Reproductive Politics and the Making of Modern India

Sreenivas, Mytheli

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Chapter 4

Regulating Reproduction in the Era of the Planetary “Population Bomb”

For two days in June 1960, S. K. Khan visited villages in Naini Tal to spread the message of family planning. As an honorary family planning education leader, Khan had been appointed by the Indian government to “mobilize public opinion and form a network of voluntary groups” to support state population control efforts. With these goals in mind and accompanied by a “Lady Social Worker,” she visited ten houses in the village of Mahomedpur, where she “spoke to the women and told them what Family Planning was.” Khan had hoped to reach a wider audience of women, but “it was not possible to hold a meeting there as the rumour had been spread that the Family Planning people would give injections and stop children being born completely. There was a certain amount of antagonism in this village, and I had to explain to the women what we stood for.” Stymied by these obstacles, the honorary family planning education leader left Mahomedpur, presumably disappointed by the prospects for family planning in the village.

Khan’s experience with the women of Mahomedpur represents one of many such encounters between the messengers of family planning and their intended targets. Their message—what Khan and her colleagues “stood for”—linked reproductive regulation to national development. The targets of this message were often women, and like in Khan’s Mahomedpur ventures, they were imagined to be ignorant of contraceptive technologies and unwilling to regulate their fertility. The discourses of family planning represented their reproduction as a threat to the nation and aimed to contain their fertility to defuse an explosion of population growth. Thus, the women of Mahomedpur, like their counterparts across India, were tasked with
regulating their bodies and reproductive capacities to align with the demographic goals of the postcolonial state. Family planners expected women to accept a range of interventions to meet these goals: attending public meetings and being lectured by strangers on the virtues of birth control, visiting clinics and subjecting their bodies to new contraceptive technologies, and ultimately limiting their childbearing to two or three children.

Family planners understood their targets as reproductive subjects whose primary contribution to state-led development was limiting their fertility. They separated biological reproduction from other aspects of women’s lives and made it the point of women’s entry into development programs. Within the field of health specifically, family planning programs delinked contraception from maternal and child health and funded the former at the expense of the latter. These priorities shaped day-to-day interactions, such as Khan’s meetings in Mahomedpur. Like her colleagues, Khan encountered women solely in order to discourage their reproduction, with little regard for the circumstances or needs that might prompt them to bear children. With no mandate to support their struggles to raise the children they already had, or to address any other aspect of women’s lives, family planners like Khan simply explained that they “stood for” contraception as a means to serve national development goals.

While the women of Mahomedpur thus encountered the state’s development agenda through their reproductive bodies, women like Khan demonstrated their commitment to development differently. By claiming to bring the message of family planning to impoverished rural and urban women, middle-class family planners like Khan became mediators between the state’s development goals and its intended targets. Yet, as the Mahomedpur women’s unwillingness to attend a public meeting suggests, this mediation was far from smooth. Women sometimes ignored, refused, or reinterpreted the family planner’s message. They ascribed different meanings to their reproductive lives—meanings that did not hinge on the supposed threat posed by their bodies or by the explosive growth of population. In particular, women who did not fit within the boundaries of normative citizenship, which was marked as upper caste, Hindu, and middle class, found their reproduction to be doubly or triply stigmatized. Their encounters with family planners negotiated this stigma while offering alternative understandings of their bodies, families, and lives.

This chapter investigates a history of reproductive politics during an era of increasing anxiety about population from the 1950s to the 1970s. I begin in 1952, with the Indian government’s official embrace of family planning
in the First Five Year Plan. Successive Five Year Plans increased the funding for family planning while vastly expanding its ambitions. A growing number of workers, both volunteer and paid, took on the task of spreading contraceptives to the masses. Numerical targets for contraceptive use, alongside financial incentives for family planning “acceptors” and “motivators,” became the hallmarks of India’s emergent family planning bureaucracy. By the 1960s, crises of development, failures in food production, and concerns about national security had all combined to make “overpopulation” a site of heightened anxiety. Growing fears of a “population bomb,” with its epicenter in South Asia, haunted the public imagination in both India and the West. Within India, this fueled the targeting of lower-caste, lower-class, and Adivasi women in desperate attempts to curtail their reproduction. In the West, racialized discourses marked black and brown women’s bodies as responsible for global overpopulation. This urgency continued into the 1970s, when it was punctuated by the Emergency, a period from 1975 to 1977 when the mechanisms of parliamentary democracy were suspended by Prime Minister Indira Gandhi. The Emergency remains the most widely known and infamous chapter in India’s family planning history, in part because it marked a temporary shift toward men’s bodies as the grounds for fighting a war on population. However, although it is often assumed to be a historical aberration—both in Indian democracy and in family planning—the Emergency also represented a culmination of the logic of reproductive regulation that had taken shape across the postindependence decades. This chapter thus situates the turn to men during the Emergency in relation to the logics and institutions that had long connected women’s reproduction to population and economy.

India’s scaled-up ambitions for family planning during this era depended, in part, upon new contraceptive technologies that enabled more absolute control over reproduction. The methods available in the 1950s were largely the same as those of earlier decades. Even in 1960, when Khan visited Mahomedpur, she would have spoken of contraceptive foams, jellies, and sponges, and possibly pessaries or diaphragms for women who could visit a physician. Just a few years later, the birth control pill, the intrauterine contraceptive device (IUD or IUCD), and the widespread use of surgical sterilization had changed the contraceptive landscape, both in India and globally. While these new technologies could enable people to control their own fertility more effectively than ever before, they also opened the door to more intensive modes of reproductive regulation by population controllers.
As we shall see, they also helped to position women’s bodies as the figurative fuse of the “population bomb.” Consequently, while visits like Khan’s to Mahomedpur aimed to teach women about contraception, their goals were also broader. As women’s reproductive bodies became a site to enact development plans, the history of reproduction became thoroughly implicated in the history of postcolonial development. Contraceptive technologies were the means to make this link, quite literally connecting individual bodies to development goals. This chapter traces these close intersections between birth control and the intimate regulation of bodies, and between the fears of a “population explosion” and the emphasis on reproduction in India’s development regime. I begin with the institutionalization of family planning during the 1950s and early 1960s. Although this period is sometimes overlooked in histories that focus on the more aggressive population control campaigns of later decades, the earlier years were central in bringing middle-class women—as family planners—into the state’s development agenda, and in situating poor and working-class women as their targets. This targeting would intensify in the later 1960s, as Western funders and Indian government priorities aligned to make population control a focal point of Indian development, and women’s bodies became the grounds to enact this development agenda. The chapter concludes with the intersection of surgical sterilization with states of emergency in the 1970s, examining the changing assumptions—about both gender and development—that underpinned reproductive politics in this era.

Targeting Women for Family Planning

The First Five Year Plan centered its implementation of family planning on women. It called for middle-class women volunteers to meet family planning goals and situated subaltern women as their targets.4 Following middle-class assumptions about women’s dependent roles in both family and economy, the planning commissioners largely ignored peasant and working-class women as producers and mentioned them primarily as recipients of social welfare. Simultaneously, the document distanced the state from such welfare activities, noting that “the main burden of organized activities for the welfare of women is to a large extent borne by voluntary agencies” rather than by central or state governments directly.5 Family planning, alongside maternal and child health more broadly, thus came to occupy a space
between state control and the work of voluntary actors and organizations. As I argue, this approach opened up a new field of national activity for middle-class women, who claimed it was their right and responsibility to bring contraceptive information and technology to their needier “sisters.” Through their work in family planning, they argued, women volunteers could bring the promise of development to poor and working-class women and simultaneously solidify their own position as dutiful citizens of the new nation. To make this claim to citizenship and development, middle-class family planners depended upon subaltern women to receive their welfare services. However, as their accounts reveal, family planners who visited villages, organized public meetings, or ran birth control clinics often encountered women who questioned, ignored, or refused their services; sometimes, women asked for entirely different means of welfare support for themselves and their families. The result was a sometimes tense negotiation between the middle-class family planners who claimed to serve both women and the nation and the subaltern women who rejected that service.

The institutional structure of family planning, which combined state direction with women’s voluntary work, was prompted in part by the efforts of Durgabai Deshmukh. A former AIWC president and activist in the freedom struggle, Deshmukh was the only woman member of the NPC that drafted the First Five Year Plan. Appointed to the commission after much of its work had already been completed, Deshmukh soon recognized that the commissioners had allocated no budget for “social welfare,” which she defined as “services intended for individuals and groups in need of special attention,” including women. To remedy this, Deshmukh lobbied the other commissioners—including her future husband, C. D. Deshmukh—to create the Central Social Welfare Board (CSWB), a largely autonomous body tasked with coordinating collaboration between the state and nongovernmental or voluntary organizations. The government approved the creation of the CSWB in 1953, with Deshmukh at its head and a budget of 40 million rupees, including 6 million devoted to family planning. By the Second Five Year Plan (1956 to 1961), a focus on women as targets of social welfare was further entrenched, as activities supporting women were located entirely under the CSWB. Health was among these “welfare” activities, and here the focus was on “family planning and other supporting programmes for raising the standard of health of the people.”

Deshmukh encouraged women’s organizations to take up family planning and channeled most of the CSWB’s initial family planning budget to these groups. In an address to the AIWC, she noted that “women workers
have been invited” by the government to propose measures for family planning and called upon the organization to prioritize its efforts in this direction. AIWC leadership evidently agreed, determining that they should “focus on collaborating with the Planning Commission,” including on family planning.10 These commitments prompted a spurt of activity centered on birth control clinics and propaganda, which figured the middle-class woman volunteer as a mediator between the state’s population control goals and its women targets. For example, in Bombay, AIWC members supported the FPAI’s newly established birth control clinic. One of the AIWC’s volunteer workers, Shanta Navkal, spoke to meetings in the “poor areas” of greater Bombay to encourage people to adopt contraceptive methods.11 Many other branches similarly did “outreach” work on birth control. According to the AIWC’s Annual Report for 1953, for instance, the Mysore branch sent one woman volunteer to address women’s gatherings in Bangalore, Bhadravathi, and the Kolar Gold Fields on family planning. The Madras branch conducted outreach work in the city while collaborating with the city corporation to start family planning clinics in hospitals. In Delhi, the AIWC worked to include three family planning clinics in municipal health centers and offered advice on birth spacing and on preventing children on medical and “economical grounds.” According to the South Madhya Pradesh branch, eight “lady doctors” had opened family planning clinics “at the instance of the branch,” while in the Madhya Bharat branch another doctor had attended trainings at the Planned Parenthood conference in Bombay.12 The FPAI was even more active in these clinical and propaganda efforts. As Avabai Wadia reported in 1959, the FPAI had opened twenty-two branches across India, many of which supported clinics and held “educational meetings” to promote contraceptive use. The organization also expanded its Bombay clinic to include several branches and opened a supplies department to send contraceptives to “welfare clinics” around the country.13 While these efforts were on a small scale, they testify to the importance of middle-class women workers in staffing the new family planning regime, and in marking it as a domain for women volunteers.

Among these volunteers were the honorary family planning education leaders, who were appointed by the state to support outreach and voluntary efforts in family planning. The government drew upon organizations like the FPAI and AIWC to select these voluntary workers, who were tasked with spreading information about birth control. Among them was Padmini Sen-gupta, a writer and CSWB member, who lamented that “constant breeding and care of children make women unfit to become intelligent members of
an active society.” She reported to the AIWC about her activities in West Bengal in 1959. Sengupta met with jute-mill workers and sweepers in the “slum of Barrackpore”; she also appointed a number of women family planning educators to continue outreach projects. Her colleague K. Meenakshi Amma, honorary family planning education leader for Kerala, reported that in April 1960 she held group meetings at Kozhencherry, Kummannoor, and Kottayam. She also visited fifty houses, formed a voluntary corps for family planning at a social welfare center in Kummannoor, addressed a meeting of women’s organizations, and inaugurated a family planning camp of three hundred women and one hundred men. Similarly, Prem Lata Gupta of Andhra Pradesh addressed numerous meetings in Hyderabad and in rural areas. Other volunteer workers, including women who were not officially appointed family planning education leaders, engaged in similar tasks. For instance, Krishna Agarwal of the AIWC worked in the Indore region. Since her husband was a doctor, Agarwal claimed she had a greater “connection with the people.” In a pilot project with the FPAI, she worked with four clinics in a “slum area” inhabited by five hundred mill families; she also addressed a meeting of Ayurvedic medical practitioners about the “Need of Family Planning and Psychological Effects of It on a Family.”

These accounts do not represent volunteer family planning workers as requiring specific training or expertise. Instead, literacy and an understanding of the purposes and mechanisms of birth control were the implicit qualifications. Perhaps most important, as Agarwal suggests, was the ability to forge a “connection” to the targets of family planning—figured here either as rural populations or as the working-class inhabitants of urban “slum” neighborhoods. As such, volunteer family planning work opened up a potentially vast terrain of activity for literate middle-class women, who were assumed to be familiar with birth control in their own lives and to have the requisite understanding of national development goals and population policy. Moreover, these middle-class women—with their ostensible connection to their poorer sisters—could bridge the gap between the state’s development agenda and the ordinary women whose childbearing decisions would shape the timing and extent of a modernizing demographic transition. Thus, while elite women with connections to government like Dhanvanthi Rama Rau and Deshmukh engaged with family planning at the level of policy, there were many more educated, literate women—often the wives and daughters of doctors, lawyers, professors, and others—who made the case for birth control in homes and neighborhoods.
Eventually, as the scope and goals of the family planning bureaucracy became more ambitious, paid workers began to join the volunteers. For instance, the FPAI reported that while “voluntary members” continued family planning outreach, in 1961 the organization hired a full-time “trained social worker, Mrs. Pramila Thakore, BA.” Thakore was tasked to conduct an “educational programme of meetings, lectures, film shows, etc. for audiences drawn mainly from the lower income groups.” In her first year in her position, Thakore ran 349 meetings with a total attendance of more than 73,000 people, both in the city of Bombay and in the outskirts and rural areas, using the FPAI’s mobile unit. Alongside social workers like Thakore, the “lady doctor” was another critical paid worker in the family planning bureaucracy. Both the government and private organizations lamented the scarcity of women medical practitioners and sought them to staff clinics.

Whether volunteer or paid, family planning workers claimed a gendered sphere of activity. So long as subaltern women were the targets of reproductive regulation, literate, middle-class woman volunteers and paid social workers and doctors were essential mediators between these women and the state. Thus, according to Prem Lata Gupta, who was then president of the Andhra Pradesh branch of the FPAI, women’s voluntary service would bridge the gap between the goals of national development—which required the “control of population”—and the “welfare of the individual and the family [in which] women can and have to play the most vital and intimate role.” Women volunteers could explain to other women the benefits and methods of family limitation, thus “educating them properly” into appropriate reproductive roles. AIWC members insisted that these efforts to spread the message of family planning ultimately benefited poor women and, indeed, “would usher in a new age for the women of India. . . . Instead of merely slaving in the name of family, love, wifehood and motherhood, women gain better health, self respect and leisure.”

Yet, as women volunteers reminded themselves, poor women could never gain these benefits through their own efforts but required the gendered service of middle-class family planners. As Dr. Aleyamma George of the AIWC argued:

Honestly speaking the educated and well-to-do class need not require any advice at all. . . . But it is in the slum areas among the poorer classes that this message has to be spread. We have seen women with bitter tears coming to us and talking to us about their miserable lives. They are not able to give proper clothing for their children. . . . It [family planning] is
really an uplift of the population. We are trying to bring them to a certain standard which is not the animal standard, if I may be excused such a word.\textsuperscript{23}

George’s comments demarcate two groups of women: those whose duty is to serve by offering family planning advice and those in need of social welfare measures to control their reproduction. This focus on service had a long history in the Indian women’s movement, which was deeply influenced by Gandhian thought. It enabled Indian feminists to argue that their movement was not solely a middle-class project, even though most activists came from middle-class backgrounds. Rather, through a commitment to serving poor women, the women’s movement advanced its claim to represent all Indian women—an argument first made during the interwar years.\textsuperscript{24} Moreover, as Emily Rook-Koepsel has shown, this appeal to service had broad resonance in Indian society, where differences of caste, religion, class, and gender posed apparent barriers to claims of national unity and connection.\textsuperscript{25} Family planning, by linking the volunteer worker to her target of service, claimed to surmount these barriers.

However, Gandhian ideals of service required not only a volunteer to provide service but also a needy target who would receive and accept that service.\textsuperscript{26} A few family planners emphasized this grateful receipt of services, as in the case of an AIWC worker in Belgaum, who claimed that “village women were very keen to know the methods and also they demanded the means for Family Planning.”\textsuperscript{27} Yet many other AIWC and FPAI workers reported a tremendous gap between the family planner and the intended recipients of her message. Consider for example the efforts of Visakha Dixit, the AIWC’s member in charge of family planning in Madhya Pradesh, who convened a meeting of village women in Sanver, in Indore District, to explain the “importance of family planning.” About eighty women attended, and Dixit “had personal talks with them about their health problems.” However, she concluded glumly, “there was very little response to family planning. Mostly the women seemed to be against it.”\textsuperscript{28}

Dixit’s AIWC colleague in West Bengal, Aroti Dutt, confronted additional difficulties when working in the Darjeeling District. She was unable to arrange any large meetings due to bad weather and was reduced to speaking only to smaller groups of women. Moreover, as a native Bengali speaker, Dutt found it difficult to communicate with her targeted audience. She wrote that it was “important to know the local language Nepali to be able to speak to the women directly,” and she decided to learn the language before visiting
Darjeeling again in six months.29 Both Dutt and Dixit voice an anxiety that the targets of their service are uninterested in what they have to offer and may even be actively opposed. Representing family planning as a form of “service” to such unwilling and uninterested women became a deeply problematic exercise, and family planners’ reports reveal a tense negotiation, justifying their efforts while grappling with limited and inadequate results.

On occasion, some family planning workers expressed frustration with the intended recipients of their services. This was especially the case when the targets were marked as religiously different and “other” from the family planner herself. Thus, for instance, Meenakshi Amma reported on her visit to fifty houses in two “backward wards” of Mulanthara and Kummannoor: “The Muslim section of the population, I found, could not be convinced about the necessity of birth control, though they are in most urgent need of it. In one of the houses, the owner Alipillai, aged fifty and father of fourteen healthy children ranging from 23 years to ten months, wanted to know whether the Central Government would give him any aid or grant for bringing up and educating them.”30 Meenakshi Amma does not recount her response to Alipillai’s query, and its inclusion in her report was perhaps meant to suggest its impossibility— or even absurdity— rather than to discuss his request for state support. Moreover, her emphasis that Alipillai was part of the “Muslim section of the population” draws upon communal discourse about the differential fertility of Muslims and Hindus and the supposed national dangers posed by Muslim reproduction. Her mentioning Alipillai’s fourteen children further fuels Hindu anxieties about Muslim population growth. At the same time, her comments mark the vast difference between the family planner as a rational, implicitly Hindu, normative citizen in service to the state, and the nation’s problematic “others,” who perversely refuse such service despite its ostensible personal and national benefits.

However, most family planners’ reports did not emphasize religious or caste differences in such explicit ways. They were more guarded in their language, leaving the differences and hierarchies between the provider and recipient of service implicit when referencing the “slum women” or “backward” areas in which they served. On rare occasions, they spoke about the class differences that made it difficult for middle-class women to gain the trust of poor women, especially on matters of sexuality and reproduction. The family planner from Belgaum, for instance, acknowledged that the “villagers . . . at first felt shy” but eventually discussed the subject with her. Because they were “not ready” to attend government dispensaries and
hospitals, she herself began to carry and distribute contraceptives. The most direct recognition of the limitations in the family planner’s mediation came from Hem Sanwal, a physician and family planning education leader in Uttar Pradesh. Based on work in the village of Gomet in Aligarh District, Sanwal argued, “If we depend on . . . the trained highly educated social workers mostly coming from urban areas and not feeling one with the village and village women, who are not even available in sufficient number to cover all the village population, we still remain very far from solving any population problem and would be depriving those who earnestly desire to adopt family planning methods.” Sanwal places some blame on the “highly educated social workers” who do not feel unity with the village women they supposedly serve. Taken further, her statement implicitly questions the very model of service that figures the middle-class family planner as the provider of social welfare measures to lower-class women.

This divide between the middle-class family planner and her subaltern targets of service highlights a “bifurcation of the female subject” that Asha Nadkarni locates in the aftermath of Indian independence. In Nadkarni’s terms, even as “bourgeois rights for women [were] written into the Indian Constitution,” working-class women were “forgotten as productive subjects, [and] targeted instead under the purview of education, maternal and child health, and family planning.” Family planners represented themselves as legal and juridical citizen-subjects within this bifurcated regime, becoming the beneficiaries of new legal rights for women alongside new opportunities for higher education and professionalization. Family planning offered middle-class women a terrain to assert their authority and professionalism as volunteers, social workers, and doctors who could spread the message of family planning. To enact this new citizenship and service, however, they needed poor, less educated urban and rural women. These women would encounter the state not through their legal and juridical rights as citizens but through their reproductive capacity. Within a bifurcated regime, their ability to reproduce—to make live, to limit fertility, to preserve life—rendered them the quintessential biopolitical subjects, whose citizenship became attached exclusively to their bodily capacities and sexual behaviors. Consequently, the middle-class family planner’s ability to represent herself as a dutiful citizen-supporter of national progress depended upon her representation of subaltern women as reproductive subjects, whose entrance into economic and political life depended upon the regulation of fertility.

However, some women who were targeted by these development programs rejected this focus on their reproduction and challenged family
planners’ assumption that limiting childbearing was a necessary step on the path to modernizing progress. These critiques remain a rare presence in the archives, which were devoted to documenting the efforts of the family planner and took little interest in noting how ordinary women received these efforts. Indeed, the voices of targeted women appear only in fragmented form in archival texts, typically when a report’s author recounts the difficulties she faced in convincing women to adopt birth control. Moreover, women’s voices almost always enter in the aggregate; reports note only that women of a particular village, or of a specific caste or religious group, questioned or rejected the family planner’s message. Thus, without assuming that these texts reveal women’s full experiences with family planning, I ask how the fragments of women’s responses that appear in the archives disrupt family planners’ attempts to connect reproduction with development. That is, while family planning workers aimed to highlight subaltern women’s biological reproductivity as a site of intervention, their reports are interrupted by alternative claims that make visible other aspects of women’s lives and other entry points into a development regime. Women who were targeted for family planning did not represent themselves solely as reproductive subjects, and their concerns about reproduction were often at odds with the anxieties of the family planner.

Some women questioned the need to limit their childbearing, and thus challenged the basis of a development logic that made fertility reduction essential to economic growth. Dhanvanthi Rama Rau reported on these challenges when describing her attempts to persuade “village women” to adopt contraception; they refused, arguing that children were necessary in every household because they could tend the fields and help with domestic work. Moreover, they insisted, children were an absolute necessity to their parents in old age. These claims resonate with the findings of many feminist critics of population control, who have since shown that the economic value of children within agrarian households was a crucial factor in driving families’ childbearing decisions. Since children in these households produced more than they consumed from an early age, and since adult children provided the only available form of care and support for the elderly, large families were a rational choice for many agrarian households. In some cases, they were foundational to the household’s survival. Rama Rau herself seemed somewhat persuaded by these women’s “reasoned and thoughtful” comments. She admits that her “only answer to these arguments was that spacing children would result in healthier mothers and children, and such large families would no longer be necessary.” Yet these assertions
about an imagined future of healthy mothers and small families, as even Rama Rau acknowledged, had limited bearing on women’s choices in the present, where they confronted high rates of child mortality and an absence of social welfare supports for the elderly.

In urban contexts as well, family planners were confounded by women who rejected the connection between large families and poverty. For instance, Visalakshi Narayanswamy, a family planning worker in Tamil Nadu, reported on three days spent in Madurai, where she led a disappointingly small meeting of “only” a dozen people in an industrial workers’ neighborhood. There, one woman “proudly declared that she was not in favour of Family Planning, as all the members of her family were working and earning enough to maintain a whole family.”37 The unnamed woman’s comments turned the economic logic of family planning on its head: if family planning was meant to limit the number of children to suit a family’s budget, then a sufficiently large income would eliminate the need to curtail reproduction. The suggestion here is that the family’s earning capacities transcended the need for reproductive control. If family planning were solely a requirement for the “poor,” the Madurai worker refused this label and asserted her right to have as many children as she desired.

Many of the voices that emerge through these records suggest a profound valuing of children that disrupts the rhetoric of family planning as a technology of economic development. We find traces of this in the reports of “rumors” that family planning would render people completely unable to conceive. Such rumors halted S. K. Khan’s efforts in Mahomedpur, discussed above. Similarly, researchers conducting a study of family planning in Bombay found that “some men and women were prejudiced against the social workers as they thought them to be the agents for stopping children from coming into the world and thereby going against God’s wish.”38 Family planners dismissed these “rumors” as examples of ignorance and superstition; in the words of one report from Kerala, people who were most in need of fertility limitation had “peculiar notions about children given to them by the grace of Allah.”39 Such “peculiar” beliefs prevented the spread of the supposedly more rational claims of the family planner. Yet, read against the grain, perhaps the persistence of rumors that family planning workers had the power to prevent childbearing entirely suggests the importance accorded to children, and an accompanying concern about infertility. Rather than viewing the rumors as ignorance or irrationality, I read them alongside the challenges that rural women posed to Rama Rau. If children were absolutely essential to the well-being of their parents and households, then limiting
or curtailing childbirth may have appeared to be the less “rational” outcome. The problem was not too many children—as family planning programs maintained—but rather their absence.

Consequently, visitors to clinics and attendees at public meetings often asked about fertility problems. According to Prem Lata Gupta, for instance, family planning meetings sometimes attracted “women who do not have children” who “ask if there is medicine for this also, and are directed to the Hyderabad Family Welfare Center.” Indeed, she advised, “it appeals more to our women if you speak to them of a Family Welfare Programme and not merely about Family Planning.”

Gupta was not alone in this observation; despite family planning workers’ commitments to teaching women how to limit their children, women themselves called for assistance in increasing their fertility or supporting the children they already had. Thus, a study of family planning programs in Bombay concluded that people were uninterested in family planning on its own and would not attend clinics. However, family planners got around this problem by offering milk to children; many mothers came to the clinic for the milk, and then family planning workers tried to “motivate” them to adopt birth control. A children’s health clinic was also an inducement, since the study’s authors concluded, apparently without irony, that “women are more interested in talking to people who help their child.” Similarly, a “sterility clinic” had helped to “eradicate the idea that family planning merely means the prevention of births.”

Within these texts, programs to feed children, provide health care, and treat infertility appear merely as inducements to persuade women to regulate their reproduction. These priorities reflected the government’s organization of its own family planning programs, which privileged contraception and sterilization over expenditures for maternal and child health or nutrition. Yet, even while biological reproduction and its control remained the official focus of family planning, women themselves broadened their concerns about “reproduction” far beyond these categories. As we have seen, they sought the means to combat infertility and to promote the survival, health, and welfare of their existing children. They challenged the notion that fewer children equaled greater prosperity and valued children for their economic and emotional support within families. Among the most powerful of these challenges were comments that Hem Sanwal reported from the village of Gomet in Aligarh District: “The women of this village . . . expressed their desire to have a school for their girls so that in times to come their lot would be better than that of their mothers.” The women’s desires gesture
toward a reproductive future that exceeds the more circumscribed horizons of family planning discourse. Women’s call for the resources to educate their daughters offers a vision of their reproductive responsibilities, of motherhood and parenting, and of development, that sets aside the demographic rationalities of the state. It refuses the family planner’s claim that women’s fertility determines their futures. It also refuses to stake claim to national development through reproductive regulation; women’s childbearing does not determine their entrance into economic or political life. The call for a girls’ school instead envisions a future in which the daughters of Gomet are not only reproductive subjects.

**Sacrificing Women in a “War” on Population**

A building sense of crisis—namely continued population growth, shortfalls in food, and national security concerns—fueled India’s population control programs during the 1960s. In the face of these crises, Indian planners increased their efforts to regulate reproduction, and women’s bodies became the terrain to enact planned development. The government introduced numerical targets of contraceptive “acceptors” that individual states were pushed to achieve. It also began to use incentives, typically cash payments, to induce acceptance of sterilization or long-acting contraception. The growing urgency of Indian family planning aligned with rising fears in the West, especially in the United States, about a “population bomb” that threatened planetary survival. Panic about “explosive” population growth in Asian, Latin American, and African countries targeted poor women’s reproduction as the source of global crisis. In India, this severed even the tenuous, bifurcated citizenship claims that had marked poor women’s relationship to the state after independence. Subaltern women were no longer represented as potential citizens responsible for controlling their reproduction in service of the nation, nor even as the recipients of social welfare. Instead, the rhetoric of the population bomb positioned women’s bodies themselves as bombs to be defused. These changes in family planning programs also changed the nature of the historical archive. The more individualized reports of family planners that I examined in the previous section, which recounted the experiences of volunteers and paid workers, gave way to an emphasis on demonstrating aggregate results. The focus turned away from the potential connections—however tense—forged between the family planner and her targets, and toward documenting the “births averted” through contraceptive use.
I trace these changes to cracks in India’s development regime that began to emerge in the 1960s. The Third Five Year Plan (1961–65) and subsequent annual plans (1966–69) grappled with the limitations of economic growth. Though industrial and agricultural production had increased during the first two Plans, the NPC raised concerns that production had not kept pace with need, had not met rising expectations, and was not sufficient for a growing population. Perhaps disillusioned by the unfulfilled promises of independence—Nehru’s “tryst with destiny”—ordinary people expressed frustration with the slow pace of change. Some turned to the ballot box, and in 1967, voters in Tamil Nadu handed the Congress Party its first statewide defeat in the two decades since independence. In that same year, peasants and Adivasis in Naxalbari, West Bengal, rose in open rebellion against the government, launching an insurrection that would soon spread across districts in several states. This mood of rebellion seemed to echo far beyond India’s borders, as popular dissatisfaction with the status quo upended politics around the world in the late 1960s. In this context, population growth came to be blamed for the failures and slow pace of economic development.

Population anxieties gained focus and momentum once again after a decennial census. The census of 1961 documented a population increase of 21 percent over the decade since 1951, a higher rate than demographers had predicted. Meanwhile, an increasing body of evidence suggested that Indian family planning efforts had not succeeded in controlling population. One notable and highly publicized failure was the Harvard-directed Khanna study. With the support of substantial funding and numerous personnel, the Khanna study had begun in 1953 with the goal of educating villagers in Punjab about family planning and providing them with contraceptive methods. By 1960, when the study concluded, it was apparent that the targeted villagers—who had been meeting regularly with study personnel for years—remained unconvinced, uninterested, or actively opposed to curtailing their reproduction. These failures raised questions about what kind of family planning program might be effective in curbing population growth. If a program as well funded and intensive as the Khanna study was unsuccessful, in other words, what options might Indian family planners have?

Two wars on India’s borders heightened these population anxieties. India’s defeat in the Sino-Indian War of 1962 raised questions about the nation’s security, the preparedness of its military, and the “quality” of its soldiers. Anxieties about security increased in 1965, when India and Pakistan fought a war that began in Kashmir and soon extended to the border areas of Punjab. The rhetoric of militarization that accompanied these
conflicts transformed the language of family planning as well. Government officials proclaimed that, as part of strengthening the nation, population control efforts must be put on a “war footing.” For instance, Lieutenant Colonel B. L. Raina of the Army Medical Corps—who, as head of the Central Family Planning Board, coordinated the government’s family planning programs—regularly invoked the language of battlefield casualties in the “war” on population. Speaking at a 1966 seminar at AIWC headquarters, he argued, “If the programme of family planning is to be implemented on war footing—which has become the cry of the day—we will have to accept the risks and wastages.”

Though Raina did not specify who would bear these risks and whose lives might be rendered “wastage,” it was impoverished women whose bodies were targeted by these intensified population control campaigns. Sushila Nayar, an AIWC member and a Gandhian who served as minister for health and family planning from 1962 to 1967, similarly made the bodies of poor women the site for wartime sacrifice. As she argued before an assembly of scientists and family planners, “If [this] is a programme on war footing an occasional casualty should not scare you away. We accept that. At the same time if we can avoid that casualty we would like to do so.”

In Nayar’s and Raina’s terms, women’s bodies might need to be sacrificed to win the war against population growth. Women appear here less as the reproductive subjects of development than as soldiers within a militarized family planning regime. Perhaps not coincidentally, the border state of Punjab, at the frontier of military conflict with Pakistan, soon became a center of the “war” on population as well. Among the most striking juxtapositions of this twinned conflict was a report from the Bharatiya Grameen Mahila Sangh, an organization that offered civil defense training for women in border states alongside a hundred “Family Planning Orientation Camps” that aimed to “motivate” women to use IUDs or be sterilized.

Adding to these anxieties was a crisis in food production. Consecutive years of monsoon failure during the mid-1960s led to food shortfalls and raised the prospect of starvation for millions of people. The Indian government looked internationally for food aid. The United States offered support but linked its provision of food to Indian commitments to population control. The explicit connections made by Americans between food aid and reproductive regulation reshaped the discourses of family planning. In Nayar’s terms, India’s dependence on food shipments from abroad meant that population control was no longer solely a question of national economic development, as family planners had been arguing since the 1940s. It was
now also a matter of national “self-respect”: “It is very humiliating to have
to ask for aid of any kind, and when the giver is reluctant or shows hesita-
tion it makes the aid all the more humiliating and galling. As a self-
respecting nation it is absolutely necessary for us to be self-reliant and to
be able to do away with this type of assistance and situations which make
us feel small or humiliated in any way. . . . It is our duty to decrease repro-
duction to make the nation self-respecting and self-reliant.”49 For Nayar,
women’s wartime sacrifice—via regulating reproduction—was critical to
this drive toward national self-reliance. Indeed, she suggested, it was
women’s responsibility to make their bodies available via IUD insertions
and sterilizations. Women’s fertility thus became both cause and solution
for India’s myriad failures of development—from wars to the “humiliating”
request for international aid.

This representation of Indian women’s bodies as wartime targets to be
sacrificed for national need aligned with transnational representations of a
planetary population “explosion” caused by the reproduction of women in
the “Third World.” Population control discourses in the West adopted the
imagery of a literal explosion to argue that family planning was an urgent
priority to combat a dangerous population emergency. For example, one
striking image of the “population bomb” published in the United States in
1960 shows an exploding earth whose overcrowded inhabitants are, quite
literally, falling off the planet (figure 4.1).50 As it had in the past, India served
as a case study for these Western representations of (over)population. Com-
mentators suggested that the country’s current-day conditions presaged
how the entire world would look if nothing was done. American author
Paul R. Ehrlich’s best-selling book The Population Bomb (1968) encapsulated
these fears in its famous opening scene, which described the author’s visit
“one stinking hot night” to a crowded Delhi street full of “people, people,
people, people” in a “scene [of] hellish aspect.”51 As Matthew Connelly
argues, Ehrlich’s imagery fueled American concern about population
growth in India and simultaneously played upon American anxieties about
domestic crime, contagion, and migration, without explicitly naming these
factors.52 The discourse of a worldwide population explosion thus contrib-
uted to a racial politics that was at once localized and globalized; it drew
upon fears of population growth in the “Third World” alongside poverty
and racial anxieties in the “First World.”

Feminist critics of population control have made visible the antiwomen
underpinnings of this discourse and have challenged the neo-Malthusian
assumptions that blame reproduction, rather than unequal distribution of
resources, for poverty and hunger. They have shown, moreover, that black and brown women—Asian, Latin American, African, and racial minorities in the US—were the ones blamed for bringing the world to the brink of a supposed population explosion and targeted for the most invasive methods of reproductive regulation. This politics of blame was often explicit in population control imagery, as in a set of images produced by the IPPF. Among these was “A Child’s Reproach,” in which an impoverished, brown-skinned child gazes balefully at the viewer. Another shows an “Unplanned Family,” composed of a dark-skinned mother and three children. Meanwhile, the “planned families” were depicted as white, including two in images titled “Reverence for Life” and “Wanted,” both showing a white mother caressing a white infant. This imagery suggested that the “unplanned” reproduction of brown bodies threatened the supposedly “planned” reproduction of white populations. It mobilized a claim about differential fertility whereby the supposed overreproduction of Asians, Africans, and Latin Americans threatened to displace their white American and European counterparts.
Such a politics hearkened back toward debates about eugenics, migration restrictions, and a global color line, discussed in chapter 2. It also gestured forward, toward a future of American imperial hegemony that seemed threatened by decolonization and the rise of a “Third World.”

These gendered, classed, and racialized anxieties of the “population bomb” provided the context for increasingly intensive campaigns to curb global population growth, and India emerged as a key test case. Foreign donors poured into India, bringing demographers and other social scientists with their own sprawling bureaucracies and networks for population control. Private US funds—in large measure from the Ford Foundation—had provided support for Indian family planning programs beginning in the 1950s. By the last years of that decade, Ford officials were working closely with the Indian government, often joining planning meetings at the Central Family Planning Board and the Health Ministry. Ford funds also launched pilot projects and paid for consultants whose ideas were widely adopted by government programs. Eventually, the Ford Foundation was joined by the US government itself. In 1966, in the wake of the Indo-Pakistan War and the US president’s insistence that food aid be tied to population control, the United States Agency for International Development (USAID) replaced Ford as the largest foreign donor to India’s family planning programs. Even at the height of USAID and Ford support, foreign funds were never more than 10 percent of India’s total health budget, but as Mohan Rao argues, these funders exercised disproportionate influence on the shape of family planning campaigns. Although the fears of brown bodies obviously held little resonance in an Indian context, racialized fears of differential fertility aligned with long-standing Indian elite anxieties about the overproduction of poor, lower-caste, and Muslim populations.

These national and transnational anxieties about population growth were apparent in the Indian government’s Third Five Year Plan (1961–65). Family planning policy moved away from an earlier focus on clinics and toward an extension approach that aimed to “motivate” people to use birth control. The program’s ambitious goal was to reduce the birthrate from forty per thousand to just twenty-five per thousand by 1973. The twin crises of war and monsoon failure led to the temporary abandonment of Five Year Plans in favor of annual plans for the years 1966 through 1969. In each year, family planning expenditures continued to increase. Increased funds prompted a huge expansion of the family planning bureaucracy, but, as in the past, this expansion was not linked to health care overall but more narrowly to family planning. Thus, for instance, Primary Health Centers—which
were meant to be the rural population’s first point of contact for health care—received more resources, but these were required to be spent on family planning, not on other services, including maternal and child health. In 1966, following a UN recommendation, the Directorate of Family Planning was relieved of responsibilities for maternal and child health and nutrition so that field-workers could focus solely on birth control.57

The expansion of family planning at the expense of health care and the continued underfunding of health services became a deep and enduring feature of India’s population control regime. These imbalances in funding reflected at a policy level what we have seen rhetorically in claims about the population explosion; women’s reproduction was held responsible for crisis, and their bodies were targets to be sacrificed in an attempt to defuse the population “bomb.” Yet even as population control intensified, critiques of these policies also began to emerge. Notably, the landmark Towards Equality: Report of the Committee on the Status of Women in India (1974), which was commissioned by the government and authored by prominent women academics, questioned the state’s focus on population control at the expense of maternal and child health and refused to make reproductive regulation an important feature of their investigation.58 These early reservations were an important precursor for the more robust feminist critiques of population control that would develop in later decades.

Contexts for population anxieties also began to shift as the global “Green Revolution” changed the long-standing equation between population and food. For a century of Indian history, as we have seen, concerns about population had been directly linked to fears of food shortfall and famine. However, with the Green Revolution, new, scientifically developed hybrid varieties of wheat and rice vastly increased crop yields and transformed agriculture. The first hybrid wheat seeds arrived in India in 1963, and the government encouraged imports of hybrid seeds during the food crisis of 1965 to 1967. The results were dramatic. Within five years, Indian wheat harvests had increased by 150 percent and rice by over 30 percent. Quelling some of Health Minister Sushila Nayar’s fears about national “self-respect” and “self-sufficiency,” the country’s reliance on food imports decreased rapidly, and by the late 1970s, Indian farmers had planted the world’s largest area of high-yield crops.59 This dramatic increase in food production suggested that perhaps the earth could feed a larger population than had been imagined before. However, although Green Revolution technology increased the amount of food grown, it did not solve the problem of hunger, which, as we have seen, was rooted not only in agrarian production but also in the
unequal distribution of land and resources. In fact, the Green Revolution exacerbated these inequalities, both regionally within India and between wealthier and poorer farmers. In retrospect, the Green Revolution also incurred tremendous environmental costs. Neither hybrid seed nor associated social and economic changes would be a panacea for Indian development.

Perhaps most surprisingly for a history of reproduction, however, the Green Revolution’s vastly increased crop yields did not overturn the Malthusian premise that underpinned population control programs. Despite an occasional claim that “development was the best contraceptive,” the changing balance between food and population did not lead planners to question the need to regulate reproduction. The system of targets and incentives seemed to continue unchanged, and women’s fertility remained the site of intervention. Indeed, as I discuss later in the chapter, during the period of Emergency rule (1975–77) some of the Indian government’s most draconian population controls developed concurrently with the greatest gains of the Green Revolution.

“This simple device can and will change the history of world”: IUDs and Struggles to Control the Uterus

By the 1960s, a growing consensus within the transnational population establishment determined that the planetary “population bomb” could not be defused by existing contraceptive technologies alone. Contraceptives in use during the 1950s and early 1960s were largely barrier methods (such as pessaries or condoms) or spermicides (such as vaginal foam tablets). They required couples to make a conscious and repeated choice during each sexual encounter. Family planners dreamed of something different: a birth control method that was highly effective, did not require continuous decision-making by couples, and was inexpensive and simple enough to be used widely across the “Third World.” The birth control pill was a landmark new contraceptive technology that seemed to meet some of these needs. “The pill” was a hormonal rather than a barrier method, and it worked by inhibiting ovulation and thickening cervical mucus, preventing fertilization from taking place. Approved for the US market in 1960, the pill proved highly effective in preventing pregnancy and promised an entirely new paradigm for birth control. However, it did not fully meet the requirements envisioned for large-scale population control because taking the pill was a daily decision made by individual women. As two Indian family planning consultants noted, “In India the lack of general motivation makes it
hazardous to entrust the pill to our women at this stage.” Thus, while “the decision to take ‘The Pill’ is left to the individual user in most developed Western Societies,” such individual decision-making was neither possible nor desirable in an Indian context. Moreover, the high cost of the pill discouraged its widespread adoption by government-funded programs.

The intrauterine contraceptive device (IUD or IUCD) seemed to overcome these limitations of the birth control pill. The device is a loop or ring inserted into the uterus by a medical professional. After insertion, it can prevent conception for years. Contraception thus does not hinge on a woman’s daily decision; her initiative is limited to the moment when she has the device inserted, and removal requires further medical assistance. By its very design, the IUD could narrow a woman’s day-to-day control over her reproduction while widening that of medical professionals. This alignment between the design features of the IUD and the goals of population controllers was not coincidental: it was designed with these goals in mind. The Population Council, an organization founded by John D. Rockefeller III with the goal of controlling global population growth, made its first grants for IUD research in 1959 to two doctors, Jack Lippes and Lazar Margulies, who designed and tested various forms of the device. In 1965, with backing from the Population Council, Lippes’s design, known as the “Lippes loop” or simply the “loop,” became the contraceptive device of choice for India’s newly launched extended family planning program. Both in its design and in its implementation, the IUD exemplifies the links between Western fears of a “Third World” population explosion and Indian anxieties about population and development, which together determined the course of Indian population control in the 1960s.

At its inception, as Chikako Takeshita has argued, the IUD “disindividuated” its users. That is, its creators did not imagine the woman who used the IUD as an individual deciding to control her reproduction; rather, “Third World” women en masse were the “implied users” of this new technology. We may trace this construction of the IUD’s users to some of the initial scientific debates about the device, most notably in a “fact-finding” conference in New York sponsored by the Population Council in 1962 to promote IUD research. At the conference, Alan Guttmacher—an obstetrician-gynecologist who was president of the IPPF’s World Population division and who would later lead IPPF’s American affiliate, the Planned Parenthood Federation of America (PPFA)—emerged as an eager proponent of the IUD. As Guttmacher remarked to the assembled gathering of health professionals, he had recently visited India and Southeast Asia, where he learned
something about population control: “The reason the restraint of population growth in these areas is moving so slowly is the fact that the methods which we offer are Western methods, methods poorly suited to their culture and to the control of mass-population growth. Our methods are largely birth control for the individual, not birth control for a nation. Therefore, I felt very strongly that new methods must be offered and, if the new methods are good and proper, results will be astounding.” The IUD, Guttmacher suggested, offered this “birth control for a nation.”

The emphasis on mass population control deprioritized the reproductive health needs of individual women users. Speaking after Guttmacher, Dr. Robert Wilson made this point explicit:

The traditional medical training is toward a single individual. We are concerned with whether an individual develops infection, or whether she has her baby safely, as one person to another. We are less concerned, by training and tradition, about groups of people, and about the welfare of the world in general. This is something that certainly has to be considered in any discussion of world-wide population control. We have to stop functioning like doctors, thinking about the one patient with pelvic inflammatory disease; or the one patient, who might develop this or that, or the other complication from an intra-uterine device; and think of the need for this in general.

For Wilson, contraception that focused on individual outcomes might never meet the goals of global population control. He thus transformed the calculus of risk. The risk to individual women patients should not be weighed against the benefits to the patient herself but rather to the supposed benefits of controlling population on a mass scale. Thus, Wilson acknowledged, the IUD might occasionally be inserted into the “wrong patient,” who would suffer complications. Nevertheless, he suggested to his audience, “perhaps the individual patient is expendable in the general scheme of things, particularly if the infection she acquires is sterilizing but not lethal.” Speaking after Wilson, Dr. Mary Calderone of the PPFA agreed. The risks to individual women, she suggested, must be accepted as “the realities of mass application of any medical technique.”

These “disindividualized” users of the IUD—whose health or fertility might be sacrificed in service of population control—were assumed to be poor women in the “Third World” or racial minorities within Western nations. In early clinical trials, Puerto Rico stood in for the former. For
instance, a presentation by Adaline Satterthwaite and Clarence Gamble about their work in Humacao, Puerto Rico, discussed their trials with 125 women. Only in one case, they noted, did pain require removal of the device. In this instance, a physician removed the spiral-shaped IUD that was initially inserted: “The spiral was removed and shown to the patient and the loop inserted immediately after that. The patient did not know that the loop had been inserted and did not complain of any pain.” Satterthwaite and Gamble represented this deception as a clever workaround to the problems engendered by what they decided was a patient’s unfounded anxiety. These results led to their recommendation that the device “may prove a highly satisfactory method for widespread population control in overpopulated countries.”

Other clinicians aimed for the mass application of IUDs for racial minorities and poor populations in the United Kingdom and the mainland United States. Dr. Don Jessen’s study at Chicago’s Wesley Memorial Hospital inserted IUDs into 121 patients selected from among the “indigent population,” of whom there were “109 Negro, 1 Oriental, and 11 white.” Jessen’s results were mixed, and in a rare dissent, he did not recommend the device for use among poor patients “unless close medical supervision is possible.” By contrast, Margaret Jackson of the United Kingdom noted that she had greater success with 192 women who were “highly fertile” and were “problem patients and mothers of problem families.”

Debates about the IUD’s design and use reflected these population control priorities. For example, a core question discussed during the New York conference was whether IUDs should have a “tail” that would extend outside the uterus. The potential disadvantage of a “tail” was an increased risk of infection. Its potential benefit would be to enable women themselves to check whether the IUD was in place or whether it had been involuntarily expelled. However, clinicians from Puerto Rico and India insisted that women would be unable or unwilling to examine themselves intravaginally to check for the “tail.” Consequently, Guttmacher concluded, the fact that “women in undeveloped areas would be unwilling to examine themselves is a strong argument against the addition of a tail.” Another scientific debate centered on the need to take detailed medical histories from potential users. Such histories might screen out women with pelvic inflammatory disease (PID), who should not have IUDs inserted. However, as Bombay gynecologist and founding FPAI member Dr. V. N. Shirodkar remarked, it was difficult in India to obtain accurate patient histories of PID. Consequently, Guttmacher suggested that “underdeveloped countries” needed fewer restrictions on insertion so as not to “lose sight of our goal—to apply
this method to large populations.” Guttmacher also pushed for insertions as soon as possible after a woman delivered a child, presumably in hopes that this would increase insertion rates. As he reminded his audience, “If we can insert early, it has great advantage. These remarks do not concern the ‘carriage trade.’ I am talking primarily about clinic patients.”

That is, the safeguards about postpartum insertion and detailed medical histories that might be deemed necessary for privileged patients in Western countries did not hold for impoverished “clinic patients” or the women of Puerto Rico and India, whose bodies needed to be made available for population control.

A few years later, when the Population Council sponsored a second conference on the IUD, these assumptions about disindividualized users and mass population control had taken firm hold. The vice president of the Population Council, Bernard Berelson, announced with excitement that the IUD was now a “truly revolutionary development in enabling mankind to deal with the major world problem of undue population growth. . . . This simple device can and will change the history of the world.”

Among the audience members listening to Berelson’s claims was B. L. Raina of the Indian government’s Central Family Planning Board. Raina was attending the conference with a collaborator, M. W. Freymann of the Ford Foundation, to present a paper on “Intra-uterine Contraception in India.” In tones more measured than Berelson’s apocryphal claims, Raina agreed that the IUD offered a welcome expansion of India’s “contraceptive armamentarium.”

The Indian government’s decision to focus on the “Lippes loop” IUD was taken in some haste. Only a few clinical trials were held within the country before the determination was made to use it on a mass scale. Within the Indian population control establishment, the rapid push for the IUD came from a frustration with existing birth control technologies, none of which seemed to meet an “emergency” need to curb population growth. As Sushila Nayar noted, for instance, “conventional contraceptives” required “very strong motivation and persistence,” and birth control pills were costly, had a high dropout rate, and required a thorough medical exam that Indian medical services would be unable to provide on a mass scale. Moreover, people were reluctant to be sterilized unless they had many children, “which means that so far as population control is concerned much damage has already been done.” The IUD thus offered a technical fix, according to Nayar: “The contraceptive that does not need that persistence and which can be used even after the first child is the loop and that is why we have been trying to push forward this program of the loop.”

The Population Council, the IUD’s
chief promoter, encouraged this point of view. The organization supplied India with one million devices in order to move the program forward quickly. Meanwhile, the Ford Foundation funded an IUD factory to ensure that India had its own national supply. The Ford Foundation also conducted a pilot study using Lippes loops in the Hooghly District of West Bengal, and this became the model for expanding the program across India. Soon after, the government was poised to introduce the IUD, or the “loop,” as it came to be known among the millions of women who used it.

Once the device was adopted, there was a relentless push to locate IUD “acceptors” and increase the rate of insertions. Though there were almost no IUD insertions prior to March 1965, a total of 800,000 were completed during the 1965–66 Plan year. Targets for IUD usage were set at the national, state, and district levels; these ranged from an ambitious twenty insertions per thousand population in urban areas to ten per thousand in rural India. If achieved, this would have resulted in four million Indian women using the device. When these targets proved difficult to achieve, the Indian government adopted the model of some state governments—and the recommendation of Ford, UN, World Bank, and IPPF consultants—to introduce incentive payments.

In October 1966, the Health Ministry announced that states would receive eleven rupees for each IUD insertion, which they could distribute among patients, staff who performed the insertions, and “motivators” who recruited and brought in patients. The inclusion of motivators, who were not necessarily state employees and had no special training or qualifications, helped to vastly expand the network of people involved in the state’s family planning program. A woman might receive an IUD and then become a motivator to bring in other women. Alternately, her husband or other family members might receive the payment for motivation; others in the community, both kin and nonkin, government employees and private citizens, might supplement their earnings by identifying and persuading IUD “acceptors.” Motivators typically brought their acceptors to IUD “camps,” which were multiday events that aimed to bring together large numbers of acceptors and insert devices as rapidly as possible. Where there were not adequate numbers of doctors to do the insertions, states organized mobile squads to visit underserved areas. Meanwhile, propaganda efforts—radio programs, family planning exhibitions, films, theater—all aimed to persuade people of the benefits of the “loop.” By July 1968, the minister for family planning, Govind Narain, reported that over 2.5 million women had been fitted with IUDs.
The technological shift represented by the IUD and its implied users led to several changes in family planning. As we have seen, the first two Five Year Plans situated birth control within a category of “women’s welfare,” then delegated such welfare work in large measure to women’s voluntary organizations. By the mid-1960s, however, the state was more directly involved, and the IUD campaign became increasingly separated, both in rhetoric and in policy, from any claims about the “welfare” of women. Voluntary organizations, in turn, shifted their activities to participate in extended family planning, whether by supporting publicity efforts or by arranging clinical services themselves. Both the FPAI and the AIWC, for instance, were proponents of the IUD. As Rama Rau proclaimed, the IUD was among “the methods likely to bring the quickest and most satisfactory results in the emergency the country faces.”

AIWC president K. Lakshmi Raghuramiah announced with satisfaction that “loop-camps have become very very familiar to our members. We have enough grounds to claim that we have played a great part in making women Family Planning conscious.” In 1966, for example, the Bombay branch’s Skippo mobile clinic had “motivated” ninety-one women and fitted them with IUDs while also supporting efforts at a loop camp. In Mangalore in the same year, the Bhagini Samaj began rural IUD insertions, and its mobile unit had worked with the Public Health Department to conduct loop camps across rural parts of the district, where they completed 788 insertions. They concluded optimistically that the “loop is catching the attention of the people and the response is encouraging.” In the following years, branches in Kodaikanal and Malabar similarly began to focus on IUDs in their mobile vans.

The numbers reported by voluntary organizations represented only a small fraction of the several million IUD insertions performed during this period. Yet the reports’ accounting suggests how thoroughly the earlier claim that birth control was a component of women’s welfare had now become folded into a relentless drive to document numbers—numbers of loop camps held, IUDs inserted, incentives provided. Numbers had long been the vocabulary of debate on population; now they were also the language of birth control. Success or failure was measured by numbers, and both state agencies and voluntary organizations aimed to measure up. If the IUD’s designers had imagined a disindividualized user whose uterus might be defused by the device before it exploded with children, its proponents in India strove to create exactly such a user. They aimed to bring in women en masse, “motivate” them to use the IUD, and then insert the device into as many women as possible. The quest to scale up use of the loop thus
became a race of the numbers against time, to inoculate as many women as possible against the threat of reproduction.

At the intersection of all this were the millions of women into whose uteruses the Lippes Loop was inserted. Their bodies bore the brunt of the undue haste that marked the launch of IUDs on a “war footing.” We may find evidence of this haste at all stages of the process. The initial devices themselves—supplied by the Population Council—arrived unsterilized and with only one inserter per twenty devices. The responsibility to sterilize the IUDs properly thus fell on medical personnel, but conditions were often inadequate within the large-scale camps and mobile vans that conducted the bulk of insertions. Moreover, medical personnel were poorly trained in insertion and removal of the device, and the limited number of doctors available increased the pressure to perform insertions as rapidly as possible. Many women received little or no follow-up after an insertion, and complaints of pain, excessive bleeding, or other complications were often ignored. As news of these problems began to spread, the IUD fell rapidly out of favor, and women refused in large numbers to be inserted with the “loop.” The result was a dramatic decline in insertions from 1967 onward.

Whereas the technological promise of the IUD had been to circumvent the question of women’s “motivation,” officials found that, instead, women refused the loop outright. As insertions fell, officials at the highest levels ascribed women’s refusal to their supposed irrationality, which made them victim to “rumors” about the IUD. Narain, the minister for family planning, blamed rumors that loops caused cancer or death, claiming that “village dais and other persons who stand to gain from illegal abortions or sale of oral contraceptives were the chief sources of such distorted statements.” The Bombay gynecologist B. N. Purandare agreed that ordinary women were susceptible to “rumor,” given their supposedly irrational beliefs and lack of education. He insisted that women targeted for IUDs had to be disabused of the beliefs that they were “committing sin by its use, of creation of the wrath of God, of going against nature, of danger of developing cancer, of injury to herself and her husband and of many other silly notions rampant among the uneducated women folk.” For Purandare these ideas represented a serious setback to the IUD program, and he blamed women even while acknowledging that some of them faced complications after insertion, such as bleeding, pain and cramping, and dysmenorrhea.

Once they imagined women as irrational and prone to rumor, IUD proponents could justify multiple methods of persuasion and even coercion. For example, Population Council consultant Harry Levin sidestepped
questions about why women might choose or refuse an IUD. He suggested instead providing a “gift” to women who obtained the device or persuaded others to be fitted. In his terms, “Things like ball point pens and small plastic gadgets and notebooks have proven very effective in other areas when used as rewards to encourage insertions.”

Levin’s startling comment, in which a plastic gadget might be traded for a decision with vast implications for women’s health and reproduction, reveals how the IUD’s implied users entered into population control discourse. Rather than framing the issue in terms of why a woman might seek contraception or why an IUD might offer an acceptable method of birth control for some women, Levin imagines an Indian woman user who is swayed by access to a ballpoint pen. Certainly there is no discourse of citizenship here, nor of welfare or development. Rather, Indian women must be fitted with IUDs despite themselves. Levin’s hopes, voiced in the early stages of the IUD program in 1965, would come to some fruition after 1966, when the government approved cash incentives for IUD “motivators.” Though cash was likely more useful to women than Levin’s plastic gadgets, the underlying implication still holds. Women were not trusted to choose birth control, and thus incentives would become the basis of the program.

Although the government insisted that the program was entirely voluntary, histories of its inner workings show that it was potentially coercive. Evidence from drought-stricken regions in Bihar, Madhya Pradesh, and Orissa, for example, suggests that starving women might have “chosen” an IUD as an alternative to hunger. Paying an incentive to motivators also opened up avenues for coercion, as those with social or economic power might exert their influence to compel others to “choose” an IUD. Such effects have been well documented for family planning campaigns in later decades. Cases in which women were denied removal of an IUD are another example of coercion; these women sometimes sought removal from private doctors or attempted to remove it with the assistance of a dai or family member.

More direct instances of coercion are rarely visible in the historical archive, given that family planners were invested in claims of voluntarism. However, one example comes from a physician working among women employed in tea estates in Assam. Dr. L. C. R. Emmet, chief medical officer of the Mariani Medical Association, took the opportunity to impose IUDs on women who had been married at ages below the legal limit. When three young women under age thirteen miscarried, Emmet claimed, “their husbands were given the opportunity to either induce their wives to volunteer
for the IUCD, or be trotted down to the local Police Station. Needless to say, they chose the former and easier course of action. 

Emmet’s curious formulation, whereby he compelled husbands to “induce” the women to “volunteer,” points to the coercive underpinnings of his IUD campaign. His assumption that an IUD insertion was “easier” for husbands further discounts the experiences of the young women. As in the case of the acceptors of Levin’s plastic gadgets, women are not represented as making reasoned decisions about IUDs but are assumed to be irrational subjects who have to be persuaded, bribed, or coerced into insertion by any available means. For such imagined users of the IUD, the line between coercion and consent was porous and, in this case, was disregarded entirely.

Even IUD promoters who were more sympathetic toward the loop’s users operated within this paradigm, whereby women’s bodies and uteruses were put in service of another’s reason. The rationality of the population controller, in other words, trumped the supposed irrationality of the IUD’s implied user, rendering her into a body that was more or less available for an insertion. This was the case for Kumudini Dandekar, a feminist demographer and critic of some population control certitudes, who conducted a study with fellow demographer Surekha Nigam to assess why IUD insertions fell so sharply a few years into the program. They were primarily concerned with “the capacity of the women to tolerate the device in spite of bleeding and similar accompanying discomfort.” Basing their conclusion on a study of 2,100 loop adopters in rural Maharashtra, they claimed that despite bleeding, most “women bore the device patiently.” This emphasis on women’s bodily abilities to “bear” the device—a language that recurs repeatedly across the scientific discourse—reinforces the turn away from any comprehensive analysis of women’s interests, choices, or reasons for controlling their reproduction. In its place, women’s bodily sacrifice became the very basis upon which the IUD program was built.

**Sterilization and States of Emergency**

Like the IUD, surgical sterilization became a key contraceptive technology to put India’s family planning program on a “war footing.” From a population control perspective, surgical sterilization was highly effective at preventing conception, was controlled by medical providers, and required patients to make only a one-time decision. Unlike the IUD, surgical sterilization was a permanent rather than temporary measure, and it was available to both men and women. Vasectomy for men was the medically simpler
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procedure, but tubectomy or tubal ligation for women also became part of the government’s family planning program. The inclusion of men as targets of family planning marked a shift from earlier technologies and programs, which had focused on women and their bodies as reproductive threats to the nation. This attention to men even reshaped the gender politics of population control for a brief period during Emergency rule, from 1975 to 1977. After the Emergency, for reasons I discuss below, vasectomy was marked as an “excess” of Indian population control, while the program for female sterilization, and its regulation of women’s bodies, was left intact.

Sterilization first became widespread in the southern states, where it was a mainstay of family planning even before the Indian government adopted it on a national level. In Madras State (later Tamil Nadu), the emphasis on sterilization was due in large measure to R. A. Gopalaswami, who served as independent India’s first census commissioner and then worked for the Madras government. In his 1951 census report castigating “improvident maternity,” Gopalaswami had argued strongly for a national population control policy, and in Madras he aimed to put this into effect through sterilization. As he explained, “Mechanical and chemical contraceptive appliances” were useful for “sections of the population who can be largely left to themselves.” These were middle-class couples, Gopalaswami implied, who might decide to reduce their childbearing for reasons of family economy or national development. However, “from the point of view of the large mass of the people who will not space their pregnancies or limit their number except as a result of Governmental action, reliance should be placed primarily on natural methods for securing the former and on surgical methods for securing the latter.”98 In other words, surgical sterilization was the technology of choice to impose the state’s will upon the reproductive capacities of the poor and marginalized. Nonpermanent methods, by contrast, were a luxury of the middle classes. The government of Madras introduced sterilization in its Family Planning Manual and noted that both vasectomy and female sterilization methods (recommended in the first twenty-four hours after delivery) were equally important to the state’s program.99 The Madras government also became the first in India to offer cash incentives for sterilization, with thirty rupees for men or women who underwent the procedure and ten rupees for the “motivator” who brought them to the clinic.100

With the intensification of family planning regimes during the 1960s, the central government joined states like Madras, Mysore, and Kerala in promoting sterilization for both men and women. The number of these surgeries grew rapidly. Government figures, though potentially imprecise,
still indicate the scope of the increase. From just over 7,000 sterilizations of men and women in 1956, for instance, there were nearly 270,000 in 1964 and 1.8 million in 1967 through 1968.\textsuperscript{101} The number of men increased still further with the inauguration of mass vasectomy camps, which eventually became a defining feature of the family planning program. The first of these camps was organized by S. S. Krishnakumar, the district collector of Ernakulam, Kerala, in December 1970. The camp aimed to bring together medical personnel and a large number of patients in a “festive atmosphere” in order to convince men to obtain vasectomies. The first Ernakulam camp provided transport to patients, was publicized widely in advance, and offered vasectomy “acceptors” a cash incentive alongside gifts. The result, as reported by the government, was more than 15,000 vasectomies in one month. A second camp in July 1971 resulted in more than 63,000 vasectomies, representing a staggering 42 percent of all such procedures performed in Kerala that year. Others adopted Krishnakumar’s approach, holding camps at a variety of venues, including even Bombay’s Victoria Terminus rail station.\textsuperscript{102}

Supporters of mass vasectomy camps promoted the procedure’s cost and efficiency. In contrast to female sterilization, vasectomies did not require hospitalization, used only a local anesthetic, and could be done relatively quickly. The main difficulty was thus not in the procedure itself, according to family planning proponents, but in convincing men to “volunteer” for it. Doctors, social workers, and government bureaucrats lamented public perceptions of the surgery, especially notions that it might lead to impotence or was akin to castration. They hoped that publicizing vasectomy camps might assuage these fears; the government also paid “motivators” to persuade men to agree to the procedure and bring them to the camps.

Whereas promoters of mass vasectomy camps touted them as purely voluntary events that destigmatized surgical sterilization, scholars have noted their coercive structures and effects. For impoverished populations, cash incentives were large enough to shape decisions about “consenting” to the procedure, especially when patients were uninformed about alternatives. The vast majority of camp attendees marked their occupation as laborers, most with monthly incomes of under 100 rupees; incentives at camps ranged from 70 to 150 rupees. Moreover, increased numbers at the camps tended to coincide with periods of agricultural crisis and scarcity; this indicates that men were more likely to “accept” vasectomy when other means of supporting themselves and their families had failed. Meanwhile, when government budget shortfalls led to the withdrawal of incentives in the mid-1970s,
vasectomy adoptions fell sharply, again suggesting that the incentive was responsible for men’s “choices” about the surgery. These implicit structures of coercion were reinforced in some cases by more explicit measures, such as at one camp in Uttar Pradesh for which the district collector arranged for police vehicles to locate and transport vasectomy acceptors. In short, the mass vasectomy camps exactly echoed the call of population controllers like Gopalaswami to make surgical sterilization the primary method to control the reproduction of the masses. In the words of one physician in West Bengal, temporary contraceptive measures could be used by the “educated community” but “sterilization would be ideal for the illiterate.”

Vasectomy campaigns departed from previous family planning programs to target men’s reproductivity as a source of national danger and a site for medical intervention. Family planning had already reduced subaltern women’s bodies to their reproductive rather than productive functions. Moreover, the state’s development regime had historically prioritized men’s productive labor in providing access to agricultural resources and technologies, while ignoring women’s contributions to agrarian production. However, the new campaigns highlighted men’s reproduction as an obstacle to national development, and with vasectomy, the state aimed for new kinds of control over men’s reproduction. This shift from production to reproduction—from agricultural extension to family planning—was not easy, as one Ford Foundation consultant noted. Despite family planners’ best efforts, he wrote glumly, “it is considerably easier to demonstrate the benefits of fertilizer than of vasectomy.” Perhaps it is unsurprising, then, that the targets of the vasectomy camps were those men least likely to have benefited from agricultural extension and rural development. These were the landless and land-poor, which meant they were more likely to be lower-caste, Adivasi, and Dalit populations that agrarian development efforts overlooked. In the absence of substantive land redistribution, their sterilization was touted as a route toward alleviating poverty. In the process, their bodies were subject to the kinds of reproductive control that had hitherto been reserved for women.

Despite this attention to men, however, we must remember that female sterilization continued uninterrupted throughout the late 1960s and 1970s. Although vasectomy was the simpler and cheaper procedure, family planners insisted that female sterilization was necessary as well, especially after the failure of the IUD campaign. But the ratio of procedures for men and women changed over time. When the government first began keeping records in the mid-1950s, female sterilizations accounted for about two-thirds
of all sterilizations performed. With the rapid rise in vasectomies in the
1960s, this proportion fell. Though absolute numbers of sterilizations
increased, women were receiving fewer of them in comparison to men,
down to just 10 percent of such surgeries in 1967 to 1968.107

The campaign for sterilization acquired new urgency when Prime Min-
ister Indira Gandhi suspended parliamentary democracy and declared a
state of emergency in June 1975. She was responding to growing economic
crises and rising social unrest, the latter spearheaded by Jayapra
kash Narayan’s anticorruption movement and call for “total revolution.” Her posi-
tion became even more precarious when, in June 1975, the Allahabad High
Court found Gandhi guilty of malpractice in the 1971 elections. JP, as he
was known to his followers, called for the prime minister’s resignation, and
the opposition staged a mass rally in New Delhi on June 25. Just one day
later, Gandhi claimed there was a threat to India’s “internal stability” and
instituted the Emergency. Under Emergency rule, the government declared
public meetings and strikes to be illegal, imposed press censorship, sus-
pended the right of habeas corpus, and amended the Maintenance of
Internal Security Act (MISA) to allow the detention of political prisoners
without charge. Thousands of people were subsequently arrested. Within a
month, Gandhi announced a “Twenty-Point Program” that claimed to
tackle economic crises by controlling prices and increasing production.
Soon thereafter, Gandhi’s son and close associate Sanjay Gandhi created a
“Four-Point Program” (later Five-Point) that explicitly included family plan-
ing among its development goals. Though he had no official government
position, he became the unofficial leader of the government’s population
control efforts, which he combined with a drive for urban slum clearance.108

In popular imagination, the Emergency is inseparable from state-
sponsored sterilization, so much so that the period is known in Hindi as
nasbandi ka vakt (the time of sterilization).109 Yet as we have seen, steriliza-
tion did not begin under the Emergency but already had a history in India’s
family planning program. The system of targets and incentives—and their
underlying coerciveness—had begun a decade earlier, as had the attempt
to introduce the procedure on a mass scale. Moreover, the notion that ster-
ilization was a necessary fix for the country’s disenfranchised, alongside the
claim that temporary birth control measures were a luxury of the middle
classes, circulated openly within the state bureaucracy. The state’s interven-
tion into the reproductivity of its citizens and the claim that such intervention
alleviated poverty and promoted national development—an economiza-
tion of reproduction—were established facts well before Sanjay Gandhi’s
Four-Point Program. In short, virtually all the systems and institutions of sterilization that underlay *nasbandi ka vakt* already existed before Emergency rule.

Given these continuities, what were the potential ruptures that linked the Emergency so intimately to sterilization, such that Emergency time itself became marked as the period of *nasbandi*? There was undoubtedly an intensification of existing policies. For instance, in April 1976, nearly one year into Emergency rule, the minister for health and family planning, Karan Singh, announced a National Population Policy (NPP) that established new targets and further increased incentives for sterilization. The NPP sought to downplay any coercive intent, as Ashwini Tambe notes, by adding the presumably less controversial goal of raising the age of marriage as a way to reduce fertility rates. Yet there were potentially coercive measures aplenty. For instance, the NPP proposed freezing states’ representation in Parliament based on 1971 census figures, thus rewarding states that slowed population growth with greater representation and instituting political penalties for those whose population grew more rapidly. At the same time, it explicitly enabled states to pass legislation for compulsory sterilization. Maharashtra soon complied with a measure calling for the compulsory sterilization of couples with three or more children; however, before this policy could be approved at the central level, the Emergency had ended. Thus, although coercive practices had existed implicitly before, the doors were now open to more explicit acts of coercion. Finally, we must remember, the coercive effects of Emergency-era sterilization policies operated within a larger system of repression. The imprisonment of Gandhi’s political opponents and the suspension of civil liberties and press freedoms were part of the political environment in which the Ministry of Family Planning pursued its sterilization targets.

This environment shaped how the government enforced its sterilization policies. State employees were pressed to meet their targets for motivating private citizens to be sterilized, and thus sterilization became a condition for continued employment or promotion. However, it did not need to be the employee who was sterilized: workers could produce “sterilization certificates” proving that they had “motivated” others for vasectomy or tubectomy. This process of “motivating” another person to be sterilized encompassed all manner of coercive methods. In her study of the Emergency in one Delhi neighborhood, anthropologist Emma Tarlo unearths a number of strategies to obtain such certificates. One schoolteacher, for instance, announced that students whose parents refused to
turn over sterilization certificates would fail their exams. Housing officials demanded sterilization certificates to allot land to people whose homes had been demolished during the Emergency drive for “slum clearance.” Sterilization certificates became a currency for obtaining state services such as health care, food rations, and electricity or water connections. To meet such demands, middlemen developed a thriving trade in such certificates—obtaining them through coercion and selling them to others for a price. Consequently, Tarlo concludes, during the Emergency ordinary citizens became newly enmeshed in the drive for sterilization, either as bodies to be sterilized or as agents in expanding the state’s reach to ever more “targets” for the surgeries. She describes this as a “forcible deal” struck by the government with its own citizens, whereby “in theory, everyone was under pressure [for sterilization]. In practice, that pressure accumulated downwards” in such a way that only those at the very bottom rungs of society, those who had nothing to offer but their own bodies, underwent the surgery. In this sense, following Tarlo, the pressure for sterilization during the Emergency percolated from the highest echelons of power down toward those living on the margins of society—urban slum dwellers and the landless poor. As each layer of the family planning bureaucracy transferred the burden of the surgery to a more vulnerable level, it was finally only the bodies of the poor that could satisfy the voracious demands for sterilization that kept the system running.

Emergency-era sterilization targets applied to both women and men, but it was the latter whose bodies were targeted most intensively as the numbers surged. Thus, during 1975–76, when Emergency family planning measures were being put into place, government figures reported over 2.6 million sterilizations, of which just over half (53.9 percent) were vasectomies. The numbers grew rapidly when the NPP and Emergency measures were in full swing, during 1976–77. As nongovernmental organizations like the FPAI continued to work closely with the state, sterilizations totaled a staggering 8.2 million. Equally significant was the shift in proportion between men and women; vasectomies totaled three-fourths of all surgical sterilizations, with tubectomies representing just 25 percent of procedures. Documentation of the Emergency’s family planning programs, which is sparse in the archives, rarely discusses this shift from women toward men. We are left only to speculate about the “efficiency,” cost, and speed of this procedure in comparison with tubectomies. In this sense, the procedure aligned with the urgency behind the NPP. Perhaps,
then, male sterilization was well suited to a state of emergency, representing both national crisis and solution.

The Emergency came to an end in January 1977, when Indira Gandhi announced elections, released political prisoners, and rolled back some of the government’s authoritarian measures. Elections, held in March of that year, led to a massive defeat for Gandhi, who lost even her parliamentary seat, and for the Congress Party, which lost its majority. The victorious Janata Alliance, a coalition of Gandhi’s opponents, came to power. Since that momentous defeat—the first faced by Congress at the national level since independence—scholars have tried to explain the Emergency in relation to the history of democracy in India, and of population control transnationally. Connecting the two, Matthew Connelly argues that the elections of 1977 represented a repudiation of population control at the ballot box. “People voting, one by one,” challenged the ideological underpinnings of the state’s drive to control population in the mass.117

Certainly, the rejection of sterilization played an important role in the election campaign, but to represent 1977 as a democratic repudiation of population control overstates the case. During the campaign, opposition parties and the media highlighted instances of horrific sterilization abuse; indeed, the Congress suffered its worst defeats in the states that Indira and Sanjay Gandhi had targeted most intensively for population control. However, these electoral defeats were temporary, as Congress and Gandhi returned to power just three short years later, in 1980. In 1983, she received the United Nations Population Award, signaling the support of transnational population control networks. Consequently, some historians emphasize the continuities that make the Emergency less an aberration and more a product of failures in Indian democracy. According to Gyan Prakash, Indian political democracy never addressed the country’s lack of social transformation—its ongoing inequalities and entrenched hierarchies. The Emergency was a “last-ditch attempt to salvage with exceptional means the global and elite-driven projects of modernization” that did not have popular support, or popular interests, at heart.118 But while the means were exceptional, the underlying norms of governance and political power were continuous with the years before, and after, Emergency rule. Understanding this period purely as aberration masks continuities in state policy regarding poverty and population.119 Indeed, as this chapter suggests, although the Emergency was a distinct moment in the histories of both democracy and population control, *nasbandi ka vakt* would have been impossible without
the institutions and ideologies that had already made (women's) reproductive bodies available for coercive control by the state. Moreover, Emergency’s end in 1977 did not signal the end of the government’s coercive reproductive and population policies.

Yet, in the immediate aftermath of Emergency rule, there was much at stake in marking those years as aberration. In the heady days after the Janata victory, journalists, activists, and politicians suggested that the Emergency was a period of “excess.” It represented a moment when the government had overstepped its bounds, and Gandhi’s defeat in 1977 marked a reassertion of these boundaries. This narrative of excess and aberration framed the inquiries of the Shah Commission, the Janata government’s only official investigation of the Emergency. The Shah Commission report, as Rebecca Williams argues, contrasted the Emergency with an implicit “normal” functioning of the state but never questioned this normality. In the realm of population control, the commission’s narrative of the normal assumed that the program had been entirely voluntary prior to the Emergency and did not challenge the system of targets and incentives that had underpinned coercion since the 1960s. Perhaps most importantly, the Shah Commission did not question the reigning ideologies of population control, which insisted that sterilization of the poor on a mass scale was a necessary component of family planning and that population control was necessary for poverty alleviation and economic development. Thus, the underlying systems of coercion within India’s family planning program remained unscathed while the commission excoriated the most egregious examples of repression during the Emergency years. The central question—for the commission as for the Janata government—became how to continue India’s population control program while rejecting the “excesses” of the Emergency years.

The Janata government answered this question, I argue, by making male sterilization the site and symbol of Emergency “excess.” That is, in the post-Emergency era, vasectomy itself stood in for the terror and repression of population control. We may trace this narrative in the Shah Commission report, which highlighted violent examples of coerced vasectomy, most notoriously in the Dujana House neighborhood in the old city of Delhi. Journalists understandably emphasized horrific instances of forced sterilization in trying to reckon with the violence of the Emergency. Even decades later, as Tarlo notes, these narratives of the most explicit forms of force and coercion circulate in popular understanding of the period. But in the process, I suggest, the Emergency’s attention to the male body was marked as
the “abnormal excess” that enabled the state’s “normal” targeting of female bodies to continue unquestioned. Women’s bodies did not figure as central in narratives about the Emergency’s excesses, even though more than two million women were sterilized and women alongside men were ensnared in the government’s “forcible deal” to either undergo the surgery or produce a sterilization certificate. Rather, even as the Emergency’s “excess” was understood to include only the most explicit acts of force in population control, post-Emergency critiques narrowed their attention to the targeting of male bodies as the sites of regulation.

Thus, rather than challenging the entire apparatus of coercive incentives and targets, or of the mass camps that prioritized numbers over safety and informed consent, the Emergency’s aftermath witnessed a renewed commitment to reproductive regulation as a component of India’s development regime. But this time, there was one important difference: vasectomy was sidelined, so sterilization patients were increasingly women. Once again, the numbers help to tell this story. In the immediate aftermath of the Emergency, sterilizations overall fell sharply, from more than eight million annually to less than a million in 1977–78. In that year, women accounted for over 80 percent of all such surgeries, in contrast to the Emergency period, when vasectomies exceeded tubectomies by three- and fourfold.122 In other words, though the “time of sterilization” supposedly ended with the elections of 1977, women continued to be sterilized, while men’s sterilizations decreased. Moreover, the effects of these Emergency years and the “abnormalization” of male sterilization have had long-lasting effects. Since the Emergency, Indian men have had low rates of sterilization, compared both to women and to worldwide averages.123 Meanwhile, female sterilization has become the most common form of contraception among women in India.124 This, too, is a legacy of the Emergency, which marked the reproductive regulation of male bodies as an excess of state power while continuing to intervene in the reproductive bodies and lives of its women citizens.

Conclusion

In one scene of Deepa Dhanraj’s 1991 documentary film Something Like a War, women are lined up for sterilization. A surgeon, while conducting the procedure, describes to the filmmaker the speed and efficiency of his techniques for laparoscopic sterilization, which enable him to “finish this operation in forty-five seconds.” Meanwhile, the camera lingers on the face of his patient, who is writhing in pain while her mouth is held shut by a
medical attendant. The camera then pans out across the clinic, where we see dozens of patients in states of bodily pain and suffering as they prepare for or recover from the surgery. Juxtaposing these images with archival footage of Indian family planning propaganda, the film suggests that India’s “war” against population was in fact “something like a war” against women. Yet despite this powerful critique, women do not appear only as victims in the film. Dhanraj’s camera also dwells on an extended conversation among women—of varying age, caste, class, and religious backgrounds—about sexuality, reproduction, childbearing, and their families. This conversation offers an understanding of reproduction that transcends the official family planning discourse. The women’s words connect their reproductivity not to population or economy but to their desires, fears, and experiences in multiple, intimate ways. We may find accounts of the connections between reproduction and women’s experiences in ethnographic research as well, as in Cecilia Van Hollen’s study of the routine insertion of IUDs in postpartum women in Madras public hospitals during the mid-1990s. Van Hollen documents that insertion occurs both with and without a patient’s consent and that women sometimes resort to private clinics for IUD removal. As Van Hollen notes, the state’s mandate to insert IUDs postpartum can be at odds with women’s own understanding of their bodies. Those who do not want or like the IUD suggest that the device “does not agree” with their bodies. Taken together, both film and ethnography suggest that women assign multiple meanings to their reproduction that contradict the state’s claims about population and their fertility.

Reproduction, moreover, never exists in isolation but is enmeshed in a wider net of social, economic, and political relationships. Here again, ethnography is revealing. Emma Tarlo’s research on the Emergency, discussed above, shows that although the stated purpose of sterilization was to control fertility and defuse the “population bomb,” this was not how or why patients encountered the surgeon’s knife. Rather, sterilization became the only means for people to access what they needed to survive, from housing and employment to hospital treatment and education. Thus, “for many of those at the bottom end of the socio-economic heap, life in Delhi without a sterilization certificate became untenable, if not impossible.” Narratives of life during the Emergency, therefore, were dominated by an “idiom of survival” in which one’s reproductive capacity became something to exchange when one had nothing else to give. This suggests the vast distances between the official discourses of the Emergency and the narratives of nasbandi ka vakt as people understood and experienced it.
Such evidence of experience is more difficult to access from the historical archive, which tends not to preserve—or ever record—voices that are so at odds with the state’s discourse and imagining. Drawing upon ethnography and documentary film can thus remind the historian that there are entire lifeworlds not accounted for in the archives. At the very least, we must leave a place in our historical accounts for these alternative understandings, and I return to that issue in the epilogue of this book. For now, we might remember that, despite the family planning program’s attempts to make women’s reproductive bodies a terrain for development, women themselves did not passively accept these interventions into their bodies and lives. They questioned the claims of “service” rendered by the middle-class family planner and evaded or rejected interventions that positioned their fertility as responsible for a population explosion. On occasion, they demanded something different or more—treatments for infertility, food and milk for their children, education for their girls. Never simply the disindividualized and docile users imagined by family planners, women assigned meaning to their reproduction that far exceeded population controllers’ more limited imagination.