Halstead SB, Walsh JA, Warren KS. Good health at low cost. New York: The Rockefeller Foundation; 1985.