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 it 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.

By Sanjoy Bhattacharya

One of the main questions that has been occupying me during my current research project, dealing with preventive and curative health in South Asia, is whether such plans and the initiatives they engendered had the ability to improve the economic situation of the most disadvantaged sections of the subcontinental population in the long term. 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 a window 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 achievements 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 (many 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 obviate 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 directed elsewhere, while local funds that were utilized to retain a rather rudimentary structure of malaria control proved insufficient. 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 intervention. These efforts brought about the desired levels of vaccine coverage, which in turn allowed for the eradication of smallpox and freedom from the high mortality levels the disease engendered. More strikingly, a wide variety of official communications, exchanged within and between the government of India and the World Health Organization, suggests that such concerted intervention in rural immunization services, via the placement of a range of the centrally employed supervisory staff, contributed to the tightening of general healthcare provisions, which allowed more equitable access to the facilities that existed. These trends seem to have comprised a general increase in health levels, which according to certain commentators had positive economic and social influences on rural communities.

Significantly, 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 civilians during the period of 'emergency'. This period of extra-constitutional central government rule that Prime Minister Indira Gandhi imposed in the mid-1970s was characterized by the introduction of forced sterilization of males who had fathered a large number of children. This campaign stumbled badly in the hands of inefficient managers, whose selection of targets began to be politically and communally determined. Indeed, as some of the main architects of the programme of forced sterilization began to distribute reports insisting that Muslims tended to have the largest 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 some of the poorest sections of the Indian population were forced to submit to heavy-handed intervention, ostensibly deployed for their own welfare.

To conclude, sustained public health interventions in India could sometimes improve health conditions amongst disadvantaged social groups, but such improvements tended to be ephemeral, even during the most positive of programmes (and I do count the smallpox eradication programme as a positive episode, which allowed the provision of healthcare delivery in remote rural enclaves). And yet, sustained official interventions could also take on a darker hue, as in the case of the scheme of forced sterilizations during the 'emergency'. Therefore, in a country like India historical precedents suggest that government interventions can make a difference, but only when these efforts are organized democratically and with the involvement of members of the target communities. Historical experience also tells us that social and economic improvements, brought about by state-sponsored developmental programmes, tend to be concentrated in urban contexts, with rural areas coming out second best in almost every case. Put another way, public health and medical work, carried out with international assistance, usually tend to have a much more marked effect in urban areas, probably because the system of electoral democracy tends to work much better there. But, the achievement of comprehensive poverty alleviation still remains a distant pipe dream in India due to the social inequalities that continue to dog its society. Public health and educational work can make a difference, as such official activities can have a democratizing effect on the poorest sections of rural society. Indeed, the realization that access to healthcare and education is a right, not a privilege accorded to a select few, is usually accompanied by greater levels of political participation. <

Lady health visitors in rural India (c. 1960)

Courtesy of Sanjoy Bhattacharya. Part of the family's personal collection.

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