

Family Planning in Twentieth Century India

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Introduction

India is one of the most rapidly developing countries in the modern world. Economically and technologically, it continually surprises the rest of the world as it advances. Perhaps most significantly, the close population race between India and China has been a topic of fascination in the international media. Since the 1950s India has been the second most populous country in the world but is expected to surpass China within the next few years. Having the largest population has never been a goal of India's, however. Despite decades of rigorous policy implementation to try to keep the population at bay, India's numbers continue to rapidly increase. By examining the rise of India's population problem, as well as the way the media has presented this extremely personal issue throughout the past century, it becomes clear that population control and family planning in India are deeply rooted in nationalism, and thus much more complex than one might imagine.

Between 1901 and 1951, India had a population increase of 51.5% (Wattal). Under the British Raj, the government of India focused heavily on making efforts to improve public health in the country. After Partition in 1947, the independent government of India introduced a series of policies throughout the latter half of the twentieth century to implement family planning, but most efforts, both British and Indian, have been largely unsuccessful up to the present. This project analyzes the stark disparity between both the British and Indian governments' stated goals and consequent approaches to family planning and the reactions of many Indian citizens to said measures. My research shows that many citizens often felt that the government's policies and methods of implementation often disregarded their values. I look at both scholarly and primary source documents to track influential events, such as policy changes or national

economic crises, as they occurred and to document the responses of concerned citizens, government representatives, and foreign scholars and social workers as they appear in Western and Indian media and in official publications. I argue that the failure of this series of policies is due to miscommunication and misunderstanding among the Indian Government, policy implementers and researchers, and Indian citizens, and has resulted in problems that ultimately led to Indian citizens, and being perceived by their government as noncompliant with, and even at times willfully defiant to, the government's policies. Despite what some government reports and scholarly articles suggest, I suggest that the reason for the failure of these policies is less the product of the illiteracy and ignorance of the Indian population and more the result the Indian government's inability to find ways to resolve the tensions between the rapidly modernizing world and the evolving values of its people.

Family Planning and Population Control

To better understand the experiences of Indian citizens, it is important to first look at the difference between "family planning" and "population control." The term "family planning" generally has a more personal connotation, implying that one has the ability to take control of one's life and the future of one's family. "Population control," however, has a more negative and authoritarian, and hence, negative, connotation, as it refers to a government's act of limiting the families of entire group of people. Carl E. Taylor, founding chair of the Department of International Health at Johns Hopkins University wrote in 1970 that "family planning to serve the individual family is appropriate at the beginning stages of program development; social and legal pressure for population control as a national objective should be applied only after family

planning is already available” (Taylor 1970, 111). Though interest in adopting family planning measures clearly existed across the subcontinent, actually encouraging people to change their living styles proved much more difficult than any policy-maker could have imagined. From the start, India adopted a top-down approach to family planning, in which efforts had less to do with individual choice and instead were heavily rooted in nationalism by framing family planning as a way to solve national economic issues. The failures of such approaches are most evident in rural areas where citizens feel unconnected from national issues and feel unmotivated to change their lifestyles for such reasons.

Throughout the twentieth century, both British India and later independent India adopted several different approaches to limiting the size of its population. Educating its citizens and providing them with options that worked best for them, such as condoms, intrauterine devices or sterilization, always seemed to be the intentions of both the colonial and the national governments. However, after India gained its independence in 1947, in times of national economic crisis, the nation took away individuals’ right to determine whether family planning was right for them. In 1976, an American reporter based in India said, “Family planning in India has nothing to do with individual choice on family size. In India, the term has always been a euphemism for population control — a tool designed to see that fewer children are born, not one meant to allow the family to maximize its own wants” (Novak, 362). In India, the intersection between personal and political choice is easily blurred, and all but disappears in times of crisis as the government removes individual choice from the equation through coercive measures. The following sections take a closer look at India’s policies, first under the British Raj, and then following the country’s independence in 1947, especially the dichotomy of economic gain for the

country and personal benefits for family in 1950-1970, to demonstrate that India did in fact lean closer to “population control” as opposed to “family planning.”

Historic Context of India’s Population Problem

Under the British Raj, the first formal census was conducted in India from 1867-1872. The results postulated a total population of about 206 million (Census of India 2018). For the first time truly aware of the exact mass of its population, British public authorities in almost all areas of India were concerned about the future of its population. Each state published its own census in the decade following the first census. During the 1870s, a greater part of the subcontinent was subject to a horrible famine that caused thousands to starve. Some British authorities subscribed to Malthusian theory, popular throughout India during this time, which posits that an unchecked population grows at a faster rate than food production (McLeish 1993). Many individual state reports were laced with Malthusian reasoning, arguing that “famine was becoming more common because the British had diminished many of the other direct population checks, certainly infanticide and possibly epidemic disease” (Caldwell 1998, 683). More specifically, the Bengal census report from 1878 stated that “British rule has established peace and security throughout the country, and so far has removed some of the causes which were at work to check the natural increase of the people” (Indian Census 1878). Other reports from the 1881 census reflected the effects of the famines throughout the 1870s and also introduced early suggestions of moral restraint, or abstinence, one of Malthus’s “preventative checks,” to keep the population at a sustainable level (McLeish 1993). For example, the report from the Baroda territory, in present-day Gujarat, said, “The preventive causes, namely moral restraint, or rather

compulsory restraint, have a greater operation in the cities and towns than they have in the districts” (Indian Census 1883a, 73). Similarly, the Madras report commented, “It may be accepted that when food is scarce there are fewer births; whether this is exclusively the result of prudence, and whether that prudence is deliberate or instinctive, it is not here necessary to enquire” (Indian Census 1883b). Low birth rates were more often than not solely attributed to the practice of abstinence, or moral restraint, and failed to acknowledge that other factors, such as malnutrition, can inhibit conception. Thus, it is clear that the British Raj was aware of the threats the growing population could have on the land, but by applying Malthusian theories and framing low birth rates during periods of famine as personal choice rather than the possible, and likely, inability of couples to conceive children, the British removed themselves from the responsibility of solving any population problems by claiming that the Indian people were practicing methods to control it.

The British began to express concern about the overall health and growth trajectory of India’s population in the last few decades of the nineteenth century, and this conversation continued into the first half of the twentieth century, until the British pulled out of India in 1947. Though aware that the growing population would likely have negative impacts on the subcontinent, the British held that the work being done to improve health conditions was of the utmost importance. A British missionary in India during this time claimed that “Britain certainly merits all praise from the world for the heroic world done here during the last century and a half and the marvelous results achieved. And she deserves the supreme gratitude of a great people whom she has raised out of the depths of semi-barbarism” (Jones 1899, 475). This illustrates the way the British viewed their role in India. They saw their efforts to control the population and

improve health conditions as something that India could never have accomplished without British intervention. Thus, nearing the end of the nineteenth century, the British Raj and Indian officials working in the government were in a precarious situation. Both were aware of the problems that could arise from the growing population, but each side blamed the other for this: the Indian government thought that the British had caused this problem by attempting to solve others, and the British thought that the Indians were ungrateful for all the help they had provided.

The late 1890s introduced a serious outbreak of the plague that ravaged the subcontinent for many years. The first outbreak of the bubonic plague in Bombay occurred in summer of 1896. The disease raged through the city for a month before any official notice was taken of it. In addition, because Bombay was a major port city and an epidemic would drastically impact trade, the British Municipal Health Officer refused to admit that the disease was the plague at all. He said, “In regard to the occurrences of cases of a peculiar type of fever, it may be mentioned that the type is of a suspicious character” (Hopkins 1897, 738). However, by fall of 1896, hundreds of lives a month were being claimed by the disease (Klein 1988, 741), and the dilemma could no longer be ignored. The British strongly felt that the Indian government was not doing enough to end the problem, but British efforts to help control the epidemic received serious backlash from citizens of India — riots ensued and thousands of citizens fled the city (Klein 1988, 743). In April of 1897, one British reporter said, “Though we cannot wholly remove from our minds a suspicion that we are oppressing, we must, we think, come to the conclusion that the risk is one which it is the duty of the Government of India to run...and that the necessary measures [to control the disease] must be carried out, if needful by force” (*The Spectator* 1897a, 470). By the end of 1896, the English knew for certain that rats, and perhaps even fleas and ants,

in Bombay were infected with the plague (*The Spectator* 1897b, 81). However, the Indian government still conceived the disease to be of airborne contagion, and their efforts were thus uselessly focused on disinfecting contaminated substances as opposed to working to eliminate pests such as rats and fleas (Klein 1988, 740). The British enacted diligent measures in an attempt to keep the disease at bay: search parties hunted out victims, forcefully segregated and quarantined infected persons, and even demolished infected places (Mushtaq 2009).

Citizens resisted and resented these official acts, perceiving government policies to suppress the plague as clashing with their cultural values, specifically related to caste and religion. For example, policies of hospitalization were often demoralizing for plague victims, as it forced women to break purdah and Brahmins resented being thrust among lower caste citizens (Klein 1988, 750). A British reporter from *The Spectator* noted that to many Indians, the idea of going to a hospital “was abhorrent, as residence in a hospital threatened, and did in truth imperil, a native’s caste if one was a Hindu; while if one was a Muslim he felt that the privacy of his home, the one social privilege for which he is ready to lay down his life, was forcibly broken up (*The Spectator* 1897b, 469). Riots broke out opposing hospitalization, and health officials were forced to modify the disease preventions measures and step away from previous measures of forced hospitalization and quarantine (Klein 1988, 739). However, officials were unable to contain the hordes of people fleeing the city, and the plague thus spread throughout the country. As the plague intensified, British officials adopted methods of voluntary inoculation which were similarly unpopular among Indian citizens, many of whom believed that doctors were actually the ones spreading the disease. Thus, when doctors showed up in rural areas to vaccinate

villagers, they were met with serious resistance and very few people volunteered to be vaccinated (Klein 1988, 749).

Despite efforts on the part of the British to control the epidemic, there were too many hurdles in the way to effectively slow the spread of the disease. The Health Ministry and Indian Medical Service's (IMS) disorganization, insufficient funds, and lack of man-power all contributed to the slow control over the epidemic. As a result, the IMS was very limited in what it was able to accomplish. The disjunction between British officials and Indian officials continued to prevail. American scholar Edward Washburn Hopkins pointed out a serious debate between the British and Indians: "The British press [was] full of complaints against the apathy of the natives, their inability to meet any crisis, their do-nothing policy as contrasted with their loquacity. On the other hand, the native press complains still more bitterly of British lack of sympathy" (Hopkins 1897, 747). Despite the fact that a ruthless epidemic was killing thousands of people, the British still felt that overpopulation was a less important issue, and one that could be solved, or at least diminished, by the plague. In an article from *The Spectator*, an English reporter said, "The Englishman is not, as an abstract thinker, at all desirous to keep masses of sickly Indians alive. He is painfully aware that the gravest danger which threatens India is overpopulation" (*The Spectator* 1897b, 469).

The plague continued to be a major issue through the first two decades of the 20th century, fluctuating throughout the years with death rates as low as .2 per thousand in 1897 and as high as 5.2 per thousand in 1907 (Klein 1988, 724). Natural immunization to the disease appears to have been more significant than any medical policies in lowering the death rates (Klein 1988, 755), and by the time World War I began, the plague had largely diminished in

severity. During the war, the British were otherwise occupied, and little dialogue on India's population exists from this time period. However, after the war, in 1919, the plague had finally died down and "the British Crown transferred responsibility for health and education to the Indian provincial governments" (Unger 2015, 484). Several British officials working in India nonetheless encouraged Indian officials to return its attention to the growing population. Although no measurably successful public health policies were implemented during this period, these decades were formative in introducing the idea of a population problem and sparking conversation among Indian health officials that would pave the way for future population policies, once the British had departed.

By the early 1920s, conversations about the population problem began to occur among several key British officials working in India. John Megaw, the Director-General of the Indian Medical Service who had served as a health officer in India for over 30 years, along with the census commissioner, J. H. Hutton, took note of the high birth rates and feared the future. These policy-makers understood that the population was stagnant only temporarily due to high mortality, and improvements in public health, though necessary and desirable, would decrease the mortality rate and cause the population to soar (Nair 2011, 234). Most significantly, it was argued by Megaw that this issue was one not just of population quantity, but population quality. By framing this problem through the lens of maternal and infant mortality, Megaw illustrated the tragic life cycle of young mothers in India who, malnourished themselves, gave birth at young ages to unhealthy infants (Nair 2011, 234), which introduced the idea that emphasis should be placed on lowering the birth rate. Though these arguments were founded in census studies showing India's growth trajectory and Malthusian theory which argued that India would soon run

out of natural resources to support its growth, the IMS struggled to get support from the British government to implement any policy changes. Megaw attributed the inactivity of the colonial government to the refusal of Indian leaders to ask explicitly for help in this realm. This relieved the British government from the responsibility of dealing with the high mortality rate (Nair 2011, 237). M. G. Hallett, the Home Secretary of the Indian Civil Service, “expressed how it would be very difficult and dangerous for the colonial government to step in and take an active part in measures of this kind given the social, religious, and political complications intertwined in such an issue” (Nair 2011, 228), which was the same argument the British used when deciding how to interfere during plague epidemics.

During the 1930s, British health officials rarely promoted medical birth control measures in India, and they were largely indifferent to the efforts made by Indian health officials to do so themselves (Samuel 1966, 51). The IMS was more in favor of “introducing educational reforms that would incorporate subjects of health, biology and sanitation in school curricula” (Nair 2011, 236). However, by 1935, the National Planning Committee of the Indian National Congress had begun to show interest in family planning and it announced support for family planning “on socio-economic grounds through self-control as well as by contraceptives” (Thapar 1963, 5). During the 1930s, the states of Mysore and Madras began to establish birth control clinics at state hospitals, and some medical schools in these states began to incorporate medical forms of birth control and contraception into their curriculums (Thapar 1963, 6). However, these efforts were conducted on a small scale and did not reach enough of the general population to be effective.

The beginning of World War II largely put a halt to British discussion about the population problem in India. Although no concrete policies were established by the British during this time, the work of the IMS under John Megaw introduced the notion of a population problem in India and helped lay the framework for family planning policies post-partition. By the early 1940s, Sripati Chandrasekhar, an Indian demographer who later became Minister of Health and Family Planning, began writing about and advocating heavily for family planning measures to be taken in India. He published several articles expressing concern for the rapid population growth occurring in India and looked closely at the sociological, economic and political reasons for India's population growth and he posited that India's growing population was due largely to the improvement of health measures, and the decrease in and control of famines and epidemics (Chandrasekhar 1943, 264-265). As a means of improving health, Chandrasekhar pushed the importance of increasing the literacy rate in India, and he suggested that a large percentage of the population was ignorant to the existence and availability of reliable contraceptives and proposes that educating the rural and lower-class and caste citizens is one of the primary ways to slow the growth of population. Because of the work of Chandrasekhar and the discussions it sparked among the Indian scholarly community, at the time of partition in 1947, India had the frameworks necessary to begin implementing family planning policies.

Post-Partition: Experimentation in the 1950s

In 1947, the British pulled out of India, and India and Pakistan formally divided. Through the partition, India decreased significantly both geographic size and population. India lost about 75 million people to newly formed Pakistan and another 1-2 million to massacres over

the divide of the two countries. India held its first census as an independent nation in 1951, four years following the partition. In the 1941 census, British India's population totaled 318 million. However in the 1951 census, independent India had a population of approximately 361 million. These numbers were staggering to scholars and demographers and sparked more fear about the growing population posing a serious threat to the country's future because it showed a significant increase, even though India also lost over 75 million during the partition. At this time, 83 percent of the population was rural (Census of India 1951), and due to improvements in public health and sanitation, the death rate was beginning to decline significantly (Agarwala 1960, 578). Following the 1951 census, the government appointed a Committee on Population Growth and Family Planning to suggest a family planning policy for the country. In fact, India became the first country in the world to implement a nationwide attempt to control population through governmental policy. The Committee urged family limitation, though the Minister of Health at the time, Dr. Sushila Nayar, protested that the country would ever be able to legislatively control the population (Samuel 1966, 53). During the early 1950s, leading government officials were more concerned with the country's economic development and did not see population control as a pressing matter, so family planning was neither heavily promoted nor well funded by the government. Thus in many ways, the 1950s was a decade of experimental family planning for India. Indeed, the Family Planning Commission spent most of its resources and funds during the first two Five Year Plans (1952-1956, 1956-1961) conducting surveys to gain a better understanding of what the citizens of India were interested in rather than promoting programs or enacting policies.

In its first Five Year Plan 1952 (1952-1956), rather than family planning, the government plan most heavily on rapid industrialization and socio-economic growth (Trow 1967, 36), as many government officials, including Prime Minister Nehru, felt that strengthening India's socio-economic growth was most important during this time. However, the government could not completely ignore the numbers of the 1951 census and the conversation it sparked among scholars. It was thus acknowledged by the Planning Commission in the first Five Year Plan that "it is necessary in the present context only to stress the fact that unless measures are initiated at this stage to bring down the birth-rate and thereby reduce the rate of population growth, a continuously increasing amount of effort on the part of the community will be used up only in maintaining existing standards of consumption" (Government of India Planning Commission 1951, 16). In other words, the government claimed that at this point in time, the population was not a big enough threat to warrant immediate action, but it warned that with continued growth, it would threaten standards of consumption in the future. Thus, the plan officially proposed that family planning be implemented in India, but on medical rather than economic grounds (Samuel 1966, 54). Because the authors of the five-year plan defined the growing population as a health dilemma rather than an economic one, it was pushed to the sidelines and received little funding; effectively positing it as an issue for a future generation to deal with, as opposed to an dilemma necessitating immediate action.

One of the first steps taken by the Ministry of Health during this time was to approach the World Health Organization (WHO), an agency under the United Nations, to help disseminate information to citizens about the rhythm method of birth control (Samuel 1966, 53). This form of birth control was promoted by government officials and the Minister of Health because it was

not in opposition to the still-popular stance of Gandhi, who opposed contraceptives on moral grounds (Samuel 1966, 59). It was also popular because it was of no cost to the government or to Indian citizens. The WHO sent an American doctor, Dr. Abraham Stone, to India “to help the government to establish five centers in which the rhythm method was taught to couples” (Chandrasekhar 1953, 322). However, the newly established Planning Commission in India was not confident in the rhythm method’s success and took these efforts a step further by recommending “planned parenthood involving the use of scientific contraceptive methods” in the first Five Year Plan (Chandrasekhar 1953, 322).

Under the Planning Commission, the Population Commission was established in the early 1950s to assess population problems and learn different views on population control held by the Indian population (Chandrasekhar 1953, 323). Several separate studies were conducted by the Population Commission, the United Nations, and Sripati Chandrasekhar to gauge the public’s interest in birth control and family planning. Most of these surveys gauged the interest of women rather than men. Chandrasekhar explained that mothers were surveyed more frequently than men because “they [were] the persons most intimately involved” in family planning (Chandrasekhar 1953, 324). Chandrasekhar surveyed mothers in Gujarat and Marathi, northwestern and rural regions of the subcontinent, and found that sixty-three percent and seventy-seven percent favored birth control, respectively, and nineteen percent and eighteen percent opposed any kind of family planning (Chandrasekhar 1953, 324). Similarly, a study conducted in villages in Uttar Pradesh, located in northern India, revealed that over sixty percent of mothers and about fifty-seven percent of fathers approved of birth control and were interested in learning family planning methods (Chandrasekhar 1953, 325). Thus, initial studies indicated a

significant amount of interest in birth control measures beyond abstinence and the rhythm method throughout India.

Although it was clear that there was little moral opposition, despite loyalty to Gandhi, on the part of the general public towards family planning, the Planning Commission under the first Five Year Plan faced many issues. For example, beyond having very limited funds, most birth control clinics were based in urban areas, despite over eighty percent of India's population being rural; between 1947 and 1953, seventeen birth control clinics were opened in Bombay alone (Chandrasekhar 1953, 327). As a result, primarily upper and middle class citizens had access to birth control. Chandrasekhar cited this as a huge problem, saying, "The families that are now most severely handicapped in terms of economic resources, health and education, are precisely those that are most poorly equipped to rear the nation's future citizenry" (Chandrasekhar 1953, 325). However, he also notes that bringing birth control to villages poses a problem as "villages are deficient in basic health and medical facilities, plagued by unhygienic conditions, insufficient running water, lack of privacy, illiteracy, ignorance, and above all extreme poverty" (Chandrasekhar 1953, 326), rendering the management of modern birth control methods challenging.

The second Five Year Plan began in 1956 and brought about more funding for family planning and a desire to implement more medical birth control methods. The rhythm method was seen as unsuccessful and was largely abandoned, its failure attributed to its complexity (Agarwala 1960, 587). During the late 1950s, test studies were conducted with hormonal pills to be taken on the 16th and 21st day of a woman's menstrual cycle. Doctors found that over half of the 272 women in the test either forgot to take the pills or took them on the wrong day

(Silverman 1959, 58). Literacy rates in rural areas were low, and many families did not own a calendar, which made these methods difficult. Surveys also showed that families did not want to spend for than five or six cents a month on contraceptives, so the government strove to cheaply manufacture condoms, foam tablets, contraceptive jelly, and other types of contraceptives that did not require the user to be literate (Agarwala 1960, 587). Two reporters writing in New Delhi for an American newspaper spoke with Dr. H. J. Bhabha, an atomic chemist in India, who said, “What India really needs is an anti-fertility chemical which could be added to the staple food — perhaps to salt, flour or sugar — and eaten every day. It would have to be highly safe, but it could be highly effective” (Silverman 1959, 58). Ultimately, this intrusive and authoritarian idea was not put into action, but it shows the extent to which some Indian scholars and officials were interested in controlling the population.

In 1957, there were only 147 birth control clinics in the county, only twenty of which were in rural areas (Agarwala 1960, 582). The target for the second Five Year Plan was to open 500 urban and 2,000 rural family planning clinics so that a clinic would be available “for every 50,000 people in the urban areas and for every 66,000 people in the rural areas” (Agarwala 1960, 582). By the end of 1959, the number of clinics had increased to about 1200, over half of which were in rural areas.

Notably, the second Five Year Plan also formally introduced sterilization as part of the family planning initiative, although sterilization had already been offered in some clinics since the early 1950s (Chandrasekhar 1953, 327). In 1957, about 12,600 men and women were sterilized, and that number more than doubled in 1958 (Agarwala 1960, 582). During this time, there were two proposed incentive programs designed to promote family planning via

sterilization: one that paid men to receive vasectomies, and another program paying women who received check-ups three times a year and did not get pregnant (Enke 1960, 1978). Although these proposed plans were not enacted during this time, they foreshadowed the future direction of family planning in India, where sterilization was incredibly coercive and rooted in nationalism.

By the end of the 1950s, it appeared that there was interest in family planning among both the urban and rural populations, though most of the surveys taken still involved women rather than men. Willingness to learn more about family planning methods was high, but surveys showed that many rural women were hesitant to use contraceptive methods or visit a clinic solely devoted to family planning because of a misconception that family planning only meant completely stopping childbirth, as opposed to spacing children (Agarwala 1960, 585). However, the Ministry of Health still felt confident that educational programs could win them over.

During the first two Five Year Plans, then, India viewed the population problem as a health issue and thus it had primarily been dealt with by the country's Health Ministry. From the perspective of the government, the Health Ministry in India was not associated with economic development, and because this was the primary focus of the first two Five Year Plans, not many resources were allocated to family planning. However, by the end of the 1950s, many leading government officials were beginning to understand that the population growth had serious economic impacts as well. For example, whereas in the past the population had been kept in check by years of famine or epidemics, the introduction of modern medicine no better controlled disease, leaving more and more mouths to feed, straining the country's resources (Silverman 1959, 53). Near the end of the decade, Prime Minister Nehru said, "It is not true that all of our

problems come from overpopulation. But unless overpopulation can be solved, solution of all our other problems will be meaningless” (Silverman 1959, 53). Through saying this, the country’s leader finally acknowledged how imperative controlling the population was. The issue was starting to be seen by the government as necessary to promote and sustain economic growth (Finkle 1971), a marked shift from the beginning of the decade. Overall, the first two Five Year Plans laid the groundwork for both economic growth and population control in India: organizational and administrative work for industrialization and agricultural development were strengthened (Amundson 1964, 91), the public’s interest in family planning had been gauged (Chandrasekhar 1953), and the government was prepared to move forward and begin implementing policies for population control.

Coercive Measures in the 1960s

The 1961 census in India showed that in only ten years India’s population had grown from the 361 million reported in the 1951 census to 438 million. This growth rate was quite high and sparked discussion among government officials about how the continual, rapid population growth would be handled. At this point, it was undeniably clear that high birth rates and increased lifespan paired with better public health and declining death rates had led to this rapid population growth, and this gap would only continue to widen as infant mortality fell (Amundson 1964, 88). Though these health improvements were undeniably good, the government was unsure of how to deal with their effects on population growth.

Prior to the 1961 census, scholarly articles and government reports about India’s demographic transition made it clear that officials were aware of this demographic gap and had

already begun planning to make legislative changes in the third Five Year Plan (1961-1966). When this plan was enacted in 1961, the government was undergoing a pivotal shift: whereas population control had been seen solely as a health issue in the decade prior, the government now viewed it through the lens of economic development. Moreover, after a decade of experimenting with birth control, the government was ready to start implementing family planning more concretely and on a larger scale. Under the third Five Year Plan (1961-1966), the goal was to reduce the birth rate from 41 per 1,000 to 25 per 1,000 (Finkle 1971, 271). Thus, the 1960s sparked an acceleration in family planning efforts and funding. The Planning Committee recommended extending birth control clinics throughout the country as many rural areas still lacked access to clinics. The Committee also recommended expanding the types of birth control available. They suggested “extending facilities for voluntary sterilization, legalizing abortion, mass importing cheap contraceptives, promoting intensive research on fertility control and providing economic incentives for those who limit their families” (Samuel 1966, 56). In fact, only a few of these were put into action during this decade. New methods of birth control, such as the intrauterine device and hormonal pills, were tested and introduced, free and cheaper options were provided, and the idea of limiting a family’s number of children became more widespread through mass media and propaganda tactics.

One of the largest setbacks to implementing the Committee’s recommended actions can be attributed both to a shortage of doctors, particularly female doctors, and to the fact that medical schools in India did not train doctors in family planning until the late 1960s. Thus, although the country added thousands of new birth control clinics during the second Five Year Plan (1956-1961) and Indian medical schools graduated tens of thousands of new doctors each

year, medical family planning techniques were not added to medical school curriculums until the latter part of the decade (Trow 1967, 36). There was clearly a gap between the government's plan and actions being taken towards achieving this plan by services working in the field. Again, Sripati Chandrasekhar emerged as a prominent voice on this topic and argued that administration at most levels was run mostly by men "who have been trained to be proficient in old and outdated methods, unsuited to the demands of a modern industrializing economy in a changing world" (Chandrasekhar 1968, 147). Up until the mid-1960s, most family planning work was limited to government doctors. However, by 1968, private doctors were "successfully being brought into the family planning program on the basis of a mutually agreed payment" (Chandrasekhar 1968, 149). The government offered to pay doctors up to 40 rupees per sterilization procedure in addition to stipends of 100 rupees per month for medical students who promised to serve the family planning program for a certain period of time after graduation (Narain 1968, 7). As of 1968, around 1,000 students had agreed to this program.

Because of this shortage in doctors, the Family Planning Program created mobile clinics and camps to reach people living in rural areas and adopted what was referred to as a "cafeteria approach" to offering birth control, in which three to four different methods of birth control and allow the patient to choose which they preferred: sterilization, intrauterine contraceptive devices (IUDs), condoms, and in some cases, the hormonal pill (Chandrasekhar 1968, 142). In April of 1968, there were over 7,000 static clinics in India and 754 mobile clinics where family planning advice and services were available (Narain 1968, 7). Though they offered several types of birth control, mobile clinics primarily performed sterilizations or inserted the newly introduced IUD, called the Lippes Loop. Mobile clinics helped boost implementation of these types of birth

control considerably, as rural areas that had never before been reached by clinics finally had access to family planning resources (Narain 1968, 4).

By the late 1960s, sterilization in India equaled roughly 50 percent of all sterilizations conducted throughout the world: in 1968 alone, 1.8 million sterilizations were performed (Narain 1968, 3). Shortly after Sripati Chandrasekhar was appointed Minister of Health and Family Planning in 1966, he announced that he favored the idea of compulsory sterilization for all fathers with more than three children,” and he suggested giving a “transistor radio to every man voluntarily undergoing a vasectomy” (Trow 1967, 35). With his encouragement, the procedure increased in popularity, and sterilizations were performed everywhere from clinics to train stations all over the country. The average age for sterilizations was 32 years old, but Zalin Grant, an American reporter working in Benares noted cases in which young boys were pushed into having the procedure done without understanding its permanence (Grant 1969, 15). Several vasectomy clinics were set up in train station in Bombay in 1967, with over 6,000 operations performed in September of 1967. In an article published in *The Reporter*, G. W. S. Trow said, “The railway station centers have raised eyebrows. They are small and inelegant and often not quite clean” (Trow 1967, 36). Promoters stood outside the railway station and were paid ten rupees for every person they were able to persuade to receive the operation (Trow 1967, 36).

In 1965, the Lippes Loop intrauterine contraceptive device was introduced to the market in India after several years of testing and pilot projects in India (Narain 1968, 4). Between 1967-68, the rates of IUD insertion were similar to the total rates of sterilization in several states. For example, in 1967-68, Punjab had an IUD insertion rate of 7.6 per thousand population, and Maharashtra had a sterilization rate of 7.3 per thousand during the same year (Narain 1968, 4).

However, the IUD program's success was short-lived. In many cases, because of under-staffing in clinics and the swiftness with which mobile clinics moved through villages, "necessarily medical procedures such as pelvic examinations and follow-up appointments were often bypassed" (Grant 1969, 15). Women frequently complained of bleeding and pain post-insertion, and unfounded rumors spread that the loop caused cancer or death (Taylor 1970, 114). These rumors were frequently spread by village midwives who gained business from performing illegal abortions (Narain 1968, 4). As a result, many women removed the loop on their own, often shortly after having it inserted (Trow 1967, 36).

Condoms, the simplest form of birth control to implement, became the most popular form of birth control during this decade, with over a million users and about 50 million condoms used each year (Narain 1968, 5). Hospitals and family planning clinics made condoms available either for free or very cheaply. In 1967, the US Agency for International Development (USAID) stepped in to help make condoms even more widely accessible and shipped nearly 200 million condoms to India and helped finance a condom factory in the state of Kerala (Grant 1969, 15).

Indeed, although several countries and international organizations showed interest in India's family planning efforts, the United States was especially eager to help. Alarmed by the rising population numbers, the U.S. stepped in to offer financial support in several different ways. In 1965, Lyndon Johnson advocated in the State of the Union for the United States to "seek new ways to use [their] knowledge to help deal with the explosion in world population and the growing scarcity in world resources" (Johnson 1965). After this speech, the US Agency for International Development's budget for birth control increased from \$2 million a year to \$50 million a year, with India receiving the largest percentage of these funds (Grant 1969, 15).

Similarly, the Ford Foundation, UNICEF, the Peace Corps and the World Health Organization (WHO) provided assistance in different ways. Some US scholars and demographers, however, criticized the nature of the United States's involvement in India's family planning efforts because of the "gimmicky nature" of their marketing techniques and because some felt there was a clear lack of guidelines to support their agenda (Grant 1969, 16).

To continue to raise awareness for the family planning agenda, India adopted creative advertisement campaigns. Press, radio, television and movies, as well as music and plays were used to promote and introduce the idea that a small family is more desirable than a large one. For example, a simple approach used was to show advertisements depicting a family of four with smiling faces and a slogan that read 'Two or three children — enough', along with the Family Planning Program's logo and locations of nearby clinics (Chandrasekhar 1968, 141). In areas where mass media wasn't readily available to the public, wall paintings, match-box labels, postage stamps, and bus and rickshaw ads were used as well (Narain 1968, 9). The United States' organizations and agencies supporting India, however, found their tactics to be insufficient, so much so that the Ford Foundation paid to have an elephant plastered with birth control posters and marched it through villages to spread the message that small families are the new normal (Grant 1969, 16).

One of the emerging foreign critiques of the family planning efforts during this decade was that the program was state-run, which meant that though the program was sponsored and funded by the central government, it was implemented by individual states (Narain 1968, 2). In theory, this seems like a good option as implementation can be conducted on state-by-state basis as opposed to being completely run by the central government, meaning that more time and

attention could be given to all areas of each state. However, because family planning was categorized legislatively as a health dilemma and under the Indian Constitution the states were responsible for health issues, the central government could provide funds for the states to implement family planning, but it could not require states to implement these programs (Finkle 1971, 276). Consistency in implementation thus became a problem throughout the country, especially in trying to provide care to rural areas. In many states, policy workers avoided working in rural areas because they were frustrated by “villagers’ low education levels, cultural traditions, and resistance to social change” (Taylor, 106). Thus, policy makers tended to “turn their attention to the cities, where it was easier to work, in the hopes that urban influences would seep out into the rural areas” (Taylor, 106). However, with over 80% of India’s population living in rural areas, focusing on rural areas was imperative. The focus on urban areas was misguided, but the idea that family planning and birth control were of national importance simply did not make sense in rural areas like it did in cities, which frustrated policy makers and public health workers who had targets to reach.

The 1960s was a complicated but productive decade for family planning in India. The government began to see it as essential for economic development, a necessary shift from seeing it solely as a health issue. However, the foreign interest and aid received from foreign organizations and agencies revealed that the rest of the world was incredibly invested in India’s population problem — possibly more than India was itself. At the end of the 1960s, studies from various parts of the country revealed that about 70 percent of urban couples and between 50 and 70 percent of rural couples were in favor of family planning. These studies also revealed that many people wanted only three children but often have more (Narain 1968, 9), which shows that

there was a distinct gap between desire and action among couples in India. Couples were interested in trying family planning methods but very few actually were. One of the biggest gaps overlooked by policy-makers during this decade was their understanding of the motivation of users to use birth control. Obviously, most contraceptive techniques require the services of medical personnel. However, they also also require a “high and sustained level of motivation on the part of the user” (Finkle 1971, 279). For users to be motivated, they need to be educated to understand the long-term effects and goals of the project. As surveys showed, many people were interested in family planning. However, “in its implementation, the program relies on the motivation of citizens in order to be successful” (Narain 1968, 1). The issue with this is that the program expected and needed citizens to be motivated, but it did not supply adequate information and services to sustain their motivation. People living in rural areas had no reason to care about an overpopulation problem in India. They needed to be persuaded that a small family was better for them personally. However, despite efforts to educate citizens, the lack of resources, short supply of doctors, and gaps in advertising made it difficult for citizens to learn about and feel safe under the program, and it felt irrelevant to many. The program’s oversight on this part can be attributed to the way it calculated success. Rather than focusing on the quality of the program and the benefits it offers citizens, the program was interested solely in the sheer quantity of people who utilized the program (Grant 1969, 16). In other words, simply educating a citizen about the benefits family planning offers was not considered a success and not considered useful unless the citizen chose to use a form of birth control. However, the decade ended on a hopeful note: there were more methods available than ever before, and the Indian

government, the general public, and the rest of the world seemed invested in implementing family planning measures in India.

Fear, Force and Sterilization during the 1970s

As India entered the 1970s, its annual population increase was about 12 million a year, “equal to the entire population of Australia” (Singh 1976, 309). In the 1971 census, India had a population of around 550 million. The fourth Five-Year Plan (1969-1974) was several years underway at the time of the census, and the cafeteria approach of disseminating birth control to couples was still being widely used (Chaudhry 1989, 104). The fourth Five-Year Plan marked an increase in urgency for family planning in India: mass vasectomy campaigns and camps were held throughout the country, and most notably, under this plan, the Medical Termination of Pregnancies Act was passed in 1972, which made abortion legally available, and often free of charge, in select hospitals and clinics across the country (Chaudhry 1989, 104). Under Prime Minister Indira Gandhi, the government continued to push family planning and encourage the small family norm as a means by which economic development could be reached.

In April of 1975, the Central Family Planning Council “passed a resolution that recommended a reinvigorated family planning program” (Williams 2014, 482), claiming family planning as an essential part of their strategy to achieve socio-economic development. This plan included “a ‘more scientific’ system of targets, an enhanced scheme of incentives and penalties for ‘indifferent family planning workers,’ and extra compensation for [those willing to undergo] sterilization” (Williams, 482). Posters advertised these incentives, claiming that men would receive Rs. 75 for a vasectomy, women would receive Rs. 75 for a tubectomy, and “motivators

would receive Rs. 10” (Tarlo 2003, 68). Just months later, in June of 1975, Prime Minister Indira Gandhi declared India in a state of emergency, launching a period of authoritarian rule that lasted until March of 1977. Gandhi claimed that her reason for declaring emergency was to protect the country’s national economic stability; however, this plan seemed to quickly shift towards focusing more on economic development as she “announced a twenty-point economic program, which included measures to control the price of essential commodities, tackle rural indebtedness, and increase production” (Williams 2014, 472). Although the plan did not include any mention of family planning, the newly appointed Minister of Health and Family Planning, Dr. Karan Singh, announced in a speech to parliament in August of 1975 that family planning had not been included in the twenty-point program “not because it was unimportant, but because it was too important to be listed as one of the points” (Williams 2014, 482). Following this proclamation, the country’s family planning program was intensified, so much so that “‘Emergency’ became a synonymous with ‘sterilization’” in India (Tarlo 2000, 242).

In April of 1976, Dr. Karan Singh announced an eighteen-point National Population Policy. Expanding on the policy introduced in 1975, this policy increased the monetary compensation for sterilizations and approved the coercion of government employees to undergo sterilization (Singh 1976). This plan also included suggestions to raise the marriage age for women to 18 as well as argued for the importance of improving female literacy rates, claiming that both of these efforts would have a significant demographic impact, as several studies found “a direct correlation between literacy rates and fertility” (Singh 1976, 311). However, the plan said that “simply to wait for education and economic development to bring about a drop in fertility is not a practical solution...the population growth is so formidable that we have to get

out of the vicious circle through a direct assault upon this problem as a national commitment” (Singh 1976, 310). In application of this statement, the long-term aspects of the policy, such as improving literacy rates and raising the marriage age, were “overshadowed by the short-term gains and statistical results afforded by simply sterilizing people” (Scott 2015, 79). Thus, though Singh made mention of some of the prevailing health dilemmas, such as maternal and infant mortality, he bypassed the importance of these issues and instead situated the policy alongside Gandhi’s economic plan. This thus set the precedence for family planning, with a specific emphasis on sterilization, under the Emergency.

The Family Planning Policy also posited the importance of India adopting small-family norms. The policy argued that it is imperative that all states work to “motivate citizens to adopt responsible reproductive behavior both in their own as well as the national interest” (Singh 1976, 311). A common theme during this time period was that family planning was both a nationalistic and personal effort. However, this notion was much more multi-faceted in adoption than in theory. Although by this point there was widespread awareness that the government thought two or three children per family was enough (Taylor 1970, 112), many cultural and religious tradition required families to have multiple children — sons are needed for Hindu funerary traditions, and rural farmers often saw economic benefit from having more children (Novak 1976, 364). Childbirth also had many benefits for women. A young wife in a village “receives favored treatment only when she is pregnant. For her, pregnancy, babies, and motherhood are God-given” (Gulhati 1977, 1303). In addition to challenging the desires of mothers, the development of small-family norms also faced the issue that male children were often much more highly regarded than female children. In the development of small family legislations, many states took

this into account and included exceptions to the rules limiting families to two or three children. For example, the governments of Tamil Nadu and Haryana set down that government employees must limit their families to only two children, unless both children are of the same sex, in which case they may have one more child before accepting sterilization (Scott 2015, 80).

Perhaps most significantly, the Family Planning Policy allocated the responsibility of carrying out sterilizations to individual state governments. Singh admitted that, administratively, the central government was not prepared to implement a national program of compulsory sterilization; however individual states, if equipped with adequate facilities and funds, were free to pass compulsory sterilization legislation (Singh 1976, 312). By early 1977, the state of Maharashtra was in the process of passing a law for the compulsory sterilization of all men with three living children. Under this legislation, failure to comply would result in forcible sterilization under arrest” (Gulhati 1977, 1304), and women with three living children who became pregnant were subject to termination of the pregnancy via abortion if the mother is less than 12 weeks pregnant or “imprisonment and a fine of Rs. 500 unless the miscreant [was] willing to be sterilized and have the pregnancy terminated” (Novak 1976, 362). Similarly, Punjab and Haryana passed ordinances denying basic amenities to government employees who did not undergo sterilization after having two children (Gulhati 1977, 1304), and basic government services, such as driver’s licenses, bank loans, and ration cards were often denied to regular citizens (Novak 1976, 363).

How one was affected by these coercions largely depended on social status and rank. Through ethnographic research among people who had lived during the Emergency, anthropologist Emma Tarlo found that deferral was often a possibility for those who worked

higher up in the government: those higher up could find someone else to be sterilized in their stead, whereas those in lower positions had no other option than to undergo sterilization procedures (Tarlo 2003, 149). There was also the common dilemma of deciding whether the husband or wife should be sterilized — in many cases, men underwent the procedure, but at other times it was women who had the procedure done either because “their husbands were unwilling or...because they wanted to preserve the strength of the family breadwinner” (Tarlo 2003, 171). In 1976-1977 in the state of Maharashtra, far more women were sterilized than men, despite health official’s preference for vasectomies. During these years, the state reported “518,781 vasectomies compared with 943,699 tubectomies” (Scott 2015, 74).

Singh warned in his 1975 speech to parliament that “while the family planning program was voluntary, if the people of India did not act voluntarily, ‘the House would have no option but to pass whatever legislation may be necessary’” (Williams 2014, 483). Family planning, with a specific emphasis on sterilization because of the populace’s resistance to other forms of birth control (Novak 1976, 362), was placed in conjunction with Gandhi’s twenty-point economic plan through propaganda that expressed that the control of reproduction and population growth was a “battleground in the war against poverty” (Williams 2014, 482). Family planning thus became an issue of nationalism — supporting family planning was supporting the country and its measures towards eradicating poverty and promoting socio-economic growth. In order to boost participation in family planning, the Ministry of Health strove to generate a sense of “healthy competition” among states (Williams 2014, 484). Sterilization targets were set for states, and prizes were awarded to family planning workers and government bodies alike for “best family planning work” or “best family planning center,” with cash prizes of up to Rs. 5,000 (Williams

2014, 484). In these ways, rates of coerced sterilization rose, especially among government employees. In many ways, sterilization was a “forcible deal needed to purchase basic amenities” — people were required to produce certificates indicating that either the husband or wife of a family had been sterilized in order to keep their jobs, homes, and health care (Scott 2015, 71).

After almost two years under the Emergency, Gandhi called for political elections in March of 1976. Gandhi lost to the Janata Party, and by May of 1976, Justice J. C. Shah was appointed to inquire into the abuse of power and excess force implemented throughout the Emergency (Williams 2014, 476). Throughout all of this, however, Indira Gandhi maintained that there were no forced sterilizations in India, and legally she was correct (Novak 1976, 364). There were no laws in place that supported the coercion and persuasion that was taking place, and the state laws limiting a family’s number of children had not officially gone into effect — they were sent to the central government for review, but the government was in no rush to pass them because the laws had “created the proper atmosphere” to coerce citizens into being sterilized (Novak 1976, 362). The Shah Commission published its findings in 1978, and as it was solely a fact-finding commission, and showed that legally Gandhi had done nothing wrong, the subject was put to rest.

In this decade, family planning was framed as a way to solve national economic issues, and as a result, politics overpowered the individual’s right to determine whether or not family planning, an undeniably personal choice, was the right decision for them. Ruthless coercive tactics were adopted and people’s jobs, homes, and even the education of their children were threatened if they did not get sterilized to support national efforts. The government showed,

ultimately, that its policies of family planning were rooted in national interest and had little concern for the values of its citizens.

Revising the Plan: Policy Focus in the 1980s-2000

In 1980, the Ministry of Health and Family Welfare commissioned an All-India Planning Survey, conducted by the Operations Research Group, to gauge the acceptance, attitudes and understanding of birth control among Indian citizens, as well as to learn about desired family sizes. The survey covered the entire country except the Assam State and gathered information from 34,831 married persons, roughly half from urban and half from rural areas, and revealed that 35 percent of eligible couples were practicing some form of family planning in 1980, 4 percent were past users, and 60 percent had never used any method (Khan & Prasad 1985, 313). Roughly 80 percent of respondents felt that “a small family is a happy family,” reaffirming the spread of small family awareness, desirability, and acceptance from the previous two decades. However, what constitutes a small family differed based largely on region, socio-economic status, and sex of children. For example, about 80 percent of urban residents considered three or fewer children a small family, whereas 60 of rural respondents said the same. In addition, 82 percent of couples who wanted more than three children said it was in order to achieve their desired sex ratio (Khan & Prasad 1985, 314).

The results of the survey revealed several large gaps in family planning efforts in India during this time. Firstly, there was a significant gap between percentage of birth control users in urban and rural areas. About 51 percent of urban couples surveyed used some form of birth control, whereas only 31 percent of rural couples used some form. This showed that family

planning efforts were still more concentrated in urban regions. Secondly, a high number of respondents expressed that they did not fully understand how contraceptive methods worked. Between 40 and 45 percent of couples who had heard of permanent methods, the IUD, and the pill still had no idea how to use them, and less than half of all respondents did not know how sterilization was performed, despite it being the method adopted by 63 percent of family planning users (Khan & Prasad 1985, 315). Respondents also reported only adopting family planning methods after they were finished having children, as opposed to using birth control to space their children. Finally, a lack of spousal communications had a large impact on matters of family planning. In 1980, only 35 percent of couples reported discussing family planning with each other, and most couples confirmed that the husband makes the final decision on family planning matters (Khan & Prasad 1985, 319). Though this number had increased from 19 percent in 1970, this still revealed a significant gap in communication between husband and wife.

In comparison to a similar survey conducted in 1970, the findings of the 1980 survey were encouraging and indicated that after almost thirty years of family planning efforts, “India’s family planning program [was] succeeding — albeit, perhaps slowly — in spreading knowledge and increasing contraceptive prevalence throughout Indian society” (Khan & Prasad 1985, 320). The results of this survey revealed that the misunderstandings and failures of family planning was an issue of policy implementation and education as well as an issue of personal agency and choice. Couples were not adequately being informed by doctors and policy makers about different family planning methods available and how to use them, but they also were not communicating with one another to determine what method was best for them.

Shortly following this survey, the 1981 census results revealed that India had reached 683.8 million people — a 135.6 million person increase from the 1971 census. The results of the census coincided with Indira Gandhi's reelection as Prime Minister of India, and her inaugural speech in September of 1981 focused heavily on family planning. She expressed great shock at the population numbers from the census and proclaimed that “the time [had] come to revamp and revitalize [India's] family planning program, to re-examine existing schemes for information, communication, and motivation” (Gandhi & Shankaranand 1981, 558). Gandhi placed family planning and economic development side-by-side, claiming that the two depended on one another to be successful, and she planned to encourage their success by expanding education — women's, specifically — and continuing to promote voluntary family planning throughout the country. As in the previous decade, family planning was again declared by Gandhi to be a national effort. She said, “Family planning must become a people's movement — of the people, by the people, for the people — only then can our hopes be realized” (Gandhi & Shankaranand 1981, 559).

Following her inaugural speech, Parliament released the *New Delhi Declaration on Population and Development*. This declaration, similar to the National Population Policy released by Dr. Karan Singh, Minister of Health and Family Planning, in 1975, posited family planning as a basic human right and as “the highest priority in [India's] national life” (Gandhi & Shankaranand 1981, 561). Whereas Dr. Singh's policy recommended certain actions, this declaration called the strict enforcement of actions such as marriage registrations to enforce legal marriage ages, differential structuring of incentives for male and female sterilization to “encourage more responsible sharing of contraception between sexes,” and for population

education to be incorporated into the country's formal education system (Gandhi & Shankaranand 1981, 562).

The rest of the decade was marked by more nationalistic efforts to promote family planning. The government's new policies were similar to those introduced in the previous decade but it was explicitly clear that all choices on the part of citizens were voluntary and in no way forced. Most notably from this decade, studies revealed that the "total number of births averted up to 1986-87 exceeds 85 million, and the cumulative total of sterilizations performed since the inception of the program in 1956 exceeds 48.8 million" (Chaudhry 1989, 117). Finally, after over thirty years of trying to control the population, it appeared that the policies, though they may not have always been ethical, had not been in vain.

In the 1991 census, the population of India totaled 843.9 million — almost double what the population was in three decades before, in the 1961 census (Dutt & Sen 1992). By this time, India had the second largest population in the world, falling just behind China, whose population had just passed 1 billion. Up until the early 1990s, the Family Planning Committee was dominated by demographic goals and measured its achievements in terms of how many couples accepted sterilization (Khan & Prasad 1985; Visaria et. al 1999). In an article published by *Economic and Political Weekly* in 1992, Debarar Banerji, professor in the Center of Social Medicine and Community Health at Jawaharlal Nehru University, heavily criticized the Indian government's family planning efforts. He claimed that the government's methods of setting sterilization targets for sectors made people "targets of their own governments" and showed the "willingness of the political leadership to at ruthlessly against its own people" (Banerji 1992).

This clearly revealed that members of the Indian academic community were displeased with the government's nationalistic tactics.

In the eighth Five Year Plan, enacted in 1992, the government acknowledged that such target-setting allowed for little innovation on the part of the program and little choice on the part of the citizens. In 1996, the Indian government officially shifted from being a target-driven program to a program that focused more directly on maternal health and family needs (Visaria et al 1999, S44). This meant that targets would no longer be set centrally, thus giving local clinics and health centers the opportunity to adapt to the cultural desires of their citizens. The family planning program in India thus became centered less around nationalism and more focused on individual reproductive health provided by health care workers who were more attuned to the values and desires of a specific community, which was both a more democratic approach as well as one grounded in cultural relativism.

In the latter part of the decade, the focus made a pivotal shift as India acknowledged a sharp increase in number of citizens infected by HIV/AIDS — by June of 1998, just under 1% of the population was infected, making India the have “the highest number of HIV infected people in the world” (*India Business Insight* 1998). Articles in newspapers and magazines expressed a great urgency in promoting reproductive health through safe sex education and promotion of condom use. In the past century, India had come full circle from the 1890s when population control was rooted in improving public health during the plague epidemic. Once more, a serious epidemic was threatening the lives, and quality of life, of millions of the country's citizens. In the 100 years since the government of British India had first posited India's population problem, the country still hadn't figured it out.

Nationalism and Population Policies to the Present

In today's world, population growth continues to be a pressing issue, and there has been an increase in dialogue among both academic communities and the media about the dangers faced by voiceless populations in matters as personal as family planning. Even after half a century of family planning policies, this continues to be a topic of discussion in India. In the 1952, India became the first country in the world to have a national family planning policy, but the country is still revising and revamping the program to find a method that works best. The country spent its first two Five-Year Plans (1952-1956, 1956-61) experimenting with different birth control methods and gauging public interest in the program. However, because the country had just gained its independence, most of the government's focus was on socio-economic growth and population control was designated a health issue, and because family planning is about personal quality of life, it was not viewed as important to building the nation. In the 1960s, the program was finally kickstarted: thousands of health centers and clinics were opened across the country, and the government realized that its family planning efforts would be much more successful if population control was viewed as an economic issue. In the 1970s, family planning culminated into a national economic issue as the country entered into a state of emergency under Indira Gandhi. Personal choice was no longer an option as millions were coerced into being sterilized to help the country improve its socio-economic standing. In the 1980s, India reevaluated its policies from the previous decade and tried to rebrand family planning as a voluntary action for citizens that they can do for themselves, as opposed to being imposed in a top-down system by the government. Finally, from the 1990s to the present, India comes almost

full circle to where it was in the 1890s under the British Raj. In the end of the nineteenth century, horrible plague outbreaks sparked concern over the future of India's population. Similarly, in the 1990s, the AIDS epidemic jumped to the forefront of the news in India, and once more, population control became a public health dilemma as the country clambered to control the spread of STIs.

On June 11, 2000, India reached a population of 1 billion. However, as several reporters commented, this was no cause for celebration. In the *Yakima Herald-Republic* in Washington state, guest reporter from India, Sawraj Singh, said this number “reflects the failure of our policies” and “the population explosion in the Indian subcontinent is not only a major crisis for the subcontinent itself, but actually should be a cause of concern for the rest of the world, particularly for the developed countries” (Singh 2000). By 2024, India is expected to have a population larger than China's.

Though family planning policies began being implemented decades ago, this topic is still of great relevance in India today as top-down decisions continue to be made. Much can be learned about the importance of cultural relativism from understanding the gaps in India's approach to family planning and population control. Specifically, an individual's beliefs and values should be understood through the lens of the individual's own culture. Adopting and implementing national policies for a country as vast and diverse as India simply does not work. This project reveals that it is not enough to have laws or technology if you cannot find a way to get people to see value in their personal lives for family planning. This issue is larger than laws and technology — it ultimately comes down to family dynamics, class dynamics, and personal relationships. Women can't use the rhythm method if they don't own calendars, and couples

can't take pills every day if their mother-in-laws strictly prohibit family planning measures of any sort (Karra et. al 1997). Family planning is a deeply personal issue that has been treated as a national economic issue for the past century in India. Before long-term, sustainable and ethical changes can be made, this has to be realized.

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