Public Health and the British Empire: From Colonization to Decolonization

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Abstract

This article traces the process of how colonization and eventual decolonization within the British Empire affected the development of public health infrastructure within British India versus British East Africa, and why these countries have developed differently into the public health systems today. Even though each nation was colonized by the same nation, they have developed different levels of health care services offered, as well as have differing degrees of influence from international organizations like the World Health Organization.

In 1947, India became the first of the colonies to fight for and receive their independence from the British Empire. Almost 40 years later in 1976, the Maldives would become the last. Following the end of World War II, nations that had previously been colonized began to see a new wave of nationalism and efforts toward independence among their citizens. Nations such as France, Britain, and others, who had once been influential powers on the world stage and holders of colonies around the globe, slowly began the process of decolonization following the war. The process was not immediate for most and some movements resulted in violence and revolt before their independence was gained.

Colonization by the British came much earlier for India, as was the case with most territories under British colonial rule. Upon colonization, British officials and military were highly affected by the spread of the cholera epidemic. Cholera, a water-born illness that originated in India, is an extremely virulent disease that kills its victims within hours of people showing symptoms. Cholera presents as dysentery acute infection, which causes extreme dehydration and eventual convulsion of the muscles which became so forceful that, even after death, the bodies of those infected continued to convulse. As a result of the confined spaces and poor conditions in which soldiers of the British military lived, as well as the continuous movement of the military forces, the cholera epidemic was exacerbated. As a result, economic and political aims of the British government within their colonies were hindered and cholera became a subject of much discussion and debate. Eventually it would be in response to this disease that the British would establish the first hospitals and sanitation infrastructure as a means of combatting it. While the infrastructure was developed under the guise of the civilizing mission, public health infrastructure in British India and later British East Africa was established as a means of continuing control over the colonies. It was developed to support military advancement and to appease growing nationalist movements who attributed low socioeconomic standards of the native populations, to the rule of the empire making any type of infrastructure established, sporadic, and for the most part ineffectual.

In British East Africa, or the East Africa Protectorate, which included the area from present day Kenya to Uganda, the rise of colonial power came at the start of World

War II and picked up again more heavily following the war. Following the war, there was also waves of increasing nationalism among the colonial people and a rise in nationalist movements. As a result, Britain sought to remain in control of their territories within Africa. The World Health Organization and other international organizations who were in favor of decolonization, such as the United Nations, had little opportunity to establish any precedent within the area. The decolonization of India, however, aligned with the advent of international organizations such as the United Nations and the World Health Organization. India, as a result, became fa strong influence in early World Health Organization discussions and served as a stage for which the World Health Organization instigated many health-based projects and developed infrastructure pertaining to public health.[1] The differences in length of British occupation as well as the types of medical practices that had been established before the rule of the British is what led to the differences in healthcare systems seen today. The influence or lack there of from outside organizations, such as the World Health Organization following decolonization, only served to exacerbate the already existing gap of inadequate public health infrastructure between the colonial regimes and their colonies.

Both India and what was known as British East Africa saw uneven developments in the form of public health infrastructure established during the rule of the British government. However, even with the rule of the same empire, both British East Africa and British India have resulted in two very diverging forms of public health that have manifested into the various infrastructures that can be seen today.

The Origins of Colonial Public Health in India

The Portuguese created the first hospital established within India in 1510. The Royal Hospital in Gao served the British Empire as a clinic for their British military throughout their occupation of India.[2] As medical care in the British Empire continued to expand, the indigenous population of India came to serve as assistant "native dressers" or "native doctors," as the British government recognized them.[3] It would not be until the Charter of 1813 that the government would set aside money for all types of formal education and development of the locals, including medical school.[4] During the time of colonization, the increase of economic trade and commerce was the primary focus of the British government and any public health concerns were only recognized when disease became an obstacle to increased trade and commerce development.

To justify their presence in many of the presence of the colonies, the British government argued that they had arrived on the basis of a "civilizing mission" in which their focus was to bring the inhabitants of nations, such as India and British East Africa, to a new moral right. This new moral right was what the British believed to be a more modern standard of living. It included components such as Christianity and adopting western views of medicine. Within British East Africa, in rare instances, African natives were also used as assistants, nurses, or were trained in some medical capacity. The locals were also hired to kill rats, which were associated with diseases, in exchange for

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[1] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Basingstoke, England: Palgrave Macmillan, 2006), 75.
[2] Kumar Anil, *Medicine and the Raj: British Medical Policy in India*, 1835–1911. Vol. 103, No. 2. (1998), 17.
[3] Ibid., 18.
[4] Ibid., 19.

compensation.[5] This ethnocentric approach used by the British government to justify their presence in each colony, while misguided and rarely seen in the political and social policies put into place, was the guiding principle behind the missionaries sent into each colony and their widespread influence. Colonial missionaries arguably propagated the colonial government's civilizing mission but did not use it as a tool for repression and justification, but more for the advancement of many inhabitants in terms of healthcare and education. Colonial missionary doctors and administrators often took into account the spiritual beliefs of the African people and acknowledged the presence of evil spirits in order to garner confidence. Some missionaries could be seen walking around a new hospital singing ritual hymns and blessing the area.[6] Missionaries also pioneered the organization of rural hospitals and the advanced training of medical officials in both colonies. Some doctors such as John Tyler, a British surgeon, even refused to speak English, and instead did all his teaching in the Indian vernacular.[7] The missionary doctors and ministers that came along with the British military were the first and most adamant proponents of the civilizing mission. They catalyzed the development of multiple types of infrastructure and provided the means for many inhabitants to gain an education. While some were centered on Western ideologies, many attempted to provide inhabitants with an education centered on their own cultural beliefs. The influence of the missionary workers was a unique component of public health development as it was not centered on the needs of the military or health officials and positively set some ground work for the implementation of colonial public health.

As colonization developed, more health infrastructure was added. Medical schools were established in India, but were primarily used for the treatment of the military soldiers as well as for generating more military based doctors. These newly trained doctors were required to serve in the army or a civil department for fifteen years after three-year medical school term.[8] This colonial outlook of promoting political and economic needs above the needs of the inhabitants of their colonies, especially in the realm of public health can be seen in the letters of Florence Nightingale to the administrative workers within India. Florence Nightingale served as the founder of modern nursing and was an icon following the Crimean War. She was also a strong proponent of colonialism as evidenced by her appeal to the use of sanitation measures as a means for maintaining a colonial stronghold in India. Through her letter "How people may live and not die in India," Nightingale blames the exacerbation of indigenous diseases, such as cholera and the plague, not on the change in climate, but rather on the "existing sanitation negligence" and the behavior of the soldiers in India. Her piece represents prevention versus curative care while also supporting measures that will increase the power and influence of Britain abroad. Nightingale also argues that reforms, specifically sanitation reforms, must happen if Britain is to maintain their hold over India.

Through the use of various statistics covering the death rate of soldiers in the Indian region, Nightingale establishes a general overview of the devastating consequences of the diseases left unchecked. Sixty-nine out of one thousand individuals were believed to be dying per year and this was not even the total that succumbed to death due to conditions within India. Many, arguably, were sent home to die and not recorded in the census of those who died specifically in India. Her calculations concluded

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[5] Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, California: Stanford University Press, 199), 42.
[6] Ibid, 53.
[7] Kumar, *Medicine and the Raj*, 20.
[8] Ibid.

that ten thousand new soldiers would be needed each year if steps were not taken to eradicate the deleterious effects of the disease. For Nightingale's intended audience, this attention to the foreseen consequences of such large reduction in the soldier count indicates both how sure the British officials in India were in their ways, as well as her belief in the importance of reforms in order to maintain control of India.

According to Nightingale's letter, there was a perception by many that the cause of the lethality of cholera and other diseases in the area was due to the climate of the region being vastly different from that of Britain. Nightingale adamantly opposed this idea and instead claimed that the causes of death were "miasmic" and that the deplorable conditions in which they lived and behaviors of the soldiers were the real culprit in the spread of disease. Miasma was the commonly believed vector of disease transmission during the beginning periods of colonialism. As was customary for soldiers, they lived in crowded barracks, lacked exercise, drank excessively as well as came into contact with water that was far from clean. She also argues that the soldiers could be more prone to disease. Therefore, disease was not brought on by climate, but rather "the effects of man's imprudence… attributed to the climate."[9] Nightingale's avid support of sanitation measures demonstrate the limited amount that people during this era did understand about disease transmission and how to curb its spread. It also portrays the reasoning behind why extensive interest was being taken in public health measures.

A small portion of the letter is devoted a small portion of the letter to the British's civilizing mission within India. While these reforms would bring greater health and lower death rates among the soldiers they would also – in what seems like an addition to the argument meant to maintain a sense of mutual benefit – bring about civilizing reforms to Indians.[10] Nightingale ends her argument with a closing directed specifically at the benefits it would have on the people and culture they had colonized. As India was seen as "the focus of epidemics," Nightingale contends that every town in India was comparable to the worst town in Britain. Therefore, it was the moral duty of the colonizer to bring about reform during their tenure.[11] Accordingly, she argues that while some improvements and innovations had been done in the way of commerce, how could any of that be sufficient if nothing is done to protect cleanliness and health? Education and expansion of internal infrastructure would amount to nothing if everyone were sick and dying of epidemics. While Nightingale advocates for the benefits of the Indian people, the argument serves as continued means to justify colonization and is a bonus to the main point of keeping power in the region. This message is vastly different from the beginning of the article, which has strong implications of colonialism and the spread of power and influence. This section seems more of an afterthought or added benefit that sanitation reform would help the locals. The commentary by Nightingale and many other scientists during this time demonstrates the growing concern over health issues as well as the prevalence of sanitation measures as common practice in halting the advancement of disease, most of which stem from the need to maintain control of the British colonial strongholds.

The use of medical schools, as well as the majority of doctors, was meant to serve the military in both India as well as British East Africa. In India specifically it would not be until the shortage of medical professionals within the military ranks that the practice of medicine would be opened up to the native inhabitants. This influx of western

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[9] Florence Nightingale, *How People May Live and Not Die in India*, (London: Emily Faithful, 1863), 7, Countway Library of Medicine, Harvard University, accessed February 18, 2015.
[10] Ibid., 8.
[11] Ibid., 9.

medical teaching practices, however, was shuttled into civilizations that had already had a fairly established medical practice underway. These contrasts as well as the ability of each nation to incorporate both Western and native forms of medicine had a noticeable influence in how medicine is practiced in the region today.

Medical Theories in India

Before the settlement of the British in India, a type of medicine referred to as "Orientalism" was already being practiced. The Hindu Ayervedic system focuses on the four humors and creating an alignment within the body. Doctors who practiced "oriental" medicine within India were known as Hindu vairds or Muslim hakims.[12] Western medicine-based hospitals, from the viewpoint of natives and those who practice oriental medicine were viewed with disdain, as the isolationist approach of western medicine directly conflicted with the familial and religious approach in India. From the viewpoint of the British colonizers, Indian medicine was seen as innately inferior and only pieces that were useful or could compliment Western medicine were used. The British also regulated their medical teachings on the basis of the four humors: yellow bile, blood, phlegm, and black bile. An imbalance of these four humors was believed to cause disease. Medical precedent was to attempt to re-establish the humors by means of laxatives, emetics, or bleeding depending on the ailment. For example, diuretics and emetics were utilized as standard treatments for patients who suffered from illnesses that were believed to be caused by a buildup of bile. Ridding the body of the excess bile therefore would theoretically rebalance the humors and cure the patients.

A tiered system existed within the British empire consisting of ranges in which ethnic groups were classified – Chinese, Arabs, and Indians were considered middle tier, while sub-Saharan Africa and Amer-indians made up the lowest level.[13] The death rates due to cholera purported by Nightingale therefore exhibit the trend of only referring to the white population, specifically the numbers involving the military losses. Therefore, very little is known about the death rates among the native populations in India.

Cultural Uses of Medicine in Africa

In early reporting's of health and illness in British East Africa, a trend existed where newspapers and journals reported only on the illnesses as they affected the white populations and the British officials in the area. In addition, death rates reported in the government-sanctioned hospitals were only disclosing the numbers in regards to whites.[14] The standard of care was also better among white citizens. Any British citizens suffering from epidemics or disease were put under supervision and sent home as soon as was feasible. In Africa, this manifestation of an "other" through the use of medicine was prevalent in the priorities assigned to patients. This "othering" of the African and Indian populations as lesser or underdeveloped in comparison to the British population was a means in which to justify the racial prejudices established as well as the need for colonization. It was also evident through the use of asylums for those believed to be suffering from mental illnesses. While there was no asylum for the insane in the protectorate, there were plans for one. Until that time, African citizens were placed in the

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[12] David Arnold, "Cholera and Colonialism in British India," *Past and Present* 113 (1986): 135.
[13] Teresa A. Meade and Mark Wallker, eds., *Science, Medicine and Cultural Imperialism* (London: Macmillan, 1991), 7.
[14] "British East Africa," *The British Medical Journal*, Vol. 1, No. 2522 (1909): 1091-1092.

"gaol," which was the African term for jail, while British citizens were sent home for treatment.[15]

Africa also quickly began to see the use of medical practices as a racially segregated practice. According to Megan Vaughan, a scholar of African and colonialism, medicine helped construct the notion of the "African," a classification that promoted colonialism by perpetuating the term of the "other" and the need to colonize in order to help the African people become more modern, or more Western.[16] Medical discourse specifically was used to create subjects and objects of study, which also aided in the "otherness" justification of colonialism. For example, "sickness, sexuality and blackness" were all linked and furthered the idea that the native people of British East Africa were predisposed to the contraction of certain diseases. This racial profiling and stereotyping of the people of African as dirty and immoral can still be seen in how the international community reacts to epidemics that arise in the continent of Africa today.

The natives of British East Africa were not entirely receptive to the new forms of Western medicine that were being implemented somewhat sporadically. As these campaigns were military regulated, they were therefore seen as expressions of colonial aggression and oppression. The burning of houses and crops were justified as being sanitary measures. Yet due to the routine raiding of villages for tax collections, as well as the nomadic lifestyle of some, it was difficult to get consent from villagers. This also made vaccination campaigns difficult.[17] Not only the lifestyle of the natives but the distrust and lack of understanding regarding the medical practices of the British, further decreased the extent to which healthcare campaigns were able to be implemented. With small pox vaccination, the natives only saw the pain that inoculation caused not the benefits. The attempts at eradicating the yaws outbreaks, a bacteria infection that causes lesions on the skin, in British East Africa were seen as the most repressive and objectifying practice of colonial medicine by the native people. All who came through the clinics were seen as a number on an assembly line.[18]

Health as a Right

The use of medical infrastructure, vaccinations, and other medical practices were not the only forms of coercion that the British used in order to maintain control of colonies. In most regards, medical investments came behind the advancement of other rights of citizenship such as education. Even with the justification of the civilizing mission, British officials found it hard to financially support the establishment of many of the progressive measures in both India and Africa. For British citizens, there was some anxiety over pouring British taxpayer dollars into British East Africa.[19] As a result, British policies pertaining to the advancement of the local people were only propagated in times of necessary public relations campaigns either to placate the inhabitants or to promote the rising international organizations in favor of removing colonialism. Education, like medicine, was pushed aside unless it was convenient or necessary in order to maintain control of the colonies. Therefore, the civilizing mission again fell into missionary hands.

The missionaries already established schools by 1895 and "were not plagued

[15] "British East Africa," 1091-1092.
[16] Vaughan, *Curing Their Ills*, 8.
[17] Ibid., 43.
[18] Ibid., 52.
[19] Ann Beck, "Colonial Policy and Education in British East Africa, 1900-1950," *Journal of British Studies* 5 (1966): 117, accessed March 9, 2015.

with the administrative troubles of the British officials."[20] One study by local British officials determined that it would take approximately 75,000 euros to educate the 500,000 children of Kenya.[21] Only British collected 575,000 in taxes from British East African residents, but argued that the British population could not be required to pay for infrastructure that they wouldn't use. Therefore, instead of allowing their taxes go to educational purposes, most of the taxpayer dollars of British East Africa went to the development of their own infrastructure; the infrastructure that historian Ann Beck argues was used by the British to exploit the Indian populations resources.[22] However, by 1930, African leaders understood the value and meaning behind an education and were actively petitioning the British government for funds and resources to be allocated for those ends.[23] World War II halted the developments of the government missionaries as well as the rising nationalist movements with their own ideas about a completely African educational system.[24]

For people within India, the right to public health was well supported enough to end up in the first constitution following decolonization and independence from the British Empire. The advent of the India Constitution provided that public health was not "binding" for all but was still one of the directives of governance over the newly defined state.[25] Therefore, the newly elected government of India looked outside of their borders at this time and began to call for international assistance from the new international organizations that were being created.

Influence of International Organizations

Established in 1946, the advent of the World Health Organization, under the United Nations was a shift in terms of healthcare management. It changed notions about healthcare from the responsibility of the national governments to the idea of international cooperation, not seen since the International Sanitary Conferences in 1851. This progression to an integrated system of public health manifested itself differently for different nations.

India was on the verge of independence from British rule by the time the World Health Organization was established. As the newly elected government began to outline a new constitution for a free state, lack of funds prevented much talk over the development of public health infrastructure. Instead, India opened its doors to the World Health Organization. The Southeast Asia region of the World Health Organization had profound effects on discussions during its early periods of the World Health Organization. The organization in turn focused much of their efforts on eradication of certain diseases, specifically malaria, in places such as India. The projects taking place in India were vastly more advanced, elaborate and organized than those taking place in East Africa, let alone Africa as a whole. The World Health Organization was able to work closely with the newly formed Indian government to implement widespread malarial eradication campaigns, venereal disease education seminars, consultations for improving the already existing healthcare institutions, and provide vaccinations for polio, syphilis, and poliomyelitis. By this time, India was already emancipated from British rule, and due to their own lack of funds took initiative in reaching out and accommodating the World

[20] Ibid., 118.
[21] Ibid., 125.
[22] Ibid., 125.
[23] Ibid., 129.
[24] Ibid., 135.
[25] Amrith, *Decolonizing International Health,* 82.

Health Organization in medical consultations. For Africa, some health projects and campaigns were discussed in the reports of the 1951 World Health Organization products, but they were fewer and far less detailed in their implementation and impact. Overall, these experiments demonstrate the types of medical research that was being done under colonial leadership in British East Africa.

Africa was still under British colonial rule, and as colonialism began to come under attack, the British focused most of their efforts on keeping organizations such as the United Nations and those associated with them out of their colonial settlements in Africa. Following precedent set forth by the establishment of the International Sanitary Conferences, international cooperation in health care planning was sought among nations, prior to the use of international organizations. According to colonial historian, Dr. Jessica Pearson-Patel, nations such as Britain, France, and Belgium went to such great lengths to preserve their colonial strongholds within Africa, that they formed an "inter-colonial technical cooperation' in order to placate the World Health Organization and keep them out of Africa. Here these colonial powers sought to meet the bare-minimum requirements of the Charter of the United Nations in "developing the non-self governing territories in which they were responsible."[26] This inter-African network of technical cooperation would deal in all matters relating to hygiene, health, nutrition, and agriculture.[27] Therefore, in Africa, unlike other nations such as India, they relied on cooperation among colonial powers versus organizations such as the World Health Organization.

By comparing the World Health Organization sponsored projects in both India and British East Africa at the time, there is substantial evidence to support the idea that the World Health Organization was underrepresented in Africa during the time of decolonization. This inability to establish relations early on has manifested into a World Health Organization regional body that has not been as successful in relation to other regions. This is evident through the recent crisis of the Ebola epidemic in areas such as Guinea, Liberia, and Sierra Leone, West Africa.

Infrastructure Developed

Following World War II, there were many advances in medical technology that were utilized by a growing surge in nationalism as well as declarations of international cooperation in terms of human welfare. This was by no means a smooth or infallible claim and enterprise, but the advancement of some countries allowed for increase in infrastructure upon which some infrastructure had already been built. While much of these measures were established in order to keep the United Nations and the anti-colonialism sentiment out of the African region, the establishment of agencies and conferences created to advance medical knowledge and facilitate cooperation generated precedent of sharing information, whether scientific or political. In many ways it was geared towards the development of the nation. The health conference of Brazzaville that took place in 1952 served as a reference point and justification for colonialism in Africa.[28] The Commission for Technical Cooperation in Africa south of the Sahara was the first official organization promoted by the colonies of French, British, Belgium, Portuguese, and South African nations. Its role was to introduce new scientific research,

[26] Jessica Pearson-Patel, "Promoting Health, Protecting Empire: Inter-colonial Medical Cooperation in Postwar Africa" etc., 219.
[27] Ibid., 221.
[28] Ibid., 231.

promote research and development of medical personnel in the region, make recommendations to member governments, and hold conferences.[29]

In India, the danger the cholera epidemic posed to the British Empire's political hold on India caused the British to develop sporadic and incomplete sanitation measures and hospitals. However, due to the rising death rates and lack of personnel, the British opened up positions as dressers and assistants to the local inhabitants. Eventually British officials were willing to set aside funds for the first British-sponsored medical school. Still even with the increased preventative measures, following decolonization and especially the reoccurring famines, Indian officials argued that the weakness of the medical infrastructure within Bengal exacerbated the effects of the famine, even though Bengal was fairly advanced in healthcare in comparison to South and Southeast Asian countries.[30] By the time of their partnership with India, the World Health Organization worked closely with institutions such as the Malaria Institute, the Mental Institute, Calcutta Medical College Hospital, All-India Institute for Public Health and Hygiene, Assam Medical College, Graduate Nursing Institutes and more departments and institutions established under the colonization of the British to promote the advancement of public health within India.[31] It is clear that at this time, India had far more advanced and established health infrastructure than the nations of British East Africa were afforded.

Epidemic Management Today

Today, both East Africa and India are still battling large disparities in public health resources that are standard in more developed nations. With the recent Ebola outbreak in West Africa, the World Health Organization Africa branch came under increased scrutiny due to what many perceived as a slow response that has led to devastating consequences.[32] In March 2014, the first case of Ebola, a hemorrhagic fever was reported in Guinea. It would not be until August of that same year that the World Health Organization would deem the epidemic a matter of an international health emergency, a characterization they have only used twice before.[33] Many critics believe that the World Health Organization laid the foundation for the epidemic to get out of control and did not contain the epidemic while it was, in fact, containable. Reports spoke about the economic consequences, such as the effects on tourism and of declaring a national emergency. Since then, the European Union alone has provided approximately 1.3 billion euros to combat the disease in ways such as promoting research as well as better and cheaper diagnostic tests.[34] Still colonialism's long history of putting political concerns over public health concerns was a major factor in the response time of the World Health Organization to the Ebola epidemic. The argument that tropical medicine is only interested in keeping the natives healthy in places such as Africa and India, still demonstrates a very self-serving manner of providing medical relief to underdeveloped and underserved nations.

Even with the amount of money raised, the preventative medicine techniques

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[29] Ibid., 277.
[30] Amrith, *Decolonizing International Health,* 71.
[31] "Periodical Reports on Projects," The World Health Organization 1952 WHO IRIS.
[32] Joshua Keating, "Why Wasn't the WHO Ready for Ebola?" *Slate* (2014), accessed March 9, 2015, http://www.slate.com/blogs/the_world_/2014/10/22/who_ebola_response_the_politics_and_economics_of_why_the_organization_was.html.
[33] "Before there was Ebola: European Responses to Diseases in Africa-Past and Present," lecture from UCIS Pittsburgh, April 14, 2015.
[34] Ibid.

follow a very similar pattern to those of the colonial era. Epidemics such as Ebola, and what was seen with cholera and other epidemics, sparks the questions of origin and could, in turn, lead to a prejudiced thinking of those countries where the disease originates as less modern, dirty, and diseased. This tendency toward the blame game today in the case of Ebola in West Africa reveals a lot about these prejudices and the tendency of the international community's need to blame someone. During the colonial era, the reaction to cholera and other distinctly colonial diseases such as malaria and sleeping sickness was to launch targeted vertical campaigns and vaccination campaigns. These campaigns were much more prevalent than the widespread establishment of public-health infrastructure in the towns and rural areas. The overall lack of training of African personnel also resulted in large challenges post-colonially. Even with the newfound independence of Africa, the hospitals had to be staffed. Because of the institutional continuities between the colonial hospitals and the hospitals in Britain, they had to be re-appropriated and staffed and trained. As the World Health Organization was kept out through the use of the "inter-colonial technical Cooperation," this personnel training and the tools necessary to take over the little public health infrastructure that was left behind has been minimal. What is evident now is the fact that the World Health Organization branch of Africa was and still is not overly equipped to handle such a large and devastating epidemic like Ebola.

For some time, Africa has also been attempting to combat the HIV/AIDS epidemics. While the numbers have begun to taper off, the sixth Millennium Development Goal of Reversal, set by the World Health Organization for 2015, has yet to be met. This has been perceived to be due to a lack of funding by internal governments and shortages of supplies.[35] This lack of financial support stems from an extensive external funding for disease-specific programs such as medications and eradication efforts as opposed to funding for broader health infrastructure.[36] A compilation of the belief that internal organizations should take responsibility, the stereotype of a diseased Africa, and the focus on protecting their own countrymen versus spreading public health infrastructure to rural and underdeveloped areas appears to have led to the unmet goals.

India has also suffered from recent epidemics of influenza in 2009, hepatitis in 2010 and jaundice in 2014. While the public health infrastructure has come under criticism within the past few years, the establishment of more advanced infrastructure allowed for a quick containment of the disease through coordinated eradication measures. Vaccines were made readily available while a task force was recruited to handle and efface the diseases.

Overall, Africa is still reliant on international and outside aid to combat healthcare grievances. India, on the other a hand, while still trying to manage the widened socioeconomic gap between a rigid class-based system, does have a more sufficient health infrastructure to meet the basic needs of its inhabitants. While the system is far from perfect, and still receptive to international aid, it has advanced enough to produce notable scientists, researchers and medical professionals, garnering awards such as the Nobel Peace Prize and others.

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[35] Daniel R. Hogan, et. Al, "Achieving The Millennium Development Goals for Health: Cost Effectiveness Analysis of Strategies to Combat HIV/Aids in Developing Countries," *The British Journal of Medicine* 331 (2005): 1434, accessed March 9, 2015.

[36] Anne Mills, "Health Care Systems in Low and Middle Income Countries," *The New England Journal of Medicine* 370 (2014): 552.

Conclusion

In the postcolonial era, Indian society has seen numerous advancements in scientific technology, from the creation of nuclear weapons to the Nobel Peace Prizes won in science and medicine. While the scientific advancements are not available to all citizens of Indian society, following decolonization by the British Empire, India has made significant progress. The former colonies of Africa, on the other hand, have not progressed as much as India following decolonization of the British Empire. During the colonization period, the rapid transmission and exportation of disease marked a significant step toward the development of the public health infrastructures of these nations. In India, sanitation measures were installed in an attempt to decrease the prevalence of cholera that was both hampering trade throughout the British Empire as well as spreading into England. The instigation of the International Sanitary Conferences in Paris in 1851 was the first transnational attempt at tackling the far-reaching problem of epidemics, such as cholera, yellow fever and the plague. While the conferences eventually contributed to the formation of the World Health Organization and set a precedent for other international cooperation in health care, as well as set the standard for public health foundations, the development between British India and British East Africa public health structures is considerably different. This was promulgated with the sporadic and ineffectual establishment of the infrastructure during the time of British colonization, as evidenced by the timing of the commentary and plans for implementation of public health infrastructure during times of military need or during times where the colonial government was looking to appease growing resentment towards colonization. The decolonization of India, however, was perfectly timed to the advent of the World Health Organization. The newly emancipated nation of India was therefore able to have a large influence in the World Health Organization's initial proceedings, leading to increased activity and aid to the southeast region. Due to the reluctance of the British still holding onto African colonies, the World Health Organization was unable to establish a presence and has since had little ability to make a lasting impact or change on the health of Africa.

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