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India

Reproducing Injustice

- Features - Feminism -

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The battle for reproductive rights is a global battle. In March, the United States Supreme Court heard [a landmark case](#) over the future of women's access to safe and legal abortions in Texas. In Poland, a [proposed law](#) by the country's right-wing Law and Justice Party would effectively outlaw abortion. And while abortions have been legal in India since the seventies, Indian women's control over their own bodies remains abbreviated.

Today, a surprising group — Indian Prime Minister Narendra Modi and the ruling Bharatiya Janata Party (BJP) — has entered the struggle. Their plan is to subsidize injectable contraceptives, providing greater access to birth control among poor women in India. Modi's contraception plan doesn't challenge India's long history of unequal reproductive health.

But scholars like Mohan Rao, from Jawaharlal Nehru University, oppose the plan, calling it imperialistic and, in light of India's history with birth control, [anti-feminist](#).

Controlling Nations and Bodies

India has a long history of controlling poor and rural women's fertility — a history that continues to inform contemporary reproductive health in the country.

The trajectory of reproductive rights in India has been profoundly impacted by the global population control movement, which began in earnest following the publication of Paul Ehrlich's [The Population Bomb](#) (1968). Ehrlich's book sparked Malthusian terror about overpopulation in a world of limited resources. Fearful observers demanded active measures to decrease birthrates and stave off mass starvation.

The population control movement had roots in the eugenics movement to be sure, but there were also political questions at play.

As Matthew Connelly argues, "all of the governments that first adopted family planning programs in the 1950s and 1960s had contentious borders, including India, Pakistan, South Korea, Taiwan, Turkey, and Honduras." Controlling bodies went hand-in-hand with domesticating borders.

In China, population control was tied to development and economic growth. In contradistinction to its 1970s "Later, Longer, Fewer" plan, which non-coercively reduced its birthrate, China's 1980 one-child policy controlled the fertility of (mostly urban) women through brutal means, radically disrupting families and creating both an [overabundance of bachelors](#) and an untenably aging population.

America's Cold War containment policies also relied on global population control. In the mid-1960s, President Lyndon Johnson argued that the youth bulge occurring in the Global South threatened the US government's power: the poor masses [could become fodder](#) for communist revolutionary uprisings.

While the elaboration of the nation-state, increasing surveillance technologies, and the threat of mobile populations coalesced to create the science of demography, India became the [testing ground](#) for manipulating demography.

International organizations like the World Bank and United Nations, and American philanthropic enterprises like the [Ford and Rockefeller](#) foundations, were front and center.

The Ford Foundation gave roughly \$33 million dollars to fund India's population-control projects in 1962, and the United Nations gave India \$40 million dollars to implement a sterilization program in 1974.

Indian elites supported these projects to be sure. But they needed the materials, expertise, and ideological backing (amid Cold War hysteria) of international donors to carry them out. If expertise and backing were the carrot, food aid (urgent because of partition and the subsequent loss of fertile agricultural lands) was the stick. India would not receive US aid unless it implemented population control reforms.

Evolving Control

India's population-control movement evolved to include "beautification" projects — slum clearances coupled with the systematic sterilization of poor, low-caste men were implemented nationwide. During Indira Gandhi's Emergency, Sanjay Gandhi used loans from international organizations like the World Bank to fund mass, [discriminatory sterilization](#) of over six million individuals. As slums were demolished, inhabitants were offered a plot of compensatory land, but only if they underwent sterilization.

These practices continue today. The Indian government funds approximately four million tubal ligations — India's contraceptive par excellence — every each year.

The programs target rural women, who already face an onslaught of barriers and maltreatment with regard to their family planning.

Offers of cash incentivize poor women to undergo sterilization. Village "motivators" receive 150 rupees, or \$2.44, for every patient they recruit. In turn, a typical woman receives 1,400 rupees, or \$23, for her terminal disavowal of fertility. And when doctors themselves have quotas, sterilization becomes a true [numbers game](#) — a game that, not surprisingly, gains public visibility only when it reaches its tragic and grotesque apotheosis, like the performance of eighty-three operations in six hours and the resultant [thirteen deaths](#) of women in Chhattisgarh in 2014.

Modi and his Bharatiya Janata Party (BJP) now claim they want to modernize female contraceptives and facilitate access to them.

The World Health Organization promotes injectable contraceptives, also known as Depo-Provera or DMPA, [citing them](#) as a safe and effective form of birth control. Apparently, Modi is listening.

[This year](#), he will make injectables free of charge. Although they have already been in India since 1993, his plan would make them free and incrementally available throughout the country.

Proponents say injectables will expand women's choices on two fronts: diversifying contraceptive choice (as it is added to the list of government-sponsored options) and allowing women to deliberately [space](#) their pregnancies.

Without reliable access to birth control, many women carry pregnancies back-to-back, increasing natal mortality and posing serious health risks for the mother. A woman using DMPA, which is injected every three months, can only

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become pregnant [twelve to eighteen months](#) after the injections stop. The longer duration of this interval corresponds to the [recommended range of spacing](#) : eighteen months to five years.

These are positive factors that could improve women's lives.

But injectables don't exist in a vacuum. Existing hierarchies of power determine how they are made available and administered.

Consider the recent case of Ethiopian Jews in Israel. Israeli health officials injected Ethiopian Jewish women with DMPA without their consent or full knowledge. Some women testified that they were told they were being given [inoculations](#) .

The practice went entirely undetected until social workers realized that the birth rate of Ethiopian Jews [dropped by fifty percent](#) in just ten years. Most Ethiopian women began their DMPA treatment while en route to Israel, underscoring how birth control can function as border control. Their entrance depended on the coerced promise that none of their progeny would be inheritors of Israel.

Power imbalances shape Indian women's reproductive care as well. Proponents like Navsharan Singh, a program specialist at the International Development Research Center, celebrate the introduction of injectables into major hospital centers because they could "strengthen the prospect of follow-ups."

But many women cannot access the hospitals where injectables will be available. India's shortage of ambient health centers means women have to travel long distances, on their own rupee, to urban areas that have major medical facilities.

Easy access to health-related infrastructure is thus central to the successful implementation of this plan. But Modi has no plan for improving this aspect of health care.

India's incredibly low expenditure on public health "slightly over 1 percent of its total GDP" has not increased. Modi's recent [dismissal of foreign health officials](#) without filling their vacancies "effectively deflating major health initiatives such as "those aimed at fighting AIDs and tuberculosis" offers no silver lining.

Moreover, given Modi's track record, his newfound concern for poor women is puzzling. In 2002, he presided over the Gujarat riots that resulted in the murder of at least one thousand Muslim men and women and [gruesome sexual violence](#) committed against Muslim women by Hindu nationalists. He banned Leslee Udwin's documentary, [India's Daughter](#), which recounts the 2012 Delhi rape case. He can hardly be called a women's rights ally.

But set against the backdrop of his broader ideological beliefs, Modi's support for injectables makes more sense. What looks like a progressive move for India's poor women is in fact a pat technological fix to an endemic societal issue: Indian women's struggles to control their own bodies.

The injectable program is, in fact, part and parcel of BJP's goal of appearing deeply committed to improving the lives of India's marginalized communities while maintaining a preference for [free-market orthodoxy](#) and consumer choice.

Modi called his 2016–17 budget plan "pro-village, pro-farmer, pro-poor." Yet his economic liberalization policies, such as "Make in India," strengthen domestic manufacturing and open the country up to foreign investment at the expense

of its vast agricultural sector.

By favoring [capital-intensive industries](#), Modi neglects half of India's workforce, which is agriculturally based. It is also these rural women who suffer the most from poor reproductive and sexual health care.

Faces of Empowerment

Resistance to injectables is not new in India. Many Indian activists and women's groups categorically oppose them.

In 1986, they [brought their opposition](#) to the Supreme Court. Recently, a total of seventy individuals, public health organizations, and women's rights advocacy groups condemned injectables in an [open letter](#) to the union minister for health and family welfare. They cite a trinity of deficiencies facing poor women: lack of infrastructure, lack of information, and lack of choice.

Gender parity in India is complex. Amartya Sen argues that it has many "faces," ranging from ownership of property to access to education and employment and the eradication of sexualized violence.

If these "faces" seem tangled and overlapping, they should "they are all fundamentally entwined with the issue of women's empowerment.

Moreover, universal access to contraceptives and medical facilities, while necessary and important, is not a panacea: with the advent of sonograms to determine the gender of fetuses and the persistent elevation of male over female children, the issue of millions of "[missing women](#)" in India has only adopted a modern guise.

These "missing women" are, due to sex-selective practices and sustained neglect of female children over their lifetime, demographically nonexistent, especially in northern and northwestern states.

Sen calculates an approximate number of "missing women" in India by using a standard female-to-male ratio, 1.02, derived from the sub-Saharan African population that boasts relatively small biases against women in health care and social status. When India's ratio of .93 is measured against the 1.02 standard, the absence of nearly twenty-nine million women "an unfathomable number" becomes apparent.

The means to gender equity cannot be solved through [corporate philanthropy](#), the coercion of those deemed least fit, or the imposition of a modern contraceptive technology without considering the interconnected "faces" that constitute women's agency.

The notion that India is the world's most populous democracy is often tossed around as a postcolonial truism. The [political realities](#) of India since Modi's 2014 election offer a different picture entirely. Under Modi's tutelage, India has become a hotbed of discontent and repression: from endorsing violence against minority communities to [incarcerating dissent](#), the grand "Make in India" plan of [neoliberal economic restructuring](#) is dependent on the ritual neglect of the undesired.

Until this plan and the ideology bolstering it is radically challenged, the introduction of modern contraceptives will be just another cosmetic change.

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[Jacobin](#)

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