Troubled Links
Public Health and the Alleviation of Poverty in South Asia

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The establishment of the World Health Organization (WHO) after the Second World War was accompanied by concerted calls for creation of better healthcare facilities in the developing world. The WHO was seen as the agent that could funnel the necessary Western aid and technology to the newly independent nations of South Asia most effectively. This view became even more widespread as the negative effects of the Cold War began to visibly affect these regions. Indeed, in a situation where superpower rivalries began to politicize the provision of aid packages, the WHO’s relative political neutrality allowed it to be seen as a more reliable source of assistance, which in turn allowed greater access to the newly established regional governments. At another level, the WHO’s messages for social and economic improvement, through sustained healthcare reform, fit in well with the messages transmitted by the new nationalist governments within their countries. However, such assessments were questioned in some official circles, even as the final push for the eradication of smallpox was being put in place. Notable in this regard were the arguments by administrators who believed that the control of population through concerted family planning could do much more than the prevention of infectious disease for poverty alleviation. The problem, once again, was that of arranging for concerted and effective intervention. Continuing problems in this regard, most notably in relation to the inability of the central and state governments to increase the use of condoms and chemical birth control measures, led to the excesses imposed on civil society during the period of emergency. Despite such apprehensions, the extra-constitutional central government rule that Prime Minister Indira Gandhi imposed in the mid-1970s was characterized by the introduction of forced sterilization of married women who had fathered a large number of children. This campaign stumbled badly in the hands of inefficient administrators, whose selection of targets began to be politically and communally determined. Indeed, as some of the main architects of the programme had to distribute reports insisting that Muslims tended to have smaller families, this community began to be targeted indiscriminately. Sustained central and state government intervention during this time led to grotesque abuses of power, where young boys, in their teens, were forcibly transported to clinics for this operation. The end of emergency forced through by widespread popular demonstrations, which caused fresh elections that swept Indira Gandhi out of power, brought an end to this shameful episode in which the politically powerful groups: the urban middle classes, caste groupings that dominated local economies and, not least, the constituencies of politicians who had entered India’s lower house of parliament and state assemblies. My quest for an answer to this question caused me to examine official deliberations in this regard more closely. I quickly realized that one of the best ways to achieve this was to look at the debates between bureaucrats based at the different levels of the administration. This allowed me to identify and then examine the distinctions between policy rhetoric and implementation. Not only do these deliberations and disagreements allow insights into the problems faced by Indian administrators, they also allow us to look into administrative attitudes, at all levels of the state, towards international aid agencies and the programmes launched by them. These views, in turn, give us a better idea of achieve- ments of particular public health and developmental schemes as well as their immediate impact and long-term possibilities. One of the most striking things is that it is very difficult to define what organized international intervention was actually composed of: paucy historians talk of ‘intervention’, but very few define what this stood for. During the 1950s and the 1960s, international agencies tended to provide assistance to national governments, and expected them to utilize the aid received according to the agreements that had been reached. This hardly ever happened, and some confidential assessments prepared by observers selected by the aid agencies warned that the money was very often being deployed for schemes other than those for which it was intended. More worryingly, such reports also pointed out that the projects that were drawing money away from schemes targeted at the poorest sections of the population were those that catered to the politically powerful groups: the urban middle classes, caste groupings that dominated local economies and, not least, the constituencies of politicians who had entered India’s lower house of parliament and state assemblies. Remarkably, a careful analysis of the correspondence exchanged between the different levels of Indian government confirms such views. At one level, provincial governments often complained in confidential memos about the fact that the central government was not giving them all the money set aside for them by aid agencies. At another level, the district administrators raised similar objections, this time about the provincial authorities’ propensity to redirect funds to urban health projects, rather than anti-malaria and mass immunization campaigns, which a range of international donors expected would receive attention. At yet another level, official resolutions obviated that general immunization campaigns in India – which were advertised to hold the key for improved health and economic conditions for the poorest sections of the population in official rhetoric – could often only be maintained right up to 1970 as a result of the provincial officials’ tendency to finance these schemes with monies drawn from funds originally set aside for the uplift of the members of the so-called ‘scheduled castes’ (who generally represented the some of the most under-privileged sections of the population). There can be little doubt that such trends irreparably harmed the malaria eradication programme in India – far too much of the international aid for this project was direct- ed elsewhere, while local funds that were utilized to retain a rather rudimentary structure of malaria control proved insuf- ficient. The smallpox eradication programme suffered from such trends as well, but this situation was rectified between 1970 and 1975, when the WHO successfully demanded a greater role in the supervision of the development of local programmes. This intervention was, of course, not widely welcomed and could sometimes only be retained with the threat of service penalties (imposed by the government of India) or even in more extreme cases paramilitary interven- tion. These efforts brought about the desired levels of vac- cine coverage, which in turn allowed for the eradication of smallpox and freedom from the high mortality rates that disease engendered. More strikingly, a wide variety of official communications, exchanged within and between the govern- ment of India and the World Health Organization, sug- gest that such concerted interventions had political impera- tions, via the placement of a role of the centrally employed supervisory staff, contributed to the tightening of general healthcare provisions, which allowed more equitable access to the facilities that existed. In the rest of the country, such trends as well, but this situation was rectified between 1970 and 1975, when the WHO successfully demanded a greater role in the supervision of the development of local programmes. This intervention was, of course, not widely welcomed and could sometimes only be retained with the threat of service penalties (imposed by the government of India) or even in more extreme cases paramilitary interven- tion. 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