Borderland City in New India

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In 2012 I stood on the fourth floor of the Shija Private Hospital in Langol Lamkahi. On the other side of the road running past the hospital and all the way along the foothills to the National Games Village – completed to house athletes for the 1999 event and then sold off, in controversial fashion, in the years following – is a church built on a hillock, a cluster of houses on various flattened patches of hill, and at street level a row of restaurants and small hotels. A small sign marking the start of the ‘reserved forest’ is lost among the advertisements for *Palmei Fooding and Lodging*, *Triune Medicos*, and scores of small signs advertising various training courses and tutors to help students pass medical examinations. As I stared out the window a bus full of young women in yellow and purple nursing uniforms passed on its way to the hospital’s own nursing college. At night, while much of Imphal is in darkness and the hills of Langol are speckled with small house lights, Shija glows from the lights generated by its own power supply. The site has been dubbed ‘Health City’; a phrase that even the Chief Minister has begun to use.

The domed main building stands out in the landscape of Langol – its reflective glass visible against the backdrop of the hills. Branching out from the main building are a series of single-storey clinics and specialist centres, offering everything from obstetrics, to cosmetic surgery (specialising in rhinoplasty and blepharoplasty), to cardiology. Along the walkway connecting these clinics is a huge board listing the names of all the doctors who practice in these clinics, and in the wards and their hours. Almost all of them are from Manipur. This is significant given the brain drain out of the region usually creates the opposite scenario.

Part of the car park is given over to the hospital’s own ambulance service. At the rear of the compound is a new blood bank and transfusion centre funded through MDONER and the NEC, the Indian Government’s special ministry and coordinating agency to orchestrate development of the region. The blood bank is the only one of its kind in the borderland. In mid-2013, on one of many visits to Shija, I toured the blood bank with the hospital’s public relations officer. I was telling him how impressed I was by the technology on display in the facility. He mentioned that the blood supply to Shija from the public hospital was unreliable, so they needed to secure their own supply. He paused and said, ‘We need a reliable supply of blood because a lot of people get shot here’.

This chapter is concerned with the endogenous liberalisation of the health sector in Imphal. The boom in private healthcare has been dubbed ‘health
city', referring to the concentration of high-quality private health facilities in the city. This poses an obvious and somewhat compelling question: What explains world-class health facilities in such a tumultuous polity? The dire condition of the public sector, Manipur's high number of health professionals, the availability of (once) cheap land on the outskirts of the city, and the injection of capital from so-called silent partners all play their part. Demand from patients in Myanmar and other parts of the borderland is also a factor. This has produced alternative ways of enabling movement mobility across the border for patients that bypass Indian authorities. However, the private health sector is also an expression of self-sufficiency, of what can be achieved independently of the Indian state and the civilian government in Manipur. For a polity where the desire to reinstate sovereignty lost in 1949 has been a power determinant of the present conjuncture, the private health sector is a model of what can be achieved if the people of Manipur are left to their own devices. In a context where state-led development reflects neo-colonial occupation, self-sufficiency is a powerful symbol of both lost autonomy and future capacity – yet future capacity is almost always imagined as an autonomous state. Imphal's booming health sector is private by necessity, not desire. The boom in private healthcare has also transformed the landscape on the northwestern edge of the city created new battles over land between settlers who moved into the peri-urban fringe in the 1990s escaping conflict and a new class of medical and other professionals seeking land and entrepreneurs seeking to build new facilities.

I begin with a discussion of health liberalisation in India and an account of a different path to liberalisation in Imphal. The second section focuses on the decaying public system and the emergence of an irresistible narrative about the benefits of the private health system; narratives supported by the quality of the facilities, care, and treatment experienced by patients. The third section returns to the puzzle of a world-class transnational health hub in the disturbed city. I argue that the health sector reflects a pragmatic response to state dysfunction and a kind of accidental liberalisation particular to Imphal. The chapter closes with an account of the ways the health city has pushed the boundaries of Imphal to the northwest, transforming the previously ambiguous zone around Langol into legible urban space.

**Building a Health City**

Throughout India there have been major changes to the provision of healthcare following liberalisation in the 1990s. As Selvaraj and Karan demonstrate
(2009), health insecurity has increased in India since liberalisation in the wake of escalating healthcare costs for inpatients and outpatients, user fees for public facilities, patients being asked to procure their own medicines, the ascendency of the private sector in medical education, and in the training retention of personnel, and a growing urban-rural divide in access to healthcare. This increases the costs of healthcare on patients and their family members, increases household debt, and influences decisions on whether to seek treatment in the first place. The Indian Government has responded with various measures, including a health insurance scheme targeting families below the poverty line, the Rashtriya Swasthya Bima Yojana (RSBY) launched in 2008, and the National Rural Health Mission, launched in 2005, that increases availability of essential healthcare in rural and remote areas. Critics argue that these schemes further enable liberalisation of the health sector as they push patients towards private health providers without significantly reducing financial risk for the poor (Selvaraj and Karan, 2012; Vellakkal and Ebrahim, 2013). In a study of RSBY in the state of Maharashtra, Ghosh (2014) critiques the role of commercial insurance companies suggesting they are ill suited and uninterested in advocating for uptake of the scheme. Parallel research into the National Rural Health Mission suggests that it has fallen short of its targets but that it has put accessible public health and health equity on the political agenda (Balarajan et al., 2011; Husain, 2011). Exploring the diverse and often contradictory findings from this research is beyond the scope of this chapter; the point here is that in the broader narrative of ‘new’ India, health is perceived as an opportunity to improve efficiency and delivery by proponents of liberalisation, and an example of both the weakening of the state and the capacity of the state to enable further expansion of the private sector.

The borderland has been specifically targeted for improved health provision. Manipur and other Northeast states were identified as ‘focus states’ by the National Rural Health Mission, entitling them to higher per capita funding through the scheme. Manipur has many positive health indicators. It has one of the lowest infant mortality rates in India at 30 deaths per 1000 live births, which is significantly lower than the national average of 57 deaths (MHFW, 2009: 12). A total of 87% of women receive antenatal care, 83% from a doctor (MHFW, 2009: 12). Child nutrition indicators are also strong. Only 23.8% of the population under three years old is reported to be underweight, which is less than half the national average (45.9%) and among the top three in India (Planning Commission India, 2007: 157). On the flip side the HIV/AIDS rate is estimated to be the highest in India (MHFW, 2009:
tuberculosis rates are the second highest in India (MHFW, 2009: 24), and levels of sexual and physical violence are among the highest in India (MHFW, 2009: 28; see also McDuie-Ra, 2012c). Manipur’s health sector is characterised by low uptake of funds. This can be seen in the gap between funds allocated and actual expenditure on public health (Berman and Ahuja, 2008: 213). Where these funds go is unclear, yet given the extent of corruption and the opaque nature of governance it can be assumed that they are absorbed at various points along the way. Annual regional health reports by the National Rural Health Mission note chronic shortages of staff in the hill areas – especially Tamenglong, Ukhrul and Chandel – though the situation is better in the regional towns in the valley, where there is a surplus of staff in certain health fields (NRHM, 2010; 2011; 2012).

The health scenario in Imphal is almost the reverse of areas outside the capital. There are five comprehensive hospitals (two public and three private) as well as scores of clinics, many advertising themselves as hospitals, specialist centres and diagnostic centres. Of these, Shija Hospital in the north of Imphal embodies the endogenous and pragmatic liberalisation of the health sector, and has extended the boundaries of Imphal. And it is at Shija where the juxtaposition between the health city and the disturbed city is most profoundly felt.

My meeting with Dr Singh, one of the founders of Shija Hospital, in mid-2013 began with mutual recognition. I worked out we had met before in early 2011 at a cultural show at the Manipur Rifles Banquet Hall, one of the few sites for evening entertainment prior to the building of the Manipur Film Development Corporation auditorium, where I was the guest of Manipur University. On that night I had recognised him from a newspaper feature on keyhole surgery and we had posed for a photograph together. He remembered the photo and this helped ease the formalities somewhat. Needless to say, he is a prominent figure in the city.

Dr Singh came to our meeting wearing a long white coat and a stethoscope. His wife and son, also doctors, came and joined us at various intervals, but both were called away for urgent matters throughout. In 1996 Dr Singh and his wife resigned from the Regional Institute of Medical Sciences (RIMS), the main public hospital in Imphal, and started a clinic at the present site in Langol. At the time the forest was being cleared by the government to build the National Games Village, and settlers from the hills, many fleeing conflicts between Naga and Kuki communities had begun to build houses and churches in patches of cleared forest. Land was cheap, so they started a clinic, which became a hospital, which became the proposed ‘health city’ that now employs over 600 people. Dr Singh spent time in our interview
detailing the early days: terrible roads, no electricity, few patients, fear of ghosts, and scorn from other doctors about going private. Yet he was adamant that it was necessary. The public system was so bad that he had to start a private clinic to provide care to more people and try to keep medical professionals in the state. It was ‘enforced’.

We spent a lot of time talking about specific medical achievements. Many of which are very impressive, especially given that high-tech medical breakthroughs are not expected to be found in the far-off, conflict-torn frontier. With limited medical expertise I soon lost track of all the specifics. I started to ask about the patients, where they came from, the treatment they were seeking, and their costs. The hospital received patients from the city and from all over Manipur, especially given the poor health facilities outside the city. There are also large numbers of patients from the neighbouring federal states of Nagaland and Mizoram, and from across the border with Myanmar. Dr Singh claimed that Shija is already the best hospital for people living in western Myanmar, particularly the Sagaing Division and Chin State that share a border Manipur. On my visits to the wards I have seen whiteboards listing patient’s hometown as Tamu, the town on the Myanmar side of the international border at Moreh. There are official cross-border medical exchanges. Doctors from Shija run health camps in Monywa, a town over 300 kilometres from the border. Shija undertook a ‘Smile Train’
mission; a travelling entourage of surgeons doing free cleft palate operations in western Myanmar. Government officials from Sagaing Division have visited Shija and have talked about building a Myanmar lodge for patients. Medical tourism is the next step.

What is striking about this are the positions being performed. The doctors from Manipur, the borderland’s dysfunctional state and India’s turbulent frontier, perform the role of technologically advanced donors extending medical care to a (perceived) disadvantaged population across the border. Part of this outreach is also publicising the hospital in Myanmar and trying to push for easier access of patients wanting to cross the border. Dr Singh is pushing the Indian and Manipur governments for a visa-on-arrival system for patients from Myanmar, even if they don’t have a passport. For him this was what the Look East Policy meant. The only thing Manipur has that they don’t have across the border is well-trained medical professionals and medical technology. Connectivity would enable a regional medical hub to grow.

This is unlikely to be granted soon, at least by the Indian Government, given its concerns about uncontrolled movement back and forth across the border. In the meantime, the hospital circumvents state notions of sovereignty and territorial control. Dr Singh passed me onto another staff member to discuss this. In an administration office I was shown a sheet of paper with eight passport photos of patients from Myanmar glued on beside their names, hometowns, and ailments. A bus crosses the border and collects the patients – usually 40-50 patients at one time. Sheets of paper like the one I was shown are presented at the border, the names of patients listed, and when the patients leave back through the border these are checked off. This agreement is reached with the district police, rather than the Indian border authorities. In this way Indian sovereign control over territory and the border is circumvented by local agreements, by local regimes of connected actors that facilitate mobility and show alternative ways of controlling movement across territory. Look East may be a Delhi-based imaginary, but it is enacted, and subverted in a variety of localised forms.

Shija’s slogan is ‘Towards Changing the Health Landscape of Southeast Asia’. It appears on their promotional material and on billboards in different parts of the city and in other parts of the borderland. This is a fairly significant statement. The hospital makes no attempt to locate itself within India. It re-places itself, and to some extent Manipur, within Southeast Asia or at least at its doorstep. Not only that, the hospital directors see a catalytic role for Shija in improving healthcare in Southeast Asia. This is certainly
a marketing strategy, however, it is drastically different to the kinds of corporate language that is usually transmitted in the borderland which focuses on the place of the borderland within India, usually at a later phase of development, suggesting the borderland lags behind the rest of India; goods, brands, and technology take time to arrive (‘Now in the Northeast’ etc.). Their arrival is a reminder of both the distance from the heartland and the place of the borderland within the nation. Shija’s slogan doesn’t bother with the nation at all.

It is not just doctors and patients that cross borders. Blood, stool samples, tissue samples, x-rays, all flow within and outside Imphal. The Babina Diagnostic Clinic, founded and run by another doctor-turned-health-entrepreneur, Dr Thongjam, is instrumental in the mobility of bodily samples and images. Like many doctors of his generation, Dr Thongjam studied outside the state and was warned against returning when Manipur began to unravel in the 1980s. He started a small diagnostic clinic in 1983 with a rented microscope and now has 60 collection centres throughout the borderland and one unofficial centre across the border in Myanmar. While touring the labs with Dr Thongjam he gave me a rundown of the different equipment, what it does, and where it came from; Germany, Japan, Korea. He made a point of introducing me to the technicians, who talked about where they had trained and why they had come back to live in Manipur; stories I knew well from my previous work on Northeast migrants. The main diagnostic centre is in Imphal at Soibam Leikai, but there are others in Nagaland, Meghalaya, and Assam. Through this network they claim to see 1000 patients a day and then refer them on to other doctors. Anything that can’t be tested in the regional centres comes to Imphal. Samples are sent throughout the borderland and in and out of Myanmar in thermal boxes using their own fleet of vehicles. During the blockades of the city discussed in chapter 3, blood and other human samples tended to be allowed through, though not without complications from time to time.

The missing element is oncology, but Dr Thongjam plans to have this up and running in the next few years. Patients seeking treatment for cancer have to travel outside the state, at great expense, to Guwahati, in neighbouring Assam, where some forms of cancer can be treated, and to Chennai, Delhi, Kolkata, and Mumbai. In these locations there are agents whose main business is assisting patients from the borderland in getting care by translating, arranging accommodation for relatives, and helping patients get admitted to hospitals. These agents add further costs that put treatment well beyond the means of many.
The Decaying Public System

There are other private hospitals and clinics in Imphal, including specialist maternity and paediatrics hospitals (Maipakpi and Leirik Memorial) and a few scaled-down versions of Shija, such as Imphal Hospital (which seems to catch a lot of overflow from those tired of waiting at the nearby public hospital) and City Hospital and Research Centre at Chingmeirong. Yet Shija is the most comprehensive hospital, research, and training facility and provides the most compelling contrast to the two main public hospitals, the Regional Institute of Medical Sciences (RIMS) and the Jawaharlal Nehru Institute of Medical Sciences (JNIMS).

The public hospitals face a number of challenges. Conversations with two senior surgeons from RIMS and with doctors who have left the public sector reveal the depths of these challenges. RIMS was once the leading hospital in the borderland, but now the facilities and technology are dated and much of the infrastructure is badly damaged by neglect and unfinished reconstruction. The site feels like a caricature of failed development: the campus has piles of rubbish, cows roaming around, broken windows here and there, and peeling paint. Corruption continually comes up in conversations about the condition of public hospitals, seemingly offering a ready-made explanation for the difference between the public and private facilities. RIMS is still a major teaching hospital, given the demand for medical training in Manipur, but competition from private training and from places like Shija and from colleges outside the state have altered the calibre of students studying at RIMS. Those who can afford to study elsewhere do.

JNIMS, at Porompat in the city's east, is in slightly better shape after undergoing upgrades in 2012 and 2013, though the facilities are nothing like those at some of the private hospitals. From time spent in conversation in the waiting areas and from friends in Imphal who have experience of the hospital, it appears that connections are required to get an appointment, especially for outpatients. I was interested in why doctors continued to work in the public hospitals when they could earn more money in private hospitals or outside the state. I was told repeatedly that doctors see patients at the hospital for initial consultations and then encourage them to visit them at private clinics or the private hospitals, where the equipment and facilities are better and where they can charge higher fees. In fact, so common has this practice become that many patients begin seeking treatment at JNIMS with the intention to then continue treatment elsewhere. Just outside the western entrance to JNIMS there is a cluster of private clinics and 'hospitals' within a few feet of the hospital walls. There are also enormous billboards
for the larger private hospitals listing their services and achievements. The message is clear; the best care is in the private sector and those entering the public hospital have this message confront them upon entry. Obviously this has major consequences for the kinds of care available to those who cannot afford to shift to the private sector.

**Accidental Liberalisation?**

The private health sector in Imphal is apparently booming. This poses a very peculiar puzzle. How is this possible? Imphal struggles with electricity, water supply, and waste disposal. Corruption flourishes in all virtually all aspects of life. Violence is routine and prolific. How has this city become transnational health hub?

Respondents in the health sector explain that the public health system was so bad that health professionals were forced to start their own facilities and patients were willing to pay for healthcare to avoid the public system. For health professionals there are several components. The private sector provides more career advancement and professional development opportunities, even simply through access to new machinery. This is difficult in the public system given the levels of corruption and the very conservative hierarchy. With few opportunities to break through this many health professionals left the state in the past to pursue careers outside the country. The private health sector is seen as a meritocracy compared to the bureaucratic, rotting, and corrupt public sector. While there are no doubt noble intentions among health professionals to improve the standard of care, there are also many more opportunities to increase earnings in the private sector. For health entrepreneurs it is also easy to expand in the private sector, adding more staff, specialists, acquiring more equipment, and, in some cases, land. This is much slower in the public system.

For patients, the standard of care is better, admission is faster, the equipment is more advanced, and the medicines are unlikely to be fake. Whether or not there is an enormous difference across all the forms of care is debatable, however, the perception is that private is better. Some of the private hospitals offer their own reduced fees or free care for poor patients (though it was difficult to gain concrete information on how this worked). Revenue from specialist and elective treatment was said to be used to cross-subsidise primary healthcare. Public money is used to subsidise costs for patients in the private sector, too, though not for all patients. This scenario also means that funds dedicated to healthcare, whether from central or federal state
pots, are spent on subsidising care in private facilities, presumably leaving less for building similar facilities elsewhere, especially outside Imphal.

The longer one engages in these conversations the more familiar they sound; the private sector is more efficient, more merit based, and a panacea for corruption and public dysfunction. It is the same kind of argument that one hears from free-market proponents throughout India. Yet in Imphal the emergence of the private health sector appears less of a calculated strategy than a kind of accidental liberalisation: a pragmatic response to state dysfunction and neglect. Though, if the private health sector began as pragmatism to deal with state absence, it has gathered state support. For instance, Shija Hospital has received funds from the Delhi-based MDONER and NEC, and the Manipur Government (though this level of support came only after the hospital was established). Several state organisations also empanel it, meaning that patients employed by certain state agencies or under certain eligible schemes, including RSBY (the health insurance scheme for the poor) in Manipur, have the cost of their treatment subsidised. The telling inclusions in Shija’s empanelled list are the governments of neighbouring federal states Mizoram and Nagaland. Government employees and those eligible for health subsidies can receive treatment at Shija rather than in their own states, contributing to the hub.

The notion of the private health sector as an enforced split from the corrupt public system is interesting for other reasons. Virtually all business in Imphal requires connections into the murky world of elites: conventional political and business elites are part of networks with figures of traditional authority, high-ranking members of the military and security establishment, and leaders of underground and ethno-nationalist groups. Rumour about silent partners affiliated with the murky world abound. One always has to be careful with this kind of information in Imphal. With such opaque structures of power it is very difficult to prove any rumours and perhaps that is beside the point. Social life thrives on speculation about who is connected to whom, on who really funded what, and who protects whom. The point to be made here is that adage that the private health sector in Imphal is clean, modern, and corruption-free when compared to the dirty, dated, and corrupt public health sector requires some nuance. Partners and protection are vital for any enterprise in the disturbed city. The triumph of the invisible hand of the market is a possible reading from a distance, but not on the ground.

A second explanation for the emergence of the hub in Imphal is human capital. Studying medicine and nursing have long been ideal pathways for young people in Manipur who want to get ahead. As one doctor told me,
studying medicine is to Manipur what studying engineering is to India. Imphal has countless tuition schools and private tutors that assist students in completing examinations to gain entry into medical training. Data from the National Rural Health Mission shows that Manipur actually has a surplus of qualified medical workers. There are almost double the required number of doctors in primary health facilities, double the required number of female health workers/assistants, as well as surplus pharmacists and technicians (NRHM, 2014). Each year vast numbers of students migrate outside the state to undertake medical training, often at great expense to their families. I encountered many of these migrants during my previous work on Northeast migrants in Delhi. Migrants don’t just head for metropolitan cities, but to medical colleges throughout India and beyond (McDuie-Ra, 2012a: 62-63). During a visit to Imphal in mid-2014, I saw a sign outside a travel agency cum education centre that read ‘MBBS in China and Ukraine’, indicating how far people in the state will go (or at least how far travel agents think they will go). Nursing is similarly popular among women in Manipur (the profession is still heavily gendered in India). Imphal hosts a number of public and private nurse training institutes. There is also migration to train outside the borderland, especially in south India. The market for medical and nursing students from Manipur is becoming well known in other parts of India and recruitment of students for training outside the state is a big business that will be discussed in the following chapter. With chronic under- and unemployment and a disrupted economy, in combination with high education and literacy levels (at least when compared to Indian national averages [McDuie-Ra, 2013: 80–81]), and a growing remittance economy, medicine and nursing are seen as crucial for the livelihood chances of young people and their families. Even the Directorate of Health Services has an imprecise view of the state’s nursing numbers, reporting that Manipur ‘is one of the biggest producers of nurses per capita probably highest after Kerala. The people of the state in general have no prejudice towards the nursing profession. The nurses are trained at various institutions outside and inside the State. There is glut of nurses in the state and many are employed outside the state’ (2014: n.p.).

There is a large pool of human capital available to the private health sector. Health entrepreneurs can target Manipuri medical professionals and offer them careers back home; something that the public sector was increasingly unable to provide as doctors could make more money elsewhere and advance their careers. This is changing. Further, the desire for families to send their children to medical and nursing colleges means that private hospitals can offer training at home, for a lower cost than sending
children outside, and use this to expand their own operations. There is still high demand to train and work outside, but there are more and more health professionals coming back. As one doctor told me, ‘Once when you finished training they said “go west”. Now you can say, “I want to go east” and people accept it’.

A third explanation is greater mobility enabled by connectivity. Imphal is a health hub because more people can get to it. The opening of the border plays a large part in this, though as seen above, even this requires some creative border practices to get patients flowing into Imphal’s hospitals. Further, health seekers from Nagaland and Mizoram, as well as other districts in Manipur, have enhanced the sector in Imphal; there are more patients, and more supplementary livelihoods serving their needs in guesthouses, transport, and food. Imphal is not exactly the geographic centre of the borderland, but as it sits in a valley surrounded by hills in all directions it does have a kind of natural pull for people living in those hills.

**Reshaping the Urban Frontier**

The booming private health industry has reshaped the urban landscape. As older planned institutions, RIMS and JNIMS have large campuses. Given the shortage of space in the city, new facilities appear to burst out of the blocks they are built on, with few ways to access the buildings, nowhere to drop off patients, receive ambulances or dispose of hazardous waste. In contrast, the two most well-known private facilities have played a major role in reshaping urban space in their vicinity. Babina Diagnostics’ current centre is built on top of a marsh in Soibam Leikai. The land was too unstable for building so remained as a wasteland and a site where neighbourhood residents carried out small-scale aquaculture. Building on this kind of land requires soil and rock, and most of that must come from the hill areas of the state and the foothills around Langol; a common cause of landslides and further fuel to the grievances of the valley inhabitants. Once the ground was stabilised, the four-storey facility was built in 18 months. The public access road was too narrow, so the diagnostic centre paid to widen and resurface the road. They maintain it and keep the area around the centre clean. This small patch of the city is almost entirely privately run. Other similar businesses have opened in the vicinity. Small operators selling medical supplies, equipment, pharmaceuticals, and smaller diagnostic clinics line the road that connects Soibam Leikai to JNIMS. As mentioned above, the area outside JNIMS is home to a number of smaller private clinics clustered around the gate.
Neighbourhoods exist behind the rows of multi-storey buildings along the roadway, but rapid construction, increased traffic and noise, and water insecurity from the disappearance of community pukhri's and ising kongs (drainage channels), combined with higher land value, has meant many residents have sold land or leased their land and gone to live elsewhere.

Langol is an area on the northern fringe of Imphal where the foothills begin to rise out of the valley and the jurisdictional boundaries between Imphal West District and Senapati District are blurred. It is an important division as it signifies where the different land use regimes of the valley and the hills begin and end. Langol was long believed to be a wild landscape: an ambiguous zone that is neither hill nor valley, neither Imphal municipality (a nominally Meitei space) nor Senapati District (a nominally tribal space). It is the frontier of the frontier city. Since 1938, 22 square kilometres of Langol have been designated ‘reserved forest’. Older residents of Imphal remember Langol as a place of plant and animal life. The steep foothills, thick trees, and swampy group made it very difficult to build houses here. Langol was occupied by bad spirits; a place for cremations for bodies that can’t be cremated in city localities – usually if the cause of death is suicide – and a place where bodies killed by security forces and underground groups were dumped so they wouldn’t be found. During fieldwork I was drawn to Langol like no other part of the city.

The journey into Langol begins on Thangmeiband Road, which skirts the base of the foothills from Yumnan Leikai, near the new state assembly building, northwest to join Langol Road, which continues in an arch, still along the base of the foothills past Shija Hospital and onto the Games Village before passing the Central Agricultural University and zoo to join the Uripok Kangchup Road that runs into central Imphal. This route is around 10 kilometres long, a considerable distance in Imphal. As Langol has grown the rest of the city is extending northwest to meet it. The road hugs the foothills as it breaks away from the densely populated localities of Imphal. The jurisdictional ambiguity and the fuzzy and poorly enforced ‘reserved forest’ boundaries have enabled gradual settlement of Langol by members of different tribal communities, mostly on the northern side of the Langol Road – the hillside. The land on the southern side of the road requires title and has been divided into lots, including vast tracts reserved for various state initiatives, such as a proposed technology university, a model farm, and the Games Village. The peri-urban spaces in between Langol and the rest of the city, especially Lamphelpat, are being divided and sold to state and private developers. Even in the time I have been visiting Imphal I have watched this land go from community rice paddy and an unclaimed grazing
area for horses and cattle (plus a large rubbish dump) to a lattice of fences and signs denoting state and private ownership.

Residents of Imphal will often cite the construction of the National Games Village and the early days of Shija Hospital in the mid-1990s as the opening of this urban frontier. Certainly these developments forced the civilian authorities to consider road access to Langol, land title, and service provision. Yet this narrative suggests that Langol was empty at this time. During fieldwork throughout Langol an alternative narrative of settlement emerges. Over several decades the foothills have been settled by migrants from the hills, and to a lesser extent from other parts of the valley. This is a sensitive area and while people were willing to talk generally about what the area was like in the past, few would talk specifically about dates of settlement. Many settlements in Langol are not legal. Ambiguity around jurisdiction and the imagination of Langol as a wild and haunted place enabled migrants to move to the area unnoticed prior to the 1990s. Some fled conflict in the hills, including operations by the security forces as well as underground groups. There is a whole series of villages formed in Langol following the Naga-Kuki clashes of the 1990s. Some people came to Langol for land to build a house and farm, some came to hunt, some to follow others, some to escape the authorities, some because they received a celestial message.

This land was undesirable for Meiteis for whom the presence of the supernatural, a lack of roots in the area (most families build houses by subdividing ancestral land), and minimal infrastructure, forest and flooding, not to mention the presence (and rumoured presence) of underground groups representing hill communities, did little to diminish the perception of a wild frontier. The reach of the civilian government was limited in Langol even as the population grew. Though the 1990s underground groups controlled the foothills; they determined who could build where, they protected residents, and they controlled movement in and out of the settlements. This could be good or bad depending on which community residents belonged to. The line between residents and underground groups is thin, many residents and their family members were and are members of these groups or of associations with close ties.

This has changed in the last decade and a half. After the National Games in 1999 the houses in the village were sold off to the public, mostly to civil servants, and awarded to successful athletes at later sporting events. The hospital acquired more land to extend its operations, including housing for staff and students. The flows of people going to and from the hospital have made the routes through Langol viable for public and private transport providers, and the route now sees a steam of auto-rickshaws, ‘magic’ buses.
vans), and Shija’s own commuter buses. Doctors started to purchase land and build houses close to the hospital. The area became a desired location for Imphal’s professional classes, driving up the cost of land. Investment in guesthouses and restaurants to serve the visitors to the hospitals has increased the value of land by the road. Developers, rumoured to be backed by Imphal politicians, have levelled more of the foothills for construction. Notable among the new mansions are several drug rehabilitation homes, a yoga retreat, and a Hindu mandir (under construction in mid-2014).

Settlers from the hills continue to come to Langol. Houses were first built at the base of the foothills along the road, and then a series of terraces were cut into the hillsides behind the road and with pathways connecting them to one another. When someone wants to build they hire an excavation machine that cuts away part of the hill and levels the land – the marks from these machines can be seen all over the landscape. Some of the cleared plots have no dwellings and are cleared in order to sell to new settlers. The earth is then sold on for construction in other parts of the city. It is a fragile ecology. Some of these areas have no electricity connections or water supply. Small shops have sprung up on the roadside where the paths begin heading uphill, selling groceries and the ubiquitous second-hand clothes.

What strikes a visitor to Langol is the enormous number of churches. These are of various sizes, ages, and stages of completion. As most of the
settlers came from the hills and are Christians, building churches has been a way to make a territorial claim in the foothills. The churches represent almost every conceivable denomination and tribal community. Residents related that building churches has a dual role; it acts to help create or recreate the community and it prevents the government from demolishing the settlements. A further tactic of marking place is to erect foundation stones. Certain stones date back to the late 1970s and early 1980s, though some residents weren’t sure if these were accurate. The foundation stones are usually very well maintained, visible from the road, and are clearly valuable tools in contentious politics over land, particularly when the civilian government has plans to develop the area and some evidence of settlement will be required to negotiate for compensation.

The population of Langol is now more diverse in terms of ethnicity and especially in terms of class. What was an area for tribals escaping trouble in the hills, unwanted attention from the authorities, or better hunting options is now a part of the city. The success of Shija drew attention to Langol from the civilian authorities and private citizens, investors, developers, builders and buyers. Further, as the Games Village was allocated to only the most connected civil servants and athletes the desirability of the area grew. The peri-urban land between the city and this belt of emerging prosperity is also being claimed, occupied and transformed. The civilian authorities have made the space of the foothills and the land between them and city legible. What was wild and unruly has become tame and orderly. Those who have occupied the land for the last few decades are anxious about whether their claims to place will be recognised in the now ordered landscape. There are various tactics necessary in the struggle for permanence: churches are constantly being built, foundation stones are continually being repainted, village jubilees celebrated publically, and new settlers brought from far off villages to shore up the community. The landscape of this part of Imphal has been profoundly changed. Yet it has been the success of the private health sector on land the dominant community could not imagine settling on that has driven urban expansion into the foothills, and turned it into a zone of contention where proving community longevity is fundamental to claiming and preserving place.

**Conclusion**

One evening I was sitting on a rooftop in Nagamapal in central Imphal with a friend, Abung. After checking on his solar panels we shared some
local rice beer in seclusion. After a few minutes the electricity went out. The soundscape of the power outage rang out: diesel generators cranking up, family members yelling out to one of the children to light candles, an increase in car horns honking, and sudden absence of the low din of TVs and music. Looking north from Nagamapal across the dark cityscape towards the hills we could see the outline of the hills at Langol against the night sky. Beneath it was a brightly lit constellation of buildings, the dome of Shija Hospital clear even from this distance. Abung chuckled, ‘the health city’. I wasn’t sure if he was marvelling at its existence, if he was angry that the city was in darkness while the hospital was lit up, or if he was just reminding me of what it was. I pressed him. ‘This place…’, he gestured around him shaking his head and trailed off, unable to put into words the enormity of Imphal’s contradictions. And that said it all. On one level, the health city is baffling. A health hub nestled in the disturbed city where patients, tissue samples, and medical expertise move back and forth within the borderland and farther afield circumventing border security and shattering the myth of the turbulent frontier.

On another level there is some logic to the growth of the health city; not just in Langol but also throughout Imphal. As discussed in this chapter, the corrupt and inept public sector, the prevalence of human capital from decades of locals seeking medical and health qualifications, and connectivity enabling patients to move to and from Imphal to seek treatment all play a role. Yet there are other factors, murky and unseen. Rumours of silent partners, of influential backers of the various facilities abound. Unravelling these threads is difficult and dangerous, and perhaps beside the point. Endogenous liberalisation of the health sector appears accidental. It began in response to state dysfunction and the notion of a superior private sector has taken hold of the ways the health sector promotes itself and the ways urban dwellers pursue healthcare. It is not the version of liberalisation imagined by the Indian Government and set out in the various policy prescriptions discussed in the previous chapter. It is liberalisation predicated on making do, conceived in isolation and now an exemplar of connectivity; bringing Manipuri professionals home to work, training locals to work farther afield, drawing patients (and pupils) from across the borderland, and taking mobile healthcare across internal and international borders. It is also an expression of self-sufficiency. It can double as an ethno-nationalist signifier. Respondents in the sector spoke with pride about what could be achieved when the overbearing and often brutal Indian state and corrupt and dysfunctional civilian government are bypassed. In a political context shaped by decades of resistance centred in one way or another around the
question of Manipur’s sovereignty, the health sector hints at what Manipur could operate like if given a clean slate. Of course, this is a microscopic example, and one that may not be replicable in other sectors given the confluence of factors discussed above.

The Manipur Government now uses the phrase ‘health city’ to celebrate the concentration of high-quality private health facilities created in the vacuum caused by its own ineptitude and corruption. Yet nothing in the disturbed city is straightforward. The health city has transformed the landscape in Imphal’s northwest, increasing land prices and bringing the city – and the authorities – to the periphery where families formed communities (illegally) to escape violence and attention from state and quasi-state actors. Yet even in the foothills of Langol new migrants continue to arrive from the hill districts, carving land out the hill-sides, clearing haunted tracts of forest, and marking territory with churches, foundation stones, and small shops. Place is made and remade on the urban periphery – the frontier of the frontier city – always a few steps ahead of the actors seeking order and control, a scenario much less possible in the more tightly controlled neighbourhoods and wards of Imphal’s core.