Special issue on Anthropology and Public Health:

An Introduction

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The thrust of this special issue is on the potentially promising endeavour of doing research at disciplinary intersections – disciplines of anthropology, more specifically medical anthropology and public health, in the common pursuit of understanding health, illness and suffering.[1] This issue seeks to chart out the productive engagement as well as tensions at the sites of such intersectionality. It consciously draws on contributions from scholars who work at such intersections i.e. biomedically trained turned anthropologically informed public health professionals[2] and anthropologists/sociologists who engage with public health either directly serving in public health institutions and/or through addressing critical public health concerns. Two liberating developments both in the disciplines of medical anthropology and public health have opened up scope for intersectional research and practice. These developments relate to the emergence of critical medical anthropology (CMA) in medical anthropology and health system research (HSR) or health policy and systems research (HPSR) in public health.

Critical medical anthropology in anthropology

The emergence of critical medical anthropology (hereafter referred to as CMA) in the mid-1980s is a turning point in redefining the scope of medical anthropology.[3] Its implications specifically for the field of public health can be discerned in two main contexts. The first, establishing a theoretical and analytical shift, it breaks itself free from a narrow focus on medical anthropology as mere cultural fillers/brokers for biomedicine and/or mainstream public health. In this role, anthropology has been expected to identify the cultural or social factors that inhibit the success of a public health program, non-compliance of the patients to a specific medical regimen or delay in seeking medical care, thus uncritically accepting the hegemonic ideologies and power relations?[4]

Farmer (1992, 1999) cautions the adoption of culture as a kind of isolated variable in public health discussion. He argues that such treatment of culture obfuscates an understanding how the larger social, economic and political processes influence the prevalence, distribution and responses to disease among different populations. Such an isolated treatment of culture, Parker and Harper (2006:2) argue, reduces 'the investigation of social and cultural aspects of

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disease to discreet, static, quantifiable 'beliefs' held by (or sometimes about) the population'. Such a 'factorial model' approach that explores biological, environmental economic, cultural factors in isolation of one another is misleading (*ibid.*).

CMA has been defined as 'a theoretical and practical effort to understand and respond to issues and problems of health, illness and treatment in terms of the *interactions* between the macro level of political economy, national level of political and class structure, institutional level of health system, community level of popular and folk beliefs and actions, micro level of illness experience, behaviour and meaning…' (Singer 1995: 81). Offering an internal critique of traditional medical anthropological works that restrict documentation of health, illness and health care to a micro-level analysis (only),[5] CMA argues for examining the local in relation to the national and global – thus shifting the units of analysis to interactions and interfaces at different levels. Such kinds of analysis, it is argued, could do justice to the holistic endeavour of disciplines like anthropology and sociology in addressing pertinent issues in the field of global health.

Using critical theoretical frameworks, CMA highlights the *political economy of health and health care* thus bringing the role of power to the foreground - interrogating the role of power in social relationships, production and practices of health knowledge, categories, policies and programs. CMA is consciously political as it distinctly recognizes that health itself is a political issue. It acknowledges the fundamental importance of class, racial and other forms of inequality as determining the distribution of health, disease and access to health care.[6] It defines power as a fundamental variable in health related research, policy and practice (Singer 1990, 1995; Baer, Singer and Johnsen 1986; Scheper-Hughes 1990). CMA thus calls for anthropology *of* medicine/public health (critically applied anthropology) contrasted with anthropology *in* medicine/public health (clinically applied anthropology).

Anthropology of public health adopts a critical and analytical perspective turning its gaze (from the individual communities alone) to the world of practitioners, policy makers, global actors, NGOs and, in fact, to the very framework of public policy itself and its consequences (intended and unintended). The notion of culture is transformed from that of cultural 'beliefs' of the lay communities to examining how medicine/public health itself is practiced, experienced and culturally constituted.[7] CMA is committed to expanding the scope of anthropological enquiry in *breadth* (dealing with innumerable issues related to specific diseases, suffering, health of minorities, reproductive and sexual health, organ trade, health system regulations and governance and bio communicability, to offer a snapshot view) and *depth* (multi-sited ethnography, inter-disciplinary research). [8] Inhorn and Wentzell's recently edited volume (2012) maps the present and future terrain of medical

anthropology's work at the intersections of different fields including public health, techno-science and genetics/genomics. Such intersectional work in critical medical anthropology in India is relatively rare.[9]

The second context in which CMA deserves significant attention for the public health project is due to its conscious effort to blend theory with practice. As Singer (1990) notes CMA is a theoretical lens to inspire action and engagement. Baer (1990) defines CMA as that which seeks to merge theory and praxis in a desire to promote experiential health (wherein health is understood in a larger sense of access to and control over basic material and non-material resources to sustain and promote life). CMA thus not merely unpacks the nuances and complexities of the on-the-ground realities, but actively seeks to engage and advocate for desired change. In this regard, Singer (1995) talks about CMA's engagement with both *system correcting praxis* (minor material improvements within the health system for example) and *system challenging praxis* that requires advocating for reorientation of existing social/power relations and knowledge frames.[10]

Elaborating the role of critical medical anthropology to global health from a health system perspective, Pfeiffer and Nichter (2008) note that, apart from other contributions, CMA can ensure that the 'evidence base that frames global public debates is inclusive and represents multiple dimensions of humane experience including the voices of those whose lives are affected by global processes' (p. 413). Critical medical anthropology thus advocates for a critical, analytical, reflexive gaze and is concerned with the world of praxis, social activism committed to equity and rights through the use of sound theoretical frameworks and grounded evidence informing public health policy development.

Health systems research/health policy and systems research in public health

If CMA shows the road to working at the intersections of public health policy and development through critical theoretical and methodological insights, the field of public health is gradually liberating itself from a positivist, technocratic notion of public health practice towards a more inclusive and multidisciplinary enterprise. This is reflected in the emergence of a sub-field within public health – health system research (HSR) or more recently health policy and system research (HPSR). A relatively newer development than CMA, HSR emerges with the realization that a focus simply on treatment and prevention of specific diseases through technocratic solutions is too narrow and insufficient to both disease control (and prevention) and addressing other critical issues of equity, access and quality of care (Tavis P. et al 2004; Jamison et al 2006; Janovsky and Cassess 1996).

This research then turns its attention to the understanding and analysis of the health system per se in order to be able to contribute to its strengthening and to improve equitable access to protective, promotive and preventive health care (Van Olmen et al 2012; Tavis et al 2004; Hoffman 2012; Task Force on Health System Research 2004; WHO 2007). It perhaps began with attempts to address several practical concerns in terms of effective service delivery, improving implementation including scaling up of public health programs and ensuring inclusive health policies The entry point of HSR is the acknowledgement of the fact that a health system is essentially complex and needs to be adequately understood.

Several health systems frameworks are being developed trying to comprehend the complexity and dynamics of health systems.[11] A 'systems thinking' perspective signals a paradigm shift seeking to understand the underlying characteristics and relationships among different components of the system and its larger context that explains not merely why a program works/does not work but for whom and under what circumstances (De Savigny and Adam 2009). The need for a holistic analysis capturing the system complexity, dynamics, interactions and interrelationships is at the core of such systems thinking. Such an understanding has necessitated roping in concepts, perspectives, methodologies and empirical work done within social sciences. In fact the term health system itself is indicative of dipping into the classical terrain of social science.[12] HSR thus unsettles the certainty, predictability, linearity and universality associated with biomedical and to some extent population health research, thus indicating its tilt towards social science perspectives of understanding social reality.

The recent extension of HSR to health policy and system research (hereafter HPSR) not merely sharpens the contributions of social science perspectives to HSR but highlights the multidisciplinary (or more appropriately inter-disciplinary)[13] characteristic of this budding field (WHO-Alliance 2007; Sheikh et al 2011; Gilson et al 2011; Bennet et al 2011; Gilson 2012, WHO-Alliance 2012; Ghaffar et al 2012). The inclusion of 'policy' in the field of health systems is not a semantic play. Rather as Sheikh et al (2011:1) clarify 'the term better captures the terrain of work it encompasses because it explicitly identifies the interconnections between policy and systems and *highlights the social and political nature of the field'* (emphasis added). This development has been steered by researchers who have brought social science perspectives to understand health systems and policies.

The understanding of health systems stretches beyond unveiling the dynamics and interactions among different components to sharpening the role of power, values, trust and in fact examining health systems and policies as social and political constructs. An interpretive and critical enquiry in HPSR is at the core of examining policies to inform effective policy and decision making. Such an

enquiry goes beyond doing research *for* policies to include research *on* policies (WHO-Alliance 2007). The potential of several interpretative and critical theoretical perspectives including Foucault (1980), Bourdieu (1990), Habermas (1981) is being relooked at to understand health system and policy concerns thus bringing CMA (discussed above) and health system and policy research closer to each together.[14]

It has been rightly argued that HPSR focuses on (re)framing research questions demanded of complex health systems followed by their investigation through multiple methodologies, theoretical and analytical frameworks (WHO-Alliance 2007; Gilson et al 2011; Sheikh et al 2011; Bennet et al 2011). Hence no specific disciplinary concerns but research questions are the entry points. One could also read this argument in the context of breaking the traditional monopoly of biomedical professionals in public health and the fact that multi-disciplinarity/interdisciplinarity is no academic fancy but a critical necessity in public health to understand and inform effective policy and decision making.

Reflexivity hence is at the core of these developments both in the field of anthropology and public health creating fertile ground for work at the disciplinary intersections. However, while one does share the initial euphoria of this juncture of interdisciplinary research, the field at this stage is marked by several tensions and challenges. Some of these tensions have already been documented (WHO-Alliance 2007, Sheikh et al 2011; Gilson et al 2011; Bennet et al., 2011). We tease out further some of these tensions relating to methodology and translations of research findings largely through reflections in the Indian context. The six research contributions in this issue amplify these further.

Qualitative tools or qualitative enquiry?

As discussed above, the strength of HSR/HPSR is multi-disciplinarity and/or inter-disciplinarity, more specifically the use of social science research methodologies to weave into the perspectives of health practitioners. However very often the strengths of such research methodologies (largely drawn from disciplines of sociology and anthropology) are (mis)perceived and limited to the mere use of qualitative research tools (more popularly semi-structured interviews and focus groups discussions). Lambert and McVeitt (2002) discuss the methodological and empirical fallout of such mis-utilization of sociological/anthropological methods. In fact they note that the focus on methods (tools) sans the theoretical and conceptual frameworks which guide these methods is to obscure the strengths of these participating disciplines. Using these tools alone does not inevitably make the research multi-disciplinary as asking a few open ended questions does not amount to rendering it ethnographic (qualitative) (Lambert and McVeitt 2002; Parker and Harper 2006). Instead, it often leads to erroneous and misleading research findings and

perceptions of qualitative data being 'subjective' 'anecdotal' and 'messily descriptive'.

One does come across public health research in India where data collected from the qualitative research tools sit as a cosmetic 'add-on' to the more trusted quantitative data or sit in isolation without any analysis of relations among several themes, disjointed from the broader research enquiry, best described in the words of one of my former colleagues as 'disconnected bullet points'. It is no wonder, sociologists/anthropologists working in public health research settings are expected to teach their practitioner colleagues the 'quick' steps to use qualitative tools and analysis (only). Qualitative research in this sense has become everybody's business without sufficient disciplinary training and/or engagement, a trend resented by Popes and Mays (2009) who note that a creative and interpretative turn in qualitative enquiry is distinctly missing in the recent upsurge of qualitative research in health sciences.

HSR/HPSR sets out to decode the complexity of health systems and policies by addressing a host of research questions that need deeper, systematic and rational investigation. It deploys a critical and interpretive enquiry that necessitates the understanding of the knowledge base of interpretative theoretical frameworks and concepts. Though there seems to be a wider acknowledgement among many public health researchers that qualitative research tools enable answering not merely *what* happens but more importantly *how* and *why* this happens (how programs work, for example). Such 'why' answers and explanations are often guided by rationalist and positivist perspectives.[15]

The danger of reductionism looms large here. The explanatory value of theoretical and analytical frameworks is conveniently underestimated. On the contrary, efforts to seriously engage with theoretical, analytical and methodological frameworks to systematically answer research questions are deemed too 'academic'. One often hears fallacious distinctions between 'academic research' and 'policy research' (assuming the need for more rigour in the former only), 'pure research' and 'policy research' (the latter referring to health system research) in formal and informal discussions in work settings.

Speaking of the methodological and conceptual challenges of policy analysis, Walt et al (2008) plead for more critical application of existing frameworks and theories in public policy to guide and inform health policy enquiry acknowledging that contributing to theory development is a goal of policy analysis itself. Hence what is needed in HSR/HPSR is not the use of fragmented and scattered qualitative research tools but a qualitative enquiry that guides the framing of questions, inevitably juxtaposing and triangulating several methods and kinds of data - quantitative data is as much a part of this as

narrative interviews, document analysis, observations, in-depth interviews and focus group discussion.

The juxtaposition of methodological insights is intrinsic to qualitative enquiry for constant validation of data and to arrive at analytical generalizability (not statistical). It is as much a challenge for anthropologists and sociologists to teach and practice (and not succumb to quick demands) qualitative research qualitatively in multi-disciplinary settings as for professionals from other backgrounds to engage with such disciplinary insights. The challenge mounts as research institutes involved in HPSR in India, are hardly multidisciplinary - at best with one sole sociologist/anthropologist or a few junior social science researchers. Mills et al (2008) in this context draw attention to the need for rigour in health system research. This seems an important alarm bell in India as health systems research emerges as a popular research destination.[16]

The lack of effective utilization of research methods indicates the limited research capacity of many HSR/HPSR professionals in low income countries including India, a finding that resonates with the recent HSR Mapping exercise led by the WHO Alliance in 2012 (Decoster, K., A. Applemans and P. Hill 2012). As this mapping exercise shows, what is critically missing in understanding of HSR (among many researchers involved in it) is the 'holistic lens' which is an integral characteristic of HSR. In India, this finding bears additional significance as on the one hand public health institutions (including research institutions on health) seem to be proliferating and on the other many university social science departments (Sociology, Anthropology specifically) are lackadaisical in instituting relevant training curriculum or even actively pursuing a more engaged anthropology.

Rarely do university departments/centres in India have public policy, CMA or anthropology of public health courses either at post-graduate or research degree level. In the same vein, one witnesses a disjuncture between public health training courses in India and the emerging research trends in health system research. While research funding to enhance capacity of students and professionals in doing inter-disciplinary research is certainly warranted, we wish to emphasize that it also requires a pro-active engagement of all professionals involved in this field towards creating a culture of 'doing research', respecting and engaging with multiple forms of knowledge and perspectives for a deeper understanding of health policies and systems.

Research insights too complex?: Evidence to policy

Another related tension that glares at researchers involved in this intersection is in interpretation and translation of research findings for effective policy making. CMA in this regard, has been self-critical of its policy shyness and seeks to shed its traditional image of speaking complex and complicated truths

(Singer 2012; Nichter 2008; Lee and Goodman 2002; Martin 2012; Van Willigen 2002). In this context, Singer (2012: 199) talks about the need for sharper attention to public policy training in medical anthropology courses to move from 'occasional to regular influence in health policy decisions and to break free of the traditional narrow characterization of anthropology as the study of the exotic and obscure'. Back home, Srivastava (2012) cautions against the danger of a tendency of 'inward gazing' in Indian anthropology and argues for the need for a more engaged anthropology.

Such reflexivity is perhaps less distinct among researchers involved in HPSR (particularly those recruited from practitioner background). While acknowledging that the complexity of health systems is at the core of the need for inter-disciplinarity in HSR/HPSR, research that unpacks such complexity is dubbed as too complex or 'too ethnographic'. Nambiar's article in this issue examines the possible repercussions of such labelling. This labelling exemplifies some of the tensions discussed in the aforesaid text including the persistence of a rationalistic worldview that sees HPSR evidence in terms of problems and solutions. Evidence that talks about processes and contexts tends to be underestimated and neglected.

There is also an underlying assumption of the top-down flow of policy decisions. Sheikh and Porter's article in this issue is a timely correction to some of these assumptions. Though there is no contestation of the fact among HSR/HPSR researchers that public health policy and practice need to be based on sound evidence, there seems to be an uncritical engagement with issues on a) what constitutes 'evidence' b) effective modes of evidence dissemination c) processes of translations of research evidence to policy and d) scope of policy research itself – subscribing to short terms goals and/or contributing to theory development as well.[17]

We join the plea of WHO-Alliance (2012:2) that calls for 'changing mindsets' to create a culture of evidence informed decision making. This call sets out to 'encourage active engagement between researchers and policy/decision makers and calls for *both sides* to understand and value the need to build capacity in HPSR' (emphasis added). The need for changing mindset evidently extends to the research community involved in HPSR as it sees it an imperative to 'unify the diverse disciplines which are weakly integrated and combine the several forms of knowledge for a truly integrated instrument of change' (ibid:2). The contributors to this issue in this regard initiate a dialogue, provoking engagement with issues raised at disciplinary intersections and showing productive pathways ahead.

The papers

Kabir Sheikh and John Porter's article uses Habermas' notion of communicative rationality to analyze the nature of the gap between national public health guidelines for HIV testing and practices by medical practitioners in urban hospitals. Drawing on data collected through in-depth interviews with a range of actors including medical practitioners in public and private hospitals in five cities in India, administrators, representatives of civil society organizations and international agencies, the article problematizes the notion of 'rationality' inherent in the problem solving orientation of the dominant public policy discourse. The authors argue that such an approach closes doors for acknowledging alternative frameworks/knowledge which could contribute to improving policy implementation *processes*. Through illustrative examples from the study, they demonstrate that 'under the cover' practices (clandestine mandatory pre-surgical testing by private practitioners for example) serve as examples of 'distorted' communications between different actors involved in framing, implementing and regulating policy guidelines. Strengthening this argument further, their study conversely shows examples of positive communication efforts (active though sometimes conflict-ridden negotiations around developing appropriate hospital policies for HIV testing, or open debates between international actors and local hospital authorities on the rationale for routine testing) creating opportunities for achieving mutual understanding for a joint course of action. The article shows why policy analysis needs to account for understanding the lived experiences and values of the different actors involved as lack of space for open dialogue and accommodation of varied experiences and knowledge (absence of communicative rationality) could explain much of the gap between policy design and implementation.

Extending the argument for a more nuanced policy and program analysis, Prashanth N.S., Bruno Marchal and Bart Criel draw attention to the critical limits of existing evaluations studies in India and build a case for why social science (more specifically anthropology and sociology) inputs could offer much-needed solace to the deficient literature on evaluations of public health programs in India. Based on a document analysis of available secondary literature, the article argues that the existing literature on program evaluations in India does not sufficiently answer *why* and *how* certain programs work for some and not for others. An adequate understanding of the processes at work is important in order to either scale up or replicate programs. Locating the paper in the emerging global literature on realist evaluation, the authors demonstrate how realist evaluation that is sensitive to the context, actors and processes could offer answers to the questions plaguing implementers and policy makers on the ways programs work. Realist evaluation employs a theory driven enquiry and adopts multiple methodologies thus answering not merely the more practical implementation related issues in a particular context but contributing

to theory building on complex interventions and the ways these could work in varied contexts.

Flora Cornish and Riddhi Banerjee elaborate further the usefulness of realist evaluation by drawing attention to the specific mechanisms and processes through which peer education and community mobilization become effective in HIV prevention efforts. In their article, they draw on the concept of social capital and identify mechanisms that corroborate the narrative of success of the sex-workers-run Sonagachi Project in Kolkata, India. Through analysis of these micro-mechanisms, they seek to argue that an important task of interventions in marginalized settings should be to nurture the 'ordinary', informal networks of community. Making a theoretical contribution to the social capital thesis, the paper shows how increasing interactions between peer educators and other community members can function to exchange practical strategies and to build norms on the basis of relationships of trust. As the evidence in this context shows, social capital is a *conduit* for expert practical knowledge, *reduces risk* by providing access to problem solving networks and is also a *social pressure* to fulfil responsibilities.

Tulsi Patel, Jaydeep Sengupta and Suhita Chopra Chatterjee in their respective articles show how research evidence in CMA and HPSR should also contribute to setting public health policy agenda thus *demanding* policy attention, specifically of neglected and marginalized health priorities. Using document analysis and drawing upon her decade's ethnographic work on reproductive health, Tulsi Patel documents the challenges of women undergoing infertility treatment in India. She situates these experiences in an increasing medical infertility market catered to by the private sector. Caught between the cultural stigma of an infertile woman and high cost fertility treatment (without guarantee of success), these women traverse several medical, personal and social encounters of hope, success and despair. These experiences are examined in the health policy context that has always privileged the strategies of fertility control and rendered problems of infertility a non-issue.

Jayadev Sengupta and Suhita Chopra Chatterjee in their paper reflect on the increasing global concern to bring end-of-life care to the public health agenda. The paper, based on a review of literature, provides insights on the contextual factors prevailing in India, including epidemiology of death and problems in the existing health system. The paper shows while the changing demographic and epidemiological trends in the country validate the agenda of end-of-life care, India is far from geared towards such a discourse. Information deficit on death and dying, lack of integrated health structures with competent workforce (conforming to needs of end of life care) and the culture of care giving in palliative care offer daunting challenges for prioritizing end-of-life care.

Devaki Nambiar's article examines the methodological entry of ethnography to health policy and systems research. Through an auto-ethnographic account of being involved in several policy research processes including the High Level Expert Group on Universal Health Coverage set up by the Government of India, she discusses the strengths and challenges of the ethnographic sensibility in HPSR. While the methodological strengths of ethnography are appreciated in HPSR, translation of certain findings is dubbed as 'too ethnographic' and in fact not relevant for the key audience (decision makers). While sharing this as a serious concern, she on the other hand sees the potential of ethnography not merely as research 'evidence' but as epistemology demonstrating its manifestation within the processes and deliberations of health decision-making. She demonstrates how the research processes leading to knowledge translation are characterized by a series of ethnographic encounters and interactions thus making the whole process of research–knowledge dissemination-informing decision, an ethnographic project itself.

The contributions together provoke engagement with several issues around doing research on public health at the intersections of disciplines. While these themes continue to be deliberated in many forums at a global level, this is missing in the Indian context.[18] We hope that the dialogue and engagement in this field continue in India and contribute in the long run to 'changing mindsets', turning the field of public health/health system research truly interdisciplinary in spirit and in practice.

Notes

[1] I sincerely thank Mark Nichter, Tulsi Patel, Devaki Nambiar, Bart Criel, Jean Pierre Unger, Prashanth. N.S. and Aditi Aiyer for their extremely valuable comments on the draft of this introduction.

[2] Such reorientation is facilitated through formal inter-disciplinary training and/or continuous, critical engagement with disciplinary insights and methodologies in anthropology/sociology. Authors of the first two articles fall into this category.

[3] Some of the early proponents of CMA include Baer, Singer and Johnsen 1986, Baer,1990 Scheper-Hughes, 1990, Ogden 1999, Singer 1990, Farmer 1992, 1999

[4] Parallels are often drawn between Anthropology's relationship with biomedicine and the history of its relations with European colonialism (see Scheper-Hughes 1990)

[5] Such woks refer largely to exploring local conceptions of health, illness, health seeking behaviour which apply the holistic analysis within the 'local'. CMA proponents would not argue that such analysis is inadequate but it is insufficient, more so, in a changing landscape of global health.

[6] CMA in this context draws inspiration from seminal works in the history of medicine.

[7] See Lupton 2010, Petersen 1997

[8] Interdisciplinarity is used here to refer to the ability to intersect on a theoretical and methodological level with one or more academic fields. See Inhorn and Wentzell 2012

[9] See Mishra 2010 for research trends in medical sociology/anthropology in India

[10] See Singer 1995, Cheney 2008 for examples of such praxis

[11] For example Van Olmen, Criel, Van Damme et al (2012) unpack the complexity of health systems through an analysis of dynamic interactions among ten elements characterizing a health system including goal and outcome, values and principles, population, context, service delivery, different resources etc. Hoffman (2012) unpacks notions of health system evidenced in 41 health system conceptual frameworks

[12] Very few public health researchers are conscious of this genealogical link and refer to health system as if it were a new invention in public health research.

[13] While multidisciplinarity would imply participation of several disciplines like sociology, political science, economics, epidemiology thus bringing in multiple perspectives, interdisciplinarity would imply methods of several disciplines interplay with each other to address research themes. The challenge in this exercise has been to epistemologically blend concepts and perspectives.

[14] See Unger, Paepe, Van Dessel, Stolkiner 2011, Shaw 2010

[15] One finds a parallel in the debate between the Latin American School of Social Medicine and the right wing public health specialists about answering such whys. While the former focuses on social determinants, the latter highlights the biological though the debate does not consider access to care an important element in this discussion. See Tejerina Silva et al 2009 for more on this debate

[16] The recently concluded Global Symposium of Health System Research organized by the WHO-Alliance with Peking University of Health Sciences, China saw a large number of 'health system researchers' from India.

[17] See an emerging global literature that examines pathways of research evidence to policy making including Orten et al 2011, Browson et al 2009, Panniset et al 2012, Elliot and Popay 2000

[18] Associations like the Society for Indian Medical Anthropology (www.medicalanthro.com), Indian Association for Social Sciences in Health (www.iassh.org), Indian Anthropological Association (www.indiananthropology.org.), Indian Sociological Society (www.insoso.org) have an important role to play in this regard.

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