RESEARCH NOTES
AND STATISTICS

A Note on Sree Narayana Guru's Teachings and Health in Rural Kerala

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Introduction

Many studies have observed that the development experience in the State of Kerala has been different from that in other States of India.[1] It has also been pointed out that socio-religious reform movements have had a major role to play in contributing to this distinct development experience (see Tharakan 1998). In Kerala, socio-religious movements began before political organisations had been formed, and the nationalist movement and other such mass movements had gathered pace. They helped shape the discourse on reform, putting forward a number of socio-ritualistic as well as economic objectives. There were a large number of social and religious reformers in Kerala in the late nineteenth and early twentieth centuries, who attracted people from different regions and walks of life towards an agenda of reforms through exhortation, advice, and preaching. Sree Narayana Guru (1855–1928) was one such prominent reformer, and the Sree Narayana movement (led by the Sree Narayana Dharma Paripalana Yogam), which he inspired, was greatly influential.

There are several studies on the influence of the teachings and advice of Narayana Guru on different aspects of social structure and social practices in Kerala.[2] This note discusses the impact of the advice given by Sree Narayana Guru on child and infant mortality, particularly in coastal and other low-lying villages of the State. Prevailing child and infant mortality rates in Kerala are impressive, and have been pivotal in the State's achievements in the health sector. Kerala has not only achieved but gone beyond the target set in the United Nations' Millennium Development Goals, with respect to the reduction of child mortality.

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[1] The seminal work in this area is Centre for Development Studies (1975). For a quick reference, see Tharakan (2007).

[2] Seminal works such as Aiyappan (1944) and Rao (1979) are available. For an immediate reference, see Isaac and Tharakan (1986).

Kerala's Early Start in the Field of Health Care

It is likely that as early as the very beginning of the twentieth century, the region of Kerala may have had a lower mortality rate than that in other regions of India. Panicker and Soman write:

> The growth rate of population in Travancore [one of the constituent administrative regions of present-day Kerala] had always exceeded that in almost all other States. Even during the period 1891–1901, the population of this State increased by 15.4 per cent when the population in several other States registered a decline and the growth rate for India as a whole came to only 1.6 per cent . . . The substantially higher and more steady growth of population in Travancore and Cochin than in the rest of India in the early decades of the [twentieth] century should imply a lower death rate in the region, unless it be that here the birth rate was higher, which is unlikely. (Panicker and Soman 1984, p. 35)

Table 1 shows that from the period 1911–20 onwards, life expectancy at birth for males and females was higher in Kerala than at the all-India level.

Table 2 presents the death rate, or number of deaths per 1,000 population, in Kerala and India. According to these figures, from the period 1911–20 onwards, Kerala had a death rate that was lower than the death rate at the all-India level. Mortality rates for this period are not available. It may therefore be safely assumed that Kerala, with a higher life expectancy rate and lower death rate than the all-India levels, had a healthier population.

Trends in Infant Mortality Rates

We now turn to infant mortality rates (Table 3).

These figures show that from 1911–20 to 1978, the region comprising present-day Kerala had an infant mortality rate that was consistently lower than the all-India level. This means that Kerala was better situated with respect to child health than the rest of India. The advent of modern or western medical practice, with a

Table 1 *Life expectancy at birth, Kerala and India, 1911 to 1981*, in years

Period	Males		Females	
	Kerala	India	Kerala	India
1911—20	25.5	22.6	27.4	23.3
1921—30	29.5	26.9	32.7	26.6
1951—61	44.3	35.5	45.3	35.7
1961—71	54.1	43.2	57.4	43.5
1971—81	60.6	49.8	62.6	49.3

Note: Figures for 1931–50 are not available.
Source: Ramachandran (1996).

Table 2 *Death rates, Kerala and India, 1911 to 1990*, per 1,000 population

Period	Kerala	India
1911—20	37	47
1921—30	32	36
1931—40	29	31
1941—50	18	27
1951—60	16	23
1961—70	11	18
1971—75	8.6	15.5
1976—80	7.3	13.9
1981—85	6.6	12.1
1986—90	6.1	10.6

Source: Ramachandran (1996).

specialised branch of paediatric or child health, might have contributed to the lowering of infant mortality rates. Such low infant mortality rates could have been attained only if at least one of the three administrative regions, i.e. the monarchical regimes of Thiruvithamkoor (Travancore) and Kochi (Cochin), or the colonially administered Malabar district of Madras Presidency, had invested money in and paid attention to this branch of medical care. There are indications to suggest that this was indeed the case.

Government Expenditure on Health

Data on government expenditure on health and related sectors are available for Thiruvithamkoor and Kochi from 1873–4 and 1887–8, respectively (see

Table 3 *Infant mortality rates, Kerala and India, 1910 to 1978*, per 1,000 population

Period/Year	Kerala	India
1911—20	242	278
1921—30	210	228
1931—40	173	207
1941—50	153	192
1951—60	120	140
1961—70	66	114
1971	58	129
1972	63	139
1973	58	134
1974	54	120
1975	54	140
1976	56	129
1977	47	130
1978	42	127

Source: Ramachandran (1996).

Ramachandran 1996). No comparable data are available for other regions. It is therefore not possible to present a clear picture of sector-wise public or government expenditure on health for Kerala, or for the rest of the country. Further, the data presented here are mainly for Thiruvithamkoor. Since Thiruvithamkoor formed a substantial part of present-day Kerala, these figures are presented as a proxy for the rest of the State.

In 1873–4, in Thiruvithamkoor, total government expenditure was Rs 5,321,000. Of this, Rs 1,45,000 or 2.7 per cent was spent on health. In the next year, the expenditure on health decreased to Rs 91,000 or 1.7 per cent of total expenditure. Between 1874–5 and 1889–90, expenditure on health remained below 2 per cent of total expenditure. In 1890–1, the share of health in total government expenditure increased to above 2 per cent, and in 1894–5, to over 3 per cent of the total expenditure. This proportion increased to 4.2 per cent in 1896–7 and to 5 per cent in 1918–9. The highest share the health sector received was in the early twentieth century, in 1937–8, when it reached 5.9 per cent of total government expenditure.

Meanwhile in Kochi, a smaller region, 1.5 per cent of the total government expenditure of Rs 1,681,000, or Rs 25,000, was spent on health in 1887–8. Compared to Thiruvithamkoor, Kochi consistently had a higher share of government expenditure on health. In 1913–4, health expenditure in Kochi was 13.1 per cent of the total. Even if this particular year's expenditure is taken as an exception, expenditure on health the following year stood at 8.6 per cent of total government expenditure. In 1916–7, health expenditure was 7 per cent of the total, and in many years of the early decades of the twentieth century, government expenditure on health in Kochi was 7 per cent of the total or higher. Though no comparable data from other Indian regions are available, the expenditure patterns of both Thiruvithamkoor and Kochi show high levels of spending on health and related sectors.

Though the expenditure on health was high in at least two of the regions that form present-day Kerala, there is no way to estimate exactly how much of it went to modern medicine. In 1891, 137,880 sick people were treated in 33 medical institutions in Thiruvithamkoor (Government of Travancore 1893, p. 365). Vaccination was made compulsory around 1915, at least in Thiruvananthapuram, the capital. By 1896, grants-in-aid were made available to ayurvedic *vaidyasalas* or clinics/dispensaries that were managed by single ayurvedic physicians, and by 1929, there were 21 government hospitals and 52 dispensaries, in addition to 19 grant-in-aid institutions (Government of Travancore 1929, pp. 309–11). In addition, the monarchical regimes of Thiruvithamkoor and Kochi, including individual members of the royal families, were supporters of modern medical practices, especially vaccination. Christian missionaries who started modern medical institutions were another source of great support to modern medicine.

The availability of modern medical facilities in the prevention and cure of illnesses is likely to have contributed to reducing death rates, and to reducing child and infant mortality rates. Table 2 shows that the death rate in Kerala was 29 per 1,000 population in 1939–40, and decreased to 18 between 1941 and 1950. This seems to have been a watershed in the evolving history of low death rates in Kerala. But if we study the infant mortality rates given in Table 3, we see that even as early as the period between 1911–20 and 1921–30, they had started decreasing decisively. On looking for likely reasons for this decrease in the early twentieth century, we encounter possibilities beyond public investment in health and the introduction of modern types of health-care facilities.

Including the Excluded: The Apparent Impact of the Teachings of Narayana Guru

There are enough indicators to prove that modern health-care facilities were extensively introduced in Thiruvithamkoor and Kochi by the 1930s. In 1916, a Women and Children's Hospital was established in Thiruvananthapuram. In 1930, the Thiruvithamkoor government initiated a public health programme with the assistance of the Rockefeller Foundation, and in 1932, it started a model rural health unit in Neyyattinkara. By 1939, Thiruvithamkoor had 108 hospitals and health centres, in addition to 150 ayurvedic hospitals and dispensaries (Jeffrey 1992, pp. 189–96). It is reasonable to assume that this must have had a major and beneficial effect on child and infant mortality rates in this region, especially in the post-1930 period. Even while giving a positive account of the Thiruvithamkoor government's efforts in the field of health care, which resulted in the "modernising years of the 1860s," a hospital, and an "ambitious programme of vaccination," Jeffrey (1992) notes that "the higher and more respectable classes of the community were the intended beneficiaries of such institutions and programmes" (*ibid.*, p. 189). Similarly, Reverend Samuel Mateer, a European missionary working mainly in southern Travancore, had said in 1883 that marginalised people, such as those belonging to the Valans caste, were unable to access health-care facilities and "fear . . . to go to the Sirkar hospitals, which, indeed, are scarcely for the low castes" (Mateer 1883, p. 96).

Observations made by contemporary and later scholars point to the wide gaps that existed in Kerala's society as a result of caste hierarchy. Even if modern medical facilities were made available, it is likely that information regarding such facilities and access to them did not reach persons at the lower end of the caste system. Narayana Guru's exhortation, made in different locations in Kerala, to prepare food for children using only boiled water must be understood in this context. Those who were mothers among his audience would have followed his advice and directly benefited from it. There are a number of villages in Kerala that lie close to the backwaters and other water bodies. With two heavy monsoon rains annually, the neighbourhoods of a large number of families were surrounded by water for a

considerable period every year. Anything that was disposed of as waste was likely to come back to its place of origin with the turn of the tide and change in the direction of flow of water. In other words, water used for cooking and drinking was likely to be contaminated by water-borne material.

We do not know how many among Narayana Guru's listeners practised what he preached. We also have no record of his original advice. But there are several people in different villages of Kerala who strongly believe that the Guru advised people to cook food for children only in hot or boiled water. Although boiling water would have meant higher household expenditure, women, who were directly responsible for the preparation of food and for feeding the children, were willing to accept this advice. The early acceptance of this advice was due to the fact that it came from a sage who was greatly revered. Its later and wider use may be attributed to the fact that the practice of heating water – irrespective of the expense involved – had by then become culturally ingrained in the village community.

The role played by culture in the formation of energy use habits is discussed in other contexts as well (Wilhite *et al.* 1996). In the specific case of Kerala, behaviour dictated by the logic of caste hierarchy created invisible but strong barriers in the transmission of vital information. It is evident that the so-called upper castes knew about the dangers of consuming ordinary water and would drink water heated with herbs. On the other hand, Reverend Mateer, while talking of the people of the oppressed castes, says that their

> . . . children going quite naked, and often suffering from indigestions, worms, and other diseases, while the parents are so ignorant that they do not even know the use of such a simple remedy as castor oil. (Mateer 1883, p. 96)

The power of Narayana Guru's preaching appears to have broken the barriers that prevented transmission of important information. By following practices prescribed by the Guru, persons belonging to traditionally lower and backward castes were able to improve their health status.

At the same time, Christian missionaries were also working among the marginalised communities of the region. In Cherthala in southern Kerala, for instance, it was reported that the missionaries were instrumental in spreading the idea of cooking food for children in hot water.[3] Yet the sweep and strength of the teachings of Sree Narayana Guru in this matter were considerable. His acceptability to a significant section of Kerala's population can be attributed to the fact that he advocated the reform of ritual practices as well as social reform. The spread of Narayana Guru's teaching is likely to have contributed to improving child health and reducing child mortality in Kerala.

[3] I am grateful to Dr Rajesh Komath, School of Social Sciences, M. G. University, Kottayam, for this information.

References

Aiyappan, A. (1944), *Iravas and Cultural Change*, Bulletin of the Madras Government Museum, Madras Government Press, Madras.

Centre for Development Studies (CDS) (1975), *Poverty, Unemployment and Development Policy: A Case Study of Select Issues with Special Reference to Kerala*, United Nations, New York.

Government of Travancore (1893), *Travancore Report of the Census, 1891*, Government of Travancore, Trivandrum.

Government of Travancore (1929), *The Travancore Administration Report for 1929–30*, Government of Travancore, Trivandrum.

Isaac, T. M. Thomas, and Tharakan, P. K. Michael (1986), "Sree Narayana Movement in Travancore, 1888–1939: A Study of Social Basis and Ideological Reproduction," Working Paper No. 216, Centre for Development Studies, Trivandrum.

Jeffrey, Robin (1992), *Politics, Women, and Well-Being: How Kerala Became a 'Model'*, Macmillan, London.

Mateer, Reverend Samuel (1883), *Native Life in Travancore*, W. H. Allen and Co., London.

Panicker, P. G. K., and Soman, C. R. (1984), *Health Status of Kerala: The Paradox of Economic Backwardness and Health Development*, Centre for Development Studies, Trivandrum.

Ramachandran, V. K. (1996), "On Kerala's Development Achievements," in Jean Drèze and Amartya Sen (eds.), *Indian Development: Selected Regional Perspectives*, Oxford University Press, New Delhi, pp. 205–356.

Rao, M. S. A. (1979), *Social Movements and Social Transformation: A Study of Two Backward Classes Movements in India*, Macmillan, New Delhi.

Tharakan, P. K. Michael (1998), "Socio-Religious Reform Movements, Process of Democratisation, and Human Development: The Case of Kerala, South-West India," in Lars Rudebeck and Olle Tornquist (eds.), *Democratisation in the Third World: Concrete Cases in Comparative and Theoretical Perspectives*, Macmillan and St. Martin's Press, London.

Tharakan, P. K. Michael (2007), "Kerala Model Revisited: New Problems, Fresh Challenges," in A. Vaidyanathan and K. L. Krishna (eds.), *Institutions and Markets in India's Development: Essays for K. N. Raj*, Oxford University Press, New Delhi, pp. 345–59.

Wilhite, Harold, Nakagami, Hidetoshi, Masuda, Takashi, Yamaga, Yukiko, and Haneda, Hiroshi (1996), "A Cross-Cultural Analysis of Household Energy Use Behaviour in Japan and Norway," *Energy Policy*, vol. 24, no. 9, pp. 795–803.