THE POLITICS OF PUBLIC-PRIVATE PARTNERSHIP IN HEALTHCARE: A STUDY OF DENGUE EPIDEMIC IN DELHI

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DECLARATION

I declare that the dissertation entitled "**The Politics of Public-Private Partnership in Healthcare: A Study of Dengue Epidemic in Delhi**" submitted to Jawaharlal Nehru University for the award of the degree of **MASTER OF PHILOSOPHY** is my own work. This dissertation has not been submitted for any other degree of this University or any other university.

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Abbreviations

PPP	Public-Private Partnership
NVBDCP	National Vector Borne Disease Control Programme
RNTCP	Revised National Tuberculosis Control Programme
ASHA	Accredited Social Health Activist
NSEP	National Smallpox Eradication Programme
BCC	Behavior Change Communication
IEC	Information, Education and Communication
RSBY	Rashtriya Swasthya Bima Yojana
CGHS	Central Government Health Scheme
NUHM	National Urban Health Scheme
NRHM	National Rural Health Scheme

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INTRODUCTION

In the last three decades, India has witnessed an unprecedented change in terms of its conceptualization of public policies pertaining to health. A leitmotif of the same has been the Structural Adjustment Programmes (SAPs) of the nineties that ushered in a neo-liberal agenda indicating a new set of measures in what came to be known as 'privatization'; further transpiring into Public-Private Partnership (PPPs). PPPs are not only restricted to the domain of healthcare but are viewed as a necessary condiment in the recipe of efficient growth and delivery of services. This argument is ensconced in the public sector bereft of resources to ensure timely access to healthcare services, which otherwise is believed can be provided by the private sector. (Raman & Bjorkman 2009) This category of 'private' providers may subsume private clinics, local private practitioners, private hospitals and laboratories.

These two organizations i.e. the public and private sector are partnered in the new public health policies with the belief that PPP is an efficacious step in preventing and controlling a disease. This partnership between the public and private sector, according to the World Health Organization (WHO) should be based the four ethical principles of "*beneficence* (should lead to public health gain); *non-malfeasance* (must not lead to ill health); *autonomy* (should not undermine each partner's autonomy); and *equity* (benefits should be distributed to those in need) (WHO, 1999) [Qadeer & Reddy, 2006, p.4] However, the presence of two organizations i.e. 'public' and 'private' amalgamated to form a 'partnership' can have two divergent functions, one that is profit driven; and the other that acts as a mechanism to control and prevent a disease, as it is spelt in public policy initiatives.

PPPs serves as an important strategy in all disease control programmes, even though the first response during any epidemic is the state's initiative. The WHO Global Strategy for Dengue Prevention and Control (2012-2020) states dengue to be a "global threat that requires a global response involving all possible partners" (WHO, 2012, p. Among a large number factors such as local community participation, inter-sectoral collaboration (health as well as non-health sectors) it also emphasizes the significance of PPPs in combating the disease.

Delhi, Dengue and Diagnosis

> "Of the "great neglected diseases of mankind", perhaps no infection commands so vast a domain as do the dengue viruses" (Halstead, 1980, p.1)

The twentieth century saw an upsurge in the rise of infectious diseases and efforts to prevent, control and eradicate them. While there have been various success stories regarding diseases such as small pox, yellow fever, cholera, plague, we have in recent decades been faced with a re-emergence of many such diseases that had been effectively controlled. The causes of re-emergence are embedded in the processes of population growth, urbanization and globalization that has led to an increase in the incidence of several diseases especially dengue. Along with urbanization, large scale migration because of globalization has also contributed in the spread of the disease (Gubler 2011) It is true that dengue remains contingent on seasonal variations, reaching its peak during monsoon and the post-monsoon period which provides an ideal breeding ground for mosquitoes. But, urban settings strained with mushrooming of slums, overcrowding, lack of sanitation and proper waste disposal system has exacerbated the incidence of dengue in recent years leading to large number of deaths.

Dengue is a vector-borne disease caused by *Aedes Aegypti* and is of four main serotypes (DENV- 1, DENV-2, DENV-3, DENV-4) that breeds in stagnant water collected in household overhead tanks and discarded or man-made receptacles such as plastic containers, water coolers, flower and bird pots, etc. On the onset of a mosquito bite carrying the dengue virus, and after an incubation period of three to five days the symptoms begin to appear in the form of high grade fever, headache, pain around the eyes, a probable skin rash etc. The treatment accompanies monitored doses of paracetamol, followed by supportive care. This has been the line of treatment for several years because we don't have a vaccine for dengue till date. There have been attempts by WHO at developing a dengue vaccination, and the first of its kind is the Dengvaxia by Sanofi Pastuer currently under clinical trial. Vaccination to prevent dengue in endemic areas, as argued by Gubler in his essay, 'Dengue, Urbanization and Globalization: The Unholy Trinity of the 21st Century' (2011) should serve four main functions, a) effective against three out of the four serotypes of dengue, b) safe to use, c) last for a long time preferably upto ten years and d) economically feasible. Regardless of vaccination being a boon in effectively controlling the adverse effects of dengue, Gubler is of the view that vaccination practices are not effectively used in prevention. It is only introduced as an emergency response when the disease reaches epidemic like situations. The emphasis, currently in the absence of a vaccine is on early diagnosis and vector control measures involving partnerships with the private (health and non-health) sectors.

Currently, India is under a pandemic threat with almost no region left from a possible dengue attack. Along with Kerala, Tamil Nadu, Pondicherry, Delhi has been under the bandwagon of this vector-borne disease with it reaching epidemic proportions[1] as latest as 2015 with 15,867 cases and 60 deaths[2]. Delhi has also witnessed dengue outbreaks as early as 1982 and 1988 in several areas of South Delhi, with the year 1996 being declared an epidemic that surfaced cases of Dengue Haemorrhagic Fever (DHF) for the very first time. (Addlakha 2001) In this regard, and as observed in recent times the state government of Delhi has suggested strategies embedded in public-private partnerships at the level of diagnosis by aligning with private laboratories across Delhi.. While policy makers at the National Vector Borne Disease Control Programme (NVBDCP), the apex institution for dealing with vector borne diseases in India have addressed various mechanisms of risk assessment to mitigate this insidious disease. The dominant preventive healthcare policies for dengue include the emphasis on partnerships with the private sector at various levels, community participation and inter-sectoral collaboration; and the use IEC materials to ensue behavioural change.

Statement of Problem

Dengue is a perennial concern for citizens, government, and healthcare organizations with Delhi acquiring epidemic proportions in the monsoon and post monsoon period. This concern is doubled with the map of Delhi being marred with construction sites, overcrowded spaces, etc. Each year, the months spanning July to September witness an insurgence in the number of dengue cases that are faced with a depreciating and bureaucratic public health sector. As a result, in many cases people are forced to resort to the private health sector which is believed to have the wherewithal to cater to the healthcare needs of the people. Nevertheless, increased expenditure remains a cause of worry, especially the poor for whom notions of accessibility and affordability are hard-hitting facts. In the absence of resources to reduce fatality for a disease which is otherwise curable, the government states PPP as a mechanism to cope with the disease burden. These partnerships constitutive of organizations with their own set of

[1] To comprehend what classifies as epidemic proportions one needs to understand what an epidemic is. An epidemic can be subjected to multiple interpretations. Firstly, it can be defined as a disease affecting a large number of the population at around the same time. Secondly, it can be defined that rapidly and periodically affects a certain section of the population. Thirdly, the detection of one single case in an area has the potential to be observed as an epidemic. (Addlakha 2001, 155)

[2] Source: NVBDCP

motivations and objectives can come to reflect the effectiveness of partnerships within disease control programmes.

Partnerships in its various manifestations are also spelt in policy initiatives undertaken by NVBDCP for dengue prevention and control with the awareness of lack of resources on the part of the government. But, each year Delhi is faced with an increasing set of dengue cases and patients complaining of untimely diagnosis and treatment. In such a scenario, preventive measures are adopted against this menace which can be manifested in either remedial or alternative strategies in general; which can further indicate the stance of the state towards its citizens in time of a health crisis.

Research Questions

The research questions shaping this dissertation are three-fold:

a) How do we conceptualize PPPs weaving together different concepts i.e., ‘public’, ‘private’ and ‘partnership’ that might have varied implications on its workability?
b) How are PPPs structured in disease control programmes, and does the existing pattern of public-private partnership in dengue prevention and control suggest robustness?
c) Is there a pre-dominant model of dengue prevention and control today, and does it reflect on the nuanced relationship between a neo-liberal state and preventive healthcare policies?

Research Objectives

This study has the following objectives:

a) To examine how conceptual categories of the ‘public’, ‘private’ and ‘partnership’ give PPPs a complex character and impinge on its feasibility.
b) To probe into the existing patterns of PPPs in dengue prevention and control in Delhi in tandem with other disease control programmes and the shift, if any that has occurred in PPPs for dengue prevention and control.
c) To investigate the predominant model recognized by policy makers for dengue and prevention and control; and comprehend the insinuating relation between healthcare and state policies.

Research Methodology

This dissertation is rooted in "studying up" (Nader 1974) organizations to comprehend healthcare policies by adopting a qualitative approach. The method deployed will largely be a secondary review of literature referring to a copious set of books, journals, government policy documents on the proposed research. However, since there is paucity of existing literature on the modes of partnership in dengue prevention and control, primary data shall be collected via semi-structured face to face interviews with the officials of the National Vector Borne Disease Control Programme (NVBDCP) as well as private laboratory owners in South, West and East Delhi. While access to NVBDCP officials and private laboratory in South Delhi was premised on 'contacts', the samples chosen in West and East Delhi were based on snowball sampling. Apart from interviews, the technique of content analysis is used to interpret the documents received from the NVBDCP outlining strategies for prevention and control of dengue. The content analysis shall be done in tandem with the literature reviewed on the subject matter covering those documents. The time span covering interviews remains contingent on the availability of government officials and private laboratories owners.

Chapterization

The first chapter of this dissertation reviews the concepts, 'public', 'private' and 'partnership' following an interdisciplinary approach, highlighting that an amalgamation of these concepts makes PPP a complex term. Furthermore, 'public' and 'private' as conceptual categories are understood from the perspective of Sociology of Organizations with the intention to examine how organizations/ institutions function within public policy initiatives as PPPs. To comprehend PPPs which have largely been the domain of policy makers, *An Anthropology of Public Policy* lends insights into the "hidden hierarchies" (Wedel and Feldman 2005) and the socio-cultural or political context these policies are embedded in. Most significantly, however partnerships are analysed within the domain of healthcare to reflect on organizational expectations, attributes as well as stated objectives and models within PPPs

The second chapter empirically reflects on the outlined fields of anthropological knowledge and perspectives in the study of dengue fever in Delhi. But, first and foremost it cogently states the methodological challenges faced in "studying up" (Nader 1974) governmental institutions, in this case the National Vector Borne Disease Control Programme (NVBDCP). With data collected from the NVBDCP, the chapter demonstrates the actual workability of PPPs and the

challenges arising out of a potential organizational incoherence in dengue prevention and control. It also delves and analyses NVBDCP documents stating strategies outlining partnership propositions in preventing and controlling dengue. In doing, the chapter exhibits how NVBDCP envisages and checks 'preparedness' for a dengue outbreak. A large body of this chapter is focussed on studying case studies of disease control programmes, such as, The Revised National Tuberculosis Programme (RNTCP) and The National Small Pox Eradication Programme (NSEP), where the latter serves as guide to state health policies are structured. Otherwise, overall the idea is to shed light on the need for and challenges within PPPs, and to present a counter-narrative to how organizations are understood as presented in the first chapter.

The third chapter takes up the shifts that have occurred due to challenges that PPPs present in preventing and controlling dengue. It critically analyses 'community participation', the predominant strategy in dengue prevention by sociologically exploring the categories of 'community' and 'participation'. The concept of 'participation' with its varied implications is juxtaposed with 'partnership' to understand if these terms are different or used interchangeably in formulating various preventive policies. Conceptual reflections on 'community participation' are embedded in the analysis of the NVBDCP document, 'India Fights Dengue: Strategy and Plan of Action for Effective Community Participation for Prevention and Control of Dengue'. Most importantly, 'community participation' is understood within the Foucauldian framework of "governmentality" to comprehend how preventive health policies in the neo-liberal era are structured.

1. Public-Private Partnerships: Partnerships, Interaction, Collaboration?

The idea of Public-Private Partnership (PPP) acquired ascendance around the early nineties with India adopting the Structural Adjustment Programmes (SAPs) under which International Financial Organizations such as the World Bank (WB) and the International Monetary Fund (IMF) mandated privatization of public services. While the story of PPPs is rather complex: the complexity primarily located and further exacerbated by a definitional crisis; it has invariably acquired roots in policy initiatives aiming at universality with finite resources (for instance, as observed in the domain of healthcare delivery). This complexity is not only confined to a definitional crisis of sorts, which I shall explore in the latter part of my chapter but associated with PPPs conjoining several other concepts such as 'public', 'private' and 'partnership'. These concepts in themselves demand critical sociological inquiry before we delve into defining what is classified as a PPP. This chapter is an attempt at cogently understanding the concept of PPP by historically tracing the existence of a public-private interaction; and looking closely at successful or unsuccessful efforts at establishing a PPP particularly in the field of medical care.

The first part of the chapter is pivoted around engaging with the concepts of 'public' and 'private' from largely two perspectives. Firstly, the two concepts serve as the leitmotif of democratization and are paramount within the political domain of society. Secondly, this exploration is essential from the perspective of 'organizations' and 'institutions'. Here I will examine two key issues, a) How can we understand organizations from the perspective of different sociological paradigms, and the lens of Sociology of Organizations; b) How organizations think and function?

Subsequently, an inquiry into understanding the 'public' and 'private' as organizations shall inform the content of the second part of this chapter, wherein a critical analysis of the existing literature on Public-Private Partnerships shall be carried out. Here, it is important to note that PPPs have been understood from a rather interdisciplinary lens, spanning across public administration, management studies, public policy, development studies to public health. Nonetheless, while collating and incorporating these into our corpus of 'what' and 'why' of PPP, the basis of the study is largely suffused by an 'Anthropology of Public Policy'.

1.1 An Anthropology of Public Policy

1.1.1 What is Public Policy?

Merill Eisenberg in her essay titled, 'Medical Anthropology and Public Policy' (2011) investigates what classifies as a public policy. "Public policy can be defined as "whatever governments chose to do or not to do," or "the actions of government and the intentions that determine those actions," or "the outcome of the struggle in government over who gets what" (Birkland 2005: 18)" [Eisenberg 2011: 96]. In fact, from an anthropological lens it can be seen as a "myth" in the Malinowskian sense of a "charter for action"; a charter that is reflective of the assumptions, values and meanings about how to live (Wedel, et.al 2005). Historically speaking, Wedel et.al (2005) trace the French origins of the word 'policy' which resonates with the sixteenth century idea of "policing" (policie), which during those times implied "to organize and regulate the internal order". (Wedel et.al 2005:35)

1.1.2 Anthropological Appraisal of Public Policy

Public policies according to Eisenberg (2011) can be understood two ways. Firstly, with the idea of how it serves public good manifested in distributive policies, that are advantageous for the entire general population; in redistributive policies, that can benefit one section of the population at the cost of the other section; and in regulatory policies which curtail practices of individuals, groups as well as corporate entities. However, Eisenberg argues that even though policies are designed to serve public good, they can be implemented by both public and private organizations. In India, in fact, government laws at present require that private health provides medical coverage for certain types of services such as hospitalization, doctor visits, prescription drugs, etc.[3] Secondly, policies are comprehended by focussing on how they work, regarding which Eisenberg states, "Policies can be "carrots" that provide subsidies and incentives, "sticks" that regulate the behaviour of individuals and other social actors, or "sermons" that sanction messages and provide information meant to influence behaviour……(Bemelmas-Videc et.al. 2006)" [Eisenberg 2011: 96]

[3] The Central Government Health Scheme (CGHS) under the Ministry of Health and Family welfare can also be viewed as a PPP model as it takes on board private sector for the provisioning of hospitalization, medicines, etc. It provides healthcare to all employees of the central government during service as well as post retirement. CGHS encompasses all government institutions such Executive, Judiciary, Legislature and all state-owned media. All employees are entitled to hundred percent medical coverage and in the case the treatment being undertaken under empanelled private hospitals is also fully reimbursed. These facilities are available under the cashless scheme. The hospitalization facilities are extended according to the position in these institutions, and the facilities means the type of accommodation viz, namely general ward, semi-private and private.
Source: https://cghs.gov.in/index1.php?lang=1&level=1&sublinkid=5783&lid=3656

Considering the above, Eisenberg (2011) makes an interesting claim which acts as a point of departure from the earlier assertion on how an attempt at comprehending the politics of public-private partnership is situated around an anthropological approach to public policy. She states that while for public health theorists the policy acquires a "prescriptive stance" designed for the larger agenda of public health promotion; for anthropologists it involves "studying through" the source, discourses, prescriptions, programmes and those who are affected by these policies. (Wedel and Feldman 2005)

In fact, Wedel and Feldman in their essay, 'Why an Anthropology of Public Policy?' (2005a) opine that public policies in the contemporary modern world possess the ability to connect dissimilar actors and institutions in a complex whole of power and resource relations. In this approach of "studying through" the actors are engaged in the charting and implementation of policy processes that can highlight the different organizational worlds that exist; explored further via the different sociological paradigms to interpret organizations. Furthermore, this approach of "studying through" is also supplemented by what Laura Nader (1974) outlined as "studying up" i.e. studying the group of professional policy makers can give insights into how they view issues and tackle them. It can enlighten us about the "hidden hierarchies" with which power functions; as subsequently observed in the literature reviewed on PPPs in reproductive care and tuberculosis.

Wedel and Feldman (2005a) offer the first notion on which an anthropology of public policy is based i.e. "Anthropologists are able to take on the complexity, ambiguity and messiness of policy debates. By focussing on players more than policies, and on the interactions in which parties to the policy process engage, (whether or not they engage willingly or wittingly, or even see themselves as 'parties'), anthropological analysis can disentangle the outcomes and help explain how and why they often contradict the stated intentions of policy makers" (2005a:2) In other words, an anthropological appraisal of policy, and in this case the policy of public-private partnership in healthcare is oriented towards examining policies from the perspective of actors. However, this approach does not merely look at the characteristics of actors involved but also focuses on the relation that exists between them.

Secondly, Wedel et.al (2005) in their paper titled "Towards an Anthropology of Public Policy" vehemently state "Anthropology of Public Policy takes policy itself as an object of study, rather than unquestioned premise of research agenda." (2005b: 34) The premise of this statement is situated within the unequivocal acceptance of policy as 'neutral' and 'rational' with the purpose

of promoting efficiency. The lack of critical insight into the meaning or ontological status of policy inevitably obscures the latent agenda soaked with a certain kind of power and instrumental reason. merely highlighting the manifest function of public good. In such a scenario, an anthropological treatment of policy would be oriented at unmasking and unfolding the power mechanisms that impact structures of healthcare and lead to unequal access (Eisenberg 2011). The modus operandi to counteract and produce an alternate understanding would demand that policies be understood within the socio-cultural context in which they are embedded. However, apart from this we need to further problematize the ideological discourses such as globalization, democratization and privatization within which public policies have acquired dominance. These discourses neglect and suppress the complexity, contradictions to achieve universal domination and acceptance. (Wedel et.al 2005b)

Thirdly, emanating from the issues illustrated above, Cris Shore in his essay 'Anthropology and Public Policy' (2012) in the Sage Handbook of Social Anthropology argues that policies apart from being a social and cultural construct; and unveiling' power mechanisms with which these come to play an anthropological of public policy brings to fore yet another dimension. He states, "while policies can be conceptualized as a type of narrative or performance, they are also political technologies that serve to create new categories of subjectivity; for example, 'citizens', 'taxpayers', 'criminals', 'immigrants' or 'pensioners'. Insofar as they become internalized, policies work also as 'techniques of the self'. (2012:10) Such an argument is rooted within the framework of neoliberalism. Neo-Liberalism with its emphasis on individual freedom was juxtaposed with what in Gramscian terms is understood as "hegemony via consent". (Harvey 2005) Neo-liberalism gained so much prominence that it led to the "abject acceptance of the idea that there was and is, as Margaret Thatcher kept insisting, 'no alternative'. (Harvey 2005:40) Secondly, Harvey argues that as a mode of governance, neoliberalism prefers governance by elites and experts. Keeping in line with this, Shore elaborates Miller and Rose's argument in their essay 'Political Power beyond the State: Problematics of Government' (1992) stating that policies curated by expert policy professionals can instil this sense of "self-regulation" that citizens invariably align their choices with ends of the government. These arguments form the content of chapter three and shall be further explored within the contours of the fieldwork conducted with government and private (medical) officials.

1.2 The 'Public' and the 'Private' in 'Partnership'

As mentioned earlier, the term Public-Private Partnership is an amalgamation of several other concepts which need to be analysed in isolation. Thus, this section draws on texts to elucidate how these categories have been understood via the disciplinary lens of Political Science and Sociology. By outlining the same, we hope to arrive at a lucid understanding of PPP.

1.2.1 Political and Sociological Analysis of the 'Public' and 'Private'.

> Concepts as Wittgenstein reminds us are context specific. This does not imply that the meaning of a concept varies from person to person or from text to text to another. It rather suggests that a concept must be understood in relation to a totality that is historically and structurally specific. Consequently, it is by referring to the institutional and ideological practices that configure within a given totality that we can understand any particular concept. We need to be attentive to this methodological insight while dealing with such concepts such as the public and the private (Mahajan 2003: 9)

Keeping this idea of tracing a concept within a socio-cultural and historical domain, Mahajan in her book 'Defining the Public and Private: Issues of Democratic Citizenship' (2003) succinctly lays out the different connotations that the public and private have acquired across contexts. First and foremost, she argues that the idea of the public and private appeared in the writing of Aristotle in the 4th century BC. Aristotle understood the private and public by defining them as *oikos* and *polis* respectively. The former came to imply the world of the household while the latter comprised the political sphere. Secondly, following this line of thought, she argues that the public as a space was open and accessible to all, irrespective of their identities. The private on the other hand was classified as an association that catered to a collective group interest. Thirdly, having emphasized the significance of a contextual understanding Mahajan stresses that while within early liberalism, the public and the private were two distinct spheres with strict boundaries, a modern conception insists for an interlinkage of the two. The former saw minimal state intervention for protecting individual freedom. Thus, a stark separation was maintained between the home and the state, private industry from public corporations, self-regulating markets from state- controlled economy. Within the latter and in the context of the market economy, Mahajan argues that the boundaries of the private are expanded to promote the concept of *laissez-faire* (wherein to promote free enterprise the market was placed in the private domain). However, sooner or later it is realized that individuals need

to be ‘regulated’ for fairness to prevail in the choices they make. Therefore, stemming from the above outlined arguments there are two issues that come to fore pertaining PPP’s. Firstly, it is suggestive of the motivations that guide the public and private sector. Secondly, it provides a basis to investigate how public-private partnerships are envisaged more so, in terms of the ‘roles’ that the public and private organizations play in a ‘partnership’.

1.2.2 Sociology of Organizations: Discerning the ‘Public and ‘Private’

The ‘public’ and the ‘private’ as discussed by Mahajan (2003) acquires similar meanings when formalized and institutionalized as organizations. In this section, I shall dwell over the field of Sociology of Organizations to comprehend how organizations are conceptualized from the lens of multiple sociological theories. In doing so I shall largely borrow from Mary Godwyn and Jody Hoffer Gittell who in their edited book, ‘Sociology of Organizations: Structures and Relationships’ (2012) locate an explanation for organizations within four classical sociological paradigms a) The Rational Paradigm; b) The Interactionist Paradigm; c) The Functionalist Paradigm; d) The Conflict Paradigm. I intend these can facilitate for a comprehensive understanding into the idea of partnerships.

According to the **rational theories**, organizations are understood as instruments to achieve goals that would otherwise be difficult for separate individuals to accomplish on their own. Most significantly, rationalist paradigm is premised on the idea of social contract illustrating that the chances of an individual can be enhanced if several joined within a group. However, these theories are always defined in instrumental terms guided by a means-end relationship. But rather interestingly, Godwyn and Gittell (2012) argue that within this unambiguous description complexities arise due to a multitude of definitions for the term ‘rational’. For instance, Weber argued that there exist two types of rationality i.e., functional and substantive. The former re-iterates the criteria of understanding organizations; while the latter “is holistic, reticular and value driven; substantive rationality recognizes the interdependency of a wide range of objectives and perspectives. (2012: xiv)

In juxtaposition, the **interactionist paradigm** views organizations from a relational perspective, classified as network organizations (Goodwyn and Gittell 2012). Herein, organizations are here seen with some sense of connection and fluid interactions resulting in a space which lends them to negotiate and construct mutual understanding. This sense of relatedness emanates from Mary Parker Follet work on organizations in her book, ‘The New State’ (1918). Firstly, she argues that unlike the rationalistic paradigm that maintains a clear

separation of household/personal and business/impersonal, the interactionist paradigm stresses the significance of social interactions and mutuality of the two spheres. Secondly, she argues that organizations need to be understood in terms of the relationships that they are embedded in and characterized with, rather than their inherent characteristics. In other words, it is not the attributes of the organizations that need attention but the 'relation' that conjoins them. Most importantly, this relation is characterized by the dispositions of the actors engaged within that organization. The highlighting principle of this paradigm is reciprocity and interdependence; a sense of "organic" organizational form over a "mechanistic" one; wherein, the former gives primacy to the value of adjustment and a redefinition of tasks that underlie an organizational firm via continuous 'horizontal' relationships. This is unlike the "mechanistic" form that is guided by a hierarchical and 'vertical' structure where interactions are ensconced with control, authority and command. Tom Burns and G. Stalker's description of the outlined forms in their article, 'Mechanistic and Organic Systems of Management' (1995) is postulated on Durkheimian notions of solidarity. For Durkheim, organic solidarity is marked by role differentiation that leads to interdependence; and unlike Weber who maintains that role specialization will eventually lead to bureaucratic organizations, Durkheim sees interdependence as a natural consequence of specialization.

The **functionalist paradigm** analysed organizations as characterized by cooperation and consensus, and the **conflict paradigm** emerged as a critique insisting that members within an organization can be competitive and hence alter the power dynamics within organizations.

1.3 Unpacking the Politics of Public-Private Partnerships

In this section I shall examine the contours of a partnership premised on the interactionist paradigm within sociology and unfold the nuances that accrue in terms of the organizational characteristics and motivations, methodological foundations and orientations, and having said that the arising and inherent complexities within a partnership.

1.3.1 The Idea of Partnerships: Networks, Interactions and Interdependencies

The foregoing discussion on the patterns of organizational forms situated within a network of free-flowing interactions is *the* framework across literature comprehending partnerships. Gyan Prakash and Avantika Singh in their essay, 'Public-Private Partnership in Health Services' (2010) locate the study of PPP within a network organization perspective precisely for the

reasons outlined by Follett (1918). They characterize network organizations as “enduring” with continuous resource and information flow. On the contrary, however they see these enduring relationships organized in a manner such that the individual autonomy of the participating organizations remains intact. This argument is further substantiated by Hans-Klijn and Teisman (2002) who have written extensively on the term ‘partnership’,In their chapter titled, ‘Governing PPP: Analysing and managing the processes and institutional characteristics of PPPs’ (2002a) they elucidate how the idea of partnership is seen as a “third way’ between the two traditional methods of market production and government production. This explanation is situated within the contours of changing institutional arrangements within the government in Europe on whom dawned upon the benefits of including the private sector in the provision of public services. Furthermore, in their article ‘Partnership Arrangements: Governmental Rhetoric or Governance Scheme? (2002a) Hans-Klijn and Teisman argue that partnerships in general and public-private partnerships in particular are based on interdependencies of different kinds of actors, who rely on cooperation rather than control to solve governance problems. Cooperation as outlined by the authors is doing away with hierarchical and market-based transactions; and shifting towards relational arrangements. However, they assert that this strategy is an acute failure on the account of a believed difference between the public and private sector. In making such an assertion, they see the public sector in rather Weberian terms as surmised on a hierarchical and bureaucratic mandate. This strict adherence to the maintenance of hierarchy thwarts the very idea of partnership. Nonetheless, if this were to be the case then we need alternative mechanisms to pursue partnerships under the rubric of a relational organizational form. But this requires, as mentioned above, a mutual adjustment to achieve goals, sharing of knowledge and resources between the actors engaged in that organization.

The interactionist engagement with partnerships ensues a complexity manifested in several actors possessing different perceptions and interpretations coupled together. In this sense, if the government must adhere to its hierarchical principles, then it may see these several perceptions as threatening and choose to decline any proposed partnerships. That is, it may lead to rolling out of the “traditional contracting out” scheme; wherein the government can control decision making and have the private sector act on its behalf. Such forms of partnerships that are identified and clubbed under the “contracting out” type cannot be referred to as partnership arrangements (Hans-Klijn and Teisman 2002).

The foregoing provides us with the first hypothesis for the failure of a potential partnership i.e. **The hierarchical orientation of the public sector hinders possibilities of reciprocity or mutual adjustment required for partnership arrangements**. It also opens the debate with respect to two issues, a) Cooperation is the salient feature of any kind of partnership; b) Contracting out schemes cannot be identified as partnership propositions.

1.3.2 Characteristics and Motivations of Organizations

Premised on the above discussion highlighting the basic features of a partnership and models to implement the same, and simultaneously reflecting on political and sociological analysis of organizations; this section dwells on the motivations of the organizations, the characteristics of PPPs, and goals underlying these partnerships.

Arjun Sengupta in his essay, 'Public Sector in a Market Economy' (2003) cogently outlines the role of the public sector and the motivations that guide it. Most importantly, he highlights the perceptions regarding the public sector which later substantiated by literature on the same topic can guide us towards our second hypothesis. First and foremost, Sengupta's definition of the public deviates from Caroll and Steane's idea of the public as formulated in their essay 'Public-Private Partnership: Sectoral Perspectives' (2001). They argue that the term public, public sector and state are often used interchangeably implying a set of institutions that have legitimate authority over the population governed. While, all institutions apart from the state or those falling within its ambit are classified as private or private sector. But for Sengupta (2003), the public sector cannot be only identified with the state but any group that is guided by the principles of social choice. In this regard, T.K. Sundari Ravindran in her article, 'Public-Private Partnership in Maternal Health Services' (2011) illustrates the 'public' as comprising of all sectors of the government at different levels, but also including inter-governmental agencies such as World Health Organizations (WHO), UNICEF, etc and private foundations who provide major funding support to countries to develop public services. I shall see the mandates by these international agencies translated into PPPs and community participation in healthcare in the succeeding chapters, particularly with reference to dengue prevention and control. She goes on to argue that some authors of PPP include NGOs and community organizations within the public category; those that function towards public welfare and are not merely profit driven. On the other hand, the private sector as defined by Mills et.al (WHO, 2002) includes all providers existing outside the domain of public services, whether their motive is philanthropic or commercial. It also includes large and small commercial

organizations, professional groups such as doctors, national and international NGO and as well as individual providers.

The above insinuates Sengupta's (2003) emphasis that what distinguishes the public sector from the private sector is motivation. In the private sector, the motivation is primarily profit driven or utilitarian. Meanwhile, the motivating factor in the public sector is decided by all those who form a part of it and go beyond individual and private benefit and "it may involve the exercise of some rights, some form of affirmative action's, or some notion of equity and distributive justice" (Sengupta 2003:.272). With this line of argument, can one that if social justice and equity are domains of the public sector, while profit and efficiency of the private sector, partnerships facilitate the bridging of these gaps?

Contextualizing the public sector within a market economy and in contradiction with the private sector, Kuldeep Mathur in his essay 'Privatization as Reform: Liberalization and Public Sector Enterprises in India' (2003) argues that the public sector suffers from "public incompetence" while the private sector is seen as having the managerial capacity, flexibility, competitive spirit to accomplish goals of efficiency and effectiveness that was earlier seen as the domain of the public sector. But, the concept of efficiency as Mathur outlines is paradoxical to the notion of social equity underlining the public sector. This is primarily because and as Mathur states,

> the quest for efficiency follows a purely economic path, which implies a least cost notion of efficiency. It is achieved when least amount of resources are used to produce a specific good or service. It does not say how this least amount is achieved. The argument is based on crude division between productive economic relations and unproductive social relations. The economic motive is given more weight than social motives (Mathur 2003:292).

Mathur states for reasons outline above that this is precisely why the public sector was never seen as a profit making, efficiency-oriented organization but only as a helping hand to the private sector and other social sectors. We shall see the implications of the same within PPPs in healthcare in a later section.

1.3.3 Public-Private Partnerships: Coordination and Control

According to Goodwyn and Gittell (2012), the sociological analysis of organization provides insights into the problems that organizations face. If coordination, conflict and control can be

identified as problems, then public-private partnership can simultaneously be solving as well as exacerbating these set of problems. They provide an outline of how each of these concepts has been defined by borrowing from those who have extensively dealt with the same in the domain of organizational studies. Firstly, coordination has been defined as the interdependence of tasks and activities between organizations, the sense of reciprocal relations that come to underlie these organizations. Considering Follet's argument on the notion of coordination, Godwyn and Gittell state,

> "Follett (1949) is arguing that effective coordination requires systems thinking, a sharing and integration of knowledge itself. Because coordination occurs through the integration of knowledge, and because integrated knowledge then informs action, Follett contends that coordination should occur *throughout* the organization, not just at the top level of the management" (2012: 128).

The above ensues that coordination relies essentially on factors of interdependence and interaction. Secondly, control is observed as the alignment of behaviour with goals/and interests that underlie an organization. In fact, this issue of coordination can be offset by control wherein the latter is imposed to achieve certain objectives. Thirdly, conflict is the complete breakdown of any form of negotiation reached due to opposing goals and interests. While in the Marxian understanding of the term, conflict can lead to change; it can potentially thwart any possibility of coordination and control.

1.3.4 Methodological Foundation, Muddled Terminologies and Mechanisms of Inclusion

This section attempts at critically analysing the existing literature on public-private partnerships in healthcare from the lens of its methodological foundations, typologies, organizational wherewithal, and strategies to include the private sector. Corroborating and substantiating on the literature dealt with earlier, I hope to arrive at my second hypothesis.

N.S. Prashanth in his article 'Public-Private Partnership and Health Policies' (2011) argues that health landscape in India is marked by an unorganized and unregulated private for-profit sector along with NGOs. Underlying these are the visibly deprecating health conditions and hence the case for partnership schemes between the public and private sector assumes importance. However, as mentioned earlier the state does not encapsulate the public (Sengupta 2003) and is marked by the presence of other organizations (Sundari Ravindran 2011). Problematizing the very idea of PPP, Prashanth locates the lacunae within the foundations on which PPP is actualized. That is, PPP as a policy endeavour is postulated on the question "does it work?"

rather than establishing it within the contours of "what works for whom and under what conditions?" The authors insistence on a methodological shift in determining PPPs is anthropologically inclined highlighting the relevance of context. Nonetheless, this shortcoming is further exacerbated by a difference between public and private sector in terms of motivation (not for profit and profit) and goals (social equity and efficiency). Finally, the policy trap of "do things work" reduces PPP to merely contracting out of services and promoting partnerships is based on a few that worked, neglecting the multitudes that did not.

The contracting out model within PPPs remains contested and its success confined to certain health projects. As cited by Amrita Datta in her article titled, 'Public-Private Partnership: A Case for Reform?' (2009) one success story is that of the US AID, PSP One Project that aims to address the health requirements of the poor. To do so, it has partnered with Hindustan Unilever Ltd that aims to establish sustainable infrastructure to broaden access to oral rehydration salt and birth spacing products to rural women in India. However, such stories are piecemeal and oblivious to the issues of equity and access; parameters that come to define PPPs as Datta would understand it. Considering the project she argues that there is no guarantee that such projects would be successful and states, "In such a context, there is not enough ground for the state to back out. If the government first has to dismantle its existing workforce, destroy the existing institutional structure, bear the costs of creating new institutions and sustain them, it's a double fiscal burden with certain risks/assumptions that the proposed PPP would be successful (2009: 76). In other words, a public-private partnership inherently puts the government at the forefront of all risk bearing tasks, while the private sector has particularly no stakes involved.

From the foregoing, considering that PPP is a risk bearing proposition for the public sector alone, Ramesh Bhat in his article 'Issues in Health: Public-Private Partnership' (2000) illustrates via case studies how such a scenario can be dealt with. He sheds light on the vast presence of the private sector in healthcare services accompanied by depleting resources and finances in the public sector. Almost two decades from when this argument is illustrated the health expenditure is still abysmally low affecting healthcare facilities (i.e. its quality and quantity) in the government sector. This financial deficit of the government accompanied by an expanding private sector inaccessible to lower income strata calls for public-private partnership. Apart from partnership arrangements, there have been attempts at introducing 'user fees'. This strategy, however has failed as the public facility system does not retain these funds and facilitate its usage for improving facilities (primarily in curative and tertiary sectors).

Hence, the emphasis was on involving the private sector as recommended in the National Health Policy of 1982. It reiterated the prevalence of financial restraints and recommended the establishing of private practice and investments by NGOs in propelling the growth of curative centres. On rather similar lines, Rama Baru in her book, 'Private Healthcare in India: Social Characteristics and Trends' (2000) illustrates that while the state is the paramount figure in the delivery of healthcare services in India, private interests in the same have never been thwarted; and have only grown during the 1970s. She reviews the various policies of the Indian state and other committee reports that reverberate the private provisioning of healthcare services prior to independence. The People's Plan and the Bombay Plan drawn prior to independence were against and for the inclusion of private interests respectively. Thus, to cater to growing healthcare needs private interests have always been given some amount of eminence.[4]

Baru and Nundy (2009) in comprehending the significance of PPPs in women's reproductive healthcare argue that partnerships preceded the 90's under the term of "collaborations" between the non-profit and for-profit sector primarily within national health control programmes for malaria, tuberculosis, family planning programme, etc. While, they do not further dwell over partnerships as "collaborations" they look into the growth of the same in women and child health programmes as envisioned in the Five -Year Plans. A cursory glance at the data referred to on the collaborations between government and the private sector in family planning and reproductive and child health programmes hints at how collaborations preceding the Tenth Five-Year Plan (2002-2007) were primarily on an individual level with private practitioners (Baru 2002). Only in the years succeeding were collaborations sought at a sectoral level with private sector and other voluntary organizations. Within these collaborations, the role of the private sector increased manifold as mentioned earlier by the 80s and 90s, wherein the government provided for subsidies in the form of land, water, electricity. Meanwhile, the private sector was also provided tax concessions to procure medical equipment, etc. (Bhat 2000).

[4] In this context, Baru's narrative dates to a recent past. If one were to further historically seek instances of public-private interactions or involvement of private practice/practitioners then Foucault in the essay 'The Politics of Health in the Eighteenth Century', a part of the book titled 'Power/Knowledge: Selected Interviews and Other Writings 1972-1977 traces the identification of disease as a social and economic problem in the 18th century. He elucidates that the 18th century witnessed the rise of a medical market of private clienteles and thus private consultation. Furthermore, while the state was the paramount authority in dealing with medical problems, there were number of different organizations and methods to take care of the same; manifested in the form of organizations such as religious groups, charitable organizations and other philanthropic organizations. The 18th century was also the time when it was realized that the health of all is a concern for and of all. (Foucault 1980)

While the National Health Policy 1982 recognized the role of the private sector in public health delivery, it was further foregrounded in the Eleventh Five Year Plan constitutive of the National Urban Health Mission (NUHM) that also identifies the significance of PPP. As enlisted under its goals to achieve equitable access to healthcare for the urban population, more so for the disadvantaged, the NUHM outlines public-private partnerships with private providers/NGOs/Faith Based Organizations. The primary reason attributed was the large presence of private providers in urban areas, the first point of contact for most people especially slum dwellers.

Coming back to the mechanism of private sector inclusion, incentive systems and contractual mechanisms were set in place to ensure effective distribution of services and improve service delivery (Bhat 2000). For Bhat, PPP stands as a strategy to tap the strengths of the private sector and thereby ensure accessibility, which otherwise is a difficult proposition given the resources that the government possess. To elucidate ways through which PPP has been envisaged at ameliorating curative and super-speciality healthcare, he takes up the case of Punjab, Rajasthan and Delhi. In Punjab for instance, PPP is envisioned through the levying of subsidised land to the private sector by the government. While in the context of Delhi, the Government of Delhi planned to set up ten hospitals under joint venture schemes. The Government of Rajasthan as outlined in the policy documents stressed the growth of primary health centres to increase access, but the growing incidence of chronic diseases shift the focus to improving curative and super-speciality care. Due to lack of unavailable funds on the part of the government leading to poor accessibility, the private sector was roped in to enhance accessibility and quality. One of the mechanisms to attract the private sector was associated with the government providing basic subsidy for initial setups in the form of reduced land prices, medical equipments, etc. Apart from subsidies, another way PPP was implemented was through the contracting out of clinical and non-clinical services. Non-clinical services included diet and catering, laundry and security, and IEC programmes; while the clinical services would include PPPs catering to problems of accessibility. In this study, my area of research is confined to the domain of clinical services within PPPs. Bhat (2000) however is critical of the private sector and thus argues that the collaboration between public and private organizations is based on critical assumptions.

The efficacy of the private sector is put to test with the upsurge in expensive services rendered by the private sector. Be that as it may, the paucity of monitoring and regulatory mechanisms questions the effectiveness and the quality of the private sector and the foundations on which PPP’s are rationalized i.e., for targeting the poor.

1.3.5 Equity, Efficiency and Economic Growth?

Foregrounding the above, Bhat (2000) opens up the debate on whether the objective of PPPs should be to protect the poor or addressing the issue of equity? Having said that, he probes into these questions raising questions for further enquiry. Firstly, PPP initiatives alone cannot cater to the poor, and we need to develop strong public facilities. In this sense at no cost can there be a reduction in public spending even if in the name of a partnership there is a probable dismantling of governmental structures. Secondly, should the initiative focus on subsidizing inputs or providing subsidy to the poor? Thirdly, are trade-offs a pre-requisite for the successful implementation of PPP, i.e. if it is not possible to promote equity, should the government focus on improving efficiency? However, as discussed earlier reasons for involving the private sector in a partnership are particularly embedded in its ability to increase efficiency? How the government works towards this initiative remains a proposition to be explored. Fourthly, we need effective communication between various governmental departments and prospective private partners to regulate the unprecedented growth of the private sector and the ill consequences that follow. Most significantly, the success of PPPs for Bhat lies in defining the distinct roles of the public and private sector, for consensual situation to lend for a succinct definition of PPP.

Besides the rhetoric of efficiency and equity, PPPs are located within the paradigm of economic growth and development (Datta 2009). Considering the rationale behind the implementation of PPP, and its potential for in reforming various sphere of society, Datta states

> PPP is the new face of development where the state and private actors, who have had a long history of conflict now work in collaboration and cooperate with each other to further common goals of a market driven growth-oriented agenda. State actors enter into partnerships with organizations in civil society, the market and with transnational organizations, to effect the governance of globalization (2009:73).

This collaboration and cooperation to seek access, equity and efficiency is however further problematized claiming it is executed in public interest and provided at a reasonable cost as illustrated in the 11th Five Year Plan (Datta 2009).

1.3.6 Complexities within PPPs: Roles, Models and Multiple Actors

Elaborating upon Bhat's (2000) argument on the lack of distinctive roles of the public and private sector, Datta (2009) locates the prospect of PPP within a developmental framework and the forms it can take in either modernizing existing public health services or delivering efficient healthcare services via the private sector. Nonetheless, while the forms maybe envisaged clearly, poor role distinction as mentioned earlier ensues PPPs as a complex relationship, wherein "PPP gives no idea what the actors are to do, how they plan to accomplish it and most importantly, the PPP designation gives us no concrete idea of how the relationship between the actors is different from what they would have been if no "partnership" had been formed" (Datta 2009: 74)

Lack of role definition as well as models that come to define these partnerships add complexity to PPPs. The most common model of partnership is contracting out services wherein it is recommended that the government should focus on improving the regulatory framework, while the onus of delivery of health services and insurance shifts to the private sector (Datta 2009). But this model is not identified as a "true" partnership per say (Datta 2009, Hans-Klijn and Teisman 2002). The other model being one in which the government provides the initial costs for installing inputs (Bhat 2000). Hence, if partnerships are purely outlined on the model of contracting out then it could translate to what Mark Nichter defines as "public-private interactions" over "public-private partnerships" because such partnerships assumes neither equality in relationships nor reciprocity in obligations (Sundari Ravindran 2011).

Baru and Nundy in their chapter titled, 'Health PPPs in India: Stepping stones for improving women's reproductive health care?' (2009) further substantiate this complexity, and locate it within the contours of a multiplicity of actors across different regions, levels of care and socio-economic context that accrue PPPs. From their review of PPPs within the women and child health programme they draw some generalized conclusions regarding the purpose of PPPs i.e. the 'why' of PPPs. The answers to the same are located within the parameters of equity, sustainability, scalability, coverage, equality. To assess the success of these parameters, the authors while reviewing PPP schemes in maternal health services question the replication of one successful story in another context. (Prashanth 2011) And, with respect to the same Baru and Nundy quote Annigeri et al (2004), stating that there are "strengths and weaknesses in each implementation intervention reviewed. These strengths and weaknesses vary from intervention to intervention based on the unique design of each" (2004: 235). Hence, it is rather affirmative

that the replicability of PPPs remains questionable devoid of the particularities of a socio-economic and institutional context in which it is embedded. Apart from raising the significance of a contextual approach to the relevance of PPPs in public health delivery, Baru and Nundy raise the issue of the relationship between PPPs and the objectives of the partners involved. How do similar or conflicting objectives raise ethical dilemmas regarding transparency and accountability in PPPs? On a similar line of thought as Hans Klijn and Teisman (2002a) who point out that hierarchy inherently encapsulated within a governmental structure can hinder the possibilities of a successful PPP, Baru and Nundy see the reduction of bureaucratization by PPPs as a fallacious argument. In fact, in ensuring accountability and transparency within PPP, the private sector views the government as the "big brother"; and with a sense of more than often being mistrusted and policed. Such issues problematize the notion of PPP promoting an equality and built amongst equals. Nonetheless, one can argue that it is not only merely the objectives and attitude of the government, but the private sector and its demand for profit in the long run that makes partnership a complex and untenable proposition.

From the foregoing we can draw our second hypothesis i.e., **A partnership's success can in some cases be hindered by the profit-driven motives of the private sector**.

As an extension of the ensuing complexity within PPPs, Baru and Nundy in their article, 'Blurring of Boundaries: Public-Private Partnerships in Health Services in India' (2008) they consider the Revised National Tuberculosis Control Programme (RNTCP) and Reproduction and Child Health Programme (RCH) as case studies. Prior to this, however they iterate the complexity arises not merely out of the multiplicity of actors but also in the plurality of designs translated in the form of models i.e., contracting out, social franchising and social marketing. In the case of the TB programme, case detection increased because of PPPs because the private sector was given the responsibility of the same. Nonetheless, the problem arose in the notification and referral of the diagnosed patients to the programme. In such a scenario, the weakness of the national programme managed under the exegesis of the government is subject to scrutiny; advocating the need for a stronger one to ensure the success of PPPs. Referring to Dewan, et.al and their work on 'Improving Tuberculosis Control through Public-Private Collaboration in India: Literature Review' (2006) they argue that the PPPs in TB control and prevention proved to be effective only with the provision of a strong public sector supplanted by advocacy, training and supervision to sustain partnerships with the private sector. In other words, one can say that the ineffectiveness of the national programme was seen as being directly proportional to ensuring the sustenance of that partnership.

The TB programme, according to Baru and Nundy (2008) reverberates a true partnership success story overcoming the complexities of organizational incoherence, lack of mutual reciprocal efforts and coordination.

> The PMP referred patients suspected of TB to the hospital where they were diagnosed, counselled and given the initial treatment. If positive, they were referred to the specified neighbourhood nursing homes that had the DOTS centres and was within reach. If they did not test positive for TB they were sent back to their respective practitioners to continue the treatment. The nursing home provided space and staff for the programme free of cost and received the drug kits from the hospital. The Mahavir hospital and nursing home kept the records for the government. The government provided TB control policy training, drugs and laboratory supplies. This model also incorporates five outreach workers who followed defaulters and motivated them to continue treatment (Venkatraman and Bjorkman 2006) [Baru and Nundy 2008: 65].

From the above quoted example we find that a partnership indicates several actors, each with a clearly defined role and perennial interaction at every level ensuring the effectivity of the partnership. Hence, characteristics such as process building, value orientation of the organization involved, commitment towards the partnership and trust are factors that facilitate a partnership apart from context. Dwelling over the models of partnership Stephen Osborne in his book titled, 'Public-Private Partnerships: Theory and Practice in International Perspective' (2001) defines 'partnership' as a "cooperative" agreement between two partners, one public and another private that will or should yield positive returns. He takes up the discussion on contracting out being equated with partnership categorically highlights the difference between the two, and why the two are often fallaciously conflated. First and foremost, he states that contracting out implies that the public sector provides the mandate and specifies the services that must be provided for by the private sector along with a required result. Ensuing from this, it is seen as a "principal agent relationship" wherein the public sector defines the problem, provides the expected result with the private sector being the facilitator to that defined expectation.

Partnership however, is not seen as a linear process but "as a commitment between public and private actors of some durability in which partners develop products together and share risks, costs and revenues which are associated with these products" (Osborne 2001:85). Furthermore,

contracting out aims to increase efficiency of the entire process, while partnership as an interactive process aims to increase the working effectiveness of both partners involved in the same. If one were to ponder over Osborne's distinction between contracting out and partnership, then probably for so long we have assumed that the latter shall increase efficiency, but perhaps only if contracting out is doled out in the name of partnership.

1.4 New Public Health Policies: Emphasizing PPPs and Negotiating Complexities

Expanding on the growth and development framework of PPPs and presenting a nuanced approach to the contextual onset of partnerships, Rama Baru and Madhurima Nundy in their article titled 'Health PPP in India: Stepping stones for improving women's reproductive health care? (2009) delve into the rise of PPPs by focussing on the level of involvement of the private sector in the context of maternal care services.

In the years up to and including the 1970s, the private sector on the whole was minimally involved and mostly concerned with primary service provisioning, community mobilization and creating awareness (Baru & Nundy 2008). In the subsequent years of the 80s and 90s, market involvement increased with the private sector being involved in the secondary and tertiary levels of care. Most significantly, with policy domains as spelled out in the National Health Policy 1982, it was recognized and accepted that the state was unable to provide for the required healthcare services; and within the same policy the role of the private sector was outlined along with the provision of subsidies in form of free supplies, honorariums, etc. The 1990s however witnessed an unprecedented change in the public health discourse with PPPs being accepted as an important element of health policies in India. This was unlike earlier times where the private sector had been roped in only at certain levels of care (Baru 2000). These were largely characteristic of the New Public Management (NPM) practices promoted by international agencies such as the World Bank that signalled a transition from the conventional administration to public management with emphasis on economic efficiency indicative of the market structure. Therefore, the precedent of new public health policies of the 90s set straight the significance of PPPs, and international agencies like the WHO stated;

> To address emerging threats to health, new forms of action are needed. There is a clean need to break through traditional boundaries within government sector, between governmental and non-governmental organization, and between public and private sectors. Cooperation is essential; this requires the creation of new

partnerships for health, on an equal footing, between the different sectors at all levels of government in society. [WHO 1997] (Baru and Nundy 2008: 62)

Baru and Nundy (2008) quoted the above description by WHO on the need to cater to growing health needs highlights three issues that form the subject matter of their argument, a) PPPs are seen as new forms of action; b) partnerships are beyond market and hierarchy; c) cooperation is seen as the guiding principle of PPPs. In their earlier reviewed essay (Baru and Nundy 2009), a chronological and contextual evolution of PPPs was traced, wherein the culmination of PPPs was situated within the neoliberal reforms of the 90s. Interestingly, while elucidating the earlier forms of collaborations prior to the emphasis on public-private partnerships they point that the latter sees both partners as 'equals' and is postulated with a memorandum of understanding, with claims of partnership foregrounded between 'equal' partners cooperating at each level, unlike a "principle-agent relationship" (Osborne 2001).

Partnerships going beyond the traditional boundaries of market and hierarchy and coming together as a whole can be understood as new forms of action for two reasons, as far as my views are concerned. Firstly, if factors of reciprocity, equality and role divisioning and differentiation are catered as seen from the case of the Mahavir Trust Hospital under the RNTCP; then PPPs can ensure cooperation and prove fruitful for healthcare accessibility. Secondly, as Goodwyn and Gittell (2012) point out and as reverberated under the RNTCP programme cited earlier, integrated forms of knowledge invariably translate into effective action. However, these new forms of action that go beyond traditional boundaries of market and hierarchy can be problematic with the presence of different perceptions and motivations of the actors involved. (Osborne 2001)

1.5 Conclusion

PPP is an interdisciplinary concept and an omnibus term occupying a multitude of parameters and connotations. My aim however was to situate it within the contours of an anthropology of public policy to highlight how state policies are structures and intentioned. The mapping of PPPs from the lens of an anthropology of public policy highlighted three interrelated issues; a) policies function on the dualism of entreaty and threat, b) policies balance between "enhanced freedom and "restricted freedom" (Harris 2001) and c) public policies can obscure latent agendas

PPP as a marriage of the three conceptual categories of 'public', 'private' and 'partnership' lends to its complex proposition. In this regard, an attempt at providing a lucid understanding

of PPPs only further reinstates the complexity that it is riddled with at the level of roles and multiplicity of actors, models of within a partnership. The effort however was not to provide a solution out of this complexity but only to unravel the politics arising out of the complexities manifested in asymmetrical power relations, conflicting objectives and motivations. In terms of the models of PPP, the contracting out model as shown in the literature reviewed is contested at the level of ubiquitous workability thereby problematizing the methodological foundations of PPP. The literature cited largely sheds light on how contracting out and partnership are often coalesced on the pretext of increasing efficiency, comprising equality which is the foundation of the latter.

The conceptual apparatus of PPPs is located within a relational paradigm emphasizing that partnerships be understood from the perspective of relations and networks; and not merely from the inherent characteristics of the organizations involved. Nonetheless, how organizations think and function present kaleidoscopic insights into a hypothetical reasoning for the success and failure of partnerships which shall be explored in the next chapter. Taking the salient features of a partnership discussed so far I shall delve into assessing the probable shifts and persistent challenges to PPPs in controlling and preventing dengue.

2. Of Persuasion, Preparedness and Prototypes: Preventing and Controlling Dengue

> Of the "great neglected disease of mankind", perhaps no infection commands so vast a domain as do the dengue virus (Halstead 1980:1)

This statement by Halstead acts as a point of departure into exploring the mechanisms undertaken by policy makers to prevent and control dengue. The WHO Global Strategy for Dengue Prevention and Control 2012-2020 to cater to "the most rapidly spreading mosquito-borne viral disease" (p. v) emphasizes partnership, coordination and collaboration as "enabling factors for implementation". This aims to reduce disease burden by effective surveillance, vector control, outbreak preparedness, etc. In this backdrop, the chapter delves into the official documents and narratives from the National Vector Borne Disease Control Programme (NVBDCP), the apex body for tackling vector borne disease in India .However, in doing so I shall also reflect on the two hypothesis I proposed in the first chapter - firstly bureaucratic and hierarchical attitudes tend to hinder partnerships; and secondly, private organizations are inherently profit oriented by taking case studies of other disease control and eradication programmes in India.

The NVBDCP also provides insights into the methodological inquiries and challenges with "studying up" in anthropology. The chapter thus begins with issues centred around the same followed by policy documents designed by the NVBDCP for preventing and controlling dengue. Regardless of these documents drafted with the intention of reducing disease burden via several preventive strategies; my focal point is to assess the emphasis on building PPPs. These partnerships invoked as a desideratum in most disease control programmes are critically analysed for dengue within the contours mapped in the previous chapter via personal interviews with NVBDCP officials, private lab owners and case studies.

Considering the aforementioned, questions such as what is the significance of public-private partnerships? Are there shifts in PPPs perceived as a panacea for public health amelioration? If there are shifts, what are those and does it fill in for the lacunae within PPPs? These questions are of concern.

2.1 "Studying Up": Access to the National Vector Borne Disease Control Programme

> We have benefitted immensely from the inputs we have received from persons like you and will continue to look forward to such inputs as they help improve……I

> will look forward to an exchange of thoughts with you" (Email message a ministerial officer 10.02.2013). This invitation – that reached me (Ursula Rao) during the third year of my research – captures the sentiment that shaped my relation to the ministerial employees implementing RSBY[5]. For them, RSBY was a "work in progress" and I was invited and actively encouraged to share my observations through verbal communication, email messages, written texts or Facebook postings. (Mauksch and Rao 2014: 29)

Rao's study as illustrated in the article, 'Fieldwork Dialogue: Reflections on Alternative Forms of Engagement' (2014) is in one way or another, a successful instance of "studying up"[6] in anthropology. That is the raison de'etre for taking it as the starting point to analyse the insights gained from personal interviews[7] with officials of the National Vector Borne Disease Control Programme (NVBDCP) regarding public-private partnerships in controlling and preventing dengue. Moreover, the anthropologist[8], Ursula Rao in her account stated above captures her ability to gain *access* into and develop a *rapport* with policy makers working collaboratively to ensure the effective implementation of RSBY at the Megapur district in Chattisgarh. *Access* and *Rapport* are quintessential to the practice of fieldwork in anthropology. Malinowski's magnum opus 'Argonauts of the Western Pacific: An Account of the Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea' (1922) elucidates at length the quandary that surrounds these two terms.[9]

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[5] RSBY i.e. Rashtriya Swasthya Bhima Yojana is a health security programme introduced by the Government of India in 2009. It aims at providing insurance cards at a fee of Rs 30 to families below the poverty line covering hospitalization services (private and public both) worth Rs 30, 000 annually. By doing so, it not only proposes to confer financial protection but also enhances accessibility to healthcare. To check its smooth functioning and effective implementation Ursula Rao enters into a 'dialogue' with the ministry responsible, i.e. the Ministry of Health and Family Welfare. RSBY at the heart of it could be a public-private partnership.

[6] In the first chapter, I have briefly laid out the scope of an Anthropology of Public Policy wherein I have highlighted that it provides for how policy experts tackle an issue affecting public good as well as illuminates the hidden hierarchies that operate at the 'top' level. Laura Nader (1974) vehemently argues for a methodological reconfiguration within anthropology and introduces the concept of "studying up" which questions the long terms fascination of studying the underdog in anthropology and the necessity to now see things "in-reverse". It also questions problems of access in "studying up' dominant institutions and the powerful people. See, 'Up the Anthropologist: Perspectives Gained from Studying Up' (1974) for the detailed argument.

[7] These personal interviews were carried out on and off over a period of 8 months during my MPhil.

[8] The prefix is a deliberate attempt at highlighting the interaction and learning process between an anthropologist and policy maker.

[9] The Introduction to his book is indicative to the problems of access and rapport in fieldwork.

There are issues of access and rapport in fieldwork when one is “studying down”[10], or even “studying sideways”[11], however keeping these aside I shall primarily focus on the issues of access along with rapport building in the context of “studying up”. Drawing from personal interviews conducted I shall dwell over the benefits and challenges of public-private partnerships within the official discourse.[12] By outlining a detailed account of personal interviews and data gathered I intend to highlight the changes, if any in the method of preventing and controlling dengue.

2.1.1 Through Approach[13]and Appointment

In January 2017 in a casual discussion with my co-supervisor, a suggestion was invoked to interview the key officials of the nodal agency for preventing and controlling dengue i.e. the NVBDCP. As the suggestion flew across, my mind struggled with the troublesome question of access. Unlike an earlier time when I had undertaken a small survey at Chota Hasanpur Village in Patparganj, Delhi[14], accessibility was not a worrisome issue as I was “studying down” and my position as a sociologist was valorised. However, doing fieldwork in such spaces was problematic on two accounts. These spaces are highly bureaucratic, and they function only via ‘contacts’. Sherry Ortner in her article ‘Access: Reflections on Studying Up in Hollywood’ (2010) elucidates her attempt at gaining access to powerful people in the Hollywood industry. She describes that despite having gained access to some initial contacts and references from her earlier high school graduating class and immediate family, most of her attempts at getting through these people were rebuffed. They didn’t respond back to her messages or attend phone calls. I had my own set of formidable experiences at getting access to the NVBDCP.

My co-supervisor had been a colleague of Dr. L, the then Director of NVBDCP. She referred me to Dr. L via email and requested him to fix an appointment to meet and discuss the guidelines regarding public-private partnerships in dengue prevention and control. Dr. L being a busy man referred me further to Dr. B, the then Additional Director of NVBDCP. However, I didn’t receive a response from Dr. B for about five days; and after repeated reminders and an

[10] “Studying Down” in anthropology implied observing and studying people considered to be less powerful and privileged than the anthropologist studying them. (Hannerz 2010)

[11] “Studying Sideways” encapsulates studying those like anthropologists situated in different transnational locales with perhaps different interests. (Hannerz 1998)

[12] By official discourse I imply both the government as well as the private officials interviewed, and the documents received from them on existing public-private partnerships.

[13] My usage of the term ‘approach’ should not be viewed in the negative sense of the term. It is indicative of the problems ensuing “studying up” in anthropology.

[14] In 2016, during my MPhil coursework as a part of the paper on Methods of Social Science Research I had undertaken a small survey in the nearby slum to analyse healthcare access for the poor primarily focussing on dengue. The survey was designed to capture the issues of accessibility across class, age, gender and citizenship.

exchange of emails spanning three more days I finally got an appointment with him. Therefore, what worked in my favour was a direct contact with the highest authority within that organization that led me to my field with relative ease, which otherwise would have been impossible.

> These and many other dead-end experiences made me reflect on the question of trying to gain access via 'contacts'. I have come to realize that probably every human being in Los Angeles has a contact in the industry [Hollywood], and is happy to give me a name and number, or even to make the initial contact with that person on my behalf. At first I thought I should follow up on all of these leads, and perhaps I should have. Yet the *Survivor* experience made me think a little harder about that. While it is probably true that some kind of approach through contacts is inevitable, it now seems to me that if the person being contacted is merely doing somebody a favour, they are very unlikely to make something really happen. They either don't call back like JB after the first time, or they pass one down the food chain till one finally reaches someone who is so far from the original contact that the whole thing is irrelevant to them- and that final person doesn't call back (Ortner 2010: 217)

Ortner's ordeal is reflective of two pertinent issues. First, of course is the issue of accessibility. Second, as witnessed in the recalcitrant behaviour of those in the film and TV industry manifested in the form of a lack of interest, an "insiders interest" as Ortner would describe it. An interest that is either pragmatic or driven by curiosity i.e. from whom the anthropologists expects to gain knowledge pertaining to her research topic implicitly reckons some benefit. Or in another case is curious and genuinely interested in the work being done and for which they are approached. If I were to ponder upon these two concerns that Ortner raises with respect to her study on Hollywood, then there is one prime concern that comes to light in the context of my study. For the NVBDCP, an amateur anthropologist like me was of no interest either intellectually or practically, and it was merely a response in the name of the contact person i.e. my co-supervisor. However, such a sweeping assertion can be repudiated as prima facie evidence; and I shall briefly recollect my initial experience at NVBDCP. As mentioned earlier, my first point of reference within the NVBDCP was Dr. B who in my first meeting referred me to a contractual consultant within the organization, Dr. G for any information that I was seeking. However, Dr. G assumed that I was expecting him to guide me through my MPhil dissertation rather than seek government data or existing action plans about public-private

partnership in dengue; and can be described as an expectation miscommunication. Moreover, in my questions towards existing PPP guidelines for dengue prevention and control, Dr. G being a new entrant into the organization was rather perplexed. In his response, he said he would discuss the same with Dr. B and suggested I get in touch with him in a week by providing me his email id and phone number. Unfortunately, he never did, and I too didn't take it up with rigour. Dr. B in his genuine efforts to guide me through and for the information I sort, connected me with a contact that was at the "end of the food chain" as Ortner calls it. He didn't possess the relevant knowledge, and his interest was primarily inclined towards responding to the contact person.

2.2 A Dated State[15] Advisory and Non-State[16]Repudiation

In an attempt at comprehending the existence of a public-private partnership for dengue prevention and control in Delhi, the next step was to probe into the 'testing' segment[17]. Dengue is caused by *Aedes Aegypti* virus and affects people across India, with a total of 1563635 cases and 226 deaths in 2017 itself.[18]Till date, we do not have a vaccination to prevent dengue, coupled by the fact that one of the most fundamental problems when it comes to dengue fever is the fact that it's symptoms only appear in the patient after an incubation period of 3 to 5 days. Till then the patient does not know whether she/he is suffering from dengue or any other infectious diseases, or perhaps from simple viral fever. Furthermore, the doctor also does not know what course of action to take except giving paracetamol initially. Thus, early detection, case confirmation and differential diagnosis from other infectious diseases is of paramount significance. There are two types of tests that the Government of India recommends i.e. NS1 antigen and MAC ELISA test for detecting dengue. However, there is also the Rapid Diagnostic Test (RDT) which however results in higher false positives, thus lacking accuracy. In 2015, the Government of Delhi capped the rates at Rs 600 and Rs 100 for the NS1 antigen test and platelet count, where previously the tests were priced at Rs 1500-2000 and Rs 200 respectively.[19] This mandate however affected private labs at a huge scale.

[15] The term here refers to the state government i.e. Delhi.
[16] Non-state here implies the private health sector, more specifically the private lab owners.
[17] See the Mid Term Plan for Prevention and Control of Dengue & Chikungunya 2011-2013, Directorate of National Vector Borne Disease Control Programme. http://nvbdcp.gov.in/Doc/Mid-Term-Plan-Dengue-Chikungunya-%202011-13.pdf
[18] Source http://nvbdcp.gov.in/den-cd.html
[19] Source https://timesofindia.indiatimes.com/city/delhi/Govt-caps-dengue-test-price-labs-protest/articleshow/48992271.cms Dated: 17.09.2015

With this knowledge I went on to visit and interview some private lab owners across various districts of Delhi to comprehend their stance on the released mandate. I knew the mandate I was referring to was two years old, but I had not got any leads on the same from the NVBDCP, hence I decided to take this up as the starting point of venturing into what could be a potential public-private partnership for dengue prevention and control in Delhi. The flexibility of possessing a direct contact helped me get across one of Delhi's well known private lab owners i.e. Dr. H of Dr. H Labs in South Delhi. Some excerpts from my interview with Dr Dang are illustrative of the problems with any PPPs.

Me: Dr. H*, could you take me through the history of PPPs in dengue prevention and control as I have heard that you were a part of a committee set up by the Delhi government?*

Dr. H*: There is no committee for the prevention and control of dengue. Each year we (private labs) receive a farman (notification) from the government to cap rates for the dengue test. That is the only PPP when it comes to dengue which cannot be accounted for as PPP and can be merely clubbed as outsourcing. We do not have PPPs in dengue as is the case with tuberculosis, which is a fantastic PPP.*[20]

Me: Then what is the current system of management? Do we see management on an individual scale?

Dr. H*: As mentioned earlier we get a notification each year around the monsoon season to cap the rates for the dengue test. If I adhere to this notification, then my profit either gets reduced or is negligible. More importantly, there are patients coming to me and I have a reputation to maintain. I have spoken on public forums about the lack of infrastructure and funds in public hospitals. But does capping rates help in preventing the disease? Is it getting controlled? Is the problem of the patient getting reduced? If the government must seriously take up this issue, then it needs to install enough PCR machines and provide subsidies to the private sector. The biggest issue however remains lack of timely payments which thwarts any possibility of PPPs.*

From this conversation we can extrapolate that Dr. H resonates his rejection for the government mandate within lack of a formal contract, subsidies and payments. In this sense, his views on

[20] Dr. H's usage of the word 'fantastic' led me to probe further into the existing PPPs in TB. To investigate its success on ground I looked up a key report titled 'Role of NGO's and Private Providers in the Revised National Tuberculosis Control Programme: A Study on the Implementation of Public-Private Partnership Strategy in Tamil Nadu and Kerala (India)' by Vangal R Muraleedharan, Sonia Andrews, Bhuvenswari Rajaraman, Stephen Jan, Indian Institute of Technology (Madras), April 2005.

PPP are in tandem with Ramesh Bhat as put forth in his article 'Issues in Health: Public-Private Partnership' (2000) on two accounts as discussed in the previous chapter. Firstly, they both argue that for a PPP to be effectively rolled out, the private sector needs subsidies from the government in any form i.e. initial medical equipment, etc. Secondly, even if PPPs are put in place public spending cannot be reduced as we require a strong public health infrastructure.

However, my interview with Dr. L [21], the now director of National Centre for Disease Control (NCDC) lent voice to the implementing agency. While referring to Dr H's insistence on no recommendations taken from private lab owners regarding the mandate, Dr. L made startling observations. Firstly, he said that a list of private labs was taken on board which included the likes of Dr. H of Dr H's Lab and Dr. X of X Pathlabs. In a meeting (date not mentioned) they had agreed on reducing the rates for the dengue tests as well as ruled the platelet test as unnecessary. Secondly, while he stated, *"yeh sach hai ki private labs badmaashi karrahein hain"* (It is true that private labs are engaged in foul play when it comes to capping rates) he resonated with the larger narrative surrounding the inclusion of private health sector i.e. new technology, methods, funds and manpower which the public- sector lacks. (Mathur 2003; Bhat 2001; Raman & Bjorkman 2017) Finally, regarding the mandate he relegated to the strategy of persuasion as the only way to convince private lab owners into following the mandate.

As stated earlier, to capture the views and opinions on reducing the price of the dengue test, I intended on interviewing private laboratories owners across Delhi. More so, Dr. H was based in the posh area of South Delhi whose clientele belongs to that class for whom standards could not be comprised. Hence, to map opinions in a space which comprised of a mixed class I visited a few laboratories in West and East Delhi. The objective of doing so was implicitly situated in Dr. H's outright proclamation of my research being flawed. Nonetheless, there were two major issues that I was confronted with. Firstly, none of the pathology lab owners were willing to disclose the rate they were charging for the dengue test. Secondly, my initial idea of doing an observational analysis across labs almost seemed like an impossible proposition. Sherry Ortner (2010) in fact raises this concern in her study of Hollywood stating that participant observation as a research technique is an impossible proposition in studying up the social structure.

[21] While it was true that Dr. L was a contact of my co-supervisor which provided me with initial access; he was not merely doing a favour in the name of the contact person but possessed immense curiosity in the research I was undertaking. Moreover, his ability to give information pertaining to the mandate on capping rates lay in him having left the directorial post at NVBDCP.

The system of appointment is perhaps a latest entry into the field of anthropology, and Ulf Hannerz in his essay 'Field Worries: Studying Down, Up, Sideways, Through, Backward, Forward, Early or Later, Away and at Home' in the book titled 'Anthropology's World: Life in Twenty First Century Discipline' (2010) argues that anthropologists have generally been involved in the process of going 'out there' into the field, far away from home and being completely immersed. However, as we take up studies that involve multi-sited research we need to start thinking in terms of what he calls a "polymorphous engagement", referring to the ever -shifting diversity of the field worker's craft (p. 77). One could say, that it involves the intertwinement of one or more research methods; and unlike an earlier time where "interactions in the field, in other words, are often limited, regulated, and timed. We may indeed have thought of the classic ideal of participant observation as "anthropology by immersion", an involvement so deep that the supposed risk was one of "going native" (hardly anybody did). In contrast, we now hear of "anthropology by appointment"- with some irony or self- irony no doubt intended." (p. 77). Not particularly relevant to the discussion here, nonetheless thought provoking is Hannerz's discussion on how those practising an "anthropology by appointment" are viewed as lacking personal engagement, having faced hardships and hence not a real anthropologist. It is assumed that "anthropology by appointment" is an easier research proposition than "anthropology by immersion". Paradoxically, I have highlighted earlier and shall further too show that an "anthropology by appointment" is equally riddled with the problems of access and rapport as experienced in "anthropology by immersion".

To deal with the first mentioned issue I executed an alternative plan i.e., I acted as if I was a patient suffering from dengue and telephoned these labs that I had earlier visited. From those phone calls it was re-instated that none of these labs were adhering to the mandate of the Delhi government precisely on the account of no return on investment if they were to do so. Hence, the possibility of identifying a potential PPP within 'testing' seemed grim and I thus moved to NVBDCP documents to locate government initiatives at various levels to partner with the private sector.

2.3 Official Documents on Dengue: Strategies towards Impending Risks

This section is an attempt at exploring the methods outlined by the NVBDCP for effectively managing and controlling dengue from the conceptual categories of prevention, preparedness and pre-emption. As we shall see, it covers the steps to be undertaken in case of an emergency outbreak and the need for developing partnerships.

Before I delve into how policy makers conceptualize the management of dengue, I shall briefly examine the notion of "impending risks" as the title of this section suggests. The idea of 'risk' has been explored by scholars such as Ulrich Beck postulated in his book 'Risk Society: Towards a New Modernity' (1992) which is premised on the seminal argument that modernization may create opportunities and aspirations, but is inherently prone to risk, danger and threat to security in its various facets of life. He takes up Giddens assertion in his book 'Consequences of Modernity' (1991) on the existence of "environments of risk" that collectively affect a larger section of the population such as a nuclear war followed by the alternatives borne in mind by the individual and the system in operation. According to Beck (1992), 'risk' can be defined as the hazards and insecurities introduced and induced by the process of modernization which have transcended from being statistically calculable to unpredictable, incalculable and uncertain. With this backdrop I explore the categories of prevention, precaution and preparedness.

2.3.1 Multitudes of Risk Technologies: Prevention, Insurance, Precaution, Preparedness or Pre-emption

Robert Castel's essay, 'From dangerousness to risk' (1991) argues how preventive strategies are structured. He states **prevention** as a strategy is constructed on a set of objectively existing heterogenous factors premised on statistical indices to mitigate probable risks and design policies.

> Each index is defined by a specialist formation (economics, medicine) in relation to a norm specific to that domain and against which goals may be set and success measured (annual income, mortality rates, life expectancy, etc.). The preventive measures will then operate as a political extension of the concerned specialist domains (economic analysis extended into politics as aid and development, medicine extended into vaccination programs, etc. (Massumi 2007)

Therefore, prevention is epistemologically located in identifying threats and applying appropriate intervention, but it has no ontology of its own and derives its logic from an exogenous source. (Massumi 2007). With prevention, **insurance** is another mechanism to mitigate risk. The anticipation of a casualty, illness, injury leads to strategies of insurance that are further classified into statistical regularities with the application of calculus of probability (Ewald 1991). These applied on a population over a period of time can convert the likelihood of an exceptional event into a predictable one (Lakoff 2007). If such is the case then, insurance

technologies can be a source for preventive interventions, that over a period can gauge and assess the probable occurrence of an event at a given point in time.

These "security rationalities" as Lakoff argues in his essay, 'Preparing for the Next Emergency' (2007) are further accompanied by the notion of **precaution**. Lakoff referring to Beck (1992) argues that as we enter the period of modernization we are shifting to a world of unquantifiable risks. The profitability of industrialization witnessed in the advancement of human welfare is now subjected to several threats. Considering threats in the form of ecological catastrophes such as the Bhopal Gas Tragedy and Chernobyl, Beck states that the damage caused by these catastrophes can be irreparable with effects of unlimited duration. This illustration of impending and irreparable doom is further taken up by Ewald (2002) who introduces the logic of 'precaution'. He is of the view that in an uncertain world that we come to occupy today several health and environmental hazards such as global warming, genetically modified diseases etc no longer can be assessed in terms of a cost-benefit ratio. Their potentiality to produce irreversible damage which cannot be compensated for has led to the logic of 'precaution'. This is situated on a complete avoidance of taking risks on the account that an event within the zone of the incalculable, improbable and irreversible is to be feared; because "fear is the palpable action in the present of a future threatening cause" (Massumi 2007)

This uncertain world, Massumi (2007) argues is no longer a set of objective structures but built on potentialities. This is to say, the potential of a threat is encompassed in a "could have/would have" narrative, which eventually led to the American invasion of Iraq with potential threat that Saddam "could have/would have" weapons of mass destruction. This "potential politics" Massumi argues is the bases for the logic of **pre-emption**, or what Lakoff calls **preparedness**. These are applicable to threats that are outside the frame of calculability and probability due to a lack of knowledge that can be statistically mapped; or those threats that have not yet fully emerged and whose enemy is unspecifiable. The management of these future events operate in the present with real- time simulations, imaginative practices, constructing scenarios, etc. (Lakoff 2007) Operation Dark Winter (June 22-23, 2001) in USA carried out by the Centre for Strategic and International Studies, ANSER institute for Homeland Security, Oklahoma National Memorial Institute for the Prevention of Terrorism and the John Hopkins Centre for Civilian Biodefence Studies is one such example. They carried out bio-terror attack simulations in the potentiality of smallpox being used a biological weapon; realizing that in the face of an actual event, medical services and democratic procedures would crumble accompanied by civilian unrest. (Naraindas 2003b)

2.3.2 Mid-Term Action Plan for Prevention and Control of Dengue and Chikungunya 2011-2013: From the Lens of Security Rationality

My intention to bring forth notions of prevention, insurance, precaution, preparedness or pre-emption is to analyse how governmental intervention functions are coded in its public policy initiatives for prevention and control of dengue; simultaneously observing the levels at which partnership with the private sector is sought. In the Mid Term Plan 2011-2013 for Prevention and Control of Dengue and Chikungunya (2011), the government highlights five fundamental approaches to dealing with dengue prevention and control. a) Vector Surveillance, b) Laboratory Diagnosis, c) Outbreak Response, d) Intersectoral Collaboration, e) Behaviour Change Communication.

Vector Surveillance is premised on the twin process of environmental modification and manipulation wherein the former suggests physical transformation of land, water without causing any irreversible harm to the environment; while the latter indicates temporarily changing the potential vector habitats acting as breeding grounds. These activities include ensuring piped water supply to reduce reliance on water storage containers that are most common vector habitats (Gubler 2011); mosquito proofing of overhead tanks, cleaning flower pots, managing construction sites and discarded plastic waste. All these are considered the principal reasons in the increasing incidence and spread of dengue. The foregoing illustrates that the NVBDCP works primarily with the logic of insurance by relying on early warning systems brought in by the monsoon and post-monsoon season. It further counts on statistical indices such as house index (percentage of houses infected with larvae), container index (percentage of water holding containers infested with larvae) and breteau index (number of positive containers per hundred households investigated) for vector surveillance activities[22]. These are further utilized within intervention activities to map the incidence of dengue in an area and modify the environment accordingly.

However, preventive strategies by the NVBDCP also revolve around tackling an outbreak and *preparing* for an ‘Outbreak Response’. For doing so, it has constituted what has been termed as a Rapid Response Team (RRT) that has an interdisciplinary approach encompassing epidemiologists, entomologists, microbiologists/pathologist and IEC officer, consultant, media officer across states, districts and municipalities. The team has two primary functions i.e. technical and logistics. The former involves the collection of blood samples, specimen

[22] Source: http://www.who.int/denguecontrol/monitoring/vector_surveillance/en/

collection and storage. Meanwhile the latter largely focuses on the issues of travel that may be required as a part of the plan to prevent the further spread of the disease. To do so however, the government envisages undertaking capacity building programmes to train dengue and chikungunya clinics in the private sector to possess scientific knowledge and carry out effective laboratory techniques. However, first if a case comes to RRT then it should check whether it has been earlier reported in that area, compare and analyse any previous data that exists on it. If there is no data available, then the next step is to visit the affected area and gather information regarding clinical signs and symptoms, history of exposures and any other information that may help in unpacking the case for further investigation.

Besides resorting to the RRT, the government also undertakes large scale media plans executed via print and electronic media. The reason underlying such an initiative is rooted in the ability to communicate an impending risk through the media to procure public trust. Most importantly, within the media plan the emphasis is on behavioural change by socially mobilizing relevant individuals and organizations that can create awareness to prevent and control dengue. These social mobilization activities furthermore are a part of the set of IEC (Information, Education and Communication) activities whose objectives are not only to create awareness but mobilize the community, strive for sustainability and enhancement of resources. Interestingly as a part of the strategy to increase resources the government calls for 'intersectoral collaboration'. It aims to involve the health and non-health sectors (government as well as private), NGO's and local communities to share human resources or adjust existing policies of other ministries. For instance, in the eve of a dengue outbreak the education ministry can channel its existing policies in a manner such that schools can develop health clubs initiating preventive activities. Meanwhile, the ministry of urban development can prioritize its policies towards slums as they possess the highest chance of contacting dengue given their living conditions.

NVBDCP's elaborate envisioning of the steps to be undertaken in the event of a dengue outbreak suggests techniques of preparedness for maintaining order in the time of an emergency. To take swift actions for immediately controlling further transmission and eliminating breeding sites. This is reflected in the illustration of a coordinated response expected from the Rapid Response Team at a technical and logistical level, with further emphasis on the media management to spread awareness. In relation to preparedness, Lakoff states, "the duration of direct intervention by a preparedness apparatus is limited to the immediate onset and aftermath of crisis, but the requirement of vigilant attention to the prospect of crisis is ongoing, permanent" (2007:254). The latter missing within the NVBDCP's

preparedness apparatus because it works primarily within the frame of an insurance technology; only checking for preparedness and intensifying activities during the monsoon and post-monsoon period. But, Lakoff (2007) argues that there are limits to insurability wherein the probability of a threat can no longer be calculated to take appropriate preventive interventions. Take for instance, environmental hazards such as global warming that lead to unpredictable weather conditions, accompanied by untimely rain showers. This unpredictability is observable in dengue cases being reported in the month of January. Furthermore, the NVBDCP preparedness apparatus is relegated to paper, with no mandate for real time simulations to minimize dengue cases and deaths to ensure sustainability.

2.4 Prototypes for PPPs in Dengue Prevention and Control?

Before I delve into drawing a comparative analysis between disease programmes, it is important to highlight that one is not doing so to draw an analogy of difference, but to primarily showcase an analogy of similarities. I shall be focusing on two cases, a) Tuberculosis; b) Small Pox.

2.4.1 A Case of the Revised National Tuberculosis Programme (RNTCP)

> The literature on PPP in TB control should be seen as part of the larger debate on the role of the private sector in healthcare market in India. Ideally one may expect the PPP experience in TB to provide a basis for shaping PPP strategy in other required areas of health." (Muraleedharan et.al 2005: 2)

In my interview with Dr. H and the literature that I referred to in the previous chapter regarding PPPs in healthcare what came across affirmatively was, that if one were to comprehend the working effectiveness of PPP, an immediate reference was the Revised National Tuberculosis Control Programme (RNTCP). Such strong opinions led me to probe empirically whether the prototype of PPP in TB could be used for designing PPP interventions in other disease control programmes.

A significant report published by the Indian Institute of Technology, Madras under the title 'Role of NGO's and Private Providers in the Revised National Tuberculosis Control Programme: A study on the implementation of Public-Private Partnership Strategy in Tamil Nadu and Kerala (India)' (2005) by Vangal R Muraleedharan, Sonia Andrews, Bhuvaneswari Rajaraman, Stephen Jan looks into the extent of involvement of the private sector at various

levels of the scheme and the institutional factors that come to define it. Tuberculosis is one of the most infectious diseases affecting India[23] and to deal with this menace the Central TB Division of the Ministry of Health and Family Welfare has outlined the RNTCP. The RNTCP adopts the DOTs strategy of the WHO to ensure delivery of anti-TB drugs as well as ensuring that the protocols of the treatment as laid out within the scheme are effectively followed.

In most cases the initial point of contact for tuberculosis patients are private practitioners who do not follow adequate and standardized procedures. As a result, the poor who are also largely affected by the disease are faced with debt; and end up accessing public healthcare at a later stage spreading the disease further and possessing a high risk of drug resistance (Engel and Bijker 2012). Nonetheless, within RNTCP the Government of India has outlined a set of reasons for the incorporation of the private sector at various levels. In the first chapter, I had outlined several factors indicating the reasons for involvement of the private sector within a PPP strategy; largely spelt out in the usage of adjectives such as efficient, cost-effective, hi-tech facilities etc. Reiterating and substantiating on the same, Muraleedharan et.al (2005) cogently put forth the rationale for private sector inclusion into five set of arguments. The inclusion of the private sector within the RNTCP can be described as an "organizational innovation" (Engel and Bijker 2012) for the reasons outlined by Muraleedharan et.al in their study. Firstly, it is stated that the entire RNTCP scheme is predicated on the notion of high competency, increased efficiency and cost-effectiveness. It follows a shorter course spanning six months (for Category I and Category III) to eight months (for Category II patients). It is argued that RNTCP would help reduce the unnecessary consumption of drugs by TB patients and reduce the economic burden. Most importantly, by roping in the non-state actors the government believes the RNTCP regime can enhance its existing model of efficiency and cost-effectiveness.

Secondly, it is widely stated in public health literature that the first point of contact for most patients especially the poor are non-state actors (i.e. as understood by Muraleedharan et.al as independent private practitioners, for profit and not for profit organizations). In this case, the RNTCP believes that by capitalizing on this, it can enhance probabilities of access to healthcare. Several authors working in public healthcare illustrate the widespread prevalence of the private sector witnessed in the health seeking behaviour of the poor in urban India; and

[23] The WHO Global TB Report suggests that in the year 2016 there were an estimated 10.4 million cases of TB globally. Out of this 10.4 million and occupying 64% of the disease burden, India was ranked first followed by Indonesia, China, Philippines, Pakistan, Nigeria, and South Africa.

for whom it remains the first point of contact. Reasons for the same are resorted in the argument illustrated in the previous chapter i.e. even though public healthcare is free, it is imbued with issues of fragmentation, poor accountability, referral systems and staff quality (Barua 2005). Compounding to this set of factors is the daunting issue of 'urban literacy' that Barua and Singh in their paper, 'Representation for the marginalized. Linking the poor and the health care system: Lessons form case studies in urban India' (2003) elucidate as the unfamiliarity with the various tests prescribed and the impersonal environment at the public hospitals. . In such a scenario, the private practitioners are "the backbone of the 'health service' of the urban poor" due to issues of easy access, quality of treatment perceived to be better, affordability, convenient timings, all-time availability of doctors and ability to better communicate their issues in an informal manner and without a large set of information. This consulting style establishes a sense of empowerment in the patient that they fail to feel with a government doctor. (Barua 2005)

Thirdly, as mentioned in the previous chapter, Ramesh Bhat (2000) argues that the health expenditure of the government in the 1980's was phenomenally low. This shortcoming is also stated in the Mid-Term Plan for Prevention and Control of Dengue & Chikungunya 2011-2013 stating that the government suffers from the limited resources and further emphasizes resource pooling as discussed in the previous section. The thrust of the argument is surmised on the acceptance that the government has limited resources and non-state actors with its possession of resources embedded in infrastructure, personnel can increase access to healthcare. In making this point, Muraleedharan et.al claim that since the government does not have the infrastructural ability and the personnel that non-state actors possess, the RNTCP can be an efficacious PPP strategy. However, as elucidated in the previous chapter Amrita Datta in her article 'Public-Private Partnerships: A Case for Reform'? (2009) argues that if the state is the one that must dismantle its existing infrastructure and workforce to establish a PPP then it is risk bearing organization amongst the two i.e. state and non-state.

My purpose for reiterating Datta's vehement assertion presents a dilemma. The dilemma is, if the government indeed has limited resources to ensure equal access to healthcare while at the same time it must "dismantle" its infrastructure to enter into a partnership, what is the choice that it has in providing equitable access to healthcare to its concerned citizens? These questions however demand inquiry based on further theoretical and empirical research, remaining outside the scope of the present study.

Fourthly, since the RNTCP scheme is seen to be cost-effective as highlighted in first argument, it is believed that the inclusion of the non-state sector will decrease the cost of drugs. Under the RNTCP scheme the cost of drugs is free, whereas otherwise if patients accessed the private sector it would lead to a handsome expenditure. The fifth rationale re-iterates the efficiency that the private sector is said to possess leading to an increase in case detection (Engel & Bijker 2012; Baru & Nundy 2008)

The forms of partnership that the RNTCP takes can be divided into five schemes: Referral, Provision of DOTS, Microscopy and Treatment Care, In-Hospital Care for Tuberculosis Disease, Tuberculosis Model. In each of these schemes there are marked levels of inclusion of the private sector stating their role, the incentives provided. Keeping these niceties aside I shall reflect on the empirical findings of Muraleedharan et.al study of RNTCP in Tamil Nadu and Kerala[24] after having interviewed the major stakeholders in the programme i.e. state and district administration, NGO's, independent private practitioners, private hospitals and microscopic centres, DOTS providers that are largely community volunteers, state level policy officials and TB patients. Firstly, there is no formal contract with the private sector/ NGOs involved in the RNTCP. Each actor viewed this challenge with their own perspective. On the one hand, for a district official it meant that a lack of formal contract could hinder any monitoring and regulation of the private sector, who within most public health literature are viewed as profit making entities with misuse of public resources (Muraleedharan et.al 2005) While on the other hand, a view from the state official states that their lack of willingness to enter into any kind of formal contract is situated in the accepted inability to release funds on time to press further for such initiatives.

Secondly, the RNTCP and the private providers follow different courses of treatment, the former follow the DOTS strategy as mandated by the WHO, the latter however follow a shorter course with disparate modes of treatment. In some cases, as revealed from the Kerala chapter, private practitioners also prescribe non-DOTS treatment to richer patients who can afford to buy the medicines. The reasons for the same are attributed to the lack of faith in the efficacy of the DOTS regime by private practitioners or lack of training in RNTCP. Another reason could

[24] For the methodology undertaken for this study refer to chapter three of the report.

be the idea of profit driven intentions that the private sector is seen to possess in most cases and hence the adoption of the non-DOTS regime.

Thirdly, the incentives (in kind and grant) provided to private practitioners/ NGOs according to the scheme do not actually come through. Nonetheless, private providers are preferred by patients because they increase access to healthcare unlike the government clinics/ hospitals which have less working hours and are situated far away from place of stay increasing cost of transportation.

These are problems arising out of multiplicity of actors with different perspectives and practices, contributing to the complexity of PPPs as described in the previous chapter. And while the RNTCP was successful in the case of the Mahavir Project in Hyderabad it might not be successful in another locale. These challenges within the RNTCP as highlighted by Muraleedharan et.al (2005) in their research study are indicative of the dual problems of innovation and control within the TB programme as elucidated by Engel and Bijker (2012). While innovation within the TB programme are demonstrated with public-private partnerships, control practices such as supervision and management of healthcare providers, patients, technologies such as drugs and diagnosis and standardization of treatment procedures create a non-conducive environment for innovation. However, innovation and control are inseparable in TB programme primarily because, “Control of TB needs innovation in order to respond to changing challenges and opportunities, to be continuously critically assessed and negotiated, but also to respond to local contexts. Innovation for TB needs a certain amount of control in order to be replicable, transferrable and responsible.” (Engel and Bijker, 2012, p. 116) In other words, the organizational innovations within the RNTCP with regard to public-private mix needs to strike a balance with the monitoring and regulatory practices of the public sector; and the need for autonomy by the private sector.

With the foregoing problems highlighted within the RNTCP in Kerala, the question arises is whether RNTCP is a “fantastic” PPP; and blueprint for other PPPs in healthcare? Moreover, while RNTCP was successful in the case of the Mahavir Project in Hyderabad it might not be successful in other locales as observed from the challenges faced in Kerala. Therefore, to state that it can serve as a universal PPP prototype for all disease control programmes is problematic, questioning its methodological foundations devoid of context.

2.4.2 A Case of the Smallpox Programme

The prototype of small pox is cardinal to study unpacking disease prevention and control programmes on several accounts. It is not within the scope of this study to delve into all factors, and therefore the arguments raised remain centred on comprehending it within the paradigm of prevention and partnership. Some of the issues raised present a counter-narrative to the hypothesis drawn in the first chapter. The meta-narrative however, is empirically ensconced within how state policies work.

The story of the National Smallpox Eradication Programme (NSEP) adopted in 1958 dates to the eighteenth and nineteenth century with the advent of vaccination; which came in a tussle with the practice of variolation. Considering the vaccination-variolation debate, its trajectory and the shifts within the twentieth century, my intention is to examine the prototype of smallpox on primarily two interconnected accounts. The establishment of vaccination as a pure prophylactic; and ensuing from this the strategies adopted by the state (Indian or colonial) to maintain the rhetoric of vaccination. These two interconnected accounts provide further insight into preventive health policies in general because, "the introduction of smallpox inoculation from Turkey into England in the 1710s heralds the paradigm of prevention. Being rather alien it was absorbed within a paradigm of therapeutics and management of disease (Naraindas 2003a; Miller 1957, 1981). But with the advent of Jenner and vaccination, the paradigm of prevention is truly inaugurated and rules supreme" (Naraindas 2007: 52).

(a) Vaccination versus Variolation: Preserving the Rhetoric of Smallpox Vaccination in the Nineteenth Century

The advent of smallpox vaccination in 1802 and its subsequent failure to reduce the smallpox epidemic and deaths in mid-nineteenth century Calcutta sets off the colonial government into a flux. (Naraindas 1998) Harish Naraindas in his article 'Care, Welfare and Treason: The Advent of Vaccination in the 19th century' (1998) brings forth startling observations regarding smallpox vaccination undertaken under the colonial government. Referring to the Report of the Smallpox Commissioners (1850), Naraindas enquires into the commission set up following the epidemic in Calcutta in 1849. The colonial government to probe into its spread and the possible causes set up a commission for which the report was submitted a year later following the epidemic. In a rather interesting scheme of events with the commission headed by Duncun Stewart the reason was located within the native belief that vaccination no longer worked to which the epidemic of 1849 added weight. However, this reasoning was reduced to native

mendacity and superstition; and associated with the "murderous practice of inoculation." (Naraindas 1998: 68). The government in assuring "public welfare" pushed to outlaw this practice by pronouncing it as a treasonous activity. Naraindas argues,

> "The *Report* was a performative moment between the introduction of vaccination in India in 1802 and the compulsory national vaccination act of 1880. It represented one trend-the major one- that saw inoculation as a dangerous public threat that needed to be formally outlawed by an enactment. Not everyone agreed with this point of view. The commissioners attempted to orchestrate, through a series of questions directed mainly at the administrative minions of the state, resounding chorus that would call for the formal outlawing of inoculation and put in its place the 'benign' practice of vaccination. It ran headlong into someone who was threatened to queer the pitch" (Naraindas1998: 68)

As the drama unfolded the man at the edge was W.C Blaquiere, magistrate of Calcutta from 1800. The commissions efforts were in vain when Blaquiere blatantly refused to accept the existence of a law in 1804 recommending the outlaw of smallpox inoculation; and he further went on to assert vociferously that the government's efforts to establish the same law in 1850 wouldn't succeed either. His reason was embedded in its lack of effective workability among the natives. While in tandem with the commissioners on the method of smallpox inoculation being infectious and communicable in comparison to vaccination, the former took the disease while the latter lacked effective efficacy. While the report established the failure of vaccination within the natives are superstitious paradigm, it did make a note of the problem ensuing vaccination; with "the quality of the lymph, the sheer difficulty of keeping the chain of transmission alive by arm-to-arm vaccination, its availability in ample measure, and its dissemination and survival beyond seasons that proved both inimical both to natural smallpox and the vaccine lymph. Understandably, vaccination often failed." (Naraindas 1998 :70)

Naraindas' foregoing instance of a member of the colonial government audaciously refusing to accept the workability of vaccination in smallpox leads him to probe into the reasons for the same. Locating his argument within another of his articles on smallpox titled, 'Preparing for the Pox: A Theory of Smallpox in Bengal and Britain' (2003), he argues that vaccination was considered as a pure prophylactic while inoculation or variolation was embedded in a larger therapeutic structure; and this could be one of the reasons for the variolation being vouched for

by Blaquiere as well as an utmost reliance on it by the natives. But what was this therapeutic structure that Naraindas talks about? Referring to Holwell's often cited letter to the physicians in London, titled 'An Account of the manner of inoculating for the smallpox in the East Indies' (1767) he states that the practice of inoculation was only a moment in the larger scheme of things which categorised the therapeutic structure premised on patterned seasons and diet. (Naraindas 1998)

Holwell argues that largely the time of the year witnessing a change in weather was susceptible to smallpox; along with fish, ghee and milk which due to their inflammatory nature proved ideal and dangerous in smallpox spreading further. Along with abstinence on certain food articles, Holwell's therapy indicated cold bathing to bring on the fever followed by the opening of pustules as a part of the practice of inoculation (Naraindas 2003a). However, with the advent of vaccination the therapy of Holwell with inoculation as only one act amongst several was reduced to or conflated with the technique of inoculation and the worship of Sitala, and "as a synecdoche of Sitala, inoculation turns into a ritual craft" (Naraindas 2003a : 309), with the disappearance of the therapeutics, "cool regimen and free admission of air" (Holwell 1767). In other words, vaccination categorically resonates inoculation with religiosity, associated with the worship of Sitala, hence dangerous; while vaccination as an effective and safe mechanism. This discourse eventually led to the practice of inoculation being rendered as unscientific, embedded in religion; and labelling of its practitioners as mendacious (Naraindas 1998).

> The vaccinator, unlike the inoculator, was not a therapeutic specialist. The care of the individual was not his brief. His job was to render the patient *inert*. This was done by making sure the patient was successfully vaccinated. The successful vaccination had a dual purpose: it ensured the patient was indeed rendered inert, hence not a public threat; and it allowed the patient to become the site of a successful extraction of the lymph for continuing the transmission. Premised upon the notion of public health and public welfare rather than individual care, the repercussions of the failure of vaccination, while severe for the individual, were a statistical embarrassment to the vaccinator (Naraindas 1998: 71)

The aforementioned by Naraindas opens up for discussion two key issues, a) the practice of vaccination, b) the notion of collective welfare. In the introduction of my dissertation, I stated that a ubiquitously accepted notion is that a health crisis or an epidemic is expected to be the

state's initiative. Continuing into the first chapter, an anthropological appraisal of public policies highlighted Eisenberg's (2011) argument that public polices serve the dual function of entreaty and threat; drenched with hidden agendas and hierarchies. The practice of vaccination postulated on collective welfare implicitly showcases a language of returns and targets continued into the mass vaccination programme of the 1960s. At the outset, I'd like to mention that while the narrative on PPPs comprehends returns in the monetary sense of the term, vaccination returns implicitly put the (welfare) state under the radar too; and we shall see why.

Vaccination as a pure prophylactic with not the same elaborate therapeutic structure as inoculation had a poor take rate, and as mentioned earlier Stewart too at the end of the Report (1850) stated that the problem with vaccination was the quality of the lymph and the keeping alive the chain of transmission by arm to arm. Even though we have managed to eradicate smallpox by the 1980s, a fear looms large that in the event of a smallpox outbreak, the young non-immunized population shall be vulnerable as it is said to have a thirty percent strike rate (Naraindas 2007: 45). Nonetheless, the rhetoric of vaccination was sustained under the rubric of collective welfare, with extensive (threatening) efforts being taken to push and preserve it; and directed to abolishing inoculation altogether. Naraindas's (1998) detailed account of instances spanning nineteenth century vaccination efforts on the part of the colonial government in India reverberate the rhetoric of returns. Unlike inoculation where the whole regimen ending with the opening of pustules was done to evict the pox, vaccination emphasized the collection and further transmission of the lymph. Therefore, on the eighth day after vaccination, the vaccinated child was to be present at the vaccination depot for the medical attendant to check if the pock was ideal and unscratched to collect the lymph, for the which according to the Report of the smallpox commissioners (1850) the party bringing the child was paid two *annas* against each child. In this regard Naraindas (1998) states, 'The pock by then had become a new sacrament: an external visible symbol not only of an internal state but of the state" (1998:77).

Prior to this compensation however, when the state decided on voluntary and free vaccination to avoid vaccination being viewed as a form of inducement, there were threatening and harassing acts as the one of Jeewan Lall, the vaccinator in Bombay Presidency in late nineteenth century. An exception amongst all vaccination cases was of Mott, an assistant surgeon and superintendent of vaccination in the Bhurtpure state, where a *Bania* woman presented her child to Mott herself voluntary for the extraction of the lymph. Recounting the instance of Jeewan

Lall, Naraindas (1998) illustrates that since the mode of vaccination was from arm to arm, the vaccinated child on his return on the eighth day was to be taken from village to village for the further transmission of the lymph. The parents of the child were often wary of this procedure and did not want their child to be taken to the next village. Jeewan Lall, however demanded a bribe for not taking the child, a payment for the safe return upon being taken to the next village or the child stood with the Assistant Surgeon Gibb probing into this case stated that as a remedy the mother/father accompanying the child were to be paid a half a rupee as compensation for the time and effort lost. Interestingly, that was the amount that Jeewan Lall also took.. In hindsight, this system of compensation to thwart any further cases such as Jeewan Lall's who by hook or crook ensured that the child was brought on the eighth day to check if the disease was taken transpires two issues. Firstly, it of course was an attempt to preserve the rhetoric of vaccination and for the vaccinator to fulfil a target and show returns. Secondly, the state may have viewed compensation and incentives as a mechanism to not only include the natives within the ambit of vaccination but to use their services too. Naraindas (1998) surmises his observation on Mott's report, an assistant surgeon appointed as the superintendent of the Bhurtpure state. It stated an administrative reorganization wherein six native deputy superintendents were removed and with the money saved a new circle was established with a European superintendent as the head along with five native vaccinators and five assistants. The money saved in this reorganization amounted to about Rs 370. The reason behind this reorganization laid not in the lack of qualifications of the Native Deputy Superintendent, but the fact that he was extremely well-qualified to take up the role of a vaccinator which according to them was extremely mechanical. However, the government knew that the native doctors were the best vaccinators and decided to pay them Rs 15 more to retain them. (Gazette of India 1864)

The vaccination programme, as mentioned earlier was not only directed at its further transmission with compensation but to dispel the very act of inoculation which was the norm for the native, and definitely took. Hence, if not banished then the *ticcadar* (inoculator) was to be converted into and re-employed as a vaccinator so as to not interfere with the entire process. To one's surprise, the colonial government in "endorsing vaccination" to establish it as a superior practice in opposition to ritualistic inoculation led to a performative act. The theatrics

of Shoolbred[25], in this regard is illustrative of the extent that the state went to in establishing vaccination as *the* mode of prevention. The performance eventually led to the acceptance of the natives with their signatures as proof that vaccination was safer and efficacious in comparison to inoculation, preventing any epidemic. Such an assertion was problematic because it could cause the big-pox or the syphilis epidemic. It was only with the introduction of freeze dried vaccines in the nineteenth century that vaccines were said to be effective. (Naraindas 1998: 88)

(b) The National Smallpox Eradication Programme (NSEP)

In 1958, India adopted the National Small Pox Eradication Programme modelled on the global smallpox eradication programme premised on the mass vaccination strategy as mandated by WHO. Harish Naraindas in his essay titled, 'Crisis, Charisma and Triage: Extirpating the Pox' (2003b) argues that as a part of the mass vaccination programme the, almost eighty percent of the population was vaccinated. The year 1967 however, witnessed an upsurge of 80,000 cases in Southern India, which as figures show were equivalent to the number of cases in the year when the programme began. Pondering over these figures Naraindas argues that the success of the mass vaccination programme being limited to certain pockets led to a shift in strategy. The new strategy that came into existence surmised on "isolation, quarantine and vaccination" of which Pawapuri in Bihar was the prime example.[26]

This strategy differed from the mass vaccination programme practiced till the 1960s beginning from the 1802 in it being vertical strategy where all the existing resources of the state where invested into the eradication of smallpox. (Refer footnote 16, Naraindas 2003b). The new strategy that came into existence was fundamentally different from the earlier mass vaccination programme on the principle account that the it was engaged in charting individual smallpox

[25]Shoolbred, the superintendent of vaccine operations in Calcutta in 1804 indulged in a performance to proscribe inoculation and establish vaccination as a safe and superior practice. The performance went like this- in the year 1805, Shoolbred invited a few inoculators to witness an experiment wherein he inoculated two vaccinated children with smallpox matter. This was also accompanied by one of the inoculators inoculating his own vaccinated child, and another instance of Brahmin girl being inoculated after vaccination. (Naraindas 1998)

[26] Bihar was the "last hot spot of smallpox in the world", and in 1975 an impending smallpox disaster loomed at large. Pawapuri in Nalanda was the site of trouble as it drew pilgrims from all over India on Mahavir Jayanti. The fear that gripped the NSEP officials was that there would be a large set of pilgrims who would come and go, incubating the virus and spreading it further. To prevent from spreading it further, Dr Mahendra Dutta, the Central Appraisal officer of Bihar during the last stage of the NSEP came with an alternative strategy. The strategy was embedded in searching for each pilgrim that had crossed Pawapuri by referring to a register that was maintained, further used to notify states, districts and villages of the returning pilgrims. This eventually led to villages being cordoned off, turning momentarily into what resembles a quarantine, and with each pilgrim being vaccinated. (Naraindas 2003b: 428-429)

cases to maintain the percentage of population vaccinated, case fatality ratio etc. While the mass vaccination programme since its inception in 1802 has been focused on ensuring successful and unsuccessful returns on vaccination. Referring to William Foege's, 'Strategy of Smallpox Eradication' in the Swasth Hind (1975) Naraindas states,

> Earlier strategies of mass vaccination, although monumental in effort and often couched in a language of attack, with their mobile squads of 'attack teams' and 'mopping up teams' were essentially strategies of fortification and defence: 'defending the individual against the agent'. The new strategy in contrast was truly offensive: it focuses on protecting the country and the individual by eliminating the agent (2003:435).

"Eliminating the agent" was a detour to the virus via the patient; and in this process if need be the patient was finished which made the new strategy "truly offensive". As a part of this new strategy, the country was divided into endemic and non-endemic zones to search for smallpox cases with special squads put in place involving the entire health apparatus. The search for agent small pox was followed up by efficient reporting to the primary health centre (PHC) which was accompanied by chain of reporting to the district headquarters, the state, the Central Bureau of Health Intelligence, WHO Delhi and eventually WHO Geneva. Reporting was also assisted by revisiting the villages for further assessment that drew information recorded in the assessment forms provided to the team indicating putting forth questions such as - Had they seen a search worker? Were they aware of the reward being given if any case of smallpox was detected? Did they see a smallpox recognition card? The searcher with a smallpox recognition card acts as a point of departure for the inquiry into a pertinent issue if analysed in the light of dengue. It remains moot if the observations made here can be used to draw larger conclusions in the field of public health. But, the existence of similarities in the manner to combat a disease does raise concerns for further investigation on the concept of partnership. Take the instance of the 'special recognition card' depicting a typical case of small pox. Naraindas (2003b) raises the problem surrounding the smallpox recognition card within which fever and rash were a template to identify any case of smallpox. He argues that small pox was the part of a class of exanthematous disease that was initially characterized by fever and rash; hence difficult to differentiate from chickenpox that had similar symptoms. In a scenario of confusion, a rumour register was maintained to prevent any misdiagnosis. It remained as rumour until verified by

clinical, epidemiological and laboratory investigation. Reflecting on this template to map the bodily manifestation of a disease, I shall take into consideration the case of dengue.

The NVBDCP has envisioned behaviour change as the primary approach to prevent and control dengue as seen in its various policy frameworks. As part of its Behaviour Change Communication (BCC) Kit it has designed several posters, leaflets, tin plates, illustrating the key symptoms of dengue and the various methods to prevent it. Now rather interestingly, dengue is a viral infection and malaria a protozoan infection symptomatically differentiated by body chills (Figure 3) but with recurrent high fever. This is further complicated by viral fever that has more or less the same symptoms as dengue and malaria but lasts only about three days. Not to ignore, all three inevitably have weakness and high fever as a necessary symptom.

My intention at focussing on this epidemiological information is that the NVBDCP outlines and disseminates to the general public (I use the term general public as against public because this research places ‘public’ as an organizational category) raises two concerns. Firstly, while in some cases it outlines body chills as the distinguishing feature in malaria, it also states weakness as one of the main symptoms (Figure 1). The description of these symptoms is problematic since weakness can accompany any disease and not only a mosquito infected one. Secondly, it does provide a list of symptoms indicating dengue, but for dengue and malaria both high fever is the defining criteria (Figure 2), Ensuing from these concerns, unlike the searcher in small pox who to prevent misdiagnosis enlisted that case in the rumour register, here can we say that this is indicative of the process of self-diagnosis? The question that arises in this regard is whether the patient is really willing to self-diagnose a disease? Even if he is willing, will he go and report it? These are questions located in the argument that the patient is mostly non-compliant. We shall see in the next chapter that we have a list of community workers who despite the public presence of these posters, leaflets, etc are instructed to conduct household to household visits, ensuring that the actions enlisted by the NVBDCP for the vector control are followed.

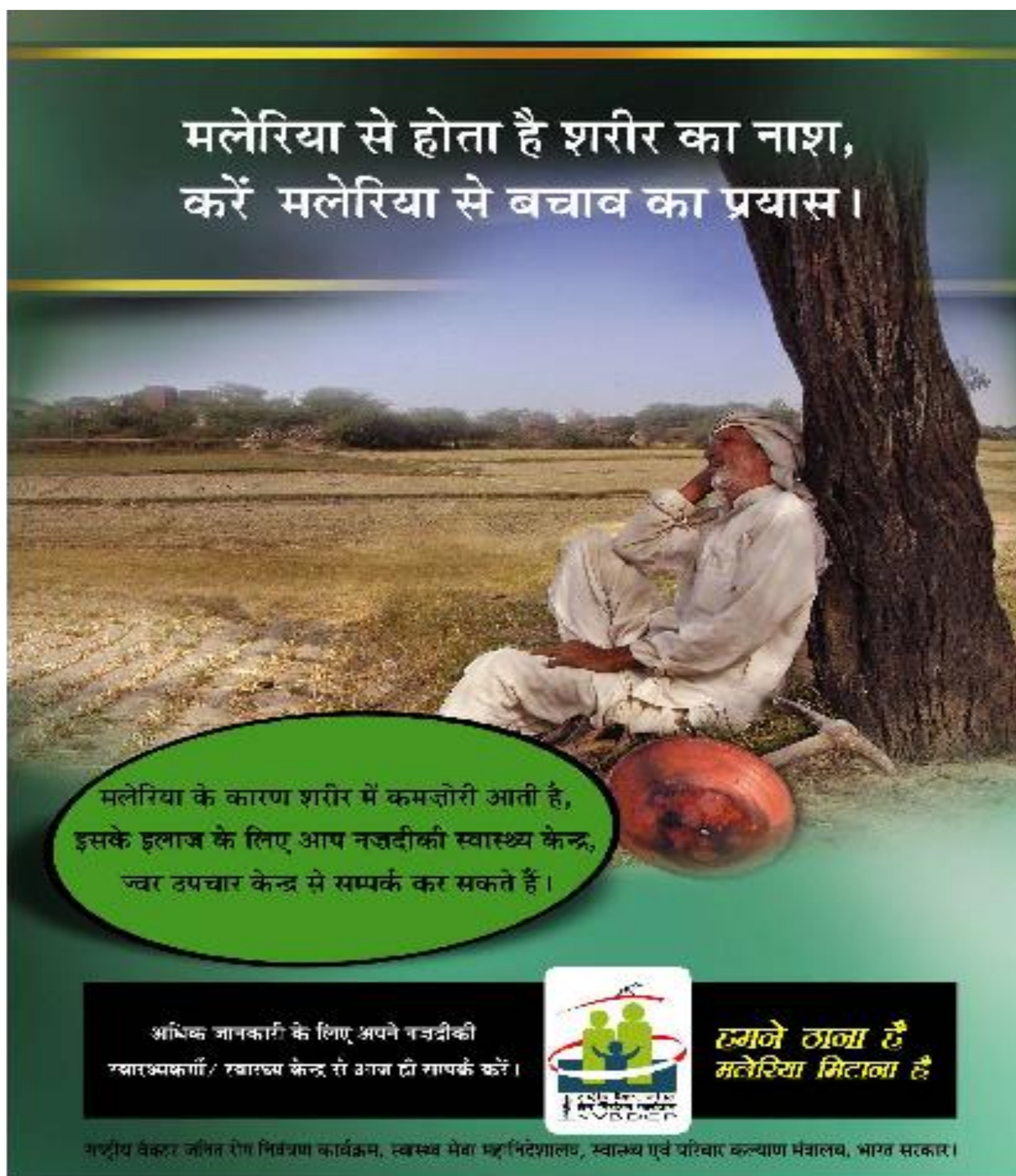

Figure 1- depicts bodily weakness as one of possible symptoms of malaria
Source: Behaviour Change Communication Tool Kit on Control of Malaria and Dengue (Poster) http://www.nvbdcp.gov.in/Doc/Posters.pdf

डेंगू कैसे करें पहचान, कैसे रहें सावधान।

डेंगू के लक्षण

डेंगू के लक्षण
- अकस्मात तेज़ सिर दर्द व बुखार का होना
- मांसपेशियों तथा जोड़ों में दर्द होना
- आँखों के पीछे दर्द होना, जो कि आँखों को घुमाने से बढ़ता है
- जी मिचलाना एवं उल्टी होना
- गंभीर मामलों में नाक, मुँह, मसूड़ों से खून आना अथवा त्वचा पर चकत्ते उभरना

कैसे बचें।

- डेंगू फैलाने वाला मच्छर खड़े हुए साफ़ पानी में पनपता है। कहीं आपके घर में या आसपास पानी तो जमा नहीं है? जैसे कि कूलर, पानी की टंकी, पक्षियों के पीने के पानी का बर्तन, फ्रिज की ट्रे, फूलदान, नारियल का खोल, टूटे हुए बर्तन व टायर इत्यादि।
- पानी से भरे हुए बर्तनों व टंकियों आदि को ढक कर रखें।
- कूलर को खाली करके सुखा दें।
- यह मच्छर दिन के समय काटता है। ऐसे कपड़े पहनें जो बदन को पूरी तरह ढके।
- डेंगू के उपचार के लिए कोई खास दवा या वैक्सीन नहीं है। बुखार उतारने के लिए पैरासीटामोल ले सकते हैं। एस्प्रीन या इबुब्रेफेन का इस्तेमाल अपने आप ना करें। डाक्टर की सलाह लें। डेंगू के हर रोगी को प्लेटलेट्स की आवश्यकता नहीं पड़ती।

राष्ट्रीय वेक्टर जनित रोग नियंत्रण कार्यक्रम, केन्द्रिय स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार।

Figure 2- outlines the symptoms of and preventive methods for dengue.
Source: Behaviour Change Communication Tool Kit on Control of Dengue.
http://www.nvbdcp.gov.in/Doc/PosterDengue.pdf

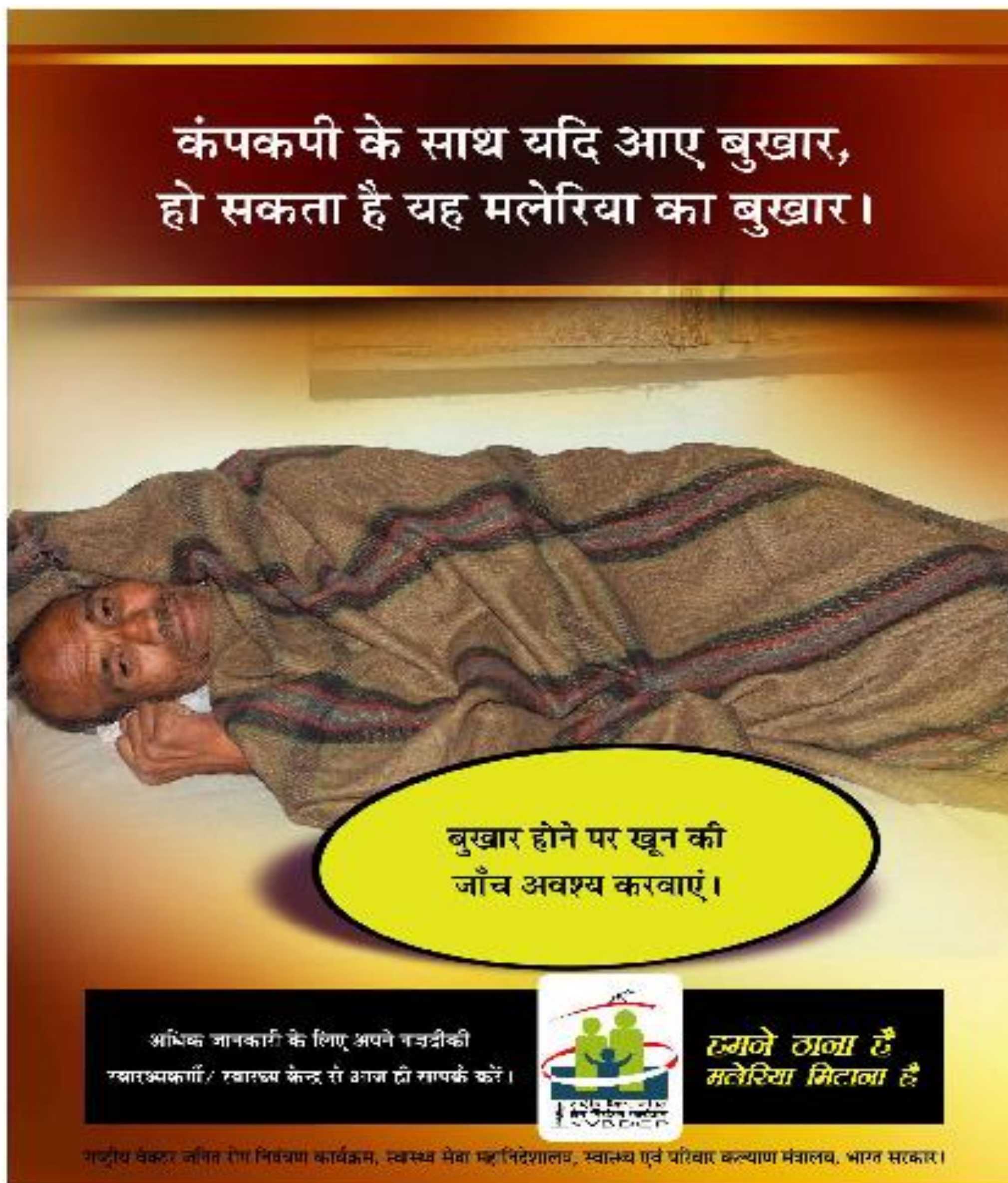

Figure 3- (a man covered with a blanket) pictorially depicts shivering as a possible symptom of malaria. Source: Behaviour Change Communication Tool Kit on Control of Malaria and Dengue (Poster) http://www.nvbdcp.gov.in/Doc/Posters.pdf

(i)Rummaging the Narrative of the State being Bureaucratic: A Case from NSEP

In the previous chapter, my first hypothesis from the literature reviewed on partnership asserted that partnerships can fail because of the state having a hierarchical and bureaucratic approach. Such sweeping claims can be problematic primarily because and as evinced from the case of smallpox wherein Naraindas (2003b) illustrates how this whole narrative can turn topsy-turvy. The illustration is of an "imprest account". In the year 1973, the programme was labelled as a campaign, an Intensive Campaign; and 1974 marked the entry of Mr. J, a senior epidemiologist who was asked to take charge of the East and West Champaran districts of North Bihar. Bihar being at that time the last hot spot for small pox cases. Tiwari Mr. J was sanctioned two junior epidemiologists who were provided with a jeep, a paramedic and a driver to fulfil the goal of surveillance and containment.

> Since surveillance and containment, built on the axes of space and time were operative grids, it called for a structure of responses that was both immediate and flexible. It called for delegation of responsibility and a devolution of power where the 'man on the spot' was at once a bricoleur and part of a larger centralized network toward which he could turn and which he was supposed to constantly keep informed…… (Naraindas 2003b: 446)

The "man on the spot" was Mr. J symbolic of a percolating power provisioned because of the imprest. Narrating from his personal interviews with Mr. J, Naraindas elucidates that Mr. J and his team were provided with a fixed sum of money that they were free to utilize for reasons that seemed necessary and appropriate. All they had to do was periodically submit the accounts from the otherwise tedious process of sanctions; in case they needed more money, it was given and no questions were asked. The imprest was a classic example of the dissolving hierarchy at the behest of a financial flexibility accorded to a field officer, that eventually resulted in efficiency and quick decisions. While the imprest is fundamentally an "antithesis of a 'sanctioning' bureaucracy" and reflective of a counter narrative it also raises one pertinent observation, i.e. the difference between 'control' and 'eradication', terms that are laced within the language of all such programmes. Mechanisms of 'control' are largely based on supervising or managing the course of events or behaviour of people; while mechanisms of 'eradication' are directed at eliminating and destroying all instrumentalities of trouble to meet the stated goal. In this sense, eradication programmes can adopt adverse and drastic means in comparison to control programmes. If this were to be the case then can one say that such possibilities exist?

However, they are confined to the sphere of such extreme scenarios, i.e. those of eradication programmes.

2.5 Community Participation as/is PPP?

“These are merely jargons for us, you may call it anything” (Dr. L, 14th December 2017)

For Dr. L , the ‘private’ encapsulated the Resident Welfare Associations (RWA’s), Mahila Mandals, Arogya Samiti; anything that could be classified as non-governmental. In putting together this notion of the private, what came to the fore was the ‘Strategy for Effective Community Participation in Prevention and Control of Dengue’ formulated by the NVBDCP in May 2017. This strategy emphasizes the reduction of vector habitats through BCC and with the help of the “community”. To further probe into Dr. L’s claim pertaining to the mandate I met Dr. D, the nodal officer for dengue in Arunachal Pradesh, Kerala and J&K. She re-emphasized the importance on source reduction and elimination as a part of the preventive term plan for dengue; with early diagnosis only being a part of a larger plan. In some sense, this hinted at a shift in focus from laboratory diagnosis involving the private sector to vector surveillance involving the “community”. About PPPs however, there were three important remarks that were made. Firstly, PPPs were under the jurisdiction of the state government, and were prepared by the NVBDCP only if asked to do so. Secondly, post a setback in PPP’s for malaria, various state governments haven’t really pushed for PPPs in dengue. Thirdly, each state’s health budget is reflective of the lack of funds to be redirected towards such partnerships. Exploring the nuances of the above however, remains the subject matter of the next chapter wherein shall critically discuss the notion of “community participation”.

2.6 Conclusion

Policy frameworks and voices outlining preventive mechanisms for dengue reinstate that each actor involved in this programme has its own perspectives and practices regarding laboratory techniques, diagnostics, national guidelines and policies. However, it would be anthropologically unconscious to assume that each of these actors possess certain inherent characteristics that affect possible partnerships as observed from the case of the smallpox programme.

These preventive and control programmes highlighting organizational idiosyncrasies shed light on the shifts occurring within the narrative of PPPs as a panacea for transforming the current public health scenario. Within partnerships, the private sector is co-opted for reasons embedded within efficiency, improved technology, resources and accessibility. However, their profit driven orientation unchanged by government persuasion; coupled by lack of funds on the part of the public sector has expanded the category of the 'private' to include what has been termed as the "community". While it is not within the scope of this chapter to assess the profitability of this prevention and control measure, it does lend insight into the reformative and development discourse surrounding PPPs. However, it shall be interesting to see if this proposition oriented towards involving the community is 'new' in terms of its approach or in terms of the actors now involved?

This shift not only brings in question the dispossession of actors, but also that partnerships by policy making agencies such as the NVBDCP are sought as a part of an emergency response and not as an ongoing process. This approach highlights two issues. One, it brings to fore that preparedness as a security mechanism is only visualized and institutionalized when dengue reaches epidemic like situations. Two, even though within the logic of preparedness partnerships are sought owing to paucity of resources and to mitigate case fatality; 'checks' on such partnerships are done at the time of increased incidence.

Most significantly however, an anthropological appraisal of these public policy frameworks and disease control programmes iterates the language of experts becoming more than apparent here in the context of all disease control programmes i.e. tuberculosis, smallpox and dengue. The WHO and its national counter parts insistence on the DOTs strategy, vaccination strategy and the collaborative strategy respectively problematizes the methodological foundations of such programmes; and its replicability in the 'local' being impervious to the context of public health in India.

3. Community Participation in Dengue Prevention and Control: Partnership, Empowerment, Governance?

> "Success of dengue control programme is *directly related* (emphasis added) to community participation and ownership" (Mishra 2017: ii)[27]

Of the many approaches directed at preventing and controlling a disease, the public health circle advocates strongly for community participation. The policy makers at the National Vector Borne Disease Control Programme (NVBDCP) have taken this as the primary approach to tackle dengue post a setback that PPPs have faced for reasons outlined in the previous chapter. It is translated into a recently published document titled 'India Fights Dengue: Strategy and Plan of Action for Effective Community Participation for Prevention and Control of Dengue' (May, 2017) In conjunction with this document that came to light during my interview with Dr L, this chapter delves into the historical, conceptual and empirical nuances of the term community participation.

Keeping in mind the arguments raised in the previous chapter, this chapter unfolds the idea of community participation by sociologically exploring the terms 'community' and 'participation'. Each of these terms have traversed the interdisciplinary boundaries of sociology, political science, development studies and public health, lending meaning for its effective implementation. In the attempt to theoretically map the connotations these terms come to acquire, the aim is to identify shifts, if any in juxtaposition with the document on community participation by NVBDCP. Notwithstanding a shift merely in terms of how 'community' and 'participation' are conceptualized separately, but how 'community participation' in toto is comprehended.

An exegesis of 'community participation' however does not remain confined to a sociological analysis of each of the terms it comprises. But, as I argue can be contextualized within the Foucauldian contours of "modern governmental rationality". I shall place the concept of 'community participation' within the Foucauldian framework to shed light on notions of 'agency', 'responsibility', 'empowerment', 'active partners', etc in tandem with the relationship between preventive healthcare policies and state practices.

[27] C.K Mishra, Secretary, National Health Mission, Ministry of Health and Family Welfare.

3.1 'Community' *in* 'Participation' *as* 'Partners'?

The audacious proclamation of Dr L on PPPs involving within its fold the 'community' and the shift that has occurred with the current emphasis on community participation in elimination of breeding source; act a point of departure to investigate the nuances of participation. I categorize these nuances at the level of forms and intentions of participation, and the emphasis on an incentive structure. This section serves as a passage into its co-option within public health and specifically by NVBDCP for dengue prevention and control.

3.1.1 Sociological Roots of 'Community': Tonnies's *Gemeinschaft*

The concept of 'community' has been of anthropological interest and study since the beginning of the discipline. An insight into the existing and pertinent understandings of 'community' shall throw light on its appropriation in the health service system, particularly within dengue prevention strategies charted out by the NVBDCP. Ferdinand Tonnies's *Gemeinschaft and Gesellschaft* (1887) translated and edited by Jose Harris as 'Community and Civil Society' (2001) elucidates the parameters of a 'community'. To begin with, Tonnies outlines a general theory of *Gemeinschaft* (community) *and Gesellschaft* (society) stating them to be "opposing forms of human social organization"

In the essay titled 'The Theory of Gemeinschaft' (2001), Tonnies defines *Gemeinschaft* on the parameters of familiarity, comfort, exclusivity, genuineness, endurance and more so, as an old entity; while *Gesellschaft* is seen as a superficial, transient and new entity. "Thus *Gemeinschaft* must be understood as a living organism in its own right, while *Gesellschaft* is a mechanical aggregate and artefact." (Harris 2001: 9) In its essence, community captures the unity of individuals occupying social organization by blood, by place or by spirit. The first two capture a sense of primary bonds within kinship or the family one is born into and living in the vicinity respectively. While community by spirit signifies working together for the same end and purpose. The latter holds unity at the level of consciousness in comparison to a unity bounded by space.

A community categorized by blood, place and spirit, is also marked by "mutual understanding". Mutual understanding is premised on the knowledge of another with a direct interests in one's life. It is also accompanied by a mutual possession of goods held in common. These are factors that create a sense of belonging and reciprocity within community life. However, for Tonnies

a community is also constitutive of authority; an authority witnessed in three myriad manifestations i.e. authority by age, authority by physical strength and authority by wisdom. The latter indicates a person possessing special knowledge and classified as an expert and in an uncertain event reigns his superiority over all others. Rather interestingly, authority and individual freedom are caught within the duality of "enhanced freedom" and "restricted freedom" symbolic of how a community is comprised of privilege and duty at the same time. Their simultaneous existence can eventually give rise to inequalities which is the antithesis of a community premised on unity and commonality. Reflecting on the three main issues Tonnes illustrates, i.e. community by blood, place or spirit; authority by age, physical strength, wisdom; mutual understanding; enhanced versus restricted freedom I shall analyse the NVBDCP document at a latter point in the chapter.

3.1.2 Participation: Forms and Intentions

This section outlines the definition of participation that became seminal to the development discourse around the 1970s, and can be traced to the beginning of Participatory Action Research (PAR) which follows a people centred approach (Rifkin 2016)

> "Modern jargon uses stereotype words like children use Lego toy pieces. Like Lego pieces, the words fit arbitrarily together and support the most fanciful constructions. They have no content, but do serve a function. As these words are separate from any context, they are ideal for manipulative purposes. 'Participation' belongs to this category of words." (Rahnema 2010:127)

To comprehend the meaning, types and contours of participation, I shall primarily draw from Rahnema's assertion on the same outlined in his essay 'Partcipation' (2010). Participation, has been understood and manipulatively sold as a "one size fits all" strategy. (Morgan, 1993) He outlines that participation can be categorized into four types, transitive or intransitive; moral or amoral; forced or free; manipulative or spontaneous. (Morgan1993). The transitive form of participation is oriented towards a target whereas the intransitive form is participation without any predefined goal. The target is usually defined in a moral or ethical character as opposed to fulfilling a vindictive purpose. Meanwhile, forced participation or coerced participation (Morgan 1993) is at the other end of the spectrum which is mandated as compulsory and invariably manipulative in its nature of activities and goals. Spontaneous participation is willingness to participate and is often understood as voluntary and bottom up. Lynn Morgan in

her book titled, ‘Community Participation in Health: The Politics of Primary Care in Costa Rica’ (1993) introduces another type of participation i.e. induced participation defined as “sponsored, mandated and officially endorsed”; and “the most prevalent mode to be found in developing countries” (1993:.5)

Rather interestingly, Rahnema (2010) cogently outlines six reasons elucidating the increasing interest government and development institutions have in the concept of participation. Firstly, it is no longer perceived as a threat, implying that the government to increase productivity at a low cost resorts to participation. He argues that this attitude is reflected in how donor agencies cater to developing countries in their assistance programs. They largely cater to three types of ‘needs’; needs associated with the power of the state i.e. the army, police and security forces, administration, transport and communication services and the mass media; needs constitutive of economic development; and finally social and cultural needs which eventually submits to the other two. In his theatrics of needs, Rahnema argues, that once the targeted population is “addicted” to these needs, then the rhetoric of participation can be pushed in the name of satisfying those needs. However, these are needs that are penned down by the First World in their development programs, and in reality may differ from what is termed as “felt needs”, i.e. the needs that are clubbed as necessary by the community or the target population. This notion of felt needs is often evoked in the literature on community participation in healthcare discussed later in the chapter.

Secondly, it has become a politically attractive slogan which “create feelings of complicity between the public manufacturers of illusions and their consumers. Politicians give their constituencies the impression that they are really sensitive to all their problems, often inviting the latter to enlighten them on their needs and aspirations.” (Rahnema 2010: 130) This reverberates Rahnema’s stance on participation asa “fanciful construction” thrown at people to confuse them with no underlying moral purpose, largely as a strategy to achieve political power (Morgan 1993) Thirdly, participation has become an economically appealing proposition with few on the ground success stories. Bangladesh’s Grameen Bank[28] initiative reflecting the sustainability of informed and active participation by the poor. Fourthly, it is seen

[28] Bangladesh’s Grameen Bank Initiative was the brainchild of Muhammed Yunus proposed in 1980. The effort was to provide micro loans to the poor in rural areas to build Bangladesh’s economic performance and work towards a poverty-free country. Unlike the conventional banks, the Grameen Bank removed the need for collateral and was based on mutual trust, participation, creativity and accountability.

as source of investment as well as effectiveness for two reasons; a) An increased knowledge of empirical reality which foreign agencies and bureaucrats cannot provide us. b) It creates a network of relations and a sense of cooperation between the local and significant organization. Fifthly, an expanded concept of participation maintains that the involvement of the private sector could enhance the developmental prospects for reasons elaborately discussed in the previous two chapters now including competitive services. (Rahnema 2010) Rahnema's formulation of "an expanded concept of participation" is rooted in the argument Hans-Klijn and Teisman formulate in their article 'Partnership Arrangements: Governmental Rhetoric and Governmental Scheme' (2002). They argue that the bureaucratic inclination of the public sector can hinder effective potentialities of partnership. In the second chapter however, Naraindas's (2003b) elucidation of the imprest account in the smallpox eradication programme forages this meta-narrative.

3.1.3 Incentivization: Participation Protocol?

The idea of incentives is crucial to partnerships as we have observed from the previous chapters. However, incentive structures are also prioritized within community participation when identifying the community as an active, equitable partner. Having said that, I draw from Sujoy Joshi and Mathew George's empirical study on ASHAs in Maharashtra as discussed in their article, 'Healthcare through Community Participation: Role of ASHAs' (2012). A layered analysis by Joshi and George facilitate an insight into questions like: what are the incentive structures place? What is the existing form of remuneration at community level? Why is an incentive system stressed for in healthcare strategies ?

(a)A Case Study of ASHAs in Maharashtra

As mentioned earlier, community participation gained force in the 1970s, and in India as Joshi and George illustrate was flagged off under the National Rural Health Mission (NRHM). The NHRM with its emphasis on community participation created the category of the Community Health Worker (CHW). Today CHWs do not remain confined to rural healthcare, and form a significant portion of the urban healthcare programmes. The National Urban Health Mission (NUHM) recognizes the role and participation of community healthworkers such as ASHAs in the provision of health services to the urban poor.[29] In another section in the chapter we shall

[29] Refer to section 1.16 of the NUHM

see the inclusion of ASHA in the community by NVBDCP as a part of its strategy for dengue prevention and control.

Joshi and George (2012) state that CHWs are those who are from the community, living with them, selected by them, and serving their health needs; but there are two crucial issues that need to be highlighted. Firstly, with CHW being a member of the community it was important to address the "felt need"[30] of the community and issues of empowerment. Secondly, the CHW are seen as "agents of change" who are often caught within structural constraints of the social-economic and political type. (Rifkin2008). However, in the context of India, Joshi and George argue that initially the CHW were seen as an intermediate between the health service system and the community. However, there was a lot of row regarding the monitoring of their work and distribution of honorarium, which raised questions around whether they were volunteers or paid employees; and if they were the latter then they could not be seen as "agents of change" but in actuality an extension of the health system.

With these two issues, Joshi and George reflect on three case studies: The Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashtra; Comprehensive Health and Development Project (CHDP), Pachod, Maharashtra; and Mitanins Programme, Chattisgarh, Jharkhand. The last programme raises some interesting insights into the issues Geroge and Joshi highlight; moreover formed bases of the Accredited Social Health Activist (ASHA) under NRHM.

In the Mitanin Programme (2002), CHW were selected and involved in preventive and promotive activities. Within the first three years of the programme, no incentives were paid and participation was seen as purely motivation driven. Furthermore, they were successful in addressing the "felt needs" of the community which led to increasing self-motivation, job satisfaction and further volunteering without any honorariums. In the drafting of the CHW programme, CHWs are largely seen as volunteers working for the benefit of their own community without seeking any monetary returns. With this perspective, India developed the ASHA programme as a part of its rural healthcare services structured on ideas occupying previous community health programmes, but the introduction of honorariums (compensation

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[30] "Felt needs" are understood as needs of the community apart from health needs such as education, food scarcity, etc (Joshi and George 2012)

for the livelihood they have lost in providing healthcare services) and performance based incentive systems illustrates a different story. On one hand we have the public health theorists who state that without money participation is impossible (PHRN 2007, Joshi and George 2012). And, on the other we have the critical medical anthropologists (CMA) studying public policies who are of the view that state policies function like ‘carrots’ and ‘sticks’ (Eisenberg 2011) That is, providing incentives to eventually further a state sanctioned programme or purpose. To look into the no cash no engagement narrative, the authors conducted interviews with ASHAs in a tribal district in Thane, Maharashtra. Through these set of interviews, they explored that the activities of ASHAs ranged from referral, counselling, providing medicines and other drugs, maintaining the records of patients, helping the health assistant and lady health visitor, etc. But out of all these activities, ASHAs were predominantly (85 percent of the 219 ASHAs in the tribal block)engaged in referral of pregnancy cases, primarily because they received Rs 600/- for each pregnancy case they referred. These ASHAs mostly worked in the agricultural sector belonging to poor socio-economic backgrounds and viewed incentives as their main source of income.

If ASHAs aligned their work to gain incentives does it not suggest an explicit failure of a community health system premised on CHW working self-lessly? Moreover, the instance of referring pregnancy cases against a particular incentive when viewed from a critical medical anthropological perspective reiterates Eisenberg’s (2011) argument. The state by asserting and promoting the role of midwives and dais through its rural health mission implicitly persuades the rural women to deliver their children in a hospital rather than at home under the eyes of a medical expert. (Naraindas 2014) “The hospital is the sine qua non of a “modern” birthing experience and “birthing women who resist the medicalization of pregnancy and childbirth are considered a risk to their unborn baby and in many situations coerced into complying with medical recommendations for the sake of their baby (Mackinnon and McIntyre 2006:59)” [Naraindas 2014: 118] Therefore, the state validates and accredits hospital birthing over home birthing by bringing in the CHWs through the incentivization.

The foregoing illustrates that incentives were seen as the sine qua non of participation, but also transformed the CHW from being a volunteer to an extension of the government healthcare system in the eyes of the community. This further prevented them from being able to “communitse” (Joshi and George 2012) Solely from the perspective of incentives this narrative is devoid of the implicit reasons why incentives are offered, and for what purpose. As we

discussed, an anthropological analysis of public policies offered critical insights into a taken for granted approach towards incentives.

(b) ASHAs in NVBDCP: Incentive Structures in Dengue and Malaria Programme

Contestations around the need for incentives remains observable in the NVBDCP document on community participation. While it states that incentives are being streamlined in the dengue programme, we observe a well established incentive structure for the malaria programme. According to the 'Guidelines for Involvement of ASHAs in VBDs', a NVBDCP document, ASHAs are involved in the diagnosis and treatment of malaria, monitored regularly and paid at the end of a monthly review by the NVBDCP, which classifies them as "an extended arm of the health service system" (Joshi and George 2012). It states the incentives for ASHAs for preparing a slide, providing complete treatment for Rapid Diagnositc Test (RDT) and for referral of cases and overall treatment at Rs 5/-, Rs 20/- and Rs 50/- respectively. While this is the current rate of incentives i.e. as of 2018, a document titled 'Update on ASHA programme July 2016' states the rate of incentives at Rs 15/-, Rs 75/- and Rs 300/- for the same set of activities respectively under the NRHM. At first glance itself these figures are startling and bring forth two issues. Firstly, these figures indicate a different story from one that is usually prevalent in disease control programmes, i.e. as the number of cases fall, the rate of incentives increase. This was reflected in the smallpox eradication programme where as a part of its strategy the public reward for searching individual cases of smallpox increased from Rs 10 to Rs 1000 as the number of cases fell. (Naraindas 2003b: 441) Secondly, ensuing from the foregoing argument it can be argued that since malaria till date unlike smallpox remains a widespread disease, the incentives are priced low. But this pes

3.2 Participation: The Rhetoric of Empowerment

The idea of 'participation' can be traced to the beginning of Participatory Action Research (PAR) which follows a people centred approach (Rifkin 2016); and can serve four crucial functions: cognitive, political (Morgan 1993), social and instrumental.(Rahnema 2000). Considering Rahnema's categorization of participation as serving four functions I shall take up these functions by substantiating three cases involving community participation in healthcare. a) "official, state sponsored" community participation in Costa Rica from Lynn Morgan's work on 'Community Participation: The Politics of Primary Healthcare in Costa Rica' (1993); b)"spontaneous participation" in Bihar, the "last hotspot of smallpox in the world" under the

National Smallpox Eradication Programme' as illustrated by Harish Naraindas in his article, 'Crisis, Charisma and Triage: Extirpating the Pox' (2003b): and c)"induced" participation in the Malaria programme in Costa Rica (Morgan 1993) I argue that all these instances implicitly reflect how state policies undertake activities to fulfil certain goal, and work on the dual notion of entreaty and threat.

3.2.1 Cognitive Function: The Predominance of an Episteme

In cognitive terms, conventional development was criticized for belonging to an "irrelevant *episteme"* as developed in Northern industrialized societies which did not cater to the objectives of a sound development. Therefore, it was emphasized that we needed to shift to a knowledge system grounded in "locally produced *techne*". (Rahnema 2010) Rahnema's formulation of an episteme, ethnocentric in its very nature can be empirically witnessed in Naraindas's (1998, 2003a, 2003b) elucidation of the smallpox programme as discussed elaborately in the previous chapter. We observe treacherous and malicious efforts at establishing variolation, the norm among the natives as ritualistic and unscientific over (scientific) vaccination ; where disobedience to the latter accounted as a treasonous activity. His reading of the note that Duncun Stewart made at the end of the Report of Smallpox Commissioners (1850) accords a 'rational' reason over the 'irrational' natives. This illuminating instance to preserve the rhetoric of vaccination is embedded in the episteme of exporting knowledge from the First World and applying it to Third World as a "one size fits all" strategy disembedded from an episteme labelled more than often as inferior.

3.2.2 Political Function: Participation is Empowerment?

Rahnema (2010) argues that in political terms, participation serves a dual function of lending voice to the powerless because participation is seen as power (Rahnema 2000, Adams 1979, Rifkin 2016) and acts a source of legitimization by representing the state as a democratic actor. (Morgan 1998) Rahnema borrowing from Participatory Action Theorists (PAR) such as Orlando Fals-Baroda and Anisur Rahman asserts that participation is a mechanism for the oppressed and the exploited to gain power and forward their interest by the very of act participation. Lynn Morgan (1993) however, adds another layer to the participation is people's power debate stating that the government can sponsor participation to push forward a certain agenda; and that translates power from being transformative to manipulative. Let us take three case studies to illustrate how types of participation mentioned earlier, i..e manipulative,

officially sponsored, spontaneous, etc function in the name of empowerment and for what purpose?

I draw my first case from Morgan's (1993) study of community participation in health in Costa Rica. Community participation cannot be disassociated from a politico-economic background, and she states "health is so inextricably entangled with politics that its definition should be expanded to encompass oppression and social inequality." (1993:81) With Costa Rican healthcare system at the heart of Morgan's analysis for the rise, fall and re-emergence of community participation, there are four factors she outlines as crucial for community participation. That is; participation, democracy, paternalism and health. The infringement of a paternalistic attitude on health within a political climate in Costa Rica reverberates "participation is power" in a manupilative sense.

As prelude to the efforts for community participation in health, the political party at the centre was the Partido Lebracion Nacional (PLN), a social democratic party associated with the three time president of Costa Rica, Jose Figueres Ferrer. The PLN emphasized increased role of the state in production and finance. After the civil war in 1948, the PLN formed in 1951 nationalized banks, dismantled the army and set up an extensive state apparatus. However, PLN was opposed by the Social Christian Partido Unidad Social Cristiana or simply Unidad under the leadership of the party president Rodrigo Carazo. Unlike the PLN which supports state ownership, the Unidad emphasized free market economic policies with the state's role being reduced in the public sector. In the 1970s, when Jose Figueres of the PLN was elected president for the third time, he set out to ameliorate the healthcare system more so by building a strong rural health network and effective social security schemes. By the 1970s however, rural health programs were at the forefront in Costa Rica with momentum that community

participation gained under the AIDSs Title IX [31] mandate and Pan-American Health Organization (PAHO)[32] in the same year.

The party's reign between the 1970 and 1978 saw the emergence of an efficacious rural health system with the establishment of 218 rural health posts, nursing auxiliaries and community health workers between the year 1973-1978 under the Daniel Oduber administration. However, Morgan asserts, "The first efforts to involve local communities in the primary health program were perfunctory, strictly utilitarian, and not institutionalized. They were designed to help the government carry out its plans quickly and inexpensively" (Morgan 1993:97) This mechanical approach to community participation within the rural healthcare system was witnessed in the mobile medical teams sent sporadically to give medicines and advice in rural areas; and sometimes a dental chair that would be set up in the van. But PLNs strictly utilitarian attitude preceding all humanitarian concerns were witnessed in its efforts to set up health posts across rural areas in Costa Rica. Referring to an interview with the member of the Ministry of Health, Morgan elucidates how the community was illusioned into believing that it contributed to the building of these several health posts. The Ministry of health set up health committees who visited the community members and told them provide spaces for the construction of the health post. Furthermore, they asked them to provide them with basic necessities and alcohol, which in turn worked in their favour because this way the community felt the obligation to seek contributions, so they would themselves help out with the health post.

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[31] AID, is the abbreviation for The United States Agency for International Development structured in Latin America to look at Kennedy's Alliance for Progress structured of the 1960s to prevent "another Cuba". It was premised on the ideology that economic growth was the sine qua non of social and political development. In this scheme of things, health was never a priority for AID. It was only in the 1970s when community participation in health gained widespread recognition for its ability to improve primary healthcare did the AID Title IX became a landmark organizational policy initiative in the history of communitarian participation in Latin America. It first and foremost shifted to political development, constructing democratic institutions and added a humanitarian component to the US foreign aid section. They provided Latin America with public health nurses vaccinating children, peace corps volunteers, schools, agricultural farmers training farmers to increase crop production. These steps were undertaken because the 1970s was also the time when the US was projecting a democratic image to the world and at home. Democratic ideals incorporated the popular participation within it framework putting community participation at the forefront. (Morgan 1993)

[32] The Pan American Health Organization (PAHO) is one of the six regional divisions of the WHO. It is key organization responsible for the development of health policies in the western hemisphere. It emphasized health coverage to those section of the population who remained untouched by effective healthcare systems via the method of community participation and primary healthcare. It saw the community as "an untapped source for vast potential, whose active cooperation could assist the governments in their efforts to improve the living conditions in the country side (Morgan1993: 67) In 1978, PAHO introduced the concept of "capacitating participation", that advocated community-based knowledge, decision making powers and equal responsibility of healthcare to the community. Most importantly, PAHO's premises of community participation overrides the conventional ideas of community participation rooted in contributing labour and material resources. It is seen to give precedence to the self-autonomy of the community as well as view them as empowering agents. (Morgan 1993)

While community participation was at the heart of rural healthcare in the 70s, the Ministry of Health by the 1980's declared community passivity and isolation for its failure.

The drama unfolded further when Unidad under the leadership of Carazo (1978-82) added to the attempts by PLN towards community participation stating that the Ministry of Health under the Oduber government did not actually promote the idea of community participation but undertook the construction of health posts relentlessly to show that the community was contributing in rather concrete terms. An official that Morgan interviewed went on to say that lack of financial resources led the PLN towards the communities to donate their land and build health posts. In fact, once the post was built they did not know what to do with communities, hence they employed them with supplying essential materials, cleaning and painting the posts as well as maintaining it. Such an approach was labelled as utilitarian and primitive to community participation. In this narrative reflective of the partisan politics, the Unidad painted PLN as the villain for monopolizing community participation to serve its ends, while the PLN claimed itself as the hero for the benefit health programs received from its emphasis on community participation. Elucidating this sequence of events, Morgan states,

> The community program of the 1970s was designed to benefit the administration then in office more than rural communities. If by promoting community participation in health an administration could gain international approval and financing while thwarting political opposition, and if these were among the primary motives for establishing such a program, then the implication of evaluating community participation in health are serious: impediments to effective community participation should not solely be sought within the communities, nor among the technical and bureaucratic details of the program organization, but in the structure of Costa Rican politics and cycles of international development policy (1993: 98-99)

My second case is Naraindas' (2003b) elucidation of "spontaneous participation" within the National Smallpox Eradication Programme (NSEP)[33] advocating "isolation, surveillance and containment". In 1973, Naraindas states the programme transitioned to an Intensive Campaign which was a joint programme between the WHO and GOI, and called for epidemiologists,

[33] Refer the section on 'Prototypes of PPP in Dengue Prevention and Control?' in Chapter Two.

volunteers, paramedics to search for “agent smallpox”. The previous chapter discussed the case of the “imprest” that gave I.C Tiwari who joined the campaign in 1974 gave him the leverage to usurp bureaucratic working of the state. I.C Tiwari’s efforts at confirming the disease obscurity registered in the “rumour register” followed by containment activities, “would have been largely unsuccessful if not for ‘local participation’.”(Naraindas 2003b: 443) Local participation within containment activities involved the youth who as I.C Tiwari re-iterated were spontaneously hired to act both as vaccinators and enumerators for its smooth functioning. As a part of the new strategy of a household to household survey in search of individual smallpox cases to vaccinate, the hired local youth were trained in twenty minutes to carry out vaccination operations. In these set of activities too, compensation was provided to for the time and wages lost in household enumeration, containment and vaccination. This sense of community participation, which provided for a “new found commensality, where it was ‘the local people who often taught and showed the way’.”(Naraindas 2003b:444) from an anthropological perspective implicitly reflects policies being dispensed and accepted as rational and neutral (Wedel et.al 2005) devoid of it *actual* intentions. This is to say, in the context of the smallpox programme the new strategy of intensified campaign sought the local youth for successful containment and vaccination.

The third case I illustrate is from Morgan’s (1993) insights on the establishment of international protocols and initiatives towards community participation in tandem with its effects on Costa Rican healthcare. Among the many international imperatives she reviews in her book mentioned earlier, Morgan reflects on the United Nations (UN) community development movement between 1955 and 1970. Re-iterating by reflecting on the UN Report titled, ‘Principles of Community Development: Social Progress through Local Action’ (1995) community participation defined as a mechanism for the social and economic progress of the community with its full and active participation. In terms of a disease affecting Costa Rica, malaria was extremely widespread and cause of concern for many international corporations and the existing governments, where the latter as Mogan argues saw community participation as a road to political power. This UN report that Morgan refers to prioritized the role of the community, but only saw it as a preferable and not an essential mechanism. Nonetheless, in recognizing the importance of community participation the report stressed on “ “vertical- style” program-designed to provide quick observable results over a short period of time” (Morgan 1993:41) These “vertical-style” programmes were implicated in malaria control for the community to see that participation with the government could be an efficacious proposition.

After a set of control practices had been undertaken the report suggested vaccination as an approach to keep the communities engaged in the malaria programme.

The UN malaria programme began in the 1950s by emphasizing the usage of household to household spraying of DDT, which the rural folk vehemently refused due to the residue it left on their walls. In this regard, the programme recruited the Costa Rican *colaboradores* (village health workers) and deployed them for three reasons. a) To convince the community the significance of spraying DDT; b) To not clean the DDT from their walls; c) To communicate with the community the benefits of UN's anti-malarial programme. The author in exploring the working effectiveness of the programme interviewed an elderly woman in the La Chira region of Costa Rica. This interview suggested that they had to empty their houses, remove their furnitures for DDT spraying which eventually left a residue on perhaps everything. But, "if people refused the spraying, they would be fined" (Morgan 1993: 41)

Morgan's foregoing articulation not only implies the dualism of entreaty and threat embedded within an "induced" form of community participation, but the superiority of a First World episteme. Having said that, the political function of participation was centred on "empowering" the powerless and voiceless (Rahenma 2010) but we saw from the three case studies that all participation initiatives had a different story to tell.

The **instrumental function** of participation was to extend, "'re-empowered' actors of development with new answers to the failure of conventional strategies, and to propose new alternatives, with a view to involve the 'patients' in their own care." (Rahnema 2000:133) In my reading of the aforementioned functions of participation suggest a rather a casual use of another ambiguous term i.e 'empowerment'; where (manipulative and state dispositioned) power is the most prominent. As we shall notice in the next section the NVBDCP also uses the term 'empowerment' in its policy document advocating community participation for preventing and controlling dengue. Before I delve into NVBDCP's conception of the same I shall theoretically delve over the empowerment narrative within the development discourse.
The **social** function meant that participation added fervour to the development discourse and became the new slogan for all institutions, groups, individuals engaged in this development process.

3.2.3 The Trajectory of Empowerment

In this section, I trace the theoretical underpinnings of empowerment by drawing from Manoranjan Mohanty's article 'On the Concept of Empowerment' (1995). He distinguishes between the 70s and the 90s usage of the term; and argues that while in the 70s, the emphasis was on "politics in command", wherein certain political criteria were put in place for the evaluating development; with freedom and equality at the heart of it. But by 90's with the new economic policies, a shift occurred within the development circle stressing "economics in command". This shift has transformed the word into a mere buzzword, devoid of its genuine meaning and value; further problematized by the shrinking of the term within state policies formulated within various sectors. (Batliwala 2007) To map definitional variations within the framework of globalization, Mohanty takes up the instance of the World Summit for Social Development in Copenhagen on March 6-12, 1995. The intention is to substantiate and unfold the critical nuances that 'empowerment' is ladened with. Two of the primary objectives stated as and quoted by Mohanty are,

> We affirm that in both economic and social terms, the most productive policies and investment are those which empower people to maximise their capacities, resources and opportunities (1995:1434)

> Recognize that empowering people particularly women, to strengthen their capacities is a main objective of development and its principal resource. Empowerment requires the full participation of people in the formulation, implementation and evaluation of decisions determining the functioning and the well being of our societies. (1995:1434)

The notion of empowerment as spelt in these objectives leads Mohanty to deduce three key observations pertaining to it. Reflecting on these observations at a later point in chapter, we shall see if the NVBDCP also categorises empowerment on similar terms. Firstly, within the parameters of the first objective, Mohanty argues that empowerment is not the goal to be achieved, but only a fragment situated and to be understood in the larger set up of production. Secondly, the importance on "strengthening of capacities" within the process of empowerment can only be actualized with the removal of structural constraints, challenging ideologies rationalizing social inequalities and questioning existing patterns of access to and control over economic, natural and intellectual resources. (Batliwala 2007: 560) Thirdly, the importance

accorded to "full participation of people" is problematic on the accord that the summit stresses stability as a prerequisite for growth. Moreover, the contours of full participation are located within the process of decentralization, and providing opportunities to the civil society and local communities to build their own resources, organizations and activities. Hence, participation is visualized within the pretext of the existing institutions of the state or new institutions; and not by replacing and dismantling the prevailing structures as it is argued would disrupt the stability required for progress. In this sense, "strengthening of capacities" can be a troublesome proposition because the existing structures can perpetuate structural constraints impinging on any possibility of empowerment. The first chapter reiterated the state being considered as a neutral agency directed towards social equity, but " empowerment was hijacked in the 90s, into interestingly bizarre locations, converted from a collectivist to an individual process, and skilfully co-opted by conservative even reactionary political ideologies in pursuit of their agenda divesting big government (for which read: the welfare state) of its purported power and control by 'empowering' communities to look after their own state of affairs"(Batliwala: 2007: 558) Within this backdrop, the introduction of the concept of empowerment within neo-liberal policies had been depoliticized and acquired a technocratic approach. It had subverted the politics with which the unprivileged had initially pursued towards empowerment. (Mohanty 1995, Batliwala 2007)

That was the politics of "conscientization" that was rooted in the work of Paulo Freire's *Pedagogy of the Oppressed* (1968) on the principles of which was conceptualized 'Participatory Action Research' (PAR). Susan Rifkin in her article, 'Central Bringing Excellence in Open Access Pursuing Primary Healthcare: Community Participation in Practice, Doing Participatory Research' (2016) argues that PAR as a methodology can be attributed to the work of German Sociologist, Kurt Lewin in 1940s who via his research in an American factory found that workers satisfaction and performance was rooted in decision making abilities accorded to them, rather than taking orders from above. Therefore, Rifkin points out that at the heart of participation is empowerment and the ability to participate in decision making abilities. Grounding the ideology of participation on conscientization with the emphasis on a dialogical interaction meant that politics of participation in 70s was premised on bottom-up approach, the denigration of a subject-object relationship wherein the freedom to pursue one's own choice of action was propagated. (Rahenma 2010) Therefore, "the intentions of the pioneers of participation were, indeed pure and noble. The right to consider that the tremendous abuses of power by oppressors had to be stopped, and the victims to be provided with new possibilities

od defending themselves. Yet, in practice, the empowerment discourse raised a number of important questions, both at the theoretical and the practical level. (Rahnema 2000 :135) While for Mohanty and Batliwala, the pursuit of empowerment contextualized within neo-liberalism ripped the concept of its initial promises. Nonetheless we saw earlier that community participation within disease control programmes like smallpox and malaria in the late twentieth century completely misrepresented the category of empowerment, or perhaps were never inclined towards that proposition.

Ensuing from the above, Rahnema (2010) however brings to fore an inherent contradiction in the manner empowerment has been conceptualized itself. His argument suggests that empowerment is born with the notion that the empowerer is the one who posses the power to empower the empowered. In this way, the empowerer is not only under the impression that the one to be empowered had no power but that the former has absolute power to empower the empowered. In this sense, "to be empowered" and "re-empowered" is problematic. The first suggests that the community to be empowered faces a deficit, "are just blank and unrelated individuals, without a history of belonging to any pre-existing social relations with power". (James 1999: 20) The second reverberates the audacious claim that power within empowerment is formal, rather than substantive; given by an external power positioned at the upper echelons rather than received via struggles, protests etc. (Mohanty 1995, Morgan 1993)

3.2.4 The Alma Ata Declaration: Community Participation for Effective Healthcare

In the domain of healthcare, empowerment as corollary to participation was realized in the years following the second world war as discussed earlier in the context of Latin America (Morgan 1993). This was the time when international agencies and foreign aid turned to developing countries facing chronic poverty and undergoing decolonization to emphasize community participation by collaborating with the community for the mobilization of materials, money and human resource (Rifkin 2016, Morgan 1993) But by the mid 1970s, a nascent idea of community participation was formalized in the WHO/UNICEF Alma Ata Declaration in 1978. It introduced and diligently focussed on Primary Health Care (PHC) and visualized on a low cost strategy including health workers modelled on China's Barefoot Doctors. Its aim was three-fold: health care in rural areas at a reasonable cost, promoting community participaton and working towards the goal "Health for All by 2000". Morgan (1993) cites a WHO report on PHC (1978), wherein "community participation was defined as a process whereby individuals and families come to view health not only as a right, but as

responsibility. The report encouraged *active participation rather than passive acceptance* of community development programs, emphasizing that participation should accompany every stage of primary healthcare process from *needs assessment to implementation*. Furthermore, individuals were to assume "a high degree of *responsibility for their own health care* – for example, by adopting a healthy life style, by applying principles of good nutrition and hygiene, or by making use of immunization services" (WHO and UNICEF 1978: 21) [Morgan: 1993: 12 emphasis added]

3.3 Contriving Community Participation: A NVBDCP Perspective

The aforementioned discussion highlighted the framework of community, community participation entrenched in the language of responsibilty, active participation and decision making in assessment, implementation and empowerment. In this section I take up the notion of community participation in dengue prevention and control as illustrated in the document, 'India Fights Dengue: Strategy for Effective Community Participation in Prevention and Control of Dengue' (2017). This document came to light in my interview with Dr L , regarding the challenges faced within public-private partnerships in healthcare. Keeping in mind the arguments made so far I examine the document from the lens of Tonnies's conception of community, the idea of "felt needs", state preparedness and individual behavioural changes.

> "Commmunity participation and empowerment is one of the most important elements of integrated vector management strategy." (NVBDCP 2017:1)

3.3.1 Targeted Behaviours, Instantaneous Preparedness and Community Needs

NVBDCP in the forefront itself states community participation to be a long term , sustainable solution for the prevention and control of dengue. It is said to be pursued with an equitable vision of partnership with the community, along with participation at various levels of decision making, assessment of community needs, implementation, monitoring and evaluation. Moreover, to ensure effective community participation individuals and households should accept responsibility. The need for community participation however, is ensconced in the failure of top-down approach due to lack of government resources as clearly stated in the document and reflected in the interviews with NVBDCP officials and private laboratories owners. Unlike PPPs that were restricted to the realm of case management and early diagnosis, community participation for dengue prevention and control is envisaged around three key issues; a) to control larval habitats around homes, workplaces, construction sites consisting of

receptacle materials that act as potential breeding sites for Aedes Aegypti mosquitoes, b) To decrease human vector contact and ensure personal protection by wearing long sleeves clothes, using repellents and insecticide treated nets, etc, c) To ensure early diagnosis and prompt treatment in case of fever. These issues reflect the emphasis on behavioural change as a part of NVBDCPs prevention and control strategies. To implement behavioural change they rely on printed material such newspapers, posters, leaflets, tinplates; and audio-video material such as radio, TV and films. I discussed the posters on dengue and malaria briefly in the section on smallpox in the previous chapter taking up instances where disease communication could fail due to various reasons stated.

Considering the correlation between behavioural change and the incidence of dengue, the NVBDCP audaciously states, "The presence, or at least the density of Ae. Aegypti to a large extent depends on human behaviour. So community participation for prevention and control of dengue should *always* (emphasis added) lead to behavioural results" (NVBDCP, 2017, p.10) The NVBDCP thus stresses community participation most importantly for behavioural change which is indicative of the claim that notions of empowerment via community participation are not a goal per say (Mohanty 1995), but perhaps only a ruse to achieve 'targets' translated into "target behaviours". . The "target behaviours" that the NVBDCP enlists stem from reasons stated necessary for the need of community participation mentioned before. Moreover, to communicate these "target behaviours" the NVBDCP carries out dissemination workshops at various levels i.e. state, district, panchayat/ ward level. Each of these workshops has a master trainer which further trains the trainers at the district and municipal level. Now, what is interesting and perhaps contradictory to its insistence on the community as active partners is that the master trainers are state nominated officials from each state. It further goes on to state that the state IEC (information, education and communication) officer, media officer and state NVBDCP official need to a part of these workshops. Are these "state nominated officials" also members of the community, participating in decision making and implementation activities?

With "target behaviours" at the core of the strategy, its alignment with seasonal variations is a point of contention within the policy document. It outlines the "target behaviours" as contingent on community actions that might vary depending on context, and risk of transmission, the time of the year and needs of the community. It also states, "No single activity or material (e.g. poster) will result in behavioural impact. Based on the community, as part of the planning exercise, a judicious mix of different but integrated actions appropriate to the

behavioural objective being sought will be required.” (NVBDCP 2017:17) Nonetheless, these community behavioural objectives are undertaken and intensified when the concerns of the local population are the highest, i.e. during monsoons when the disease takes over the city or when virological surveillance indicates the risk of a potential outbreak; rather than all year around. In the second chapter, referring to the Mid Term Plan on Prevention and Control of Dengue and Chikungunya 2011-2013 we observed that preparedness is not an ongoing activity with partnerships (with private health and non-health sectors) developed when the disease reaches epidemic like situations. In comparison to the Mid Term Plan, the Strategy for Effective Community Participation vehemently vouched for sustainability. Can we seek sustainability in prevention and control of dengue when the plan on community participation too is grouned actions on taken at the time of increased incidence?

Time as a factor for heightened community participation and ushering in behavioural impact is also accompanied by the needs of the community affecting levels of participation and change in behaviour. With regard to the same, it states that community actions undertaken for dengue prevention and control can be synthesized with other priorities of the community such as waste water disposal or lack of provision of portable water. Are these priorities the ‘felt needs’ (i.e. needs that the community feels as important for its own development) of the community or those that obstruct effective community participation? I raise this question because at another juncture in the document the NVBDCP states, “identify the needs of the community instead of imposing what the programme has to offer” (NVBDCP 2017 :7) What are these needs? Are these needs only health needs? Or are they the “felt needs” of the community? The policy however is concerned with not rebuffing community belief and knowledge with the intervention of new techniques for dengue prevention and control. In recent years a large section of the community relies on goat’s milk and juice of papaya leaves for increasing platelet count in a dengue infected person. The policy document does not mention it as a step in its effective control, while the Ministry of AYUSH, Government of India has declared it as a go-to cheap and effective solution.

3.3.2 An Expanded Concept of Community ?

NVBDCP’s concept of community, includes those who might propagate and practice these preventive techniques based on their own knowledge. The contours of this community are outlined to cater to the mentioned “target behaviours”. An exhaustive list that the NVBDCP provides is suggestive of an expanded concept of the community. It includes households,

RWAs, Opinion Leaders, Panchayati Raj Institutions, schools and colleges, youth groups, NCC/NSS, Private Doctors, Traditional Healers, Medical Associations, Self Help Groups, Ward Committee, Community Based Organizations, Faith Based Organizations, Religious Leaders, Mahila Arogya Samiti, NGOs, Environmentalists, Commercial Business Owners, Construction Site Managers, Village Sanitation and Health Committee, Peripheral Health Workers- ASHAs, ANMs.

While community participation is not a new strategy, the concept of community from its earlier conceptions has been altered. In Tonnies formulation, it transcends from being a community by blood and by place, to one largely premised on community by spirit. I would like to suggest that the reasons for the same could be two- fold. Firstly, dengue as a disease is not confined to a particular socio-economic group. It is true that it may come to affect a particular socio-economic section adversely but mostly in terms of their ability to seek effective treatment. Secondly, and the above insinuates that the NVBDCP seemed to have *curated* an exhaustive list to ensure wider community participation to fulfil "target behaviours" at each level. While, 'who' constitutes a community might have been ameliorated with NVBDCPs list, at the other end of the spectrum , structures of authority and hierarchy might still be intact. I claim this because the NVBDCP has a particularly exhaustive list with organizations and individuals from different socio-economic, political and cultural backgrounds. While the NVBDCP notes and recognizes that the operation of hierarchy may hamper possibilities of effective community participation, it is the state government's prerogative to keep a check on these.

3.4 Foucauldian Governmentality, Community Participation and Preventive Policies in Health

> Other than its own policy action and initiatives, the government has the *obligation* (emphasis added) to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have the least capacity to make choices and engage in their lifestyle or living conditions that might improve and protect their health. (NVBDCP 2017:5-6)

Culminating at the process of state health policies involving a multiplicity of organizations implicated in disease control programmes with varying policy initiatives such as community participation, we reflect on the Foucauldian notion of governmentality. In this section, we explore Foucaldian ideas on governmentality to reflect on how such programmes and policies

can be governance strategies referring to Foucault's article on 'Governmentality' in the book 'The Foucault Effect: Studies in Governmentality' (1991)

3.4.1 Polity, Power and Policy

Foucault's ideas on governmentality associated with the emergence of the problem of population which is at once individualizing and totalizing can be specifically understood with the current emphasis on community participation in dengue prevention and control. However, before I delve into the principal ideas of governmentality traced across historical domains, it is important to know what one means by "governmentality".

> "Foucault used the term 'rationality of government' almost interchangeably with 'art of government'. He was interested in government as an activity and practice, and in arts of government as ways of knowing what that activity consisted in, and how it might be carried on. A rationality of government will thus mean a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those whom it was practised" (Gordon, 1991, p. 3)

Michel Foucault in his essay on "Governmentality" (1991) traces the "art of government' from those based on a sovereign state to one of political economy and finally of population. Premising the art of government rooted in the reason of the state, Foucault takes up the example of Machiavelli's The Prince (1532) elucidating that the prince stood external to his principality that was either acquired via inheritance, violence, treatises or complicity; and with the ultimate aim of protecting his principality from conquest or capture. His efforts, however directed towards protecting the territory and his subjects were not objective in nature, but stood in relation to what the prince owned i.e. the territory and his subjects. In his essay, Foucault however is critical of such an art of government and dwells over texts that bring forth a 'new' art of government by the eighteenth century with the beginning of liberalism unfavourable to the reason of the state. While liberalism is critical of the reasons of the state, nineteenth century liberalism draws attention to the "question of the state" overlooking its duties and dangers. (Donzelot)

He refers to Guillaume de La Perriere's Le Miroir Politique (1555) where La Perriere first and foremost takes up argument of externality. He argues that there are government's which are

also internal to the state involving a multiplicity of people, such as the head of the family, a teacher or tutor; and in this sense there are many forms of government which are internal to the state with the government of the prince only being one form. To outgrow this Machiavellian understanding of the state, the state was understood under the rubric of *Polizeiwissenschaft* or "science of police" (Gordon 1991) and manifested into what Foucault calls "downward continuity" implying that if the state functions well then the same is reflected in the behaviour of individuals and management of the family. *Polizie* literally translates to 'policy' (in English) which I discussed at length under the burgeoning field of anthropology of public policy in chapter one. While policy is intentioned to "regulate internal order", an anthropology of public policy comes to reflect on two key issues. Firstly, it unfolds the power complexities within policy perspectives (Wedel et.al 2005) Secondly, policies of the neo-liberal era also creates new categories of subjectivity such as 'citizens', taxpayers', 'immigrants' etc (Shore 2012:10); where such "enhanced freedom" can give away to "restricted freedom".

The sixteenth century however, is also the beginning of the prominence of the economy which by the seventeenth century had transcended into exercising power. The rise of mercantilism, which Foucault describes as a tactic of the government, inclined not towards increasing the wealth of the country and its population but the accumulation of wealth by the ruler. At the same time, it stresses that the wealth of the state is surmised on the strength and productivity of its population. "This, Foucault writes, is 'central paradox of police': the aim of the modern art of government, viz., to develop those elements of individual lives in such a way that their development also fosters the strength of the state." (Gordon:1991:10) I shall take this up when I discuss the art of the government centred on the problem of the population futher entangled in the complexities of discipline and security.

The second observation Foucault reflects on La Perriere's statement, "government is the right disposition of *things*, arranged so as to lead to a *convenient end* (emphasis added) (Foucault, 1991:93) Unlike Machiavelli, where the prince's power was derived from control over his territory, governing *"things"* implied,

> "what government has to do with is not territory but rather a sort of complex composed of men and things. The things with which in this sense government is to be concerned are in fact men, but men in their relations, their links, their imbrication with those other things which are wealth, resources, means of

> subsistence, territory with its specific qualities, climate, irrigation, fertility,etc.; men in their relation to that other kind of things, customs, habits, ways of acting, and thinking, etc. ; lastly, men in their relation to that other things, accidents and misfortunes such as famine, epidemic, death, etc." (Foucault:1991:93)

In this sense, *"things"* ensconces multifarious connotations with territory being only one of the many things; with the assertion that art of government is rooted in its potential to govern these things. The second half of La Perrire's statement suggests that the government has to ensure that things are 'disposed' in a manner such that it eventually leads to a convenient end for those who are governed. Firstly, in Foucault's formulation these convenient ends reverberate efforts on the part of the government to ensure *"things"* such as subsistence, wealth and reproduction of the population. Secondly, and rather interestingly these *"things"* are 'disposed' not under the obligation and obedience to law but via tactics i.e. the arrangement of things in manner that the planned ends are unambiguously achieved.

3.4.2 Population, Welfare and Security

By the eighteenth century however, there is more than ever a reluctance to the unquestionable power of state reason displaced by the emergence of the problem of population. Unlike, the sovereign state, here the government is built on the notion of the welfare of its population, improving its health condition and longevity. To achieve these ends, the government either acts directly on the population through programmes or through techniques adopted without the full awareness of people. The significance of population is immense in every sense of the term because to be able to govern rationally the government needs to be associated with the processes of the population. In the management of population, disciplinary power still holds importance, however remaining restricted to control of individual bodies; later replaced by an art of government embedded in mechanisms of security to mark "the ensemble of population" (Gordon 1991). To address the notion of security along with population as the ultimate end of the government premised on political economy as the fundamental basis with the rise of liberalism and neo-liberalism, Grenier and Orlean in their article 'Michel Foucault, Political Economy, and Liberalism' (2007) make two significant points with regard to population. Firstly, as the staticians of the eighteenth century point out, the population has a set of regularities reflected in figures such as birth rate, death rate etc. Secondly, the emergence of liberalism with the notion of 'laissez-faire' gives rise to man as a subject of interest marked by individual choices and preferences (Gordon 1991) which shall eventually serve the general

interest of the population. In this scenario, with population as the ultimate end of the government, Greiner and Orlean argue that governmental techniques is faced with two issues. Firstly, it seen that the individual is the sole agent possessing the knowledge to his/her own interests with the government not possessing the werewithal to address these variables; and the population viewed as opaque and autonomous. However, here is the second point where the existence of these regularities makes the behaviour of people accessible to the government; and within these two observations is ensconced in Foucault's assertion that modern government rationality is individualizing and totalizing at the same time.

To govern through the nineteenth century and continuing till period of neo-liberalism, Colin Gordon in his essay, 'Governmental Rationality: An Introduction' (1991) reflects on Foucault's three conflicting but crucial observations Firstly, Foucault argues that studies of governmentality cannot view the state and society as a monolithic unit (Hobbes), but to be understood from the stand point of "multiple regimes of the governmentality" or what is called "modes of pluralization of the modern government" where we observe that the representative boundary between the state and society is restructured. This restructuring is reflected in the the interplay of public and private agencies and knowledge (as reflected in policy formulation such as PPPs in healthcare), the creation of autonomous spaces within public institutions of the government; and role of voluntary organizations and private individuals in the delivery of social services and governmental endeavours such as medicine and hygeiene respectively. .
Secondly, with neo-liberalism we observe the emphasis on the individual as an enterprise, in a sense that the individual is constantly engaged in the preservation, reproduction and reconstruction of one's own capital in what Foucault calls the "techniques of the self" for collective good.. Neo-liberalism focuses on individual rationalities embedded in notions of self-care, self-improvement, self-examination etc which has been reflected in the health strategies of various disease control programmes. By the mid 1970s as discussed earlier much of the public health literature pressed for individuals to protect themselves from any health risk that they might be subjected to. (Peterson 1997)

Community participation is built on individual responsibility of healthcare, reverberating Foucauldian notion of "care of the self" as mentioned earlier. Peterson (1997) points out that Foucault's conception of governmentality is built on the twin process of "technologies of the self" and "technologies of domination", such that the latter overrides the former in the effective subjugation of voluntaristic behavioural actions. The population is expected to align and

regulate their personal goals, conduct and behaviour with public good; paradoxical to the neo-liberal idea of individual as an enterprise. (Shore 2012)

3.5 Conclusion

From the aforementioned discussion there are primarily three conclusions that I shall draw. Firstly, with Dr L's statement, "These are merely jargons for us, you may call it anything." (December, 2017) I set out to explore the contours and connotations of the concept of participation. From the literature I referred to, it was axiomatic that participation suggests the dualism of entreaty and threat. On a similar line argument, I delved into the incentivization structure within participation as understood from Joshi and George's (2012) fieldwork in Thane, Mumbai. It suggested that ASHAs were seeking incentives to maintain income which led them to be viewed as an extension of the health service system, rather than a member of the community serving their needs. This however, is only one side of the story which does not look at the epistemology of incentivization rooted in preserving and pushing for state policies.

> "The strategy of 'community participation', universally applauded by new public health commentators as the means of 'empowering' citizens, establishes its own disciplines of the self (e.g. the requirement that one engage with formal political structures and with various experts, and the ability to demonstrate commitment to shared goals and to manage interpersonal conflict), and may serve as a strategy of exclusion (Petersen 1996; Petersen and Lupton 1996)" [Peterson:1997: 204]

Secondly, questions raised while analysing the document serve as a road map to examine how preventive policies might be formulated. Having said that, communtiy participation stresses empowerment and equitable partnership, which we discussed might not be *the* goal but only a detour to fulfil the "target behaviours". In this sense, the community might be seen as an active partner with the ability for "care of the self" is only a ruse to serve particular ends.

Thirdly, a language of targets and returns while stressing community participation and empowerment at the heart of the integrated vector control strategy can perhaps hint that the state in its policies follows a result based approach over a rights based approach. (Batliwala 2007) However, the development of an exhaustive list of the potential members of a community for the stated community action might infact show that a "community by spirit"

could lead to effective participation; thereby preventing and controlling dengue to a great extent. . The applicability of such an assertion however is to be empirically explored.

CONCLUSION

This dissertation highlighted that Delhi is an endemic zone for dengue, and emphasised PPP as one of the many strategies in dengue prevention and control. With this idea, the dissertation began by exploring three research objectives. Firstly, PPP is an amalgamation of different concepts i.e. ‘public, ‘private’ and ‘partnership’ which can have huge implications on its usefulness within healthcare programmes. Secondly, the existing model of PPP within dengue prevention and control could be reflective of the implications insinuated by these three concepts, analysed in tandem with other disease control programmes. Thirdly and finally, I looked into current model of dengue prevention and control, the reasons behind its rise and assertion. Overall, the three objectives were embedded within how state policies for public healthcare are structured; and each of these were individually and elaborately explored in three chapters that outline this research.

Chapter One examined each of the three conceptual categories within the sub-field of Sociology of Organisations, and from the lens of different sociological paradigms i.e. rationalist, interactionist, functionalist and conflict. Insights gained here reflected, that the public sector is expected to fulfil the goal of social equity, the private is perceived as profit oriented and utilitarian in its approach; and partnerships are to be understood within the framework of relatedness. This further insinuated that PPP is a complex proposition due to the presence of multiple actors having different perceptions and motivations, along with lack of role differentiation. This organizational difference between the public and the private eventually led to the formulation of two hypotheses, a) the public sector is primarily bureaucratic in its approach, b) the private sector is largely profit driven. These two hypotheses asserted that a lack of coordination and cooperation can thwart a possibility of a potential partnership between the two entities. In the larger scheme of things, the chapter examined PPP as a public policy within the contours of an anthropology of public policy, reflecting the dualism of entreaty and threat which formed the underlying argument in the subsequent chapters.

Chapter Two looked at the two hypotheses outlined above within dengue prevention and control strategies in Delhi. As part of the same, interviews were conducted with NVBDCP officials as well as private lab owners with Delhi to understand the dynamics of PPP at the level of early diagnosis and testing. But, before I delved into the aspect that presented challenges for PPP within dengue prevention and control, I myself was faced with

methodological challenges highlighting that government institutions comprised of public policy makers was not an easy domain for an anthropologist. Herein, the problems of access and rapport intrinsic to anthropology were reflected here more than ever. The drama unfolding the process of "approach and appointment" illustrated that "studying up" necessarily involved the availability and familiarity of a contact in the concerned institution; without which getting data from governmental institutions could be daunting.

The first hypotheses, i.e. private sector envisages a return on investment, resonated with Dr. H's views regarding the mandate demanding a capping of rates for early testing and prompt diagnosis of dengue. His narrative asserted that the private sector does not function solely on notions of social justice but is inclined towards return on investment. This argument was also stated and substantiated by Dr. L of the NVBDCP, who resonated it in the ability of the private sector to provide for newer technologies, efficient delivery of services along with cost-effectiveness. Regarding the second hypothesis, i.e. state is bureaucratic in its approach case-studies from tuberculosis and smallpox, served as prototypes which either supplemented or rummaged the premise of the hypothesis. In referring to these disease prototypes, one is aware that each disease has it own epidemiology and the possibility of comprehending and implementing PPPs is programme specific.

The prototype of PPP in TB, which is said to be blueprint for all PPPs across disease control programs re-instated the emphasis on returns as did the private lab owners interviewed. The TB program highlighted five reasons why private sector inclusion was necessary, b) increasing efficiency, b) private is the first point of contact, c) government has limited resources, d) private sector when roped in RNTCP will reduce cost of drugs, which if solely accessed from the former will be provided at a higher cost, and e) increasing case detection. But the programme faced several challenges as empirically explored in Tamil Nadu and Kerala (Muraleedharan, et. al. 2005), for reasons that were three- fold. To begin with, firstly, there was no formal contact with the private sector, as was the case with private lab owners, where a notification surfaced during the monsoon season, indicating a reduction in the prices of dengue tests. This sense of vigilantism was also explored in terms of how the NVBDCP, conceptualises preparedness for dengue prevention and control. Secondly, RNTCP and private providers follow different courses of treatment which causes for a disparate functioning of the programme. Lastly, incentives and grants provided to the private practitioners in the TB scheme, do not actually come through, re-iterating Dr.H unwillingness to partner with the Delhi government.

On the other hand, the prototype of the Smallpox Programme emphasized that sweeping assumptions as made in the second hypotheses can be problematic as illustrated in the "imprest" account of the NSEP. On the whole, the smallpox program served as a prototype, for the reasons embedded in the argument that the state policies function of the dualism of entreaty and threat. The same was reverberated, in the description of the variolation verses vaccination debate in the 19th century. The assertion of and for the latter by the government, not only highlighted the latent intentions of the state but also the superiority of an episteme archetypal of an image of the Third World dependent on the First World to ameliorate its health conditions. Moreover, to preserve the rhetoric of vaccination, the state was oriented towards the language of returns and targets witnessed through its mass vaccination program for which it adopted various strategies as discussed in the chapter. Another section of the chapter examined the inability of the Delhi state to tackle the current or a potential dengue epidemic through the notion of preparedness. In suturing the data of the NVBDCP with the theoretical underpinnings of preparedness, what came through was that the NVBDCP only responds and establishes partnerships when the disease reaches epidemic like situations. Such an approach therefore, hinders the possibility of a sustainable model for prevention and control.

Chapter Three stated that sustainability is sort by the NVBDCP within the community participation programme. Community participation forms a point of contestation, for which I delved into its historical and conceptual nuances from the perspective of an anthropology of public policy. Prior to that, the chapter dwelled over the conception of the term, its connotations, and typologies by drawing case studies of two disease control programmes in Cost-Rica and India, i.e. malaria and smallpox. On lines similar to chapter one, the intention was to sociologically analyse the terms, 'community' and 'participation' ensconced in the rhetoric of empowerment, responsibility, active partnership etc with the community. A critical sociological examination of the concept of 'community' and 'empowerment' formed the bases for an exploration into how the NVBDCP envisions community participation for dengue prevention and control.

My analysis of the NVBDCP document, in tandem with the literature reviewed on 'community', 'participation' and 'community participation' in toto; highlighted four key issues. Firstly, the document enlists a set of targeted behaviours to be taken up by the community members to bring about a change in individual behaviour towards dengue prevention and control. Secondly, it presses for heightened alertness during monsoon and post-monsoon period, or when a virological surveillance indicates a dengue outbreak. This idea of

preparedness re-iterates a lack of continuity and questions the sustainability of the programme. Thirdly, and lastly the document realizes the significance of community knowledge and beliefs without rebuffing them. But, as an instance it does not state the upcoming and pressing belief placed in the utilization of alternatives, such as papaya juice leaves and goat's milk. Lastly, it potentially obscures the notion of 'needs', not stating what those 'needs' constitute. The chapter culminates at the theoretical exploration of the assertion that the state functions on the dualism of entreaty and threat, an underlying and running theme across chapters. I refer to Foucault's notion of "governmentality" to explore this dualism. The argument that at a point in time the welfare of the population becomes the ultimate end of the government highlights the 'tactics' undertaken by the latter as also reflected in its preventive healthcare policies. It highlights the ability of the government to access patterns of population behaviour eventually used to govern them by adopting disciplinary powers.

In conclusion, the dissertation can provide insights and guide policy makers to design healthcare policies not on a means to end continuum, but with the criticalities that accrue this research. In addition, theoretical explorations into the organizational characteristics and differences can present the challenges head on before formulating policies and implementing them in the field. Moreover, it can be further elaborated by considering the (efficacious or non-efficacious) working of community participation for dengue prevention and control empirically which I have not be been able to do due to paucity of time. Lastly, while this research is confined to the field of bio-medicine, emphasizing early detection and vector control strategies, it can be extended further by exploring the dengue prevention within the field of alternative medicine.

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