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The Implications of U.S. Development Aid on Public Health: Understanding the connection between India's 1975 Emergency State and the President's Emergency Plan for AIDS Relief (PEPFAR)

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The Implications of U.S. Development Aid on Public Health:
Understanding the connection between India's 1975 Emergency State and the
President's Emergency Plan for AIDS Relief (PEPFAR)

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of Bard College

by
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Abstract: This essay looks at the public health consequences of U.S. development aid to both India and PEPFAR. A close analysis of the U.S.-India development aid relationship presents an important case study for the purposes of this essay, as it is one of the oldest and longest development aid stories in U.S. history. The evolution of U.S. development aid is traced throughout its history with India. In other words, the varying outcomes that occurred as a result of the presence of paternalism in U.S. development aid are chronologically imprinted in its development aid relationship with India, an important component when assessing the influence of U.S. foreign and domestic policy over its development strategies. The case study therefore, provides critical information that will allow certain assumptions to be made about the future of PEPFAR as U.S. development aid manifests in a similar pattern to India's experience. These two state development aid cases are deemed as success stories, from a U.S. standpoint, which highlights the external public health outcomes. The parallels that can be drawn between the paternalistic manifestations in the U.S.-India development aid relationship and PEPFAR programs currently being implemented in focus countries, are explored in order to try and understand the future public health outcomes of the PEPFAR program.

Foucault: Criticism is a matter of flushing out that thought and trying to change it: to show that things are not as self-evident as one believed, to see that what is accepted as self-evident will no longer be accepted as such. Practicing criticism is a matter of making facile gestures difficult.¹

Introduction

USAID's Mission Statement: "We partner to end extreme poverty and to promote resilient, democratic societies while advancing our security and prosperity."²

The means by which development aid has been promulgated is, in a respect, a product of a market driven society. An overarching theme of U.S. development assistance has been to

¹ Michel Foucault, *Politics, Philosophy, Culture* (New York: Routledge, Chapman & Hall, Inc., 1988), 155.

https://monoskop.org/images/9/96/Foucault_Michel_Politics_Philosophy_Culture_Interviews_and_Other_Writings_1977_1984.pdf.

² "Mission, Vision and Values," USAID, accessed October 2016, <https://www.usaid.gov/who-we-are/mission-vision-values>.

reduce the vast areas of inequality that are starkly contrasted between developed and underdeveloped nations, while simultaneously bolstering U.S. economic growth. With this in mind, it happens that the fundamentals of U.S. development aid are pushing against certain humanitarian efforts due to its political and economic interests that drive development aid initiatives. In a case study analyzing the early history of the U.S.-India development aid relationship, I will explore the apparent disconnect between the determination of the success of the relationship viewed as such by the U.S. and the public health outcomes that took place as a result of the Indian 1975 Emergency State. The evidence from the India case study will be used to critique a present day U.S. development aid project, the President's Emergency Plan for AIDS Relief (PEPFAR). The events of the India case study provide evidence of the paternalistic nature of U.S. development aid manifesting in multiple ways. The reasons for why U.S. development aid in a market society is at odds with public health become apparent once the paternalistic nature of development aid is explored in both India and PEPFAR.

The first chapter is a discussion on paternalism. Before diving directly into the critique of paternalism and development aid, a more individualized understanding and definition of paternalism will be explored. As a large portion of this paper uses historical analysis as a means to understand current events, the origins of paternalism and its critique of liberty act as a foundation for the more broad and relevant discussion of paternalism and development aid as it steps outside of state borders. The argument used to critique the paternalistic nature of U.S. development aid builds from the contemporary discourse on the role paternalism plays in development aid today. This chapter serves as a basis from which four specific critiques of U.S. development aid will be drawn. While the paternalistic nature of the aid lends itself to the overall argument, particular arguments, drawn from the India case study, act as steps in the evolution of

development aid initiatives, each furthering the public health consequences of the receiving state. In order to understand the opposition that development aid creates in response to public health initiatives, concepts from paternalism theory are discussed. As the political and economic environment plays a crucial role in the development of India's family planning program, paternalism will tie together the four arguments from an overarching vantage point that considers as many of the contributing factors as possible.

The second chapter contains the case study of India. The historical analysis is used to understand the motivation behind the 1975 India Emergency state. The history of U.S. development aid to India contains a variety of initiatives and concepts that were a direct result of academic and political thinking at the time. The case analysis will be the foundation upon which the four arguments are referenced. In order to create an accurate and clear picture of this specific period, the U.S.-Indian relationship will be placed in a larger political context in order to reference events and connections that influenced the political decisions of both nations. With that said, the political climate will be analyzed only to the extent that it relates to the U.S.-India development aid relationship. The chronological order of the case study is used to show the extent to which U.S. development aid influenced the decisions of the Indian government, and in particular, the role the U.S. played in influencing India's coercive sterilization practices. The purpose of analyzing the initial development aid relationship between the U.S. and India provides evidence of influence. This level of influence being analyzed is used to decipher the type of paternalistic relationship that development aid has to public health and how it was misinterpreted or ignored due to economic and political incentives. The case study shows how the paternalistic nature of the relationship evolved in different ways, and how its evolution continually served U.S. goals, which were at odds with the public health of Indian citizens.

The third chapter will be a deeper discussion and critique of the ways in which U.S. paternalistic development aid manifestation. Each argument will be discussed as they pertain to the case study, including the reasoning behind their initiation, execution, and overall result. The effects of certain development aid strategies highlight a number of developments that were ignored throughout the relationship for reasons other than benefitting the public health of the Indian population. This ignorance of effect will be discussed in particular detail as it opposes or mocks the concept of forward thinking in relation to U.S. development aid. This becomes clear once understood within the context of U.S. foreign policy goals. There is an undercurrent in each of the arguments that attempts to address the issue of public health being treated as a commodity. It analyzes how treating humans as capital or as a means to, interferes with any attempt to ameliorate public health issues. The arguments, once analyzed through past events, will take form in the critique of the ongoing public health initiative, PEPFAR. The case study of India and the U.S. evolves to show how development aid, in its relation to public health, continues to act in the same way today, creating a cycle of public health initiatives lacking the fundamental element of foresight, or the foresight directed towards interests unparalleled with public health. The four arguments propose an alternative to the understanding that U.S. development aid initiatives to India were not successful and that current public health initiatives are continuing to be subjected to a system influenced primarily by a U.S. market-based mentality.

The fourth chapter discusses the present U.S. initiative, PEPFAR. PEPFAR was chosen as a present day critique of U.S. bilateral development aid for several reasons. First, “PEPFAR [is] the largest bilateral aid program.” Second, PEPFAR was enacted as a five-year strategy, but has been extended to continue indefinitely. Today, PEPFAR’s strategy is not confined to a time frame, but rather an open-ended target of delivering “an AIDS-free generation.” PEPFAR is

therefore a current, evolving, and large targeted public health development issue being administered by one of the largest bilateral aid donors. It is these components of PEPFAR that make it an important initiative to critique in light of the history of the U.S.-India development aid relationship. PEPFAR is an example of the fact that U.S. development aid has not evolved so as to address public health issues from a sustainable foundation.

Today's market-based system has struggled to find a solution that alleviates issues of public health that incorporate state interests when they are addressed using a bilateral strategy. The history of the India case study is such that the public health outcomes that unfolded can be directly connected to U.S. development aid. When similar disconnects that were found between U.S. development aid goals and the public health of Indian citizens were found as well in PEPFAR, the future public health outcomes of the program underwent analysis. In other words, the similarities drawn between India and PEPFAR suggest that the future success of the PEPFAR program does not imply a successful public health initiative.

Chapter 1. Paternalism and Development Aid

Of the multiple ways in which paternalism in U.S. development aid manifests, this essay draws out four specific criticisms. These four arguments analyze the evolving influence that U.S. development aid has over recipient countries when it is directed towards public health initiatives. The paternalistic nature of development aid stems from the theory of paternalism at a more personal level, as is found in Gerald Dworkin's essay *Paternalism*; "By paternalism I shall understand roughly the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person

being coerced.”³ While there are undoubtedly moments in development assistance when an individual’s liberty is interfered with, the preexisting discourse surrounding the concept of paternalism and development aid provides a more direct connection to the four arguments. I use Dworkin’s definition however, as a founding basis for the concept of paternalism as experienced by an individual, though this essay focuses on the experiences of societies as a whole. The theory of paternalism and development aid offers a deeper analysis of the relationship between public health and development aid and *offers* a conceptual framework from which the four arguments will draw. Maria Eriksson Baaz, author of *The Paternalism of Partnership*, argues, “[There] is a contradiction between the discourse of partnership which emphasizes and denotes equality and disavows paternalism, and the discourse of (evolutionary) development according to which the ‘partners’ are not equal, but instead are situated at different stages of development and Enlightenment.”⁴ The four arguments that are highlighted in this paper were found to evolve in succession and as such, will be presented in the order in which they occurred. The evolution of their succession was uncovered in the India case study, and their presence in the PEPFAR program were therefore critiqued in the same chronological order.

In *Paternalism*, Dworkin begins his article by examining a quote from John Stuart Mills’ *On Liberty*; “That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others.”⁵ This quote is pertinent to comprehending how harm to others is calculated or understood in a larger context,

³ Gerald Dworkin, "Paternalism," *the Monist* 56 (1972): 65, <http://www.jstor.org/stable/27902250>

⁴ Maria Eriksson Baaz, “Paternalism: The ‘Outside’ or ‘Rejected Inside’ of Partnership?” *The Global Times* 7 (2007): 1, file:///Volumes/Storage/2531-6250-1-SM.PDF.

⁵ John Stuart Mill, “On Liberty: Introductory,” in *On Liberty*, (Bedfordshire: AUK Classics, 2011), 26. ProQuest ebrary.

especially if the harm being referred to is a projected evaluation. This quote touches upon one of the fundamental components in the justification for why U.S. development aid was used in the context of India's family planning programs. In other words, In Mill's understanding of paternalism, this form of coercion is his only exemption to his critique of the theory and thus, presents the case for why the paternalistic nature of U.S. development aid, when directed towards public health, is being critiqued. This essay is not a critique of paternalism itself; rather, it analyzes how its undeniable presence in U.S. development aid influences the success of public health initiatives. The coercive nature of paternalism can take different forms depending on whom the coercive action is being taken against; "the class of persons whose good is involved is not always identical with the class of person's whose freedom is restricted."⁶ This form of paternalism will be explored in both the India case study and PEPFAR, as both cases are examples of public health initiatives that contain coercive action taken with the benefits of future generations in mind. Paternalism "will always involve limitation on the liberty of some individuals in their own interest but it may also extend to interferences with the liberty of parties whose interests are not in question."⁷ The four critiques will explore how in both the U.S.-India aid relationship and PEPFAR, the paternalistic nature of U.S. aid not only interferes with the liberty of citizens in receiving states, but that harm is inevitably incurred by citizens of aid receiving states as well. The case study of India and PEPFAR are examples of public health initiatives motivated by the understanding that exceedingly worse outcomes would occur if an alternative response of inaction were taken. The examination of each of the arguments is placed within the context of the India case study. Once the arguments have been presented and the case study examined, their presence in the PEPFAR program will be analyzed.

⁶ Dworkin, "Paternalism," 67.

⁷ Ibid, 68.

Chapter 2. The India Case Study

The U.S. State Department created the National Security Council Paper 68 (NSC-68) in April 1950, a most concise document outlining the U.S.'s foreign policy strategy.⁸ The document states; "For us the role of military power is to serve the national purpose by deterring an attack upon us while we seek by other means to create an environment in which our free society can flourish."⁹ The 1950's marked a turn in U.S. strategy as it began to shift its focus away from the military, though not entirely, and direct its attention towards the development sector.

American foreign policy at this time, and throughout the Cold War, was fixated on stopping the spread of communism, and conversely promulgating the benefits of democracy. As the Cold War was much more than just a military battle, it was a battle of ideological differences and a race to ensure one governmental understanding over another's. This was a war of persuasion. The U.S. had to prove that democracy was more sustainable; that it would provide other governments with economic benefits so as to ensure their citizens a way of life that was measurably better than the one they were currently experiencing. When, in 1949, the People's Republic of China declared victory over America's ally, Chiang Kai-shek, the leader of the Nationalist Party, the U.S. turned towards India to bolster democratic influence.¹⁰ As a newly independent, heavily populated, democratic nation, India represented the obvious next step in halting the spread of communism. At the same time though, India was in poor economic

⁸ "NSC-68, 1950," Office of the Historian, accessed November 18, 2016, <https://history.state.gov/milestones/1945-1952/NSC68>

⁹ "A Report to the National Security Council - NSC 68," The Truman Library, accessed November 18, 2016, https://www.trumanlibrary.org/whistlestop/study_collections/coldwar/documents/pdf/10-1.pdf.

¹⁰ Warren I. Cohen, "The United States and China during the Cold War," *History Now: The Journal of the Gilder Lehrman Institute*, <https://www.gilderlehrman.org/history-by-era/seventies/essays/united-states-and-china-during-cold-war>.

standing, “according to new global measures of gross national product per capita, [India] contained more than one quarter of the world’s poor.”¹¹ U.S. involvement in Asia did not decrease with the loss of China, but the loss made the U.S. reevaluate its tactics.

Many U.S. lawmakers and academics attributed the loss of China to communism as a result of China’s famines. China’s Civil War had been more than a matter of ideological differences, it was the deciding factor for which of the two political parties, would control and provide for the people, which of the two parties would end a need for societal uprisings. There was a debate circulating around Washington, citing that America had spent too much time focusing on the major cities in China as opposed to its rural population and had lost the opportunity to show that democracy was not only the most inclusive form of government, but also the most efficient, in terms of labor production. India, unlike the vast majority of regions the US was involved in, was not struggling with a major internal military struggle. On the contrary, India had just experienced a reunification during its fight for independence providing an opportune moment for the United States to flex its non-military efforts at foreign policy. Indian Prime Minister Jawaharlal Nehru’s ruling democratic administration was not seeking military aid; rather it suffered from economic constriction which shifted the emphasis of U.S. support from military aid towards the use of economic aid in the fight against communism on the Indian front.

Before India’s independence in 1947, the events of the Cold War were unearthing the difficulties that lower economic performing countries were facing with food shortages and

¹¹ Nicole Sackley, “Village Models: Etawah, India, and the Making and Remaking of Development in the Early Cold War,” *Diplomatic History* 37 (2013): 765, <http://eds.a.ebscohost.com.ezprox.bard.edu/eds/detail/detail?sid=72d5719c-5399-4b64-91dcb9268ea532d0@sessionmgr4005&vid=1&hid=4208&bdata=JnNpdGU9ZWRzLWxpdmUmc2NvcGU9c2l0ZQ==#AN=89866279&db=aph>.

population growth. Theories behind population control grabbed the attention of American academics and several key figures linking economic development to population control would figure prominently in the introduction of family planning in Indian policy. The loss of China to communism was a strong motivator to try and understand the necessary steps in order to control political revolutions favoring communism; “[Population] growth was understood to lead to resource shortages, economic stagnation, and political instability: in short, conditions believed ripe for the spread of communism.”¹² When India became independent and U.S. interest shifted from China to India, there was a general consensus that Indian political stability was imperative if democracy was to withstand the spread of communism.

One theory in particular that discussed the role and trajectory of population control was transition theory. Transition theory provided a three-step process by which countries underwent population surges in relation to industrialization and economic development. In the early 1940s, a group of demographers at Princeton’s Office of Population Research provided an alternative view to transition theory, “which reconfigured the theoretical link between population growth and (under)development.”¹³ In other words, as opposed to transition theory where population control happens naturally alongside modernization, the reformulated theory reversed the order, maintaining that population control was a necessary component for modernization to occur. This way of thinking about population control and economic development led to the creation of the Population Council in 1952. Organized by John D. Rockefeller, the Council was a conglomerate

¹² Rebecca Jane Williams, “Storming the Citadels of Poverty: Family Planning under the Emergency in India, 1975-1977,” *The Journal of Asian Studies* 73 (2014): 479, doi:10.1017/S0021911813002350.

¹³ Williams, “Storming the Citadels of Poverty,” 479.

of “demographers, scientists, academic administrators, and population activists.”¹⁴ Among the demographers was Frank Notestein, a prominent academic who strongly believed that population growth hindered the economic prospects of a country.

A famine in 1951 brought Prime Minister Nehru, conscious of his country’s hard-won independence and steadfast in his position of neutrality, to the hard-pressed position of asking the U.S. for aid. The inadequate Indian food supply was due to flooding in 1948 and severe droughts in 1950. Fortunately for the U.S., Nehru understood that it was the only country readily able to provide the necessary resources.¹⁵ Even though his options were limited, Nehru asked that the aid be given as a gift, with no political strings attached, but with little leveraging capacity, the anti-aid mindsets in Washington had no such intention of giving gifts to the non-aligned and believed-to-be communist leaner. In a statement to Congress in February, Truman attempted to sway the decision-making process by highlighting India’s struggle as a new democratic nation; “It is important to the free world that the democratic institutions which are emerging in India be maintained and strengthened... Its continued stability is essential to the future of free institutions in Asia.”¹⁶

Truman was unable to respond to Nehru’s request for immediate assistance until after Congress’s approval in March of 1951, five months after Nehru had admitted to needing U.S. aid. Then, in June of that year, the India Emergency Food Aid Act was signed, authorizing a \$190 million loan. The money would be used to purchase grain for the people of India, an amount determined by the average food consumption of the Indian population. With no ability to

¹⁴ Matthew Connelly, “Population Control in India: Prologue to the Emergency Period,” *Population and Development Review* 32 (2006): 633-634. <http://www.jstor.org/stable/20058922>.

¹⁵ McMahon, *Cold War on the Periphery*, 90.

¹⁶ Harry S. Truman, “Public Papers of the Presidents: Harry S. Truman, 1945-1953,” *Special Message to the Congress on the Famine in India*, Harry S. Truman: Library and Museum, <http://www.trumanlibrary.org/publicpapers/index.php?pid=241&st=development&st1=India>.

negotiate on the terms of the loan, it was given on the condition that India would pay it back using certain “rare minerals valuable in nuclear weapon production.”¹⁷ While there was still contestation in Congress about the necessity of development aid to India, there was a desperate undertone by those who believed food instability would weaken the Indian government and surely, if the U.S. did not step up, communism would.

In the early 1950s, Indian Prime Minister Jawaharlal Nehru disagreed with the understanding that population control brought about economic development. He believed that overtime the process of modernity would move the country into a naturally lower growth rate.¹⁸ With that said, India’s first five-year plan is evidence of the fact that he felt that family planning was associated with the welfare of the Indian citizens. Family planning was incorporated into India’s public health program, but the government prioritized rural development and industrialization over family planning. Allocating government resources primarily to the latter two programs was considered as a better investment in India’s future. The funds for the family planning program were hardly touched as the Ministry of Health made it exceedingly difficult for states to access the funds in order to set-up their own family planning programs.¹⁹ India’s Minister of Health Rajkumari Amrit Kaur agreed with Nehru that prioritizing economic development over family planning was correct if economic development would bring about family planning on its own.

Both Truman and Bowles believed that without a significant increase in U.S. aid, the First Five-Year Plan would fail and communism would spread over the region. Advocates for aid to India pushed Congress for an increase, but it was not until 1954 that a steady supply of grain

¹⁷ Sackley, “Village Models: Etawah, India, and the Making and Remaking of Development in the Early Cold War,” 766.

¹⁸ Williams, “Storming the Citadels of Poverty,” 480.

¹⁹ Connelly, “Population Control in India,” 641.

was being sent to India. During this time, the U.S. was spending a significant amount of money on grain storage due to increases in production as a result of its subsidization during World War II. It was agreed upon that the grain would be sent directly to India, as opposed to working through a third party, using Public Law (P.L.) 480.²⁰ One senator, Hubert Humphrey, stated that “[agricultural] excess was an inescapable consequence of American technical proficiency... just as Asia’s traditional agriculture inevitably entailed shortage.”²¹ When the farm bill failed that same year, P.L. 480 provided an answer to both a domestic and international issue. In July 1954, President Eisenhower signed the Food for Peace Program after the U.S. government agreed to send grain under P.L. 480.

Using the grain supplied through the Food for Peace Program, the Indian Food Ministry decided to ensure its distribution by setting up “a network of 50,000 fair-price shops offering discounted flour... Intended for the poor, [these shops] soon appeared in affluent suburbs.”²² Bread and other wheat products soon became staples in the Indian diet. A range of food products, that had been previously considered common staples to the Indian diet, fell, as wheat prices were by far the cheapest commodity. While “[community] development and irrigation increased wheat acreage... yield per acre [declined] by 12% from 1952-1958 and then stagnated.”²³ This problem of production was the result of farmers losing their incentive to produce unwanted food products, loss in income from low sales, and sporadic weather that decimated crops. India’s future looked bleak when U.S. aid was absent from the calculation, but the repercussions of continued aid were

²⁰ Shyam J. Kamath, “Foreign Aid and India: Financing the Leviathan State,” submitted May 6, 1992, <http://www.cato.org/pubs/pas/pa-170.html>.

²¹ Nick Cullather, *The Hungry World*, (Cambridge: Harvard University Press, 2010), 142.

²² Cullather, *Hungry World*, 144.

²³ *Ibid*, 144.

also presenting serious consequences, though in reality, these factors were the ones remaining absent from any future projections.

Elections in 1957 turned out a win for India's Communist Party in the southern state of Kerala. A panic-stricken U.S. decided to increase aid, as the nightmare of a communist India seemed to be coming to fruition. The United Nations and a select few in Congress maintained that grain imports were damaging the Indian economy, but the outcome of elections in Kerala along with the impending gap depicted in the Second Five Year Plan allowed no time for the negative effects of aid to be considered. In the early months of 1958, the U.S. announced its emergency aid package to India, totaling to a \$225 million loan and increased food supplies through P.L 480.²⁴ Even after factoring in the resources provided by the emergency aid package, India continued to project a food shortage. In 1959, the Ford Foundation published a Food Crisis Report for India, "[forecasting] an impending gap of 28 million tons of grain by 1965... Experts identified 'the crux of the problem' as a gap between food supply and a 'rapidly increasing population.'²⁵ Again though, there was little consideration for the possible effects of P.L. 480 or the idea that high infant and maternal mortality rates would offset the growing population as well as the death toll that certain diseases contributed to annually. This lack of responsibility on the part of the U.S. was the catalyst for what was to become India's dependence on U.S. food aid. "Just as with calls for a transparent partnership, calls for the need to activate 'partners' agency can be seen as a reflection of a perceived lack – a lack of 'partner' responsibility and commitment."²⁶

²⁴ McMahon, *Cold War on the Periphery*, 239.

²⁵ Cullather, *Hungry World*, 154.

²⁶ Baaz, "Paternalism," 2.

In 1959, along with the projected food shortages, China's famine had solidified the argument for agricultural development, family planning, and the continuation of U.S. food supplies. Congress passed Kennedy's development plan, officially known as "The Foreign Assistance Act of 1961," and while there were a range of ideas and disagreements about what development in India would look like, there was a general consensus that the reasons for the aid were necessary in the fight against communism. The Act had four distinct features; "central planning, human resources (education, health, and family planning), 'disinterested' aid without political strings, and scientific agriculture."²⁷ This plan was not centered entirely on India, but it was understood as the guide to how the U.S. would conduct its foreign policy in Asia as a whole, which greatly depended on how India would fair.

Section I. The Pre Emergency Period

The push for family planning policies changed when the President of the World Bank, Eugene Black, asked the Princeton academic, Frank Notestein to conduct research on population control in India and, more specifically, its link to increased economic growth.²⁸ Notestein declined to write the report, on the principle that not enough research had been conducted to back the claim. Declining to write the essay, an agreement was made between the World Bank and Princeton's Office of Population Research in 1954 that Notestein would oversee the research being completed at Princeton by the two demographers Ansley J. Coale and Edgar M. Hoover.²⁹ It was Notestein though, after declining to write for the World Bank, who wrote to Minister of Health Rajkumari Amrit Kaur, during the early stages of Coale and Hoover's work, and

²⁷ Ibid, 156.

²⁸ Williams, "Storming the Citadels of Poverty," 480.

²⁹ Ibid, 480.

explained the possible detrimental outcomes for India if population control was not more heavily advocated for. In 1955, he stated; “To me, it seems clear, that the slower rate of population growth would assist the program of economic development in achieving its ultimate goals, i.e., relief from crushing poverty and sustained additional gains in the health of the population.”³⁰ This swayed Kaur’s opinion and she would later defend the push for family planning in front of the Central Family Planning Board, stating, “[Population] growth was impeding efforts to improve the standards of living and needed to be addressed through a national family planning campaign.”³¹

Hoover and Coale publish their work in 1958 and the initial reversal of transition theory was adopted. The book, *Population Growth and Economic Development in Low-Income Countries* ends the initial hesitation of whether population growth could actually hinder economic development. “The book presented three projections for future per capita adult income in India under different rates of population growth... The key message was that a reduction in population growth would produce ‘important economic advantages.’”³² With that said, Coale later wrote in his autobiography that “our conclusion indicated significant prospective economic progress even with continued high fertility, and significant if somewhat modest additional progress should fertility be substantially reduced...”³³ However, both the Population Council and Princeton were responsible for ensuring that the book was received by Indian policymakers, including the prime minister.³⁴ The book became central to India’s shift from promoting

³⁰ Frank W. Notestein, Letter from Notestein to Rajkumari Amrit Kaur (1955), quoted in Rebecca Jane Williams, “Storming the Citadels of Poverty,” 480-481.

³¹ Williams, “Storming the Citadels of Poverty,” 481.

³² Ibid, 481.

³³ Ansley J. Coale, *Ansley J. Coale: An Autobiography, Volume 236* (Philadelphia: American Philosophical Society, 2000), 37.

³⁴ Williams, “Storming the Citadels of Poverty,” 481.

economic development more broadly, to family planning. New family planning initiatives were organized with an urgency that was absent prior to the book's dispersion. Once population growth was linked to economic stagnation, the Indian government began passing legislation, almost immediately, pushing states to focus their efforts on the family planning campaign.

1959, Madras was the first of the Indian states to initiate an economic incentive program that would motivate citizens to undergo contraceptive procedures. "R. Gopaldaswami, chief secretary of Madras, resolved to pay people 30 rupees (\$6.30 in 1959 dollars) to undergo sterilization and to pay 'motivators' 15 rupees for each person they delivered to the clinic door."³⁵ The state of Madras had set a precedent for the rest of the country. In 1959, India's Central Family planning Board went ahead and prepared the country's medical facilities for the influx in people seeking family planning procedures. The bolstering of medical facilities began by "strengthening the staff at 3,000 hospitals and maternity homes... [This enabled] them to conduct more sterilization operations free of charge while compensating low-income patients for travel expenses and lost wages."³⁶ The rate at which India was passing family planning legislation however was not matched by initiatives to finance larger medical facilities, increase the number of facilities, or promote education for doctors and nurses.

In 1960, family planning had moved from a small public health initiative to the center of India's development plan. India's third five-year plan provided family planning with "a sixfold increase in funding and projected a fivefold increase in the number of clinics."³⁷ The energy dedicated to family planning created areas of intense pressure, where individuals would undergo sterilization due to the sheer number of people all receiving the same procedures; "During a five-

³⁵ Connelly, "Population Control in India," 643.

³⁶ Ibid, 643.

³⁷ Ibid, 645.

week ‘intensive Family Planning campaign’ in 1960 [in Maharashtra] more than 10,000 men were vasectomized in camps designed to create a carnival-like atmosphere and maximize group pressure.”³⁸ Maharashtra received the first family planning award that same year.³⁹ It happened that sterilizing men became more common than sterilizing women due to the measurable difference in speed, for a man could become vasectomized was a much quicker process than sterilizing a woman.⁴⁰ Even with the addition in the number of clinics, the rate at which men were becoming sterilized was so high and with the cost to receive the procedure so low, maintaining standard hygiene standards was difficult to ensure.⁴¹ The evidence supporting population control as not only as effective, but a necessary step towards economic development was leading India into a massive family planning campaign.

Justification for including family planning in the third five-year plan came from the literature published by Coale and Hoover. Their projections “for income increase per adult under current and reduced levels of population growth” were given as official government responses as to why family planning was given greater priority over the previous rural and economic development plans.⁴² The reasoning for reprioritizing India’s goals had not changed, economic development was still the main impetus and was espoused by the Indian government as such. The connection between income growth and population control brought an additional 158,000 Indians to be sterilized in 1962; “the Ministry of Health began to encourage the use of mobile units to reach people institutionalized for tuberculosis, leprosy, and mental illness.”⁴³ There was a push from all directions to reach new quotas issued by the central government. The national

³⁸ Ibid, 645.

³⁹ Williams, “Storming the Citadels of Poverty,” 484.

⁴⁰ Connelly, “Population Control in India,” 645.

⁴¹ Ibid, 645.

⁴² Williams, “Storming the Citadels of Poverty,” 481.

⁴³ Connelly, “Population Control in India,” 645.

goal had been set; by 1972 the birth rate would be reduced by 40 percent; “No government in since wartime Japan had pursued a population program with specific demographic goals, and this was the first in history aimed at *reducing* population growth.”⁴⁴ This push to reduce population growth led to several family campaigns for contraceptive procedures for both men and women. The campaigns varied in severity, but the larger they were the more women and men were negatively impacted as a result of India’s poorly financed health infrastructure. A 1965-67 program for IUD insertions led to 29 million Indian women receiving IUDs (intrauterine devices).⁴⁵ Many of these quick and non-sterile procedures led to pelvic inflammatory disease as well as other infections that were left untreated as follow-up appointments were uncommon.

Along with the literature provided by Coale and Hoover, the Indian government had several organizations working in collaboration in an effort to deliver family planning advice for future initiatives. By 1965, the United States was not the only donor working closely and providing recommendations to the Indian government on its family planning programs. The World Bank, the United Nations, and the Ford Foundation each had teams in India working strictly with policymakers on India’s family planning campaigns.⁴⁶ One of the most drastic population control thinkers was Stephen Enke, an economist for the Rand Corporation and working in India in the 1960s. Enke approached the Ford Foundation with the argument “that paying poor people to agree to sterilization or insertion of an intrauterine device (IUD) would be 250 times more effective in promoting economic development than other kinds of aid.”⁴⁷ While the Ford Foundation did not follow through with Enke’s policy suggestion his work made its

⁴⁴ Ibid, 645.

⁴⁵ Ibid, 630.

⁴⁶ Ibid, 648.

⁴⁷ Matthew Connelly, “Controlling Passions,” *The Wilson Quarterly* 32 (2008): 62, <http://www.jstor.org/stable/40262142>.

way into the American government. It was first given to Robert Komer, President Lyndon Johnson's future National Security Advisor, which, when the time came, would be given to the President himself.⁴⁸ Stephen Enke's proposal was a direct argument for economic incentives. The fact that population growth was not only purported to impede economic growth, but that spending money to incentivize individuals to undergo contraceptive procedures was more economical.

Leaving out the fact that Enke had applied the negative economic value associated with children in order to propose a financial rewards system that would justify such coercive sterilization programs, Komer edited Enke's economic theory when he spoke with President Johnson about using U.S. foreign aid as leverage in order to ensure that population control initiatives were employed in developing countries.⁴⁹ Just like Coale and Hoover's work made its way into Indian policy, Enke's work can be linked to U.S. foreign policy. After Komer addressed President Johnson with the possibility of using U.S. aid as leverage, Johnson made two significant policy announcements in reference to population control. The first happened only two months after his conversation with Komer; "Johnson publicly declared that less than five dollars invested in population control was worth a hundred dollars directly invested in economic growth."⁵⁰ The second initiative was directed solely towards India.

Since 1951, the U.S. had provided millions of tons of grain per year to the Indian people. Johnson took Komer's advice and announced that every wheat loan to India, from then on, would have to be approved by Johnson himself. This policy enactment was known as "the short leash" and was described as trying to ease India off U.S. aid, including India enacting population

⁴⁸ Connelly, "Population Control in India," 646.

⁴⁹ Ibid, 647.

⁵⁰ Ibid, 647.

control policies.⁵¹ With America attempting to ease India off U.S. wheat, India had little choice, but to implement policies that would appease the U.S., as well as plan for a future with significantly less foreign food aid. The U.S. was not India's only donor attempting to influence the country's progress in its domestic family planning programs. Organizations such as USAID, the World Bank, the United Nations, and the Ford Foundation were also pushing for stricter initiatives and as they "provided most of India's annual \$1.5 billion aid package" India was economically bound to heed their advice.⁵² Winning the election in 1966, this was the political environment in which Indira Gandhi entered the office of prime minister.

In 1966 the number of IUDs and vasectomies began to drop with a small number of exceptions. The majority of IUD programs that were emplaced left no financial room for routine checkups or cleaner facilities. The financial incentives given to physicians were for IUD insertions only; "the ministry's method of funding state family planning programs actually discouraged better care, requiring them to absorb the cost of treating those with contraindications... out of the three rupees they received for each IUD insertion."⁵³ Whether due to the way in which IUD insertions were conducted, the rates at which women were receiving IUDs dropped significantly in 1966. With less than 50,000 IUD insertions in October 1966, the national annual IUD target had very little chance of being met at the rate insertions were being implemented, which seemed to be the same fate for sterilization rates, though these were higher than IUD rates.⁵⁴ One of the few exceptions was an IUD program in Punjab. The program created in Punjab paid, not only motivators of family planning procedures but also acceptors. The state of Punjab, for example, paid "IUD acceptors, and it achieved 277 percent of its target

⁵¹ Ibid, 647-648.

⁵² Ibid, 651.

⁵³ Ibid, 655.

⁵⁴ Ibid, 656.

for 1965-1966. Madras instead concentrated on sterilization, with higher incentive payments for both acceptors and motivators than any other state-and the highest performance per capita.”⁵⁵

Thus, the creation of a larger scale incentive-based initiative was designed.

At the same time Indira Gandhi took office in 1966, there was a drought brought on by a dry monsoon season. The drought left over one hundred million people residing in the states of Bihar, Rajasthan, Madhya Pradesh, and Uttar Pradesh at risk of famine.⁵⁶ The authorization of continued food aid had yet to be affirmed by President Johnson as a result of the new “short leash” legislation. When the time came for the U.S. to reexamine its wheat loan in light of India’s drought, President Johnson refused to authorize another wheat loan to India before speaking directly with Prime Minister Indira Gandhi, emphasizing the need for a strong and direct Indian initiative to address population control. This refusal came at the same time “Johnson signed a ‘Food for Peace’ act [which required] that a country’s family planning efforts be taken into account before granting food aid.”⁵⁷ The leaders met in Washington in 1966, marking the beginning of U.S. food aid to India being contingent on India creating a policy that directly addressed the issue of population control. It also marked another level of coerciveness. While the U.S. used India’s dire need for food to leverage its own desires for population control, Indira Gandhi enacted similar policies, using the Indian people’s need for nourishment and finances.

Recognizing the success of the Punjab and Madras state family planning programs the central government announced increased funds for all state family planning programs in October of 1966. The central government though, gave states the power to allocate funds where they saw

⁵⁵ Ibid, 656.

⁵⁶ Ibid, 656.

⁵⁷ Ibid, 656.

fit; “it provided states 11 rupees for every IUD insertion, 30 per vasectomy, and 40 per tubectomy (later increased to 90 rupees). Out of this sum, states could pay whatever incentives appeared necessary.”⁵⁸ The states that were most affected by the drought, Bihar, Rajasthan, Madhya Pradesh, and Uttar Pradesh, is where India saw dramatic upticks in IUD and sterilization procedures after monetary incentives were added to the programs. Previously, Bihar had one of the lowest levels of sterilization and IUD insertion rates, “But in 1966-67, with some people eating leaves and bark, a total of 97,409 ‘acceptors’ suddenly came forward.”⁵⁹ The number of ‘acceptors’ increased for many states, not just Bihar, as a result of the famine and increased economic incentive combination. Some states used the funds provided by the central government for their family planning initiatives to pay not only “acceptors”, but also “motivators”; “Punjab, like Uttar Pradesh, enlisted revenue collectors, [who] threatened to punish workers who underperformed, and paid ‘motivators’ according to the number of people they brought in.”⁶⁰ States began penalizing families who had three or more children, sometimes two or more depending on the state. The push for family planning became increasingly more pressurized by the state and central governments;

At the end of 1966 both Kerala and Mysore had begun denying maternity leave to government employees with three or more children... [In June 1967] Maharashtra announced that in 14 months all state employees who elected to have more than two children would henceforth be denied government scholarships, grants, loans, and maternity and housing benefits. In a conference of the chief ministers of Indian states, all but two said they favored mandatory sterilization.⁶¹

However, increasing sterilization and IUD insertion rates would again begin to fall by the end of 1967. The fact that these family planning measures most often affected the poorest of India’s

⁵⁸ Ibid, 656.

⁵⁹ Ibid, 657.

⁶⁰ Ibid, 658.

⁶¹ Ibid, 660.

citizens is critical in understanding the overall product of the population control development policy. In order to create a successful family planning program, India and its donors, utilized the desperate conditions of the 1966 drought to press for continued family planning progress.

In 1971, Mrs. Gandhi was re-elected under the campaign slogan *garibi hatao*, meaning, “remove poverty”.⁶² This slogan became the discourse woven into Gandhi’s State of Emergency, a period of time about to start four years after her 1971 re-election. Several months before the Emergency, the Central Family Planning Council passed a family planning program in April, “recommending a reinvigorated family planning program, including an increased financial outlay, a ‘more scientific’ system of targets, an enhanced scheme of incentives and penalties for ‘indifferent workers’, and extra compensation for ‘acceptors’ of sterilization.”⁶³ Gandhi had tied her campaign push for poverty eradication to family planning, finding the two intrinsically woven together. This reinvigorated push for family planning would set the stage for the family planning experience about to unfold during Indira Gandhi’s Emergency State.

Section II. The Emergency Period

In the mid-twentieth century, academics and politicians were convening to discuss the intricate relationship that economic development and population control seemed to garner. The outcome that was the product of these conversations came to life in India, during the Emergency Period of 1975 to 1977. This period embodies a multiplicity of themes that enveloped the U.S.-India development aid relationship. In June 1975, the Allahabad High Court found Prime Minister Indira Gandhi guilty of electoral fraud. The Court renounced Gandhi’s position and title

⁶² Williams, “Storming the Citadels of Poverty,” 471.

⁶³ Ibid, 482.

of Prime Minister, but she remained in power for another two years. This verdict, along with the pressure from the political opposition of Jayaprakash Narayan's socialist campaign brought Gandhi only to tighten her hold on her position as Prime Minister. The same month Gandhi was found guilty, she declared a state of Emergency in June of 1975, which would continue through to 1977.⁶⁴ The State of Emergency was labeled and sold as a fight against poverty; "Gandhi and her Congress Party government vigorously pursued a program of economic development under the rallying call of *garibi hatao* (remove poverty)."⁶⁵ When the State of Emergency was declared in 1975, population control was already viewed as a critical component to India's economic development plan.

In response to the instability of the country, Gandhi's State of Emergency was followed by a twenty-point economic plan. This plan described the goals designed to bring India into the modern era and to rid the country of poverty, an aspect that was understood as hindering the growth of the nation. Though coercive family planning measures were a large narrative during the Emergency Era, family planning was not included in Gandhi's twenty-point plan. Its absence though, did not mean that the components of the family planning measures were carried out separately from the federal government; "the link that was understood to exist between population growth and underdevelopment meant that, when Gandhi's rhetoric turned to economic development in 1975, family planning was also brought center stage."⁶⁶ This rhetoric seeped into the twenty-point plan, and the pursuit of population control through family planning initiatives fell directly under Gandhi's understanding of economic development.

⁶⁴ Ibid, 482.

⁶⁵ Ibid, 471.

⁶⁶ Ibid, 482.

As was seen in April with the strengthening of the role of the Central Family Planning Council, the government allocated more funds and support to the national family planning program, two months after initially bolstering the Central Family Planning Council, during the declaration of the twenty-point plan.⁶⁷ During the Emergency Period and earlier, the federal government provided budgets and requirements for each state, making room for the states to choose the means by which those funds were spent or how the goals would be achieved. Once Gandhi had strengthened the abilities of the national family planning program, states handled the initiatives with varying degrees of vigour; “In some states, police were involved in ‘motivating’ men to ‘accept’ vasectomy; government servants were given quotas of people to ‘motivate’ for sterilization and, in many cases, were themselves required to produce sterilization certificates.”⁶⁸ By giving states the power to decide for themselves how family planning policies would be carried out, the central government had created a sense of competition as well as a reward system for the states.

The fact that it was not explicitly mentioned in Gandhi’s twenty-point plan was due to the overwhelming importance of family planning and if the plan was to reduce the amount of poverty laden throughout India, then family planning would be one of the most important tools to do so. Singh, a strong believer in the link between the reduction in poverty and family planning, stated, “family planning had been omitted from the twenty-point program ‘not because it was unimportant’ but because it was ‘too important to be listed as one of the points.’”⁶⁹ Singh himself would be a proponent of forced sterilization, believing that the Indian population was increasing too rapidly to wait for citizens to make

⁶⁷ Ibid, 473.

⁶⁸ Ibid, 473.

⁶⁹ Karan Singh, Shah Commission of Inquiry Papers. (National Archives of India, 1976), quoted in Rebecca Jane Williams, “Storming the Citadels of Poverty,” 482.

the choice themselves. Singh's opinion was made clear when in October 1975, he wrote to Gandhi explaining the importance of the Crash Programme.⁷⁰

Following the initiation of the Crash Programme, Gandhi gave a speech in January 1976 at a joint conference of the Association of Physicians of India, and announced her decision to push for compulsory family planning practices. She stated, "We must now act decisively and bring down the birth rate speedily... We should not hesitate to take steps which might be described as drastic. Some personal rights have to be kept in abeyance, for the human right of the nation, the right to live, the right to progress."⁷¹ Here, Gandhi is making a direct connection between the need for 'drastic' family planning initiatives and the ability of the country to progress. The fact that individual rights would be subsided becomes denoted as a necessary step in bettering the lives of the entire population, though the majority of those who will undergo compulsory procedures are the same individuals who would be more susceptible to economic incentives. Gandhi's argument that family planning would help to rid India of the poverty that continually held it back would morph into a program designed to rid India of its impoverished, pitting disaster on an entire group of peoples instead of their economic state.

One month after Gandhi's speech, Sanjay Gandhi, Indira's son, declared his own four-point program. Sanjay's program did include family planning, and though constitutionally he had no political power, the program's acceptance by the Congress Party was a testament to Indira Gandhi's influence and increased power since the State of Emergency. Sanjay's four-point, and later five-point, program is also historically

⁷⁰ Williams, "Storming the Citadels of Poverty," 484.

⁷¹ Indira Gandhi, speech at the Association of Physicians of India. (New Delhi, 1976), quoted in Rebecca Jane Williams, "Storming the Citadels of Poverty," 484-485.

noteworthy due to his own political influence. The influence given to him by his mother was the only legitimacy granting him political clout, but Sanjay's position in Indian politics was not insignificant by any means. Sanjay began acting in Mrs. Gandhi's stead, when she would refer "callers on a wide range of issues to Sanjay."⁷² As such, Sanjay was seen as a representative of Gandhi herself. This position granted his views on family planning much more power, leading him to play an important role in the intensity of the Emergency Era; "Such behavior constituted a vastly greater emphasis on family planning than ever before demonstrated by a top-level political leader, and it came at a time when the concerns of India's top-level political leadership carried vastly more weight than ever before."⁷³ The acceptance of Sanjay's unofficial four-point program was an event that would foreshadow his involvement in India's family planning campaign.

The desire for faster family planning results brought the Indian government to increase incentivization. In February, states were awarded a whole range of 'prizes' to ensure their residents were continually seeking family planning procedures; "Prizes ranged from trophies to cash prizes of up to 5,000 rupees. Simultaneously, the Ministry of Health also asked chief ministers to take disciplinary action against government staff who were not pulling their weight."⁷⁴ The fact that the majority of these states were lacking in personnel and facilities only increased pressure on the health systems, especially for the poorer states where facilities were exceedingly rare. In states like Uttar Pradesh, one of the poorest states, performance levels soared as targets were reached and states were awarded accordingly.

⁷² Davidson R. Gwatkin, "Political Will and Family Planning: The Implications of India's Emergency Experience," *Population and Development Review* 5 (1979): 35, <http://www.jstor.org/stable/1972317>.

⁷³ Gwatkin, "Political Will and Family Planning," 35.

⁷⁴ Williams, "Storming the Citadels of Poverty," 484.

The progress shown after February's award system was replaced, incentivization to meet family planning quotas was reintroduced as a main component to the National Population Policy (NPP), passed in April 1976 by India's Minister of Health and Family Planning, Karan Singh.⁷⁵ The program, while increasing family planning quotas, also provided states with complete control of their family planning policies as long as they continued to meet the targets issued by the central government. States were allotted contraceptive targets by the Central Ministry of Health and Family Planning depending on "population size, social and economic situation, and previous family planning performance."⁷⁶ Although the desired targets of the central government were already steep, "a number of states increased incentives and targets even beyond those announced by Singh. The NPP also allowed states to pass compulsory sterilization legislation."⁷⁷ The monetary incentives issued to the states led to a variety of legislation, each varying in degree of harshness:

Madhya Pradesh's granting of irrigation water at subsidized rates to all persons from villages producing specified numbers of sterilization patients... Some ordered government servants *themselves* to be sterilized or lose certain benefits (Uttar Pradesh's order to teachers to be sterilized or forfeit a month's salary)... others instructed government employees to have *others* sterilized or face penalties (Uttar Pradesh's decision to withhold the pay of family planning and health department workers who failed to produce the specified number of acceptors).⁷⁸

With the NPP being directed towards the states, the Ministry of Health announced that the central government would follow suit, and set an example for the rest of the country. In November 1976, central government employees "were told to ensure that they had no more than three children after September 1977 or face the loss of maternity leave, accommodation and

⁷⁵ Ibid, 473.

⁷⁶ Gwatkin, "Political Will and Family Planning," 40.

⁷⁷ Williams, "Storming the Citadels of Poverty," 473.

⁷⁸ Gwatkin, "Political Will and Family Planning," 38.

allowances that would only be restored upon production of a sterilization certificate.”⁷⁹ The states that had the highest rates of sterilization, Haryana, Himachal Pradesh, and Madhya Pradesh, surrounded the Union Territory of Delhi, “whose government was essentially taken over directly by Sanjay Gandhi during the emergency... [With Delhi itself having] the highest reported sterilization performance of any state or territory.”⁸⁰ The closer in political and cultural ties a state had to the central government, the higher the sterilization rates were. While Sanjay Gandhi drive for family planning was markedly more vigorous than his peers, the country as a whole experienced the central government’s urge to eradicate poverty with the understanding that modernization and progress for the country would follow suit.

In comparison to the initial sterilization targets issued in 1976, many states had surpassed their targets by early 1977, some by 200 percent.⁸¹ Officially, the national sterilization target or goal was roughly 4.3 million acceptors. “All but three of India’s major states (the exceptions being Assam, Kerala, and Jammu, and Kashmir) raised their targets. These self-proclaimed targets totaled over 8.8 million, twice the central ministry’s original figure.”⁸² The drive to perform above and beyond the calculated quotas was due to the aforementioned incentives, both at the individual level as acceptors of different forms contraceptive procedures and at the state level. The cash incentives, forced sterilization, and for the states closest sharing political and cultural ties, such as the three best performing states surrounding Delhi, each provided their own motivation for the successes of the family planning initiatives.

Statistics provided by the Indian government show that during the Emergency an estimated “8.25 million people were sterilized during 1976-1977, around 6.5 million of them

⁷⁹ Williams, “Storming the Citadels of Poverty,” 486.

⁸⁰ Gwatkin, “Political Will and Family Planning,” 42.

⁸¹ Williams, “Storming the Citadels of Poverty,” 486.

⁸² Gwatkin, “Political Will and Family Planning,” 40.

during the six months of July-December 1976.”⁸³ The government had pushed for family planning more than any other program that had been determined as important in Mrs. Gandhi’s platform of ridding the country of poverty and bringing progress to the nation. The Emergency Era, particularly the July-December 1976 period, saw the largest increase in the number of sterilizations performed; “the 1976-1977 performance increased the number of sterilized people by more than half relative to what had been accomplished during the previous quarter-century.”⁸⁴

In January 1977, Indira Gandhi called for an election, subsequently ending the State of Emergency. Before the election, Mrs. Gandhi retracted the strict censorship laws she had emplaced at the beginning of the Emergency. After lifting of the press censorship ban, news outlets reported on the impacts of the harsh family planning programs; “press reports abounded of what came to be termed the ‘excesses’ of the Emergency.”⁸⁵ Increased disdain for Indira Gandhi’s family planning policies, as well as the restriction of many other freedoms, led the Congress Party on a campaign overhaul in an attempt to reframe the discourse around Indira’s State of Emergency. The Party repeatedly professed that the family planning campaign was of a voluntary nature. The campaign was unsuccessful however, and Gandhi lost the election in March. The election showed where her biggest adversaries resided, losing heavily in the states where the “family planning program was pushed most aggressively; and a clear inverse relationship exists between interstate family planning performance and the Congress Party’s electoral fortunes.”⁸⁶ The coercive nature of family planning initiatives during the Emergency is indisputable. Many citizens of India had had their civil liberties and personal freedoms

⁸³ Ibid, 49.

⁸⁴ Ibid, 49.

⁸⁵ Williams, “Storming the Citadels of Poverty,” 473.

⁸⁶ Gwatkin, “Political Will and Family Planning,” 49.

threatened as a way to increase the number of sterilization procedures, an experience that lacked a feeling of volunteerism; “the available evidence suggests strongly that the frequency of indisputably coercive practices significantly exceeded the ‘isolated incident.’”⁸⁷ Though the states closest to New Delhi experienced the highest rates of sterilization the country as a whole felt the coercive nature of the Emergency Era’s family planning campaign.

This in-depth analysis of the Indian Emergency period is an exploration of the links between the policies of the U.S. government and the policies of the Indian government. Population control was, by every means, an issue attempting to be controlled by the largest international institutions. While the intentions of the U.S., India, and the institutions involved were not explicitly acting to harm the Indian people, short sightedness is not a claim by which any government, group, or individual has the right to hide behind. The U.S. government played a strong role in the sterilization of millions of people, and importantly, a large majority of India’s citizens lost faith in state provided healthcare. This is an issue that health organizations are dealing with to this day. That while many believed population control was for the benefit of the majority, it was disastrous for millions of Indians.

Chapter 3. The Four Arguments

The first argument to be uncovered as result of U.S. paternalistic development aid to India focuses on the political and economic domestic interests that are systematically applied to U.S. development aid. The USAID mission statement, quoted at the very onset, serves as a reminder of the attitude states have towards development aid; that it is an extension of U.S. foreign policy. Development aid has proven to be largely driven by the interests of donor states

⁸⁷ Ibid, 48.

and as such a certain amount of forward thinking is required when deciding on a development aid project, but the large majority of that forward thinking is often centered on the donor state and not the state receiving the aid. This critique of U.S. political and economic interests examines the history behind the aid, looking at the type of political and social environment that surrounded the decision makers of the aid at that time.

“[Structured] paternalism aims to nudge citizens toward choice sets that will promote their well-being while discouraging them from choices that will disastrously undermine it.”⁸⁸ This argument finds that the paternalistic nature of U.S. development aid combined with the motivation of U.S. political and economic interests attempts to merge the idea of promoting the well-being of individuals of a recipient state while ensuring U.S. interests. The India case study shows that U.S. interests trumped the welfare of Indian citizens demonstrating an ineffectual merge with the development aid. Family planning was purported as a critical step in the development process of India’s economy. In the case of India, one group of people in particular was subject to the coercive component of the family planning initiatives more so than others due to their socioeconomic class. This first argument is where the coercive nature of the development aid originates. In terms of population control, Indian citizens were subjects of coercive family planning procedures due to inaccurate predictions and portrayals of the Indian political, social, and economic environment. The justification behind the falsified economic development reports stems from the domestic interests that fueled U.S. development aid to India.

The case study of India shows how U.S. development aid was not solely focused on bolstering the abilities of India to tackle its own public health issues and that U.S. domestic

⁸⁸ Jennifer M. Morton, "Tough Choices: Structured Paternalism and the Landscape of Choices." *Educational Theory* 6 (2014): 539. accessed March 30, 2016, doi: 10.1111/edth.12081.

interests played a large role in the issuing of aid. The U.S. government was incentivized by the prospect of enriching its own political and economic standing by using its own products, companies, and theoretical concepts when electing to partake in or initiate any type of development aid to India. The impact this had on the health of Indian citizens receiving the aid varied. The varying degrees in health outcomes will be discussed at greater length, but in many cases, it was the socioeconomic status and geographic location that determined an individual's health outcome. For the U.S., exporting wheat to India was seen as beneficial. In fact, shipping wheat in the form of aid solved an expensive issue the U.S. was experiencing with storing excess grain and thus food aid to India opened an economic channel in the form of aid while simultaneously providing the desired political security in India. This initial aid package was void of a critical analysis of whether wheat exports to India would have negative consequences for the Indian population in the long run. The India case study presents the issue of U.S. development aid being destructive to a population when the aid is of higher value to the donor country. The political and economic interests of the U.S. overshadowed the needs of the Indian population and were instead examined most prominently through the lens of U.S. interests.

This second argument finds that state development aid deepens dependency in the health sector of the receiving state. The paternalistic nature of the relationship between the donor and receiver evolves in such a way that development aid agitates health problems. This issue of dependency follows as a result of the previous critique, that state development aid is not solely focused on the health issues of a particular population. If political and economic reasoning dictates where and how aid is distributed then the health issue, by the very nature of the aid, becomes secondary to the interests of the donor state. This propels the receiving state into a dependent relationship with the aid. The deepening of dependency detracts from the institutional

issues that perpetuate health problems and washes over the deeper historical factors, allowing them to continue without an in-depth, sustainable response. In India, U.S. food aid became crucial to the survival of the Indian population and, if taken away, risked the lives of that many more people it was designed to assist. The U.S. had complete control in the development aid relationship, leaving India at the will of the U.S. Due to the nature of dependency; the U.S. was able to leverage the wheat and pushed for stricter Indian family planning. This dependent relationship places the donor state in a position of power over the receiving state, allowing for coercive agreements to begin formulating, if the coercion was not already present at the time of the initial aid agreement.

When the U.S. issued the first wheat loans to the Indian government, a Congress pressured to bolster India's political strength in an attempt to maintain a strong democratic presence in the region. Maintaining a democratic majority in India was key to the success of the Cold War, and as a result, the wheat loans acted as an insurance policy. From the Indian perspective, India's dependence on U.S. wheat loans was a result of shortsightedness. The fact that India developed a dependent relationship with U.S. imported grain seems a transparent fact in retrospect, but obvious or not, the U.S. was able to maintain the upper hand throughout the relationship due in part, to India's dependency, a dangerous position for India's public health sector; "If people pay too little attention to the long term, and enjoy short-term benefits at the expense of significant long-term costs, then a concern for people's welfare might require, rather than forbid, certain forms of paternalism (potentially including hard forms)."⁸⁹ As was found in the case study, India's population became dependent on U.S. wheat, a product that was

⁸⁹ Cass R. Sunstein, "Paternalism and Welfare," in *Why Nudge?: The Politics of Libertarian Paternalism*, (New Haven: Yale University Press, 2014), 108. <http://www.jstor.org/stable/j.ctt5vm0nr.6>.

unaccounted for when India was projected to have large and devastating food shortages. These projections created a cycle of increased wheat loans, deepening India's dependence, and, eventually, coercive family planning programs.

Dependency forms when, as opposed to applying the developmental issue to a domestic cause and then centering the aid on that, aid is imported. Aid that is imported is not only referring to a tangible product, but conceptually as well. Ideas and theories are also applicable, and can be thrust upon a population in the form of developmental theory. In the case of many public health initiatives, populations become dependent on products that are provided by the donor state. Such aid is provided in the first place as a result of the receiving state being unable to produce or procure a necessary amount to sustain or support their population through non-aid channels. The importation of the good is then continued out of necessity and the structural weaknesses of the receiving state are ignored and surpassed by the dominance of the donor state. India became highly dependent on U.S. food, slowing down India's progress towards self-sufficiency. Though this relationship was mutually dependent, the success of the development aid initiative was determined not by both parties, but by the U.S. Democracy in India was a high priority for the U.S., a foreign policy focus that remained so throughout the Cold War. The dependency also detracts from the receiving state's ability to invest in its own infrastructure, which can cause the deterioration of medical facilities or the stalling of their creation.

The third argument is born from the idea that development aid dictates the demands of a population. These demands implicate the health of a state's population in a multitude of ways. In India, both development theory as well as tangible imported aid resulted in dictating the demands of India's development aid needs. A state that receives development aid is importing a resource that would otherwise be significantly less abundant or completely absent from that society. The

aid causes a shift in the demand and therefore a shift in the future projections of a society's demands. The goals of a development aid initiative are the reason for this shift. The steady flow of U.S. food aid was issued due to the short term interests of the U.S., but with little consideration for the long-term effects on the health outcomes it would have on India's population. The unsustainable reality of development aid leads a receiving state to reassess its priorities in terms of providing for its people, basing its own capacity on that of the donor state. U.S. development theory dictated how the Indian government understood the development of its own society. It created a sense of urgency that ushered in drastic demands by the Indian government for increased sterilization efforts. This effect that development aid can have on a receiving state, implicates many different aspects of a society's health, ranging from government initiatives to address issues that will occur as a result of new demands or preparing for huge gaps in the public health sector as development aid decreases.

When the natural measurement of a population's consumption is interrupted, projected plans for improvement shift in response to the introduction of the aid. They can also shift in response to what a donor state deems beneficial to a society. This can take form in the introduction of new public health policies or governance that has been shaped by outside concepts. Shifting demands can also cause governments to enact policies out of fear that their domestic products and services cannot cope with the shift in demand without the supply of development aid. This reassessment of a society's demands comes at a cost, particularly for the health of the citizens belonging to such a society. The shifting demands, caused by development aid, prompt a population to consume a product originally absent or scarce, which can have major consequences on the health of a population. The most dependent and vulnerable individuals in a society will also be hurt the most by the imposition of an imported product, or development

theory. As in the case of India, those on the lower end of the socioeconomic spectrum were most likely to participate in cash-incentivized sterilization procedures. If aid is cut off, the natural demand will take time to shift back to equilibrium, and again those most vulnerable in a society will experience the harshest consequences.

The fourth argument finds that development aid causes externalities to occur that are equated as disconnected or unrelated, or never even accounted for, from the aid. The introduction of a new product or concept into a market can alter the way a market or society functions. In this sense, development aid acts in a monopolistic manner. Foreign imports can upset the demand and production of products that were determined based on their consumption prior to the introduction of the aid. This argument goes back to the fundamental understanding that development aid works within the constructs of a market-based society. This argument critiques the fact that even though development aid may change the demands of a population and upset the original constructs of a system, the aid will continue to be provided so long as it benefits the donor state. In other words, there will be no direct connection drawn between the skewed order of the system and the exposure of the state development aid. In this sense, demand, demand for economic development, becomes the sole context from which importation of development aid is determined. This critique was formed after exploring the results of India's sterilization efforts. After understanding the extent to which the three previous arguments effected Indian public health policy, it was found that there were health outcomes due to such policies that were absent from the determined success of the aid relationship. These outcomes are considered externalities due to their relation to the U.S. development aid programs. With Indian family planning at the forefront of U.S. development aid policy goals, the history of Indian sterilization programs suggests success in light of these goals. In other words, the policy agenda of U.S. aid programs

to India at the time of the case study were deemed as successful, from a U.S. standpoint, regardless of the resulting public health effects.

Chapter 4. PEPFAR

This section analyzes how the four paternalist critiques of U.S. development aid, birthed from the U.S.-India development aid relationship, have also taken form in one particular present day case of U.S. development assistance for HIV/AIDS. According to the World Health Organization, from 2002 to 2010, the U.S. was the largest contributor to public health initiatives worldwide. While many other nations provide funding for global public health, the fact that the U.S. is the largest of those donors makes for a substantial amount of data and research. The President's Emergency Plan for AIDS Relief (PEPFAR), is the "largest by any nation to combat a single disease internationally."⁹⁰ In order to make comparisons between India and PEPFAR, the size of PEPFAR plays an important role in being able to analyze the program using the four arguments outlined in the India case study. It is also necessary to use a current U.S. bilateral global public health initiative in order to try and understand the future role of PEPFAR. Notably, the U.S. was recognized as the largest aid contributor to public health during the time that PEPFAR was enacted. President George W. Bush garnered support from both democrats and republicans to pass the act in 2003. In 2003 the initiative was signed into law "by the *United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (P.L. 108-25)*."⁹¹ A \$15 billion budget was allocated for the 5-year initiative. The funding was directed towards "15

⁹⁰ "About PEPFAR," The United States President's Emergency Plan for AIDS Relief," accessed January 15, 2016, <http://www.pepfar.gov/about/>.

⁹¹ "The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)," Kaiser Family Foundation, accessed April 02, 2016, <http://kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for/>.

hard hit ‘focus countries,’ and multilateral contributions [were made] to the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) as well as UNAIDS.”⁹² 12 of the focus countries are in sub-Saharan Africa, and also include Guyana, Haiti, and Vietnam.⁹³ The public health goals of PEPFAR are continuously changing as the program goes through reauthorization (there are now 36 countries and regions with PEPFAR programs).⁹⁴ Due to this fact, the impacts of PEPFAR will be critiqued as recently as evidence allows. With that said, the program’s pledged continuation, signed by President Obama in 2013, place the initiative in a critical time period for analysis of bilateral state development aid and its effects on public health to be understood within a present day context.⁹⁵

PEPFAR is also significant, for the purposes of this essay, due to its esteemed regard. The legacy of President George W. Bush is often portrayed as bleak and unpopular, with the exception of PEPFAR.⁹⁶ When PEPFAR is espoused as a success it is in relation to how the program has reached its intended goals. As shown throughout the case study of India, U.S. interests adjust and evolve with the changing domestic and international political and economic environment. With that said, the overarching goals of U.S. development assistance have remained the same; to “[further] America’s foreign policy interests in expanding democracy and

⁹² “The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).”

⁹³ Alan Ingram, "Governmentality and security in the US President’s Emergency Plan for AIDS Relief (PEPFAR)," *Geoforum* 41 (2010): 610, doi:10.1016/j.geoforum.2010.02.002.

⁹⁴ “Countries,” The United States President’s Emergency Plan for AIDS Relief, accessed January 15, 2016, <http://www.pepfar.gov/countries/>.

⁹⁵ “President Obama Signs Reauthorization of PEPFAR,” Centers for Disease Control and Prevention, accessed March 01, 2016, <http://www.cdc.gov/media/releases/2013/p1205-reauthorization-of-PEPFAR.html>.

⁹⁶ Patrick Ellis Cha, “A Quiet Success in Stemming a Global Epidemic,” *The Africa Policy Journal*, (2014): <https://apj.fas.harvard.edu/a-quiet-success-in-stemming-a-global-epidemic/>. See also, Robyn Curnow, “George W. Bush’s new mission: Helping those with the least in Africa,” *CNN*, July 2, 2013, <http://www.cnn.com/2013/07/02/politics/africa-bush-legacy/>.

free markets...”⁹⁷ As a U.S. development aid program, PEPFAR shares in these goals, but the program itself has a much more specific strategy catered towards fighting the HIV/AIDS epidemic. Interestingly, the initial sub-Saharan African countries chosen to receive PEPFAR funds were “significantly more democratic on average compared to non-focus [sub-Saharan African] countries.”⁹⁸

The case study of India demonstrated that U.S. development aid programs were successful in that India created strict family planning programs. Though these programs were harmful towards Indian citizens, by definition, the U.S. development aid program succeeded in influencing Indian public health policy nonetheless. As far as recent history shows, PEPFAR is successful in reaching certain program goals; “As of September 30, 2015, PEPFAR is supporting life-saving antiretroviral treatment for 9.5 million people.”⁹⁹ This last chapter explores how these successes do not refer to the program success as a whole and in fact, have hindered the public health structures within target countries. PEPFAR’s ongoing status makes it so that examples from past U.S. development aid programs will be used to try and understand the future implications of the program. The case study on India was longitudinal which allowed for a complete analysis of the relationship between U.S. aid to India during the period of time outlined in the case study. This important aspect of the India case study allows for parallels to be drawn from the initial stages of both India and PEPFAR. With these parallels, projections can be made about the future of PEPFAR, given its current trajectory. Unlike the India case study however, there are many ongoing PEPFAR programs in multiple countries and while each case will have

⁹⁷ “USAID History,” USAID, accessed November 07, 2016. <https://www.usaid.gov/who-we-are/usaaid-history>.

⁹⁸ Lee and Izama, “Aid Externalities: Evidence from PEPFAR in Africa,” 290.

⁹⁹ “FY 2015 Global Results,” The United States President’s Emergency Plan for AIDS Relief, accessed March 04, 2016, <http://www.pepfar.gov/funding/results/254970.htm>.

its own catered response to the programs this analysis will critique the strategy of the initiative as a whole using evidence from a variety of programs.

Whether PEPFAR will follow in the same path, as India is dependent on four questions raised by the four arguments: First, is PEPFAR of greater value to the U.S. than to those receiving PEPFAR funds? Second, is PEPFAR causing the health systems in focus countries to weaken? Third, have shifting demands in focus countries prompted populations to consume something that was limited or absent prior to PEPFAR and has this caused negative health outcomes? And lastly, can the success of PEPFAR for the United States be attributed to the success of the program as a whole?

“Above all, a cultural analysis is not the same as a culturalist analysis, which ignores political and economic contexts.”¹⁰⁰ These political and economic contexts are never absent from U.S. development aid, as demonstrated in both India and PEPFAR. In order to satisfy this first question of who is benefitting more so from a particular development initiative the interests of the recipient state are just as vital in order to minimize the health consequences of the citizens of a recipient state. There are two angles from which U.S. domestic interests should be analyzed in the case of PEPFAR. The case study of India suggests that both foreign and domestic interests are applied to U.S. development aid initiatives and implementation. In 2001, the Central Intelligence Agency “warned that AIDS in China, India and Russia, as well as in Africa, is a national security threat to the United States.”¹⁰¹ Just as political instability in India during the Cold War represented a security threat to democracy, AIDS is and was understood as “a national

¹⁰⁰ Baaz, “Paternalism,” 9.

¹⁰¹ Sheryl Gay Stolberg. "Bush Proposal On AIDS Funds Shows Concern About Security." *New York Times* January 29, 2003, http://go.galegroup.com/ps/i.do?id=GALE%7CA96985244&v=2.1&u=nysl_se_bardcsl&it=r&p=AONE&sw=w&asid=d30c4e3440f919089a591643b8d4d595.

security threat that could breed the next generation of terrorists.”¹⁰² This was the political environment from which PEPFAR was born. The U.S. Department of Defense committed its services to PEPFAR, stating that PEPFAR’s “HIV/AIDS interventions would ‘provide goodwill humanitarian aid capable of countering terrorist recruitment efforts.’”¹⁰³ Not even two years after 9/11, the idea that AIDS could foster a potential breeding ground for terrorist activity was undoubtedly a motivating factor for the largest disease targeted initiative. While PEPFAR presents itself as a development aid program responding to a U.S. national security issue the program was also implemented with domestic political goals in mind.

When PEPFAR was enacted there were stipulations attached in order to further U.S. domestic interests in terms of family planning education. This will be the first aspect of PEPFAR to undergo analysis in terms of domestic interests harming the citizens of states receiving public health assistance. The PEPFAR report contains a detailed set of guidelines, goals, and funding conditions. The report contains an approach entitled ABC Guidance (Abstinence, Be Faithful, and correct and consistent Condom use).¹⁰⁴ “Beginning in 2006, PEPFAR specified that 33% of all prevention (and two thirds of funds for sexual transmission) would be earmarked for AUM [Abstinence-until-marriage] programmes.”¹⁰⁵ While AUM is no longer advocated for with such ferocity as in the initial stages of PEPFAR, the specificity of the AUM portion of the ABC approach can be found on the PEPFAR webpage. One section in particular highlights the

¹⁰² Stolberg, “Bush Proposal.”

¹⁰³ Ingram, “Governmentality and security,” 610.

¹⁰⁴ “Defining the ABC Approach,” The United States President’s Emergency Plan for AIDS Relief, accessed March 12, 2016, <http://www.pepfar.gov/reports/guidance/75837.htm>.

¹⁰⁵ John S. Santelli, Ilene S. Speizer and Zoe R. Edelstein, “Abstinence promotion under PEPFAR: The shifting focus of HIV prevention for youth,” *Global Public Health* 8 (2013): 3, doi: 10.1080/17441692.2012.759609.

disproportionate weight the AUM and Be Faithful approaches were given over the correct and consistent Condom use approach;

Young people who have not had their sexual debut must be encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those youth who have initiated sexual activity, returning to abstinence must be a primary message of prevention programs. Implementing partners must take great care not to give a conflicting message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that appear to encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices.¹⁰⁶

Initially, the AUM approach was highly prioritized in order to gain domestic support and funding.¹⁰⁷ The fact that AUM was often the sole educational approach when informing children and young adults about HIV prevention was not only ineffectual, it was counterproductive. AUM policy requirement represents a level of implementation failure that was ignored for political reasons. According to the Center for Disease Control and Prevention the Community Preventive Services Task Force found “insufficient evidence to determine the effectiveness of group-based abstinence education interventions delivered to adolescents to prevent pregnancy, HIV and other sexually transmitted infections (STIs).”¹⁰⁸ In 2015, a study conducted by a Stanford medical student found that; “Nearly US\$1.3 billion spent on US-funded programmes to promote abstinence and faithfulness in sub-Saharan Africa had no significant impact on sexual behavior in 14 countries in sub-Saharan Africa...”¹⁰⁹

¹⁰⁶ “Implementing the ABC Approach,” The United States President’s Emergency Plan for AIDS Relief, accessed March 12, 2016, <http://www.pepfar.gov/reports/guidance/75852.htm>.

¹⁰⁷ Santelli, Speizer, and Edelstein, “Abstinence promotion under PEPFAR,” 2.

¹⁰⁸ “Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Abstinence Education Interventions for Adolescents,” The Community Guide, accessed March 18, 2016, http://www.thecommunityguide.org/hiv/abstinence_ed.html.

¹⁰⁹ “US PEPFAR abstinence and faithfulness funding had no impact on sexual behavior in Africa,” nam aidsmag, accessed April 02, 2016, <http://www.aidsmag.com/US-PEPFAR-abstinence-and-faithfulness-funding-had-no-impact-on-sexual-behaviour-in-Africa/page/2949285/>.

“Globally, young people ages 15-24 represent about 40% of all new cases of human immunodeficiency virus (HIV) among persons 15-49.”¹¹⁰ With this in mind, a large portion of young individuals in PEPFAR countries were receiving an incomplete education that was drastically increasing their risks of contracting HIV as proper condom use was not taught in certain AUM-only programs. Along with the negative impact of the AUM programs, two more PEPFAR regulations failed to reach a highly marginalized group of people. These were individuals considered at high risk for contracting HIV; “specific groups of youth are often at increased risk, including young people engaged in sex work; young men who have sex with men; and intravenous drug users.”¹¹¹ When PEPFAR was first enacted it prohibited NGOs from issuing PEPFAR funded treatment to sex workers. As of June of 2013, in *USAID vs. Alliance for Open Society International (AOSI)* the Supreme Court deemed the requirement in violation of the First Amendment.¹¹² Though the U.S. government is banned from selectively excluding sex workers from receiving treatment, many individuals ranging in ages, were denied and stigmatized by the program. While sex workers are no longer excluded from treatment funded by PEPFAR, the program excludes individuals who may be involved in the latter high risk behavior. PEPFAR contains a “conscience clause” that “[exempts] faith-based groups and other organizations from engaging in activities that they deem morally objectionable.”¹¹³ “PEPFAR’s

¹¹⁰ Santelli, Speizer, and Edelstein, “Abstinence promotion under PEPFAR,” 1.

¹¹¹ *Ibid.*, 1.

¹¹² Paul M. Smith, et al., ““Supreme Court Issues Significant Decision on Unconstitutional Conditions Doctrine.” *American Bar Association* 30 (2013): http://www.americanbar.org/publications/communications_lawyer/2013/november/courtside_supreme_court_issues_significant_decision_unconstitutional_conditions_doctrine.html.

¹¹³ Tiaji Salaam-Blyther, “The President’s Emergency Plan for AIDS Relief (PEPFAR), U.S. Global HIV/AIDS, Tuberculosis, and Malaria Programs: A Description of Permanent and Expiring Authorities,” Congressional Research Service, September 27, 2013, <https://www.fas.org/sgp/crs/misc/R43232.pdf>.

‘conscience clause’ allows organizations with a moral or religious objection to opt out of providing services to patients with a sexual orientation of which they disapprove.”¹¹⁴

The countries that receive PEPFAR aid have all had a long history of receiving development aid. PEPFAR differentiates itself from former aid relationship for two reasons. The first, as stated earlier, is the fact that PEPFAR funding is allocated unilaterally.¹¹⁵ The second aspect is that PEPFAR is the largest targeted public health initiative of its kind. Combined, these two components of PEPFAR have deepened the dependency relationship between PEPFAR receiving states and the U.S. development aid. As such, the amount of funds and resources that have been imported into the health sectors of countries that receive PEPFAR aid will be extremely difficult, if not impossible for those governments to replicate if aid was discontinued; “PEPFAR aid is also large in magnitude relative to the size of the recipient countries’ health sector budgets, sometimes accounting for more than the total amount of government health spending.”¹¹⁶ Due to the nature of PEPFAR funding, it does not appear within the budgets of recipient countries, which makes it that much more difficult for countries to even attempt to budget for increased HIV resources; “In 2008, for example, PEPFAR accounted for 118% of the total government health budget in Ethiopia, 128% in Rwanda, 155% in Kenya, 234% in Mozambique, and 249% in Uganda.”¹¹⁷ As opposed to strengthening the health systems of focus countries, PEPFAR has created a series of separate systems entirely dedicated to HIV/AIDS. These systems are implemented at the expense of the autonomy of PEPFAR recipient states, for

¹¹⁴ Lawrence O. Gostin, “PEPFAR’s Antiprostitution ‘Loyalty Oath’: *Politicizing Public Health*,” *Hastings Center Report* 43 (2013): 11, <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=6346>.

¹¹⁵ John W. Dietrich, “The Politics of PEPFAR: The President’s Emergency Plan for AIDS Relief,” *Ethics and International Affairs* 21 (2007): 227, DOI: 10.1111/j.1747-7093.2007.00100.x.

¹¹⁶ Lee and Izama, “Aid Externalities,” 281.

¹¹⁷ *Ibid*, 284.

these governments, with the exception of South Africa, are provided with little negotiation powers when it comes to PEPFAR policy requirements.¹¹⁸

Such large targeted aid packages can also take a toll on the health systems of receiving states. With such a narrow focus on one disease, as opposed to health systems as a whole, resources are funneled away, slowing the process for these countries to create stronger independent systems. Instead, while HIV/AIDS continues to receive vast quantities of attention and funding, receiving nations are placed in a seemingly never-ending cycle of requiring aid as a result of weak health systems. In other words, because other conditions and diseases are receiving less funding and resources the percentage of the population with such diseases may increase. These countries will then, due to their underfunded health system, continuously need aid to combat each targeted disease; “Funneling large sums of external funding to a handful of high-profile disease risks neglecting not only other diseases, but also state health systems as a whole.”¹¹⁹ While fears of corrupt governments deters development aid donors from directly channeling funds into strengthening the health systems of receiving states, PEPFAR is an imported and temporary response that has bolstered the dependent relationship between development aid and the health systems of receiving states.

There are certain components to PEPFAR that have allowed the U.S. to dictate the demands of PEPFAR nations. In terms of prevention policy implementation, PEPFAR “[marked] out a series of populations in need or at risk, and sought to manage their exposure to HIV by intervening ‘in their relationships with things like customs, habits, ways of acting and

¹¹⁸ Krista Johnson, “Between Self-Help and Dependence: Donor Funding and the Fight against HIV/AIDS in South Africa,” *Africa: Journal of the International African Institute* 78 (2008) 508, <http://www.jstor.org/stable/29734369>.

¹¹⁹ Lee and Izama, “Aid Externalities,” 282-283.

thinking.”¹²⁰ While this aspect of PEPFAR originates from the theoretical components that determine U.S. interests, such as AUM programs, this attempt at ‘reeducation’ is an example of an implementation failure as a result of U.S. interests. PEPFAR has drawn a lot of focus and resources from these focus countries as well as other donors; “HIV/AIDS prevalence in Uganda stands at 7.3%, while the under-5 mortality rate is 90 deaths per 1,000 births... Malaria is responsible for over 30% of all child deaths, while HIV/AIDS is responsible for 6%.”¹²¹ Yet, the majority of development funding, and half of Uganda’s health budget in particular, is allocated towards HIV prevention and treatment.¹²² The overarching goals of PEPFAR are not specific to any one country, yet the international and domestic attention that has been brought to the HIV epidemics in each focus country has pressured these governments into allocating their own scarce resources towards HIV/AIDS.

Before the U.S. proposal of PEPFAR, there was a call from the international community to act through multilateral channels to combat the HIV/AIDS epidemic; “In the spring of 2001, UN secretary-general Kofi Annan put new pressure on world governments by proposing the creation of a Global Fund to Fight AIDS, Tuberculosis, and Malaria.”¹²³ The U.S. agreed to help support the Global Fund, but pushed for effective prevention rather than treatment programs. The funds provided by the U.S. were minimal in comparison to what it was about to pledge to PEPFAR. The reasons behind why the U.S. was first adamant about prevention programs over treatment initiatives are unclear, but once PEPFAR was enacted the emphasis turned to treatment. This major shift in approach to the HIV/AIDS epidemic is indicative of a donor country’s ability to dictate how a public health issue should be carried out. Not only did

¹²⁰ Ingram, “Governmentality and security,” 610.

¹²¹ Lee and Izama, “Aid Externalities,” 284.

¹²² Ibid, 284.

¹²³ Dietrich, “The Politics of PEPFAR,” 278.

PEPFAR demonstrate the shifting of the U.S. approach, it required that all medication used in PEPFAR programs be name-brand; “President Bush did maintain a Clinton-era policy that allowed companies in such countries as India and Brazil to make generic versions of U.S.-patented drugs, but stipulated that these companies were not to export those drugs.”¹²⁴ Today, generic drugs are used more widely as a result of a policy change in 2005. The policy required the FDA to first approve the generic brands before their use in PEPFAR countries, though the WHO had previously approved the generic versions.¹²⁵ Before this change of policy, the money used to purchase name-brand drugs, brought American pharmaceutical companies a billion dollar business deal. At the same time, the number of individuals in PEPFAR nations needing antiretroviral drugs was significantly reduced as a result of the higher costs.

The last of these arguments, the creation of negative externalities, stems from one of the examples discussed earlier in the second argument. It is the notion that the large, targeted nature of PEPFAR aid has a negative impact on the existing health structures in focus countries. In a study done by Melissa Lee and Melina Platas Izama, data was compared from sub-Saharan African states that received PEPFAR funds from those that did not. The study found that “[focus] countries have seen a small slowing in the reduction of neonatal mortality, an indicator that closely tracks with the performance of the public health system.”¹²⁶ As previously mentioned, this can cause states to become ever more dependent on development aid. A reason behind the occurrence of this externality can be attributed to PEPFAR program’s need for personnel, known to the receiving states as internal brain drain. Internal brain drain, detracts health workers from other health sectors and draws them to higher paying programs, such as PEPFAR programs;

¹²⁴ Ibid, 285.

¹²⁵ Ibid, 285.

¹²⁶ Lee and Izama, “Aid Externalities,” 291.

“specific sectors that benefit from the influx of aid funds can offer higher wages, better equipment, and increased resources that may pull the best and the brightest health workers and other personnel away from other important yet underfunded health programs.”¹²⁷

Conclusion. The Future of PEPFAR

Foucault argued that liberalism was such that “it was born with a market governmentality, rather than the rights of man at its heart.” There has been a continuous effort to tackle issues of poverty through monetizing society. In other words, a large portion of the motivation behind development projects has been incentivized by economic and political means. This market mentality has proven to be ineffectual in improving global public health. The results of current U.S. development aid strategies, having been produced in a binary relationship with economic strategy, have played into the understanding that by monetizing humans as capital, public health issues cannot be factored into the same institution as state development aid.

The purpose of the case study of India was to provide a general outline of the evolution of U.S. development aid directed towards a public health policy outcome. The amount of time available for analysis in the India case study was pivotal as this similarity was the first parallel drawn between PEPFAR and India as well as the fact that both cases were examples of U.S. bilateral initiatives. The four paternalistic arguments drawn from the case study were proven to be successful components in ensuring a democratically stable India and therefore a successful U.S. development initiative. The success of the Indian initiative, in light of the Emergency period, suggested that the four arguments were also a basis for understanding why U.S. development aid had a consequential impact on the health of Indian citizens.

¹²⁷ Ibid, 283.

The spanning time line of the history of the U.S.-India development aid relationship creates an imprint, or fossilizes, the way in which U.S. interests were interpreted and applied to its development aid strategies towards India. In using these four arguments pulled from this case study, PEPFAR exemplifies the same issues with the paternalistic nature of U.S. development aid as found in India. The future implications of PEPFAR on the public health of the citizens of recipient countries are increasingly worrying as each of the previous chronological arguments that occurred in India, are coming true in PEPFAR. What is unclear is what the externalities of PEPFAR will be. The case study on India demonstrated that it was not until Indian democracy trumped the threat of communism that the U.S. found its development aid initiatives to be successful. In order to ensure this success though, the case study shows that forced sterilization was the externality caused by the drive for the initiative's success. While PEPFAR presents different strategic goals for the U.S. than in India, given its current trajectory, there is strong evidence to believe that a successful U.S. initiative will lead to poor public health outcomes for the citizens of recipient nations. Allowing for a change in the public health trajectory of PEPFAR states will depend on whether or not PEPFAR's success can be perceived by both the United States and PEPFAR receiving states.

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