Nature of Nepali State and Hegemony of Technocentrism and Behaviorism in Health Practices in Nepal

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Abstract

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By situating the interventions in the area of children's health during the last six decades in Nepal within the broader context of development interventions, this thesis argues that national political context is an important factor in the domination of technocentric and behaviorist knowledge and practices in health in Nepal. The post-Second World War project of development was framed in techno-behaviorist terms by international development agencies. The formation of academic institutions, the production of knowledge and its dissemination through a wide network of information, education and communication activities was central feature of international development. However, the domination of these knowledge and actions in specific context was contingent upon the national political context.
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List of Abbreviations

OECD=Organization of Economic Cooperation and Development

IEC=Information, Education, Communication

UNDP=United Nations Development Program

IMCI=Integrated Management of Childhood Illnesses

ARI=Acute Respiratory Infection

HMG/N=His Majesty's Government/Nepal

USOM=United States Overseas Mission

US=United States

USAID=United States Agency for International Development

FP/MCH=Family Planning/Maternal and Child Health

HIV/AIDS=Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

UNICEF=United Nations Children's Fund

WHO=World Health Organization

MDG=Millennium Development Goal

NGO=Non-governmental Organization

UN=United Nations
Chapter 1

Introduction

This paper has two main objectives: first, to critically examine the production of knowledge and interventions through which technocentric and behaviorist thinking in health have come to be hegemonic in the field of health in Nepal; and second, to analyze the nature of forces that dominate the Nepali state which made this hegemony possible. More specifically, while development, of which health interventions were one important part, was conceived in largely technocentric and behaviorist terms from the very beginning, it's deployment and hegemony in specific national context was contingent upon the national political context. I seek to do this by analyzing the interventions legitimized and carried out by the Nepali state and national and international development institutions in the area of children’s health in Nepal during between 1960s and present. I situate these interventions in the context of the development regime that gained prominence in the Cold War geopolitical context (Escobar 1994).

People’s health: transforming inequality or changing biology and behaviors

Ideally, interventions carried out and legitimized by the states in the field of health take broadly two forms or a mixture of them. First, by locating health in a broader social context, they can intervene in transforming existing inequalities and ensuring basic necessities for its citizens. Interventions in the area of resource redistribution, creation of public goods such as health care and education, active promotion of employment and self-
employment opportunities, ensuring food security, among others, are important components of this type of interventions.

Second, by focusing on the individual, states and other institutions could deploy technologies to bring about changes in biological health and behavioral change as important measures of achieving individual’s health. In this scheme of things, the role of the state is maintenance of law and order, enforcement of contracts in the market place, promotion of individual responsibilities, promotion of health education, and active facilitation of the creation and augmentation of market exchange. It is in this scheme of things that technocentrism and behaviorism gain their prominence as organizing and legitimizing principles of interventions in health. Technocentrism refers to the idea that interventions for change are designed and implemented through the deployment of a set of technologies, without regard to existing social context. In health, technocentrism is reflected in increasing definition of health problems in terms of disease and available medical technologies. Behaviorism refers to the notion that health can be achieved through focusing on changing individual behaviors.

Which of these two approaches—one focusing on transforming unequal social relations, and the other focusing on changing individual biology or behavior—becomes dominant is contingent upon the nature of forces that control the state. These approaches are ideal types and in the real world, they are not neatly separated. Still, this distinction is conceptually productive because it points towards different ways of intervening in life and these different ways of interventions are favored by different and often times opposing political forces. Moreover, this distinction is helpful in understanding how the meaning of health and how it can be promoted are sites of struggles. Building a more equal society in
which basic needs such as food, shelter, and health care are fulfilled for people is different from the deployment of technologies and behavioral change strategies.

**States in the making**

I argue that while technocentrism and behaviorism were produced through the practices of knowledge production and interventions (specific ways of saying and doing things) (Escobar 1994) in health in Nepal, these practices were made possible by the nature of forces that controlled the Nepali state and other international and national institutions involved in development interventions in general and those in the field of health in particular. Theoretically, I also argue that the states do not by nature promote technocentric or behaviorist health interventions. In fact, there is nothing natural about nation-states other than a few general principles such as the territoriality, exclusive control over armed forces and permanent institutional structures. What forms they take, the policies they promote and the interventions they legitimize and carry out, and the outcomes in terms of people’s health, are contingent upon the struggles between different forces, such as the political parties, social movements, and professional organizations.

In the field of public health, Navarro and Shi acknowledge that there has been widespread interest in inequalities of health and the social context of these inequalities. However, there still is very little interest in examining the linkage between the nature of political forces that dominate national states and the health outcomes. Navarro and Shi (2003, pp.195-216) analyzed long-term data to examine the impact of major political traditions in the Organization of Economic Cooperation and Development (OECD) countries in four areas: the main determinants of income inequalities; levels of public expenditures and health care benefits coverage; public support of services to families and the level of population
health as measured by infant mortality. They looked at different countries ruled by broadly different political parties: social democratic, Christian democratic, liberal, and ex-fascists, which ruled the respective countries between 1945 and 1980. Based on their finding, they argue that “political traditions more committed to re-distributive policies (both economic and social) and full-employment policies, such as the social democratic parties, were generally more successful in improving the health of populations” (p.195). Wing (2005) does not specifically looks at political parties, but sees organized social movements as movement for justice and health (pp.54—63). Briggs and Briggs (2003) have indicated the nature of changes in the area of health following the rise of Hugo Chavez in Venezuela.

The health inequalities among people and the nature of forces that control states are highly correlated in non-OECD countries, too. The dramatic decline in infant mortalities and increase in life expectancies in China resulted largely from the Communist state’s active policy of land re-distribution, and universal access to food and other basic necessities. In different context, the Indian state of Kerala has the lowest infant mortality rates, high income equality among populations. This was possible because of first massive land reform initiated by the Communist Party of India in the late sixties (Navarro and Shi 2005).

**Biopolitics, discourse and post-structuralist critique of development**

In anthropology, the post-structuralist scholarship has shown the political nature of international development apparatus. Foucault’s concepts of bio-politics and discourse analysis have had tremendous influence in post-structural analysis. Foucault (1976) in defines bio-politics as a general organizing principle of interventions—carried out by an ensemble of institutions including the nation-states—ostensibly aimed at the promotion of life at the population level. Foucault discusses the shift from the regimes of power aimed at
disciplining and regulating individual bodies, to bio-power aimed at augmenting life at the
population level in Europe in the nineteenth century. This shift is reflected in interventions
carried out at the level of populations to deal with “propagation, births and mortality, the
level of health, life expectancy and longevity” (Foucault 1976, p.138). Production of
knowledge about these aspects of life—“life-as-species”, as he put it—was a central part of
these interventions. He primarily locates this shift in the context of capitalism. Increasing the
productivity and volume of labor power was necessary for industrial production (p.141).

After the eighteenth century, according to Foucault, the problem of deaths through
epidemics was largely becoming secondary as higher productivity and resources in
agriculture “allowed a measure from these profound threats: despite some renewed
outbreaks, the period of great ravages from starvation and plague had come to a close before
the French Revolution; death was ceasing to torment life so directly” (p.142).

In a historical study, McKeown (1979) shows that there had been a large scale decline
in mortality in England and Wales well before there were any effective medical technologies
available to significantly intervene in the disease process. In fact, mortality declines occurred
even when working and living conditions were deteriorating during the industrial revolution.
By eliminating the role of medicine and role of sanitary interventions as possible
explanations of much of this decline, McKeown argues that the increased availability of food
in Europe during this period might have led to this.

Both McKeown and Foucault are, however, conspicuously silent about how, for
instance, this increased availability of food was translated into accessibility for the general
populations. Or, their analyses do not tell us, as Davis (2001) and Sen (1999) have shown,
how increased availability of food in most of the colonies existed side by side with the
widespread and recurring famines and starvation. In analyzing longitudinal data, Zurbrigg (2001) has attempted to correlate the malaria deaths with changing food prices that determined the flow of grains out of Punjab, India. She argues that the prices of food grain and malaria deaths are significantly correlated. In other words, while food availability was not a problem, the price rise led to spikes in malaria deaths. The price rise, in turn, was the result of policies actively enforced by the British colonial state.

In trying to be an objective historian of epidemiology and demography, McKeown’s aim was to merely point out the historical truths about the role of food accessibility in mortality declines. His purpose was to question excessive focus on medical intervention as panacea for major health problems (1979). He was not interested in commenting on the larger political economic context in which access to food was augmented, or curtailed. On the other hand, Foucault’s aim was not to look at the shift from disciplinary power to power over life as sites of struggle, but to merely show this transition as historical reality.

Besides the concept of biopolitics, Foucault also has used discourse analysis to examine the operations of power at various sites such as schools, prison, and clinics. Discourse analysis, according to him, involves seeing how objects of knowledge get created through specific practices of knowledge and actions. Discourse analysis helps us to see how this knowledge-action regime sets the boundary of what could be done and said about the formed object. While Foucault is ambivalent about what he means by ‘power’, his analysis has given rise to several post-structuralist scholarships that have looked at the processes through which international development institutions (development apparatus) have produced objects—such as the ‘third world’, ‘underdeveloped areas’, ‘small peasants’, ‘poor’,
‘children’, among others—through the production of knowledge in such a way that these objects are subjected to management through technocratic interventions.

Notable among these analyses are Escobar’s (1994) work on the making of the ‘third world’, Ferguson’s (1989) work on the formation of development as an ‘anti-politics machine’, and Li’s (2007) work on the proliferation of “technologies of improvements” in Indonesia. Escobar examined the formation of the ‘third world’ as an object to be managed by the international development regime. This involved the formations of institutions (such as the World Bank) mostly in the US and/or with US leadership, the setting up of academic disciplines such as nutrition management science and development economics/development studies; the training of experts; continuous documentary production of problems through surveys and research; their increased visibility through the circulation of this knowledge at multiple levels through information, education and communication (IEC) activities, conferences, and publications; and organized interventions ostensibly aimed at tackling these problems (Escobar 1994). This process defined the boundary between what could be said and done, by allowing certain modes of being and doing possible and simultaneously by disqualifying or invisibilizing other modes of thinking and interventions (Escobar 1994).

In trying to transcend the Marxist and pragmatist analysis of development, Ferguson looked at the operations of development institutions in Lesotho not as instances through which some pre-set political economic interests of institutions and nation-states are realized, but the effects these acts have had in terms of greater entrenchment of state into people’s lives and increasing depoliticization of concrete social problems (Ferguson 1989). Ferguson, notes that the state of Lesotho, in which rural development was implemented by a plethora of international and state agencies, is a part of “all-powerful and all-benevolent policy making
apparatus” (p.280). He recognizes that “the interests represented by governmental elites in a country like Lesotho are not congruent with those of the governed, and in a great many cases are positively antagonistic” (p. 280). He also recognizes that “the toiling miners and the abandoned old women know the tactics proper to their situations far better than any expert does” (p.281). He recognizes that the state of Lesotho has “paternal guiding hand” (p.281). He also recognizes the participation of “various categories of Bosotho” in making changes that are happening, “be they mineworkers joining the large and rapidly growing National Union of Mineworkers, political activists working with the liberation movements, women fighting for empowerment and autonomy in the villages, or targeted “farmers” resisting the encroachments of the bureaucratic state” (p.283). What Ferguson does not tell us, however, is if these forces are resisting the “bureaucratic state” or the “state” per se. In other words, were these forces imagining a situation in which they won’t be encroached by the state or are they imagining different kinds of state? Ferguson is not clear.

On similar lines, Li (2007) has looked at how technologies of improvements have become ubiquitous in Indonesia. By using Foucault’s concepts of bio-power and governmentality, she examines how activities aimed at improving the lives of Indonesian people have become ubiquitous through the practices of experts both during colonial times as well as in the post-colonial context. The dominance of expert techniques ensured certain modes of seeing the problems and doing about them that made the broader social context invisible. Techniques that the experts possessed became the fulcrum around which interventions were and continue to be organized. Li also fails to explain if these techniques are endemic to ‘the states’ or to specific nature of Indonesian states given its context.
Fujikura (1996) has looked at the practices of community development as it came to be organized, thought out and deployed in Nepal from 1950s onwards. He specifically looks at how Nepal was represented as a ‘development laboratory’ in which community development could be experimented upon. Pigg (1997), on the other hand, has examined how development practices have created new ways of relating with each other among people in Nepali society. The operation of development regime, according to her, has produced certain concept of who is a villager and who is a modern subject of modern nation. The tradition and modernity have come to be new lines along which people in Nepal began to see themselves and others. All of these writings provide critical insights about how development has been successful in producing normalized practices and entrenchment of state institutions in people’s lives, although it has failed in terms of achieving its stated objectives. Here also, he fails to tell us about the national political context in which Nepal’s status as ‘development laboratory’ became easily operationalized.

In fact, now interventions carried out by the states in the realm of life in Nepal and many other places have become ubiquitous. Moreover, most often the states claim their legitimacy through their claim to augment life such as through the promotion of health and well-being of its citizens. The critique provided by post-structuralist scholarship has opened the way for looking at development not as an innocent exercise aimed at the betterment of the people in what began to be constituted as the third world, but as the formation of ‘third world’ and ‘underdeveloped areas’ through the operations of knowledge and power to be managed by the apparatus of development (Escobar 1994).

I agree that they have shed light on the international political economic context within which development as a project was imagined and deployed with specific political objectives.
in mind. These international conditions were necessary for the creation of these objects of knowledge and ensemble of interventions. However, to the extent that these were deployed within given nation-states, they were also contingent upon the nature of forces that controlled these states.

In the context of the formation of ‘children’s health’ as an object of technocentric and behaviorist interventions in Nepal, I will attempt to show that the absolute monarchy was an important part of this objectification and problematization of children’s health. While the international development regime was central to the formations of objects through the production and circulation of knowledge about children’s health, the deployment of this knowledge was contingent upon this absolute rule maintained through both ideological as well as military apparatus. To be more precise, the deployment of technocentric and behaviorist discourses was possible primarily because it was useful to those forces who controlled the Nepali state, and therefore, this was not an unintended consequences of developmental practice, but internal to it. In other words, the development regime did not produce an ‘anti-politics’ machine, as Ferguson (1989) suggested, but, on the contrary, it was a highly political machine throughout. After all, most of the nation-states, with which the international development apparatus collaborated, were also controlled by brutal dictators who justified their rule in the name of development and improvement of people’s lives.

**Normalization of technocentrism and behaviorism in Nepal**

In Nepal, technocentrism and behaviorism have become hegemonic forms of intervention in health. This is reflected at multiple sites: in series of interventions carried out in the area of health in Nepal, in the way mass media represents health issues and in public policy pronouncements. For example, on October 31, 2007, the public health chief
superintendent of Kalikot district of western Nepal, Mr. Mohammed Aujer Alam, informed journalists in a press conference at the district headquarters that, between mid-March and October, altogether 113 persons had died of different illnesses in Kalikot. Out of them, according to him, 76 persons died of diarrhea, 15 from pneumonia, 20 from dysentery and 2 from serial cough (whooping cough). The dead included 73 children. The reporter concluded by saying: “The diarrhea epidemic was controlled after a team of (the) health workers had reached Dhaulagoha of Kalikot district in an army helicopter after (the) diarrhea took the form of an epidemic in the face of Dasain.”¹ This was a culmination of series of reports published in October and earlier months in 2007 on widespread incidence of diarrhea and other infectious diseases in many districts including in Kalikot. A few international news agencies even reported these epidemics as cholera epidemics. For example, Xinhua a Chinese news agency headlined its report: "Cholera outbreaks in Nepal after 10 years' eradication."² It is interesting to note here that virtually no report published inside Nepal even mentioned that the epidemics was cholera. Some of the headings of the news reports within Nepal were as follows: “24 VDCs³ severely plagued: Diarrhea toll in Dhanusha reaches 19”; “26 die as diarrhea sweeps two districts”.

Reports of epidemics were not unique to 2007. A cursory analysis of news reports published between March and June 2003 revealed that 38 of Nepal's 75 districts had continuous bouts of epidemics of different varieties and proportions. On March 17, 2003, in  

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¹ Nepal’s biggest Hindu festival which falls mostly in October during which offices and schools close for between 1-2 weeks. www.kantipuronline.com/kolnews.php?&nid=126992

² See Xinhua report on October 25, 2007, at (http://news.xinhuanet.com/english/2007-10/25/content_6942085.htm). According to this report, “the bacteria of cholera was found after research was carried out by a microbiological team.” It is interesting to note here that virtually no report published inside Nepal even mentioned that the epidemics was that of cholera.

³ Village Development Committees: under the existing constitution, this is the lowest unit of administrative and political governance institution run by locally elected representatives.
yet another example, The Kathmandu Post, a daily English newspaper, reported that 21 people had died of "mystery diseases" in Kalikot, the same district from where the news reports flowed in regularly in for several months in 2007. In news reports during March-June 2003, deaths were profusely attributed to cold waves, heat waves, diarrhea, pneumonia, flu, lack of hygienic behavior, lack of awareness, failure of health service system, lack of medicine, among others (Bhattarai 2003). Besides the news reports, various institutions--state, NGOs, international development agencies--have been carrying out regular health surveys; social scientists and public health experts also have been carrying out research on Nepal's health situations on a regular basis. These surveys and research have consistently shown over the last five decades that epidemics of diarrhea and other infectious diseases, for example, have been recurrent features of Nepal's health problems.

What are the causes of the widespread incidence of these infectious diseases? Another report on October 25 on the Kantipuronline, titled ‘Diarrhea not yet epidemic,’ states, citing an epidemiologist at the Ministry of Health and Population: “continued spread is due to the monsoon (italics added) that lasted for quite a long period of this time and also due to lack of awareness (italics added) among people.” While emergency medicine (medical personnel flying in military helicopter to save lives in remote villages) has been presented as the savior, two factors are implicated behind these deaths: the behavioral inadequacy of the people who fall ill and die (lack of awareness, unhygienic behaviors, for instance), and the culpability of nature (monsoon, bacteria, cold waves, heat waves).

In a different context, the Nepal Millennium Development Goals Progress Report 2005 identifies “increased awareness and accessibility to programmes that prevent child deaths” as the main factors in bringing about “progress in reducing child mortality” (UNDP
These programmes collectively presented as “Integrated Management of Childhood Illnesses (IMCI)” include a package that consists of four components: “control of diarroheal diseases; control of acute respiratory infection (ARI); immunization and nutrition including micro-nutrients; and a community component” (p.38). While the first three include a set of technological interventions, the community component includes “improving knowledge and changing behaviors for birth preparedness and reducing neonatal mortality” (p.39).

In Nepal, the efficacy of bio-medical technology and inadequacy of villagers' behaviors have assumed the status of ‘common sense.’ This common sense has been the primary basis of health interventions carried out by the Nepali state, international development agencies and other national and international organizations during the last over five decades. In other words, the domains of thought and action in the field of health in Nepal, social inequalities--expressed in terms of class, caste, ethnicity, gender and geographical location--have remained either unanalyzed.

This lack of analysis is revealing because the production of statistics through surveys during the past several decades have consistently shown unequal health outcomes across different social groups. For example, according to Nepal Demographic and Health Survey 2006 there have consistently been higher average mortality rates in rural areas than in urban areas, and that the child mortality rates for the lowest wealth quintiles and highest quintiles were 98 and 47 per thousand live births respectively (HMG/N et al 2006, p. 126). Compared to past rates, there has been a considerable decline in average mortalities, as successive surveys have shown. However, there have been consistently unequal outcomes for different social groups. These inequalities are also acknowledged in public policy pronouncements.
For example, *Millennium Development Goals Report 2005* acknowledges: "girls are nearly 1.5 times more likely to die between their first and fifth birthdays than boys" (UNDP 2005, p.38). Why does this difference exist? The report is not definite, but provides "the most likely" cause as "gender discrimination in child rearing and health care seeking practices, since biologically, boys are more likely than girls to die in this age group" (p.38). In other words, if social context is analyzed it was in the context of specific discriminating behaviors.

**Organization of the paper**

In the next section, I provide the genealogy of the field of ‘children’s health’ as it was constituted through the practices of knowledge and interventions. It is through a set of practices of knowledge production and circulation that the boundary is set as to what can be said and done in that field. In discussing this, I will also highlight the way development interventions including interventions in family planning and children’s health became useful for further entrenching the absolute rule of the monarchy. In the final section, I will discuss the importance of examining the nature of political forces that control the state.
Chapter 2

Production of technocentrism and behaviorism

I attempt to answer two broad questions in this section: how was ‘children’s health’ as an object of interventions constituted in technocentric and behaviorist terms through the production of knowledge and interventions? How was this technocentrism and behaviorism tied to the rule of absolute monarchical state from 1960-1990 and to the neoliberal state in post 1990 Nepal?

Caring of children in general and their health in particular has been the universal human practice within the family and society in Nepal, although these practices varied among people and places and over times. The notion of who is considered a child; what could be considered as children's health and well being; and what are considered as necessary sets of practices to ensure a child's health have been varied and diverse. The interest in children's lives including their health, largely remained within the realm of family and local community for a long time. The diverse rituals of birth, naming rituals, rituals surrounding feeding and other activities continue to be an integral part of social life in Nepal.

The inauguration of the development project in the early 1950s brought about important changes in existing practices and knowledge. Who is considered a child and what constitutes a child’s health became standardized along with the classification of age groups through the production of census in 1951. The first census was produced in 1911. A pamphlet urged people to come forward and provide information to the census enumerators
in 1911 arguing that, in the absence of records “regarding our people, it would be difficult to provide services for them when necessary by the state” (National Commission on Population 1985). This pamphlet did not elaborate on what services the state had in mind. Similarly, this census did not classify the population according to specific age groups. However, it was the beginning of a construction of an entity called population, which would have larger impact in discourse about children’s health from the 1960s onwards, as I will show in the later part of this essay.

It was four decades later that ‘scientific’ census was produced. Production of this census was a mammoth exercise. Carried out during the span of two years between 1952 and 1954, this involved transporting about 19 tons of census schedules and publicity materials from Kathmandu to different parts of the country and back again to the center, mostly on the back of porters, and in which a one way journey to the enumeration site took as long as four weeks (Thakur 1963).

It was during this time also, that the ruling elites began to show some care for their subjects, if not for any altruistic reason, at least for self-interest. They began to build a few schools and colleges, a few hospitals, and, at around 1940s, a few new factories. The political economic order was maintained through legal-military institutions both aimed at institutional control and production of fear. The fear of death and punishment had been the main instrument through which the ruling elite maintained control over the people. The presence of military as well as the meting out of harsh punishments formed the core of the regime.

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4 The language used in this is interesting. Not many in the country would have believed then that the regime, whose sole purpose was the extraction of surplus from the peasantry and through monopoly in trade, mineral and forest resources and exaction of unpaid labor from general masses, would bother about providing services.
Punishments, including executions, were routinely carried out in public as a way of instilling fear.

At an everyday level, an elaborate network of functionaries was created to transfer surplus from peasantry to the ruling elites. This process led to the construction of a hierarchically organized network of elites who lived off the extraction of surplus from the primary producers. The objective of extracting maximum surplus from the peasantry was enforced with a vengeance even when it led to widespread famines such as in 1860s (Regmi 1978, p.143).

Nepal's first allopathic hospital, Bir Hospital, was built in 1890. This was followed by several of its branch hospitals in different parts outside the Kathmandu valley (p.13). A cholera hospital, later named as Sukra Raj Tropical and Infectious Disease Hospital, was built in 1890 (Dixit 2005 [1995]). The primary objectives of these hospitals had been the provision of medical services to elite rulers and their relatives. They were located in the major administrative centers where the elites lived. Additionally, these hospitals were also built in response to cholera epidemics of the early twentieth century. A few attempts were also explicitly made to provide services to the poor, such as the opening of a hospital near the Pasuhiati temple in Kathmandu for the benefit of the poor people of the locality (Dixit 2005 [1995], p.17).

Another area of public involvement in children's health was vaccination. Attempts were made by Raj Baidya, the main traditional doctor in Kathmandu valley, to vaccinate children, but those attempts ended in deaths of children, presumably because of vaccination with attenuated strains. Around late 1940s, municipalities in Kathmandu valley were asked to record births and deaths and to promote inoculation and vaccinations during the time of
epidemics (Dixit 2005 [1995], p.18). These interventions evidently could not have much impact on the overall health of the populations, nor do we know if these actions were taken effectively. However, the fact that these acts were announced shows some amount of interest on the part of the state in the health of population in Nepal.

Evidently, the state’s involvement was motivated by the care of the elites and, if the commoners also became part of it, it was because they had to be included, for example during the epidemics, for the safety of the elites, for example, from cholera (ibid.). Moreover, this was also a time when the elites were also increasingly interested in becoming what Liechty (2003) calls “suitably modern”. Besides military control, they also attempted to present a benign face and to make themselves visible. The hospitals, colleges, canals, and railways were named after the rulers. Therefore, if any announcements were made, they remained largely at the level of rhetoric and even that limited to a very small section of the population as there was no means of communicating those announcements across the country.

In 1947, a constitution was adopted which created local institutions that had the capacity to raise revenue locally and provide services such as education, health, transport and electricity and the upkeep of public buildings (Shah 1996, p. 185). In other words, if the health of the Nepali people, including that of Nepali children, was the subject of state discourse, it was in a very limited sense until the political change in 1951. In terms of geographic reach, in a mountain country with no roads, airports, or trains, in which the only means of mobility across the plains and steep mountains was by foot, the existence of a few hospitals and medical delivery centers hardly made much difference in terms of people’s access to medical services.
After 1951—democracy, development, and neoliberalism

The year 1951 marked departure from the past in two important ways. First, that was the year an armed revolution led to eventual dissolution of the previous hereditary transfer of power, although this became short-lived, as I will show later. Political parties began to compete for political power both at a national level and local level. They saw the role of the state in the area of social welfare, redistribution of productive resources and provision of basic services. Two major political forces: the center-left Nepali Congress and Communist Party of Nepal—had radical redistribution of land as their main agenda. Besides that, both of them saw a very active role of Nepali state in the provision of public goods. Around the early twentieth century, political leaders and organizations began to imagine a new Nepali state based on the ideas of justice, democracy and social good. These ideas were generated as some radicalized intellectuals who came in contact with a variety of anti-colonial struggles in India (Shah 1996). More specifically, transformation of political power through the restructuring of the land ownership system, instituting of representative democracy and modern judiciary, were important parts of the new ideas about the state.

The interim constitution, adopted on April 11, 1951 imagined the state as an institution that “shall strive to promote the welfare of people by securing and promoting as effectively as it may a social order in which justice—social, economic and political—shall inform all the institutions of national life” (Excerpted in Shah 1996, p.251). At the level of imagination, this was a significant departure from the past. Instead of becoming the machine for the forcible extraction of surplus from peasantry, the state’s role would be that of protecting them through the provision of public goods. Moreover, the state was to be central
institutions in re-distributing the land away from the largely absentee landlords towards the peasantry.

That was also the year that Nepal formally entered into the development and modernization process. On January 23, 1951, the United States Operations Mission (USOM) and the then Nepal Government signed the Point IV Agreement for Technical Cooperation (Skerry, et. al. 1991, p.1). This was part of the US-led efforts in the 'underdeveloped areas' as announced by the then newly elected president of the United States Harry Truman on January 20, 1949 (Escobar 1994).

The first batch of community development experts who came to work in Nepal as part of the village development program initiated by the Point IV program did not consider their lack of understanding of Nepali reality was a problem. They thought that the problems were self-evident, and what Nepal needed was provision of a few missing pieces, and that Nepalis were aching for change (Skerry et al 1991). Truman himself in his inaugural speech pointed out that there already were knowledge and skills available to deal with the problems. He said:

For the first time in history, humanity possesses the knowledge and the skill to relieve the suffering of these people.... I believe that we should make available to peace-loving peoples the benefits of our store of technical knowledge in order to help them realize their aspirations for a better life. (quoted in Escobar 1994, p.3).

The problem, therefore, was not about knowing what to do--but increasing access to "our store of technical knowledge." Capital, science, and technology were the missing parts in the "underdeveloped areas." The first batch of US community development experts arrived in Nepal with a community development manual in hand (Fujikura 1996: 271--311). These experts assumed that the successful demonstration of various technology of improvements—
in the areas of health, agriculture, hygiene, community development—would lead to the successful adoption of these techniques by the Nepali people (Skerry et al 1991, p.7). If there were not enough personnel to carry out the extension work, then the problem was that of training more personnel adept at the skills and techniques of demonstration. What they were doing was to follow what Latour (1988) calls “the diffusion” model of establishing (scientific) truths (p.133). In it the problem of knowledge is considered one of diffusion of existing techniques, rather than producing better understanding of the situation. I find that this mode of transferring the ‘facts’ was possible, also in a situation where there is monopoly over the means of diffusion of ideas such as during the thirty years of absolute monarchical rule.

It was also necessary for the consolidation of nascent democratic system. A summary report prepared by the USOM pointed out: "The need to expand these services to every district, every area, every village, is essential to the successful establishment of a democratic way of life..... Only as a government shows a satisfactory response to the felt needs of its people can a democratic government exist." (quoted in Skerry et all 1991, p.14). Under the "direct transfer of knowledge" outlined in Point IV program, between 1952 and 1959, USOM provided training to 164 Nepali participants in the United States universities. Among them 31.29% were trained in the area of health and sanitation (Skerry et al 1992, p. 15). It was also the time when development economics and the issues of what came to be labeled as the third world were gaining prominence in the US academic institutions (Escobar 1994). More importantly, this was also the time when ‘the population problem’ was gaining widespread visibility among general public, corporations, political institutions and the US state, through the concerted actions of what Greer (1984) called the population lobby.
The assumption that the provision of some missing pieces would take Nepal into a self-sustaining path of progress was short lived. For example, the first village development program had set the goal of training 14,000 village development workers. By the end of the project phase, they could train only 4000 of them. After a few years, it became apparent that the hope that Nepalis will be on a self-sustaining path towards modernization was misplaced (Skerry et al 1991). Political fighting between and within political parties meant that the smooth progress of development projects was marred by perennial problems. However, the two approaches to social change—one enshrined in the Point IV program based on the "direct transfer of knowledge", and the other enshrined in the imagination of different political parties based on the transformation of social inequalities, existed side by side. This changed after the king staged a coup.
Chapter 3

Between 1960 and 1990: autocracy, development and technology of improvements

The transition from open democratic politics to absolute monarchy was accompanied by an elaborate set of policing mechanisms through which any dissent that questioned the legitimacy of the king’s rule was brutally suppressed. The political parties were banned. Freedom of the press was severely curtailed, and building of organization was allowed only for those who supported the king’s rule. Most of the political leaders, their cadres, and supporters were either imprisoned or exiled. The monarchical regime faced occasional rebellions—both armed and unarmed, but it was powerful enough to repress them until 1990.

But this rule was also not the replica of the pre-1951 state which was exclusively organized for the purpose of extraction of surplus for the elites. In the King’s rule, land ownership was not transformed completely, but surplus extraction by the local and national functionary in the form of direct transfer of the primary product was curtailed. Development of the nation became the sole justification for the King’s rule. To be more precise, “to break-open the fountain of development” [bikasko mul phutaunu”] was the sole motto of King’s rule (Adhikari 1996, pp.345—364; see ibid. for a detailed analysis of how development became the overriding topic of everyday discourse). The king spoke about this in his speeches. Songs were written and played in radio programs. Radio plays were enacted on this. A feature film called Parivartan (Change) was made and promoted in many places.
Before 1951, the rulers exercised their control over their subjects, the primary source of the surplus, through an elaborate network of functionaries involved in revenue extraction. The new King’s rule began to further institutionalize control at various levels through an elaborate network of local institutions and development projects. However, its resource did not come from agriculture. Foreign assistance was the primary sustenance for the Nepali state from the 1960s onward.

It was in this context, that development discourse intensified. Development in the form of road, air transport, increasing numbers of schools, building of an elaborate network of administrative institutions, expansion of police and military institutions went hand in hand. The King declared that the political system based on political parties was leading to bickering and infighting, thereby stalling the process of development. Doing development became the sole guiding principle of the king’s political regime tightly maintained and entrenched through elaborate institutionalization of a police state. It was in this context development based on technical interventions and behavioral change was legitimized by the Nepali state. The two major parts of this thinking were family planning and child survival.

The international development agencies, USOM being dominant among them, were initially concerned about the political change. In fact, USOM even significantly curtailed its programs after the King’s takeover of power (Skerry et al 1991). But by 1962, however, the international development institutions began to be involved back in the process of development. They began to argue that the development interventions are too neutral to be affected by the change in political system. Once the field was sanitized from the possibility

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5 Expansion of military and police institutions have not yet been researched in Nepal. In fact, until 2001, military enjoyed virtual immunity from public scrutiny. It will be interesting to examine how ‘benign’ component of national development apparatus was paralleled by the expansion of overt military and police institutions.
of political contestation, it was easy for the development regime to produce its objects and modes of interventions. It was in this specific political context that the nature of interventions and truths began to be produced, including in the area of children’s health. In this political context, international agencies could have an almost unchallenged sway in setting the agenda of what needed to be done and said as long as king’s political power was not questioned.

Population control and family planning for health

During this period, one of the problems that United States Agency for International Development (USAID) identified was the lack of comprehensive statistics (Skerry et al 1991, p.6). It helped set up institutions for the production and analysis of statistics. Along with series of intervention programs, production of data and other forms of information proliferated, most important among them being the decadal production of census. By 1961 when the census was done, it was becoming clear that Nepal’s population was on the rise. However, until mid-1960s, population was still considered as resource and not a problem.

Family planning programs were started in 1959 with the initiatives of Nepal Medical association (Dixit 2005 [1995], p.67). However, it expanded only during the King’s rule. In 1965, the USAID began technical assistance program to run family planning and it was later integrated with children's health. In 1966, The Family Planning and Maternal and Child Health project was initiated in three districts in the Kathmandu valley. Part of children's health intervention involved the distribution of milk power to those who were underweight and in need of support. This also involved immunization of children (ibid.). But the overriding objective was the promotion of family planning services.

It was also the time when international population lobby (Greer 1984, p.348) had already consolidated its position within the US political establishment. Most of the influential
members of the United States administration, members of US Congress and general population were beginning to accept that increasing population was a sure recipe for widespread left wing revolt in the third world. Growing population was increasingly seen, therefore, as a security threat for the US. The problem of development had been the problem of US security in the context of the cold war. Escobar (1994) writes:

“The control of communism, the ambivalent acceptance of the independence of former European colonies as a concession to preventing their falling into the Soviet camp, and the continued access to crucial Third World raw materials, on which the U.S. economy was growing increasingly dependent, were part of the United States’ reassessment of the Third World in the period that ended with the Korean War” (p.34).

But population control, of which the national family planning and maternal and child health was to become an integral part, was not yet considered as a national security issue. In 1959, the then President of the US Eisenhower said:

“Birth control is not our business. I cannot imagine anything more emphatically a subject that is not a proper political or governmental activity, or function or responsibility” (quoted in Duden 1992, p.200).

But by the late 1960s, there had been fundamental turnaround in the position of the US government. Through the concerted campaigns of big private foundations, the overpopulation of the third world was put on the national agenda in the US. This began to seep into the discourses of United Nations agencies, and the United Nations Population Fund was eventually established.

In April 1974, the then US administration sponsored a security study aimed at finding “the implications of worldwide population growth for US security and overseas interest” within the jurisdiction of the then Secretary of Agriculture, Director of Central Intelligence
Agency and the Secretary of State. According to the terms set for the memorandum, this study was to address among other things, the following:

- The corresponding pace of development, especially in poor countries;
- The demand for US exports, especially of food, and the trade problems the US may face arising from competition for resources, and;
- The likelihood that population growth or imbalances will produce disruptive foreign policies and international instability.\(^6\)

The study was also to “offer possible courses of action for the United States in dealing with population matters abroad, particularly in developing countries, with special attention to the following questions”:

- What, if any, the initiatives by the United States are needed to focus international attention on the population problem;
- Whether technological innovations or development reduce or ameliorate its effects
- Could the United States improve its assistance in the population field and if so, in what form and through which agencies—bilateral, multilateral, private?\(^7\)

The report was submitted in December 1974. The report acknowledged that “the world is increasingly dependent on mineral supplies from developing countries, and if rapid population frustrates their prospects for economic development and social progress, the

\(^6\) [http://www.population-security.org//11-CH3.htm#letter](http://www.population-security.org//11-CH3.htm#letter) (accessed on April 19, 2008.)

\(^7\) [http://www.population-security.org//11-CH3.htm#letter](http://www.population-security.org//11-CH3.htm#letter) (accessed on April 19, 2008.)
resulting instability may undermine the conditions for expanded output and sustained flows of such resources” (p.5).

The report further acknowledged the hostile attitude of the developing countries towards the US. It notes:

“The developing countries, after several years of unorganized maneuvering and erratic attacks have now formed tight groupings in the Special Committee for Latin American Coordination, the Organization of African States, and the Group of Seventy-Seven. As illustrated in the Declaration of Santiago and the recent Special General Assembly, these groupings at times appear to reflect a common desire to launch economic attacks against the United States and, to a lesser degree, the European developed countries. A factor which is common to all of them, which retards their development, burdens their foreign exchange, subjects them to world prices for food, fertilizer, and necessities of life and pushes them into disadvantageous trade relations is their excessively rapid population growth. Until they are able to overcome this problem, it is likely that their manifestation of antagonism toward the United States in international bodies will increase” (p.64).

After strongly presenting the case that the rising population of the third world countries was national security threat to the United States, the report highlighted the possible areas of interventions. It recognized that fertility reduction could not occur simply through technological interventions. It identified reasons for the high birth rate as: “inadequate information about and availability of means of fertility control”; “inadequate motivation for reduced numbers of children combined with motivation for many children resulting from still high infant and child mortality and need for support in old age; and “the slowness of change in family preferences in response to changes in environment” (p.6-7)

But the report went on to argue that the US “cannot wait for overall modernization and development to produce lower fertility rates naturally since this will undoubtedly take
many decades in most developing countries, during which time rapid population growth will tend to slow development and widen even more the gap between rich and poor” (p. 122). Therefore, the report urged for massive technical interventions for population control. It envisaged USAID as the lead institution to take this agenda forward and one of the major steps was to convince the national leaders about the necessity of population control for development. Following this, USAID’s involvement in population planning began to expand phenomenally (p.122).

This sentiment had already been echoed back in the late 1960s. Nepal's first health survey was produced in 1965. As the first comprehensive survey, it claimed to provide information needed for comprehensive health planning (Worth and Shah 1969, p.1). Although the calculation of infant and child mortality rates had been done for the first time in the 1950s, this survey provided a more detailed health profile of the Nepali population during the sixties. The survey was carried out between July 1965 and May 1966 in 24 randomly selected representative villages across the country, covering a population of around 6500 people (ibid. pp. 2-3).

The survey provided information about the environmental conditions; vital statistics; reproductive attitudes, beliefs, and practices; nutrition and nutritional deficiency diseases; diseases transmitted by direct contact; disease transmitted by the respiratory route; diseases transmitted by fecal contamination; diseases transmitted by insect vectors; diseases of specific organs such as eye, ear, lung; cardiovascular diseases; diabetes, among others (ibid.). Although, it did not generate specific disease profiles of children, it nonetheless produced mortality rates of children, which were expectedly found to be very high (ibid., p.29). The birth rate was also found to be very high.
Where should the priority lie, then? The reduction of infant mortality was risky, the report concluded, because this would lead to a sharp increase in dependent populations very sharply (ibid. p.31). The report recommended focusing on reducing the fertility rate first and focusing on those conditions that impact the health of the young adult age group as a way of augmenting the supply of healthy human resource for the economic progress.

It was perhaps not a mere coincidence that malaria and family planning projects saw phenomenal expansion from the late sixties onward. The family planning component of the project was called Family Planning and Maternal and Child Health (FP/MCH), but the focus had been in the promotion of family planning. This got further impetus as the population problem began to gain greater visibility in the seventies following the publication of census and public visibility of fertility trends.

The first health survey had concluded:

“Meanwhile, during the next decade as a larger and larger percentage of children go to school, there must be built into the school curriculum some concepts of the demographic realities for Nepal, so that the boys and girls will emerge from school with newer ideas about the necessity for spacing their children and having fewer of them. When there is some indication that these ideas have become living realities, then the infant and child health services mentioned above can safely become high priority items” (Worth and Shah 1969, p.116).

Demographic surveys began to be published regularly after the first fertility survey carried out in 1976. The annual report of ministry of health, the five-yearly planning documents began to be regularly produced since early 1970s. Disease-specific surveys as well as demographic surveys were carried out on a regular basis since 1980s. But these reports did not circulate in publicly. As Onta (2005) notes, these documents were kept from circulating in public (p.25). The government, for example, banned the publication of
HIV/AIDS statistics; Nepal did not report cholera to the international organizations; and the state did not allow the testing of drinking water distributed by the government in the Kathmandu (Onta 2005, p.25).

However, the behaviorist and technocentric discourses were integral parts of the interventions through the popular media. This was the time of intensification of discourse at the everyday, popular level. Throughout 1970s and 80s, a few vertical disease eradication programs and family planning programs constituted the major chunk of health interventions. In fact, all the major health initiatives were integrated with family planning activities. An integral component of these interventions involved the dissemination of information as a part of behavior change strategy. This was called information, education, and communication (IEC) strategy. Nepal’s mass media—the radio and newspapers, for instance—regularly disseminated the truths about children’s health, the need of family planning for the health of children and mother, the ill-health resulting from overpopulation, the need for washing hand before meal, the need to see a doctor when sick, and the ways of making rehydration solutions in cases of diarrohea, among others. The focus was exclusively on the necessity of population control. In fact population control through wide spread provision of family planning services was presented as the panacea of the major ills facing the country (Bhattarai 2004, pp392-417).

These programs and institutions that run them were presided over by the royal family members, and therefore, what they said on a regular basis—as a ‘message to the nation’, or inaugural statement of seminars and workshops—made headline news for several days in radio and newspapers.
The concern that sharp reduction in the mortality of children would result in population explosion and therefore, the idea that effective intervention had to be timed well with perceptible declines in fertility dominated the thinking of USAID and Nepali officials (Worth and Shah 1969). During the seventies and early eighties, family planning itself was presented as important means of dealing with child health. The argument was straightforward: if too many children died too young, then averting the birth itself would reduce the number of those deaths. Family happiness was increasingly presented as the direct outcome of family planning. One poster promoting family planning reads: “Let’s only have two children, so that we could provide enough care for them.”

In another example, a set of two posters designed for neo-literate adult compares two families: one small family and the other big family. The “small family” shows a mother and a father and a girl and a boy. The girl is showing the alphabet book to her small baby brother boy. Mother and father are both tending the vegetable garden. The vegetable saplings are planted in straight row. There is a cattle shed adjoining the one story traditional hill Nepali house with slanting roofs. All the four are smiling. In the second picture, depicting “large family”, there are two parents and seven kids. The mom shown holding one of the daughters hair in rage, a small boy is clinging to her, another boy is shown crying, and the rest four kids are shown fighting with each other. A man—apparently the father of the family—is coming in the house with rather creased lines on his face and a somber look. There are shards of a broken earthen pot lying on the floor.

In yet another poster, a group of people—men, women and children—are shown queuing up to a doctor’s clinic. The poster reads: “overpopulation and health”. Message such as these were constantly transmitted through radio, newspapers and magazines. While
overpopulation was presented as the source of major problems of health, environment, and food security, as a corollary, population control (janasankhya niyantran) was the solution for them. More specifically, in the area of children’s health and well-being, family planning was the most effective panacea (Bhattarai 2004). But this was short lived.

**Child survival for family planning**

The family planning establishment was beginning to realize that the fertility and the mortality declines were connected to each other, and that the risk of death was the driving force behind higher fertility was beginning to dawn on family planning establishment (Skerry et al 1991, p.335). Demographers had realized this for long time. In fact, the National Security Study Memorandum 200 also acknowledges this, although it emphasizes overt technocratic interventions because of the urgency of the time. A reversal occurred in the later half of the 1970s in Nepal. While initially family planning and population control was presented as the cure-all, now the survival of children was becoming the pre-requisite for the promotion of family planning itself.

The first fertility survey was conducted in 1976, as a part of first World fertility survey. It revealed the persistence of high fertility and high mortality. While maternal and child health was still integrated, a renewed focus on survival of the children began in the late 1980s. It was in this context that children’s health became an important arena of knowledge and action. A series of surveys were done on discrete aspects of children’s health situation from the late 1970s onward. Several nutrition surveys, diseases specific surveys were conducted on a regular basis. For example, a morbidity data in 1982 showed that respiratory illnesses constituted about 42% of child morbidity in Nepal followed by alimentary illnesses (30.2%) (Dixit 2005 [1995], p.78).
If any disease specific programs were initiated, they were done with the acceptance of family planning services among people. It was a carrot offered to the population to attract them to family planning services. For example, an Integrated Family Planning and Parasite Control Project was initiated in 1979 with the help of Japanese Organization for International Cooperation in Family Planning. “The main objective of this integrated project”, the project introductory booklet says, “is to eliminate the widespread prevalence of round worms, hook worms, teak and other parasites through the participation and cooperation of people as a way of gaining public confidence in family planning, the other important pillar of public health” (Family Planning Association of Nepal—Integrated Family Planning and Parasite Control Project n.d., p.3-4).

The visibility of children’s health as the problem of specific interventions further increased in 1980s. While the excessive focus on family planning was not producing the much needed reduction in fertility, the fertility survey carried out in 1976 showed potential linkages between infant mortality and fertility.

The argument that fertility decline and mortality decline are two discrete outcomes gave way to an increasing belief that ensuring the survival of the children was key to less demand for children. It was in the 1980s that a series of interventions were intensified, which came to be labeled as “integrated management of childhood illnesses” (Dixit 2005 [1995], p.79). The main objectives of this program were:

- Improving the case management skills of health workers
- Improving the health system to deliver IMCI
- Improving the family and community practices (Dixit 2005 [1998], p.79-80).
The first Nepal National Nutrition Status Survey was carried out in 1975 involving 6,578 children under six years of age in 221 sites throughout the country (Dixit 2005 [1995], p.83). It was following this survey that the Nepali government established a National Nutrition Policy Coordination Committee. In 1977/78, the United Nations Children’s Fund (UNICEF) carried out another survey of 749 children. This survey revealed that while 11.8 percent of those surveyed were suffering from serious malnutrition, another 36.4 percent were suffering from mild malnutrition (Dixit 2005 [1995], p.84). Besides the large scale surveys, several studies were also carried out to locally examine the nutrition situation of children. Between 1975 and 1990, there were 111 studies carried out on issues ranging from Protein energy malnutrition to vitamin A, Iodine, Iron deficiency and general health (ibid. p.86). The 1990s also saw the continuation of various surveys, the comprehensive and regular among them being the family health survey, which has been renamed as demographic survey.

The timing of IMCI is interesting. In 1979, the World Health Organization (WHO) had produced the Alma Ata declaration that argued for comprehensive primary health care to be managed locally. It envisaged health in terms of the broader social context, and not only the absence of disease. The WHO was still the main policy making international body at that time and it had widespread influence in the thinking and practices of health interventions (Koivusalo and Ollila 1997).

This declaration coincided with the neo-liberal shift in the US with the election of Reagan as the president and in the United Kingdom with the election of Margaret Thatcher as the Prime Minister. Immediately after the Alma Ata declaration, the Rockefeller foundation produced a counter strategy called selective primary health care. This was an attempt at
creating proposals to counter the increasing focus on comprehensive, publicly provided primary care.

Walsh and Warren (1979) were recruited to produce cost-benefit analyses of disease specific intervention packages. They began with the assumption that while comprehensive primary health care was a laudable goal, priorities had to be set in terms of selecting the areas of interventions given the limited resources. Their economic and epidemiologic analysis eventually led to what came to be known as selective primary health care.

Under the Reagan administration, this was a time when USAID was veering away from the concept of primary health care to one of individualized, disease-specific programs to be run increasingly through the private sector. By the mid-1980s, Nepal had already embarked on the structural adjustment program, the aims of which included cutting down on state’s involvement in social sector including health care. However, because of population control and increasing visibility of the linkage between the survival of children and the fertility rate, it was not possible to completely cut down on health care spending. It was within this context that disease-specific interventions on child survival gained prominence during the eighties.

By the end of 1980s, the messages of children’s health, the institutions that took the responsibilities of providing maternal and child health, and various intervention programs had expanded phenomenally. For example, the office of Family Planning and Maternal and Child Health (FP/MCH) was established in 50 out of 75 districts, and their intervention programs were present in all of 75 districts (Skerry et al 1991). Within the neoliberal context, certain kinds of expansion of state power occurred, in ways that directly enhanced the existing political system’s technocratic forms of power.
What's in a name?

It is important to note that the interventions also produced the cultural hegemony of monarchical rule. By looking at how, during king’s rule, the state and its functionaries were actively involved in changing the names of local places along increasingly Hindu lines, Adhikari (1996) showed development was also a project of cultural hegemony. For example, in Midwest Nepal, where Magars have been the first settlers, the local place names were actively changed from Magar names to Hindu names. However, naming was also an exercise of direct power. Besides transforming the cultural names along increasingly Hinduized ones, the state also actively made the names of royal family members ubiquitous by establishing towns, programs, projects, and institutions in their names.

King Mahendra had two wives: Kanti and Ratna. Hospitals and health posts were established in the names of both these queens. Town names like ‘Mahendranagar’, ‘Birendranagar’, Ratnanagar, had become common in many new settlements in the southern plains. Birendra hospital, Aishworya Hospital (named after his queen wife Aishworya), Mahendra hospital (his father, who staged the coup in 1960), among others, are ubiquitous throughout Nepal. The Royal family members also ran the major institutions such as the Leprosy Program, the Cancer Society, Child Organization, Family Planning Association, Social Service National Coordination Council.

8 After present (suspended) king Gyanendra was forced to give up his absolute rule in April 2006, many of these names are being actively changed. A constitution drafting council is going to be formed in May 2008, the first act of this council is to constitutionalize the abolition of monarchy. We will see in foreseeable future more of these name changing. In fact, on October 4, 2007, the new Nepal Government decided to change the name of the country’s oldest maternity hospital from “Shree Panch Indra Rajya Laxmi Devi Prashuti Griha” to “Paropakar Maternity and Gynecology Hospital”.
Chapter 4

Post 1990—Democracy, neoliberalism and contestated terrain of politics

The People’s movement, during which several were killed in police firing, forced the then King Birendra to part with his absolute rule and to accept the role of ceremonial head of state in 1990. A new constitution was drafted which guaranteed the freedom of speech, the freedom to open political parties, and other fundamental freedoms. This also provided the condition for the emergence of organized struggles over many issues such as access to public resources, the ending of caste and gender-based discrimination, right to a better wage and equal wage between men and women, and also rights of children.

Paradoxically, while the political change of 1990 led to the emergence of public call for greater involvement of the state in the area of service provisions and dealing with the existing inequalities and discrimination, this was also a period of intensification of structural adjustment programs in Nepal, which focused on redefining the role of state away from being a direct provider of public goods to the arbiter of rules in the market place. If the services had to be provided by the state, it was to be for a section of populations too weak to compete in the free market. It was in this context that many of the vertical, disease-specific programs and micronutrient supplementation programs continued to expand across the country.

After 1996, however, the Communist Party of Nepal (Maoist) initiated an armed struggle. By 2000, armed conflict had already spread in most of Nepal’s 75 administrative districts. Between 2000 and 2006, Nepal was again mired in serious political conflict. During
this period, the military conflict escalated. The political parties, which were part of the then existing parliament, limited their presence in big cities and district headquarters. The opened political space was increasingly curtailed, eventually leading to the then King Gyanendra’s takeover of state power.

It was during this period that international developmental agencies became the main force in setting the agenda of what Nepali state could do and could not do. This became even more pronounced after the Nepali Army was mobilized against the armed Maoist guerrillas.

In the mean time, Nepali children’s health gained further visibility through regular periodic surveys, and series of interventions—some of which were the continuation of interventions initiated before 1990. A WHO study in 1995 revealed that diarrhea accounted for about 51% of children deaths, followed by acute respiratory infections. The same study showed that malnutrition was the cause of these conditions in 54% of the cases (Dixit 2005 [1995], p.79). Children’s hand washing habits were scrutinized, and information regarding the correlation between hand washing habits and parent’s education were generated (Laston et al 1993, pp. 61-75). The three demographic surveys have been carried between 1996 and 2006.

The statistics continued to show that over the last three decades, there has been notable decline in infant and child mortality rates in Nepal from 200 per 1000 live births to 64 per 1000 in 2001. As an important measure of health statistics in a large population, this decline signifies very large improvement in the overall health of populations. Why was this decline possible? However, Nepal’s mid-term millennium development goals (MDGs) report sees this decline in a host of technical interventions. It states:
"The most likely cause of the decline in IMR are improvements in the management of diarrhoea, improved immunisation, Vitamin A supplementation, and the improved management of acute respiratory infections, especially pneumonia." (UNDP 2005, p.37)

But, the visibility was not limited in the realm of disease and illnesses, but also in the broader conditions within which Nepali children were living. The Nepali state ratified the United Nations Convention on the Rights of Children in 1990 and this included the responsibility on the part of the Nepali state to provide for the welfare of the children (Dixit 2005 [1995], p.74).

Aside from the specialized health interventions, the political change in 1990 also saw tremendous growth in public concern for the situation of children in Nepal. Various child-focused Non-Governmental Organizations (NGOs)—both international and national—came into existence and development agencies began specialize on children's issues, including on their health. The welfare of the children, including their health, was no longer the issue for state to deal with in the aftermath of the political opening in 1990.

Children's rights became the focus of a number of non-governmental organizations. Initially focused on the child labour issue, the ratification of children's rights was followed by a number of NGO initiatives and campaigns. One of these initiatives was to produce annual reports on state of Children in Nepal to be submitted to the UN General Assembly. It was after the 1990s that a set of time-bound targets in children's health were set by the Nepali government, among them being targets on child and infant mortality.

The turn of the century saw renewed focus on children’s health. One of the eight numerical goals set following the United Nations Millennium Summit was the reduction of
under-five mortality to half between 1990 and 2015. Being one of the signatories of the Millennium Declaration adopted by the United Nations member states on 8 September 2000, Nepal began preparing assessment reports and integrating the goals and ideas enshrined in those goals in its development plans and policies. At the end of the United Nations Millennium Development Summit, heads of the UN member states and governments came out with a 32 point *United Nations Millennium Declaration*. The subsequent eight-point millennium development goals (MDGs) were developed from this declaration. MDGs list eight concrete goals and twenty-one targets to be achieved by the United Nations member states by 2015. The goals include: eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and developing a global partnership for development. Each of these goals was accompanied by a number of targets to be achieved.

Within the MDG strategies, we see the continuation of a set of techno-centric approaches. It acknowledges the decline in infant and child mortality rates in the last decade. However, it explains these in terms of a set of technocratic interventions carried out in the past, without any serious analysis as to how, in the absence of proper health care delivery system in place, these planned interventions were implemented. It was simply assumed to be true. Harper (2002) has shown how Vitamin A project began to be presented as the major child-survival strategy and how people have come to increasingly accept it. Like family planning during the absolute monarchy, projects such as Vitamin A were promoted through widespread campaigns and mobilizations.
For most of the years, Nepali state was ruled by Nepali Congress party, which followed and accepted the neo-liberal prescriptions of the international development institutions. This is reflected in the national health policies it produced immediately after being elected to parliament in 1992 (Maskey 2005, pp. 180-187), in the second long-term health plan that it prepared (Mishra 2005, p.162-179), and eventually in the framework that informed the millennium development goals. The focus became increasingly liberalizing the health care sector, actively promoting privatization of government beds, and increasingly delinking the concept of health from broader social context and narrowing it to bio-medical interventions.

During much of conflict, there was virtually no political contestation except between the armed rebels and the military state. In many ways, the political context was similar to the time immediately after the king took over power in 1960, except in one crucial respect. It was conducive environment for the domination of technocentric and behaviorist agenda.

But, again, this period was not the replica of King’s rule. Freedom of press was still allowed as long as people did not attack the monarchy directly. It was also the time of widespread critique of NGOization—both in academic as well as in broader press. Journalists regularly produced the malfunctioning of state institutions, the issue of environmental destruction, social justice, women’s rights, among others (Onta 2006). It was also a time of widespread questioning of international development assistance—albeit the critiques ranged from the ones based on pragmatic considerations (as aid not being able to achieve its stated goals), to the ones based on political imperatives of the international agencies.
Chapter 5

Conclusion

Anthropology of development has been divided into pragmatic camp and post-structuralist camps. The pragmatic camp sees development as an enterprise aimed at improving the life of people in the third world and therefore anthropologist’s role within this becomes that of providing expert knowledge about the local cultural practices so that development interventions could be carried out in a culturally competent ways.

On the other hand post-structuralist camp has looked at development as a transnational enterprise that emerged in the context of Cold War geo-politics and tried to manage the ‘third world’ through a series of object formations and interventions. Taking a cue from the post-structural critique of development, my aim in this paper had been to situate this process of object formation within the broad national political context. More specifically, I tried to situate the production of technocentric and behaviorist practices within the political context dominated by military conflicts, curtailment of fundamental freedoms and control of the Nepali state by the forces that favor neo-liberal policies.

This has been either generally overlooked when anthropologists focused on local practices or subsumed under the rubric of development apparatus that comprised of international, national, and local level operations. The institutional ethnography pioneered by post-structuralist scholarship such as done by Escobar (1994), Ferguson (1989), Li (2007), Fujikura (1996) have been useful in shedding light on how development regime produces its
objects as entities manageable through a set of techno-fixes, and I would add, behavioral fixes. Hindman (2002, pp.99—136) has looked at continuity in the practices of USAID despite shifts in development ideologies over time. Leve (2001), by looking at the shifts among development institutions towards women’s empowerment, argues that “the current interest in gender-led development strategies and women’s empowerment programming on the part of donor agencies is not the happy consequence of a new appreciation of gender equity for its own sake, but rather a reflection of the successful role that international development is coming to play in establishing new modes of governance that operate by interjecting neo-liberal forms of rationality and subjectivity into new social and spatial domains” (p.110). These kinds of analysis have helped us understand the implicit goals of the international development organizations.

What these analyses leave out, however, is the context of political struggles within Nepali state and the relations of these struggles with the development regimes. While hegemony at the level of what constitutes development is real, it is also real that the political forces that compete and struggle for power within Nepali state have their own set of visions. After all, the thirty year of King’s absolute rule have shown that nation-state is a site where power is exercised not only through the normalization and disciplining practices, but also through military and police institutions. This is important to take into account because the production of near total hegemony of technocentrism and behaviorism was possible not only because certain ways of object formations occurred, but also because the police state sanitized the political space of dissent. In other words, development as much as it was a process of technocratic management, it was also overtly political endeavor.
The situation of Nepali state’s dependency on foreign aid creates a condition in which the national political forces have to accommodate and negotiate with international development apparatus. Between 1960 and 1990, Nepal was ruled by autocratic monarchy and development became the public ideological rationale for this. The shift from short-lived open democratic politics to autocratic monarchy in 1960 kept the basic structure of social inequality intact. In 1951, when hereditary control over Nepali state ended, most of Nepal's land and other resources belonged to very small powerful people in Nepali society. An elected government tried to implement land redistribution in 1959. But this halted after the king staged a coup in 1961. The ruling classes--Mishra (2007) identifies them being "the aristocracy, the land-owning nobility, the urban administrative, technical and business elite and national and local level politicians" (p.164)--entrenched their own power through development. The political neutrality of development meant that projects implemented did not aim to transform the structures in society that perpetuated inequality--between classes, between castes, between genders, and between people located in different geographic locations. If at all, the supposedly neutral projects were in fact vehicles for augmenting the power of the powerful (Mishra 2007). Development projects done mostly with foreign aid freed the 'native resources' to expand the repressive state structures such as the policy, military and bureaucracy (Mishra 2007, p.168-9).

The political change in 1990 opened the space for transformative politics in a limited sense. Issues of inequality, discrimination and marginalization began to come to public visibility through conscious actions of peoples and organizations located in different social spaces. This juxtaposed uneasily the neoliberal public policies adopted by Nepali Congress. Within neoliberal public policies, social transformation as agenda of health was replaced by a
set of technical and behavioral interventions such as the Vitamin A Program (Harper 2002). It is still necessary to note here that Nepali Congress party, which ruled much of the post-1990 period, did not choose to follow neoliberalism just because donors forced it, but also because it adopted a vision for itself that was based on increasing focus on marketization of social goods. After a few years of open democratic politics, Nepal again got mired in vicious armed struggle and counter insurgency.

Following the second People’s Movement in April 2006, King Gyanendra was forced to give up his absolute power. It also paved the way for the inclusion of the Communist Party of Nepal (Maoist) into a national interim government and suspension of armed hostilities between the communist guerrillas and the Nepali army.

The health ministry was given to another radical communist group, the United People’s Front, Nepal. In 2007, the Health ministry announced universal and free health services throughout Nepal. The fact that it announced this program is very significant when the international development regime still is pushing for increasing role of private market in health care services. Moreover, the existing health care infrastructure is a lot less than adequate and highly unequally distributed across the country. However, it was the political commitment that made it possible to indicate fundamental policy change. Besides this policy change, most of the political parties included right to food, education and health care and spelled out these as the responsibility of the Nepali state.

It will be theoretically productive to do serious ethnographic work on the linkage between the development apparatus and political forces in Nepal and also generally, because anthropology of development has paid much less attention to this than is warranted by the stakes at hand.
Bibliography


