Bodies in Poverty

Family Planning and Poverty Removal in India

SAYANTANI SUR

How and when did family planning become a blanket term for population control as well as poverty alleviation in India? How did contraception emerge as an economic virtue in family planning discourse, instead of a corporeal one? This paper interrogates whether poverty was the reigning theme in family planning, or the body, as the state—especially during the Emergency—moved from indirect interventions on the bodies of the poor through sterilisation programmes, incentives and disincentives, to the elimination of the poor themselves by demolishing their homes. When material poverty flowed into bodily poverty and transformed into an identity, Garibi Hatao became Garib Hatao.

I would like to thank the anonymous referee for the insightful comments and suggestions. Special thanks to Prachi Deshpande and Manabi Majumdar for their invaluable contribution in shaping this article.

Sayantani Sur (*sayantani2006@yahoo.com*) is a doctoral fellow at the Centre for Studies in Social Sciences, Kolkata.

In 1971, the *Yojana Patrika*[1] printed an advertisement on family planning that featured a conversation between two men—a practitioner of family planning and a non-practitioner. One man says to the other, "Tell me, brother, how can you live so well while I can hardly make both ends meet?" The other man replies, "I have few mouths to feed—only two children." The first man confesses, "My wife has a baby every year! What should I do?" To this, the other replies, "Do what I do—use Nirodh[2]." The tagline of the advertisement reads, "A family you have planned is a family you can provide for."

India's family planning programme, officially launched in 1952, was part of the First Five Year Plan (1951–56). In the 1960s, the tempo of the movement began to accelerate as condoms, loops, intra uterine devices (IUDs) and contraceptive pills were marketed widely and family planning was publicised through advertisements. "Family planning" soon became a blanket term for population reduction as well as economic growth and poverty alleviation. The advertisement described above exemplifies how poverty and economic hardship were linked with family planning, and how contraceptives became the immediate prescription for the removal of poverty. Official family planning advertisements portrayed an idea of inadequacy and overall distress as the result of failure to practise family planning. Contraception, in effect, emerged as an economic virtue instead of a corporeal one.

This paper examines the link between the economic and the corporeal in the discourse of family planning in India. While scholars have pointed out the classist nature of family planning in the 1970s and how it targeted the poor, only a few have tried to understand the conceptualisation of poverty within the postcolonial regime of "planned" development. This paper therefore interrogates the genesis of the idea of poverty and the poor within family planning discourse in India. The corporeal is also crucial in this context, as in the late 1960s and 1970s, under Indira Gandhi's electoral agenda of *Garibi Hatao* (poverty removal), the state attacked the bodies of the poor through interventions that ranged from disincentives to slum demolition and forced sterilisation. When material poverty flowed into bodily poverty and transformed into an identity, Garibi Hatao became Garib Hatao (removal of the poor).[3] This paper examines the confluence of the economic, social, bodily and environmental forms of poverty. In effect, it explores the projected relationship—altercation, almost—between poverty and the body, to ask: is poverty the reigning theme in family planning, or the body? It traces

how poverty elimination was transformed into the elimination of the poor themselves.

I first locate the genealogy of poverty within family planning, and track how both emerge as part of the same rationale known as the "Plan." I then locate and consolidate "the body" within family planning, interspersed with ideas of poverty, first through "indirect" economic measures, and then through more "direct" interventions such as slum demolition. Poverty itself shuttled between various kinds of bodies—of Muslims, lower castes, leprosy patients and the poor. It was during the Emergency (1975–77) that state interventions made such violent and insidious inroads into the domain of the intimate that it brought down the Congress government in the Lok Sabha elections of 1977.

For scholars, the crux of the debate lies in whether coercive family planning methods were adopted even before the Emergency or whether coercion was new to family planning, adopted only during the Emergency. Most scholars adopt the continuity versus change thesis in defining the "excesses" of family planning during the Emergency. Within this thesis, the debate has often moved between voluntarism versus coercion, and sometimes the amount or nature of coercion. It was the Shah Commission Report,[4] published in 1978, that first characterised the Emergency in terms of "excesses." Commissioned and conducted by the government that took over after Indira Gandhi—the Janata Party—the report was in some ways a political tool. Michael Henderson (1977) believes there was a sharp break that points to the voluntary nature of family planning prior to the Emergency. Marika Vicziany (1982; 1983), however, argues that family planning in India was never genuinely voluntary and whoever accepted sterilisation did so under some kind of coercion. For Vicziany, therefore, there was continuity not only in terms of the socio-economic profile of the sterilisation targets but also the methods used; only the introduction of disincentives and violence were new factors. Another continuity theorist, D Banerji (1976), contends that coercive family planning existed in India before the Emergency; there had simply been an escalation in violence since the 1960s, owing to the government's antenatal policies. However, Matthew Connelly (2008) has noted a break in the orientation of family planning owing to Sanjay Gandhi's rise to power. D R Gwatkin (1979) has also indicated that it was during this period that there was an emergence of political will in family planning, which made all the difference. The history of the postcolonial state, or even the history of family planning, seems to find a climax in the 1970s, during the Emergency. Gwatkin carefully explains how political will was translated through public policy processes and political and administrative channels. Therefore, in spite of claiming that it was a period of continuity, these scholars have defined an element of "change" during this period; if, for Gwatkin, it was political will, for Banerji it was the escalation of violence.

This "political will" in family planning, adopted through the electoral agenda of "Garibi Hatao," soon transformed into "Garib Hatao." Gangadharan et al (1978) first pointed to the elimination of the poor. They write, "In the name of beautification, the poor were being evicted. 'Garibi Hatao' was getting a new interpretation: eliminate the poor" (Gangadharan et al 1978: 33). In recent times, Rebecca Williams has rightly pointed out that it was during the Emergency that Garibi Hatao transformed into Garib Hatao. For Williams, Garibi Hatao meant not "an attack on the roots of poverty but an assault on the bodies of the poor" (Williams 2014: 471). Williams, however, does not elaborate on the process. Instead, she provides a brief sketch of the history of poverty within overpopulation discourse and how it was institutionalised within the Plan. This paper engages with, and builds upon, Williams' essay in pointing out the ways in which this transformation took place. The paper conceptualises the body of the poor as another kind of poverty, which the state was required to discipline. It discusses the deliberate targeting of minorities (Muslims and Dalits) and clashes between Muslims and family planning workers in West Bengal, Uttar Pradesh, Bihar, Maharashtra, Haryana and Rajasthan, as recorded in the Shah Commission Report. Williams has mentioned other cases, such as Gujarat, where special incentives were provided for sterilisation "acceptors" in tribal areas, and Bengaluru, where family planning methods were made available "on an urgent and priority basis" to "alleviate the sufferings in certain special sections of the population like the beggars and those suffering from leprosy" (Williams 2014: 477). Thus, Garibi Hatao became an engulfing agenda. Together with the new-found zeal in family planning, the state created a new language of governmentality which was institutionalised in poverty and played out in the bodies of the poor.

Writings on the history of family planning have been so inextricably entangled with aspects of the Emergency that a metanarrative of the Emergency almost always runs through histories of family planning. Emma Tarlo (2003) has pointed out how in popular memory the Emergency constitutes the "*Nasbandi ka vaqt*" (the time of compulsory sterilisation). This paper consciously chooses not to write a history of family planning overshadowed by the Emergency. The Emergency is therefore a non-landmark and will be looked upon only as a period of culmination of political and social vulnerability rather than as "excesses." In the process, it questions the use of the term "excess," which conveys a benign view of what actually transpired.

Locating Poverty in Family Planning

Poverty and family planning both emanate from a series of common anxieties. Gradually, family planning emerged as a quick solution to ending poverty. The history of poverty and family planning is heavily loaded with overlapping interactions of eugenics, birth control, Malthusianism and planning, primarily aimed at controlling the subaltern population. By the end of the 1940s, "Indian eugenics dovetailed with family planning and was subsumed by it because both agreed that the most pressing problem of the day was Indian poverty, and that this poverty could be alleviated by the judicious application of eugenic birth control" (Hodges 2006: 134). There was also an ideological alliance between neo-Malthusianism and eugenics.

Malthusian arithmetic was deployed to support the overpopulation claim and "the Indian middle class/upper-caste male advocates of birth control in the name of the nation and also the Hindu community attempted to institute various 'reforms' aimed at marginalising subaltern groups while simultaneously preserving the existing structures of the elite privileges" (Ahluwalia 2007: 35). Further marginalisation of the subaltern was actually followed through in the postcolonial period. In broader ways, this is how the overpopulation discourse gained momentum.

In 1938, the Indian National Congress set up the National Planning Committee (NPC). In May 1940, this committee, under Radhakamal Mukherjee, warned that "disparity in the natural increase of different social strata shows a distinct trend of mis-population" and recommended "selectively sterilising the entire group of hereditary defectives" (Connelly 2008: 141). In fact, early in the 20th century, economists were already discussing poverty and overpopulation as a hindrance to modernity (Hodges 2004: Nair 2006). In 1944, the Department of Planning and Development was set up and in March 1950, the Government of India institutionalised planning through the National Planning Commission. The Planning Commission of India sought to reorganise the economy through the "Five Year Plans," and family planning was thought to be the primary solution for development and poverty alleviation. Meanwhile, in 1943, a committee was set up, headed by Joseph Bhore, one of the members of the viceroy's executive council, to assess the conditions of health then prevailing in British India. This report (Bhore Committee 1946) directly linked poverty to overpopulation and made it clear that steps had to be considered to curb population growth as the census recorded a steep rise. A subcommittee of the Planning Commission in April 1951 recommended fertility limitation both for the sake of the mother and child and to stabilise population "consistent with the requirements of national economy." It recommended free sterilisation and contraception on medical, social and economic grounds (Gupta et al 1992). Through the "science" of planning, the leaders sought to reduce population and bring about material progress, something which colonialism had failed to generate. Thus, poverty was institutionalised within the scope of family planning.

Meanwhile in the United States (US), the Princeton group of demographers came up with the Demographic Transition Theory. The theory suggested that all populations passed through three principal demographic stages: a "traditional" phase followed by a "preindustrial" phase characterised by high birth rates balanced by high death rates, when there was little growth in population. This was followed by a period of large-scale industrialisation and modernisation that led to improvements in living standards and consequently a substantial growth in population. While this would reduce mortality rates, it would at the same time see a fall in birth rate owing to the impact of modernisation, urbanisation and industrialisation (Szreter 1993; Williams 2014). In the early 1940s, this theory was turned on its head as demographers argued that in non-industrialised countries, high fertility itself was an impediment to economic development. Fertility reduction was therefore a prerequisite for economic development (Greenhalgh 1996; Hodgson 1983; Szreter 1993; Williams 2014). This theory got further consolidated as its inverted version was included in the First Five Year Plan.

The First Five Year Plan was essentially a post-war rehabilitation plan, primarily aimed at rectifying the imbalance caused by the wars and partition, and to generate the development of certain basic resources (Ledbetter 1984). Though the family planning programme took off as early as 1952, funds were not available until the 1960s. The famines of the 1940s dealt a heavy blow, followed by a huge influx of partition refugees, food crises and hoarding. The transition of political power in 1947 could do little to change the nature of the economy, which showed a "striking unity" from the 1920s to the 1960s (Tomlinson 1996: 180). In fact, by the end of the 1950s, there was discussion around the failure of the plan as planners and economists were disillusioned with its effectiveness. The final nail in the coffin came in the form of the foreign exchange crisis of 1956,[5] which shifted the authority of the Planning Commission to the finance ministry. In less than a decade of the conception of the Planning Commission, the spirit of planning was dying. Developmental planning failed to organise strong institutional foundations in India (Kudaisya 2009). While population control was considered a prerequisite for development, developmental planning itself took a back seat though the facade had to be maintained. Family planning emerged as part of poverty and birth control.

Consolidation of Poverty: Introduction of Economic Measures

In the next phase (late 1950s to 1970s) poverty was further consolidated as international agencies took a keen interest in India. In 1952, World Health Organization (WHO) consultant Abraham Stone visited India. Soon after, in February 1954, the Ford Foundation declared its first big grant for the Population Council, a major part of which was used to establish the United Nations Demographic Training Centre in Bombay. The Rockefeller Foundation also set aside a quarter of a million dollars to fund the Khanna Studies project in rural Punjab, and in 1956, the Rockefeller Brothers Fund gave the Council $540,000 for biomedical research (Connelly 2008). As the economic crisis intensified, India had to depend on foreign aid; an Aid-India Consortium was created in 1958, made up of Canada, Britain, the US, West Germany and the World Bank. Meanwhile in 1958, American demographers A J Coale and E M Hoover published *Population Growth and Economic Development in Low-Income Countries*, which argued that a reduction in population growth would produce "important economic advantages" and the sooner a reduction in fertility occurred, the greater the benefits would be (Coale and Hoover 1958: 335). This book hugely influenced Indian policymakers, and Coale and Hoover's projections appeared in the official government reports of the Mudaliar Committee (1962).[6] The committee warned that "if the growth in population does not show any significant downward trend during the next five years, the

introduction of appropriate legislative and administrative measures will have to be considered" (Mudaliar Committee 1962: 405–06). India's economic problems had become so severe that by 1965, the then Prime Minister Indira Gandhi declared a "plan holiday" to stall the five year plan and buy some time to stabilise the country. It was during this period that the government launched what would become the largest and most vigorous government-sponsored family planning programme in the world. The state introduced a programme of graded incentives and disincentives to encourage people to accept family planning.

In 1959, the Mudaliar Committee had formulated one of the most powerful tools, known as disincentives, in family planning. Disincentives, though not spelt out in uniform material terms, were introduced in the form of certain financial disadvantages to discourage reproduction. The members of the Health Survey Committee could not come to a unanimous decision on the "right" method of family planning, and came up with two sets of recommendations:

(i) The general recommendation suggested intensifying the existing family planning programme by measures such as training, education, demographic studies, free supply of contraceptives and voluntary sterilisation. They also suggested the formation of an independent ministry at the centre to deal with the problem of population, or enlarging the ministry of health by appointing a minister of state for family planning. (ii) The second recommendation was for a more drastic family planning programme, signed by five eminent physicians who recommended legislative action to accelerate family planning. These recommendations included: (a) graded rate of taxation from the fourth confinement onwards, (b) removal of disadvantage in income tax for unmarried persons, (c) withdrawal of maternity benefits for women refusing to accept family planning, and (d) the introduction of abortions for socio-economic reasons.

By the end of 1967, Kerala and Mysore had refused maternity leave to government employees with three or more children. In June 1967, the Maharashtra government proposed that India should not only deny free medical treatment and maternity benefits to those with three or more children but also institute compulsory sterilisation. After lengthy debates in the cabinet, compulsory sterilisation was ruled out by the union government, but incentives and disincentives continued to find favour. Immediately after incentives were announced, there was a rise in the number of sterilisations and IUD insertions. In October 1975, then Minister for Health and Family Welfare, Karan Singh, wrote to the Prime Minister stating that the Emergency provided "an appropriate atmosphere for tackling the [population] problem" (Connelly 2008: 318). In March 1976, a note submitted by the Ministry of Health and Family Planning to the cabinet declared that although family planning was a purely voluntary programme, the existing demographic situation called for and justified the introduction of stronger measures in the form of "a judicious package of incentive and disincentive" (Shah Commission of Inquiry 1978: 158). Following this, incentives for sterilisation were raised to ₹150 for those with two children and ₹100 for those with three. Not only were incentives augmented, but disincentives and compulsory sterilisation for willing states were also permitted. The central government did not spell out any uniform policy of incentives and disincentives, and state governments were free to apply and introduce their own rules.

In sum, the genealogy of poverty within the scope of family planning can be divided into two phases. In the first phase (1940s–50s), anxiety about overpopulation supported by eugenics and Malthusianism was formalised within the plans as the primary cause of poverty, to be tackled through family planning. During the next phase (1960s–70s), poverty was consolidated as a global issue through research conducted by international agencies, with the US taking a keen interest in Indian family planning. At home, however, poverty took a political turn with Indira Gandhi's electoral agenda of Garibi Hatao. Family planning accordingly evolved alongside the evolution of poverty.

Economic Measures and the Indirect Disciplining of the Body

Bodies are central to the discourse of family planning. Bodies are also fundamental to the idea of poverty. Poverty remains an empty category unless embodied. The body serves as the intersection, the interface between family planning and poverty, and the bodies of the poor are dominant in family planning discourse. In the 1960s, the state introduced certain incentives and disincentives to alleviate poverty. The incentives and disincentives were conditional to certain conditions of the body, which were redeemable for money, and therefore directly affected the integrity of the body. The body of the poor was at the centre of family planning discourse. While reproductive sexuality is generally looked upon as respectable sexuality, for the poor, charged with "overbreeding," reproduction claimed no respect. This section tries to bring out the biopolitics of poverty by using three particular features of family planning during the Emergency. Using incentives, disincentives and slum demolition as tropes, this paper offers an understanding of how the social body was disciplined and controlled in ways that created fresh dimensions of poverty, rather than alleviating it. While incentives became "technologies of the self" (Foucault 1997), through disincentives, the state discriminated and punished the unworthy poor who "overproduced." Slum demolition, on the other hand, had a deeper effect on the body. As the "domain of the body," the demolition of slums had an upfront and immediate effect on bodies. Demolition also implied a direct attack on the edifices of poverty.

As incentives were introduced, sterilisations increased manifold in Bihar, Madhya Pradesh, Uttar Pradesh and Odisha. Connelly writes that it was because of these states that there was an overall hike in the number of IUDs and sterilisations, which together numbered 1.8 million in 1966–67 (Connelly 2008: 226). A study undertaken by the Centre for Policy Research and Family Planning Foundation in April 1976 and published in 1978, spoke adversely of incentives and concluded that evidence of incentive schemes leading to sterilisation could not be established, although when coupled with official pressure, they had some influence on acceptors. The study

shows that the policy of incentives and disincentives was based on erroneous data about the motivations of the people. For instance, the idea of additional financial rewards was based on the assumption that they would encourage people to accept sterilisation. The evidence collected during the study showed that this was not true. Not a single person admitted to having been influenced to undergo sterilisation by the lure of higher incentive (in terms of money) "in spite of the much advertised poverty of the Indian masses" (Pai et al 1978: 145). This report implicitly suggests that incentives were more coercive than rewarding. Regardless of incentives or disincentives, it was really the amount and nature of government pressure that led to extreme coercion. The fear was so intense that many of the acceptors would not admit that they had accepted family planning under pressure from the officials. The study suggests that 58.7% of the acceptors had adopted the programme because of the pressure of officials, but only 13.8% admitted it openly. The two categories together make up 72.5% of the acceptors (Pai et al 1978: 141). Satia and Maru (1986) have reviewed available research reports on the impact of incentives on the quality of family planning services. Their study, conducted in four states—Maharashtra, Gujarat, Tamil Nadu and Kerala—reviewed important reports such as Rogers (1971), Repetto (1968), Khan and Prasad (1980), Murthy (1983), Ghosh and Khan (1976) and Gopalakrishnan (1981). Although their research and methodologies vary widely, the studies suggest that incentives to acceptors helped increase contraceptive acceptance and did not seem to have an adverse effect on their quality of life or choice of method.

While incentives encouraged the opportunity to get money in exchange for bodily capacities, sterilisation led to loss of reproductive capabilities, and this lack of reproductive capacity in the long term also affected economic capacities. The fact that a poor person after sterilisation could no longer bear children had a direct impact on his future, economically. It led to a different kind of poverty. Economic poverty was therefore transformed into poverty of the body. This marked off the next stage of the cycle, as the fewer the children, the less the number of hands to supplement the family income.[7] Sterilisation thus gave rise to a mire of poverty, an unending cycle of economic scarcity mingled with bodily complications. What, then, was the role of incentives? How did they influence sterilisation? Official numbers confirm that incentive schemes did boost mass sterilisation. First, they legitimised trade in bodily capacities. Second, though immediate poverty may have seemingly been alleviated, their future was crippled by an unending cycle of poverty that they would not be able to combat with their bodies. With fewer offsprings, sometimes no offspring at all, there was no one to cover for their old age. In addition, there was zero post-operative care, as pointed out by Pai et al in their 1978 study. The weakness of the body comes up as a critical concern in Tarlo's narratives as well.

In one of his lectures, Michael Sandel (1998) talks about the moral limits of the market, pointing out things that money cannot buy. He advances two specific arguments: first, in extremely unequal circumstances, people's choices are manufactured consent; they are coerced and not voluntary. Second, he points out that whether voluntary or not, there are certain things that are inherently immoral to buy or sell in the market. Contraceptives or family planning in general could have come to function as a "technology of the self"—what Foucault explains as "certain modes of training and modification of individuals" that allow people to transform "their own bodies and souls, thoughts, conduct, and the way of being" (1997: 225). However, it was really the monetary schemes that came to function as such. Incentives in their various forms coerced the poor in such a way that sterilisation became a way of life, a technology to "take care" of the "self" by trading reproductive capacities for money. This care of the self was, however, more economic than corporeal; the postcolonial state could never portray family planning as liberty of the body, as relief from the pangs of childbirth. Therefore the "technology" at work was economic rather than corporeal. The body was denied at several levels. Thus, instead of family planning becoming the transformative factor that could change conditions for the individual, incentives became "technology." While sterilisation was in itself a method of family planning and occupied a central place within it, sterilisation entered the space of poverty removal rather than family planning, with coercion and violence as its two poles. Therefore, incentives becoming "technologies of the self" is situated in the context of sterilisation as part of poverty removal, rather than just family planning. The "self" in this genre of thought is not the body or bodily integrity, but the material conditions of it.

Discriminatory Process

The system of incentives and disincentives was, in essence, an intrinsically discriminatory process. It came across as an effort to identify and sift the "worthy poor" from the "unworthy poor." Couched within this idea of deserving and undeserving was the idea of deviance, social and moral. As Handler and Hasenfeld (1991) have pointed out, "The distinction between the 'deserving poor' and the 'undeserving' poor" is a moral issue; it affirms the values of dominant society by stigmatising the outcasts." Incentives were awarded to that category of the poor who complied with state policy and agreed to sterilisation. Disincentives were applied to those who did not undergo sterilisation or practise birth control, and therefore reproduced more frequently. Disincentives therefore served as a medium to bring the deviant under state discipline. According to the Rajasthan government's reply to the Shah Commission's questionnaire on family planning, "The birth of fourth child to a government servant will be deemed as 'misconduct' for which necessary amendment would be made in the rules" (Shah Commission 1978: 166).

The use of the word "misconduct" is alarming. While one of the primary aims of incentivising or disincentivising people is to bring about behavioural change, ideas like "misconduct" point to something that is arbitrated by morality. "Misconduct" here implies delinquency. It directly questions "character." The reproduction of the poor was, therefore, tainted in morality.

Ironically, the "undeserving poor," whom the state deemed unfit for assistance, were the poorest, with not only multiple numbers of children and multiple mouths to feed but also lacking the knowhow and motivation to practise family planning. They were economically deficient, lacked awareness, and sometimes also knowledge and knowhow. A study[8] on the introduction of incentives and disincentives conducted in the four states of Uttar Pradesh, Bihar, Madhya Pradesh and Punjab in April 1976 under the auspices of the Family Planning Foundation, divided the population into four major groups: the economically weaker section, and low-income, middle-income and high-income groups. While it is understandable that the economically weaker section formed the single largest group of acceptors, it is interesting that this very section of the economically weak also made up the largest group of non-acceptors. They were the unworthy, the non-deserving poor, the bearers of disincentives. Though the economically weaker section constituted the single largest group among both the acceptors and the non-acceptors, proportionately there was a big difference between the two categories. Whereas the weaker section formed 39.3% of the acceptors, they formed 56.1% of the non-acceptors (Shah Commission 1978: 93). Amongst non-acceptors, the largest majority was of those who had four children each, followed by those who had three and then two. Together, the economically weaker section constituted 60.6% of non-acceptors, which is substantially more than the acceptors. The majority of non-acceptors consisted of those who did not consider having three to four children sufficient to practise family planning. Hence, disincentives were applied to them. One fell prey to disincentives from the third to the sixth child.

Disincentives thus directly challenged the right of the poor to have a progeny and interfered with their reproductive freedom. It is important to point out that disincentives in India took the form of denial of maternity leave. By denying maternity leave, the state thought it could stop the poor from "overproducing." When the Bombay Maternity Benefit Bill[9] was passed in 1929, the debate revolved around the fear that the Maternity Benefit Act would lead to excessive breeding of the working classes. Parts of the debate also involved working class women needing protection from their husbands, as most working class men were seen as drunkards with uncontrollable and excessive sexual impulses. For the working class mother, even reproductive sexuality was not respectable. This image of working class sexuality was predominantly the sexuality of the unworthy, undeserving poor, viewed as deviant and excessive, and therefore deserving of being penalised and pressurised into the two-child norm.[10] The denial of maternity leave also came as a punitive measure to the post-partum body. The disincentive scheme thus was a mode to discipline and punish the body, a technology of power for the state. Ruth Grant (2006) has explored the issue of incentives beyond the economic sphere within the discourse of politics, as a question of ethics and power. She is in favour of exploring incentives/disincentives through three basic criteria: first, whether the incentives/disincentives serve a legitimate purpose; second, whether they are voluntary and generated through consent; and third, their effect on the character of the parties involved. While we could argue that the primary objection to disincentives is that they were not voluntary, Grant warns against voluntarism becoming the only point of judgment, as consent can be manufactured. Even if we underplay the role of consent in disincentives, the fact that it is based on the idea that the "overproducing" poor were unworthy of state welfare and had to be punished through economic measures is in essence unethical, doing nothing to "correct" the behaviour of the poor and only pushing them into further vulnerability. Applied to the "undeserving poor," disincentives were not only modes of discipline but also mediums to punish.

After the elections of 1977 were declared, certain disincentive schemes were withdrawn. Since there were no uniform rules, the gap between what was prescribed and how it was executed swelled. The Shah Commission (1978) recorded incidents where lack of uniformity and overenthusiasm led to the extreme marginalisation of people. The Kendriya Vidyalaya Sangathan, an educational organisation of the central government, issued a notice saying, "Children of parents who have two or more children and have not undergone sterilisation of either parent should not be entitled to seek admission in Kendriya Vidyalaya." In a bid to do away with disputes regarding disincentive schemes and clear the confusion, the Ministry of Health and Family Planning received a note from Prime Minister Indira Gandhi's office which pledged to "review and withdraw all disincentives which linked sterilisation to the availability of normal facilities" (Shah Commission 1978: 160).
It also noted that

> … while the Kendriya Vidyalaya Sangathan could have said that admission will, in future, not be given to the third or fourth child onwards, they went to the extent of laying down that if a person has two children or more, none of his children will be given admission, unless he produced a sterilisation certificate—thus making it compulsory for this purpose. (1978: 160)

In the process of resolving disputes and in trying to portray a liberal attitude, the state not only redefined and reorganised the punitive nature of disincentive schemes, but also officially indicated that it could not bear the responsibility of every third or fourth child. The state has a direct obligation to take care of the children in a family, and in denying that obligation, the state almost dismissed their being and their bodies and tampered with certain basic rights. The state thus was taking one step at a time—from indirect interventions on the body through incentives and disincentives and the alleviation of poverty behind the facade of punitive and disciplinary economic measures, to the big leap of removing the poor altogether by demolishing their residential areas. This was a direct violation of the body and the rupture of an illusion called Garibi Hatao.

Direct Interventions on the Body: Slums and Demolition

Bodies, both real and imagined, construct space. Slums are often seen as a geographical boundary, as a site inhabited by all kinds of bodies—of the worthy poor as well as the "unworthy" poor. Inhabited by bodies imagined as immoral,

diseased and unworthy, slums were central to the agenda of poverty removal. The *jhuggi-jhonpri* (hutments) removal scheme initiated in 1960 was a resettlement scheme of urban renewal and environmental improvement within the five year plan. Initially, the sterilisation drive and the demolition drive worked independent of each other to remove the urban poor. This meant that during the first 10 months of the Emergency all the people whose homes had been demolished were entitled to a Delhi Development Authority plot without having to get sterilised. This was primarily an effort to relocate the urban poor into newly-built colonies. As the Emergency progressed, however, the situation was transformed, and sterilisation became a criterion for bargaining for a roof in Delhi. Family planning policy was soon incorporated into housing policy.

Indira Gandhi announced the Emergency in June 1975 along with a 20-point economic programme. By 1976, a five-point programme was tagged on to the 20-point programme under the leadership of Sanjay Gandhi, and at his insistence family planning attained a new intensity. The "emergence of political will in family planning" (Gwatkin 1979: 29–59) added a new dimension to the cause, as family planning turned out to be a "key Emergency-era project by virtue of its already-established position as a cornerstone of economic development" (Williams 2014: 474). To this was added Sanjay Gandhi's agenda of urban beautification, which primarily took the form of demolition. Sanjay Gandhi had a four-point programme of his own (which later became the five-point programme): family planning for two children only, increase in adult literacy, abolition of dowries, and slum clearance. It was under Sanjay's instructions that parts of heritage Delhi were demolished, squatter colonies resettled and areas of the city "beautified."[11] In most cases, demolitions proceeded without prior intimation or planning for the resettlement of the people. In cases where relocation was provided, the settlers were obliged with undersized plots of land to build on. Market prices were charged, with no compensation whatsoever (Shah Commission 1978: 89). Even this was, however, conditional to their being able to produce a sterilisation certificate. It was at this point that family planning and urbanisation converged, making a case for poverty removal. Prior to the Emergency, from 1973 to June 1975, the Delhi Development Authority, Municipal Corporation of Delhi and New Delhi Municipal Corporation[12] had undertaken 1,800 demolitions, whereas during the two years of the Emergency, up to 23 March 1977 the total figure was 1,50,105 (Gangadharan et al 1978: 26).

The bracketing of slum clearance and family planning in Sanjay Gandhi's political agenda was a direct blow to the bodies of the poor. Slums were the domain of poor bodies. They were therefore seen as a space occupied illegally by an assemblage of the unhealthiest, most diseased, and poorest bodies, a space of undefined tendencies, a breeding ground for bodily, economic and social poverty. To remove poverty from the roots, its very domain had to be attacked. Those who were relocated were sterilised and transferred to newly built colonies, thus giving birth to a new kind of social bodies—bodies that were controlled by the state. The state thought it would be able to remove poverty by disciplining sexualities.

Communal and Caste Character

By now, poverty removal had reached the stage of physical removal of bodies. The postcolonial state was actually fighting the very idea of poverty, and much of this idea was driven by frenzied imagination and international discourse. "Poverty" itself became a fluid category, taking on imaginary dimensions. In April 1976, removal of poverty also took on a communal and caste character, as communal tensions spread in Turkman Gate, a part of Old Delhi primarily inhabited by Muslims. While resentment had grown when the socialite Ruksana Sultana opened a family planning clinic in the Muslim-dominated area of Dujana House, close to this site, in Turkman Gate, demolition squads were getting ready to demolish houses. As the locals resisted both family planning and demolition, riots broke out. What followed was a massive police crackdown on a protesting crowd that left 12 people dead. Meanwhile, the head imam of Jama Masjid announced that last rites would be denied to all those who got themselves sterilised. Muslim resistance to the programme was the greatest. Emma Tarlo (2000) suggested that by pressurising the Muslims to get sterilised, the government was trying to "compensate for the general reluctance of Muslims to participate in the family planning scheme." However, that does not deny the communal character of the programme, as Tarlo recalls talking to a Muslim toolmaker who was asked to get only "Muslim cases." Such a demand that only Muslim sterilisation certificates would be accepted from Muslim applicants for various government welfare schemes "had the effect of inviting people to turn not only against their own religious doctrine, but also against their own community in the struggle for survival" (Tarlo 2000: 257).[13] The Shah Commission report also mentions clashes between Muslims and family planning workers in parts of West Bengal. It mentions that in August 1976, there was a "scare" among Muslims and non-Bengalis in Calcutta leading to bouts of violence (Shah Commission 1978: 198). Communal violence was therefore not restricted to Delhi. Communalism grew with the "otherisation" of the Muslims, and the age-old fear that Muslims would one day overtake the Hindus in number.[14]

As caste and class is linked in India, Dalits were also targeted. The primary reason for sterilisation of members of the Scheduled Castes was poverty. In the 1950s, following reforms in favour of "positive discrimination," Dalits were appointed in public sector industries as sweepers and as lower-level staff in government service. At some point of time during the Emergency, it became mandatory for central government employees to get sterilised and therefore a large number of Dalits working with the central government got officially sterilised (Tarlo 2000). Leprosy patients were also sterilised during the Emergency (Williams 2012). In the wake of the Sterilisation of the Unfit Bill[15] which resurfaced in 1964, there had been a debate on sterilisation of leprosy patients. During the Emergency the government took the opportunity to fulfil sterilisation targets by sterilising people suffering from leprosy. Even though leprosy is not hereditary, the government during

the Emergency took every opportunity to do away with these "unfit" individuals. This was Garib Hatao again at its best. Thus, poverty alleviation ran fluidly from the economic to the bodily and the social. Meanwhile, family planning was hailed as an economic virtue instead of a corporeal one and reproductive functions were typecast, constructed and categorised in terms of what is moral and what is not. Targeting for family planning had come to be centred around identity and social category. Postcolonial poverty thus became a chequered notion of reality and imagination which took on bizarre proportions under the "economic justification" of the Emergency period.

Conclusions

This paper is based on a Foucauldian understanding of family planning as a disciplining mechanism. The family planning incentive programme may have led to immediate relief from poverty, but it exacerbated long-term poverty. The effect of disincentives was graver. Disincentives were a way of constructing the Other, of typecasting, name-calling and body shaming. It was a political agenda of denying welfare to the deviant Other. Disincentives did what incentives could not—by creating extreme conditions, through punitive measures, it pushed the masses from poverty to vulnerability. It is interesting how poverty, be it in the form of ignorance or lack of education and/or unmet need for contraception, allowed population to grow, and vice versa; one nurtured and preserved the other. The enthusiasm about poverty eradication reached such a pitch that the category of poverty/the poor itself became fluid. Poverty morphed into an identity, a marker that was placed on the body itself. The state was not only fighting economic poverty. In postcolonial India, more than anything else, poverty became a social discomfiture.

Starting with Katherine Mayo's Mother India,[16] images of Indian poverty were both mythical and real. In fact, Western perceptions of poverty and population have always had a role to play in poverty alleviation measures initiated in India. In the 1950s, India not only served as the first experimental field for British and American birth control activists, it also attracted the first United Nations (UN) advisory mission in demography. It served as the host country for the first International Planned Parenthood Federation meeting, and was the first country to adopt family planning as an official policy. Gradually, family planning in India became a field for foreign investment by the World Bank, USAID, the Ford Foundation, key UN agencies, as well as private business. At a conference in June 1952, at which the Population Council was formed, discussions revolved around controlling the growth of poor countries as Western-minded elite societies feared they would be "engulfed by those peoples with a lower level of intelligence" (Connelly 2008: 158). This idea was animated by the fear of the spread of communism. Therefore, even before population control took solid shape, the fear of differential fertility and who should inherit the earth plagued the agenda of population control. Later, as international propaganda on population control became sharper, philanthropists John D Rockefeller and Frank Notestein both insisted on a revision of attitudes, as they feared that eugenics and the Cold War agenda could disrupt the cause of family planning. In India, however, such revisions never took place. In India, family planning evolved essentially from eugenicist and Malthusian concerns, turning into a population control programme influenced by international reflections on Indian poverty, population and economic growth. The very first official population research programme in India included studies comparing birth rates among caste, class and religious groups, as well as the development of intelligence tests appropriate for each group.

The role of US and other global agencies in India can be explained in terms of cryptoeugenics, which is "fulfilling the aims of eugenics without disclosing what you are really aiming at and without mentioning the word" (Connelly 2008: 163). While it can be argued that the US and other international agencies did not directly influence state attitudes on family planning, economic incentives and disincentives were manipulated to a large extent by international research and experiments in biotechnology, use of contraceptives, unmet needs, and contraceptive failure. In a bid to appease international agencies and donors, the Indian state's mindless fulfilment of targets did approach cryptoeugenicism. The spirit of eugenics and fear of differential fertility that is inherent in family planning and population control surfaced most strongly in times of crisis.

The official family planning discourse was, thus, based on the idea of birth control as an economic virtue rather than a corporeal one. It was almost a deliberate attempt to look away from the individual and the individual's body and bodily desire. In trying to control bodily capacities through family planning, the state ultimately denied bodily desire, and this denial of desire was followed by the denial of reproductive freedom.

NOTES

1 The *Yojana Patrika* was established in 1965 under the editorship of Khushwant Singh as the primary media instrument of the state. It provided an overview of India's post-independence economy and polity. This particular advertisement appeared in the 10 January 1971 edition, p 44.

2 The government launched Nirodh condoms in 1962, distributing them free or at subsidised rates. In 1969, a unit of Hindustan Latex Ltd in Trivandrum undertook the production of 144 million condoms in collaboration with a well-known Japanese firm.

3 Williams (2014) has pointed out that during the Emergency, Garibi Hatao transformed to Garib Hatao as poverty eradication through various coercive measures took the form of elimination of the poor themselves.

4 The Janata Party government appointed the Shah Commission to look into the injustices committed during the Emergency. Based on the narratives of the victims, the committee, headed by Justice J C Shah, brought out its final report in August 1978. Several attempts were made to suppress this report when the Congress government returned to power.

5 In July 1956, India faced its worst foreign exchange crisis as silver sterling accumulated during World War II was exhausted. This was a serious blow to the economy as prices of essential imports rose and India's share in the world economy fell.

6 The Health Survey and Planning Committee appointed in 1959 and headed by Lakshmanswami Mudaliar was popularly known as the Mudaliar Committee. It was formed to track developments in public health since the Bhore Committee of 1946.

7 There is, however, no unequivocal position on this. Some argue that more children mean

more income, others argue that more children mean more poverty.

8 A study was undertaken in 1976 under the auspices of the Centre for Policy Research and the Family Planning Foundation to understand the policy implications of family planning incentives and disincentives during the Emergency. By the time it was published in 1978, family planning had already been converted into a voluntary family welfare programme.

9 The Bombay Maternity Bill was the first labour legislation in India that recognised the rights of a working class mother.

10 Amrita Chhachhi (1998) has argued that the Maternity Benefits Bill of 1929 was written in a language of protection for women workers rather than rights.

11 This was part of a global initiative to beautify urban settings and redirect migration to underdeveloped lands, as pointed out by Matthew Connelly (2008).

12 Delhi is divided into three urban regions, each under three municipal heads—the Municipal Corporation of Delhi (MCD), New Delhi Municipal Council (NDMC), and the Delhi Cantonment Board. The Delhi Development Authority (DDA) was created in 1955 to oversee the development and urbanisation of Delhi.

13 As family planning became increasingly coercive during the Emergency, those who could afford to would pay the poor and vulnerable to get sterilised instead of going for sterilisation themselves. This process was called giving out "a case," where the rich acted as motivators as well as shielded themselves at the cost of someone else, going on to avail of government welfare schemes on the basis of the sterilisation certificates obtained by giving out "a case." This set off a process of co-victimisation, as the obvious target also became an active agent in search of another set of victims (Tarlo 2000).

14 Datta (1993) has pointed out how population fears were successfully used by communal politics to fuel anxieties about "dying Hindus." These anxieties were also visible in the narratives of sterilisation in Tarlo's writing (2003).

15 In 1953, a bill for compulsory sterilisation of adults who were unfit on grounds of insanity or incurable disease was introduced in the Lok Sabha. In the face of strong opposition, the bill was withdrawn. It resurfaced in 1964 and was left inconclusive (Buckingham 2006).

16 Written by American historian Katherine Mayo, *Mother India*, published in 1927, exaggerated Indian poverty and generated much controversy. See Mrinalini Sinha (1983) for a critical understanding of how this book influenced the feminist and nationalist movement in India and abroad.

REFERENCES

Ahluwalia, Sanjam (2007): *Reproductive Restraints: Birth Control in India 1877–1947*, University of Illinois Press.

Banerji, D (1976): "Will Forcible Sterilisation Be Effective?" *Economic & Political Weekly*, Vol 11, No 18, pp 665–68.

Bhore Committee (1946): *Report of the Health Survey and Development Committee (Vol III),* Government of India Press.

Buckingham, Jane (2006): "Patient Welfare vs the Health of the Nation: Governmentality and Sterilization of Leprosy Sufferers in Early Postcolonial India," *Social History of Medicine*, Vol 19, No 3, pp 483–99.

Chhachhi, Amrita (1998): "Who is Responsible for Maternity Benefit: State, Capital or Husband? Bombay Assembly Debates on Maternity Benefit Bill, 1929," *Economic & Political Weekly*, Vol 33, No 22, pp L21–L29.

Coale, Ansley J and Edgar M Hoover (1958): *Population Growth and Economic Development in Low-Income Countries,* Princeton University Press.

Connelly, Matthew (2008): *Fatal Misconception: The Struggle to Control World Population*, Cambridge: Harvard University Press.

Datta, P K (1993): "'Dying Hindus': Production of Hindu Communal Common Sense in Early 20th-Century Bengal," *Economic & Political Weekly*, Vol 28, No 25, pp 1305–19.

Foucault, Michel (1997): "Technologies of the Self," *Ethics: Subjectivity and Truth*, Paul Rainbow (ed), New York: New Press, pp 223–51.

Gangadharan, K, P J Koshy and C N Radhakrishnan (1978): *The Inquisition: Revelations before the Shah Commission*, New Delhi: Path Publishers.

Ghosh, B and M E Khan (1976): *Mass Vasectomy Campaign Approach in Gujarat: An Evaluation*, Baroda: Operations Research Group.

Gopalakrishnan, T D (1981): "A Study on Motivational Factors Influencing Sterilization (Vasectomy) in Mass Family Planning Camps," *Journal of Family Welfare*, Vol 17, No 3, pp 17–24.

Grant, Ruth (2006): "Ethics and Incentives: A Political Approach," *American Political Science Review,* Vol 100, No 1, pp 29–39.

Greenhalg, Susan (1996): "The Social Construction of Population Science: An Intellectual, Institutional, and Political History of Twentieth-Century Demography," *Comparative Studies in Society and History*, Vol 38, No 1, pp 26–66.

Gupta, J P, N K Sinha and A Bardhan (1992): *Evolution of Family Welfare Programmes in India,* Vols I and II, National Institute of Health and Family Welfare, New Delhi.

Gwatkin, Davidson R (1979): "Political Will and Family Planning: The Implications of India's Emergency Experience," *Population and Development Review*, Vol 5, No 1, pp 29–59.

Handler, Joel F and Yeheskel Hasenfeld (1991): *The Moral Construction of Poverty: Welfare Reform in America*, Sage Publications.

Henderson, Michael (1977): *Experiment with Untruth*, Delhi: Macmillan.

Hodges, Sarah (ed) (2006): *Reproductive Health in India: History, Politics, Controversies*, New Delhi: Orient Blackswan.

— (2004): "Governmentality, Population and Reproductive Family in Modern India," *Economic & Political Weekly*, Vol 39, No 11, pp 57–63.

Hodgson, Dennis (1983): "Demography as Social Science and Policy Science," *Population and Development Review*, Vol 9, No 1, pp 1–34.

Khan, M E and C V S Prasad (1980): *Fertility Control in India: A Critical Evaluation of the Role of Incentives in Promoting Sterilisation among Industrial Workers*, New Delhi: Manohar Publishers.

Kudaisya, Medha (2009): "'A Mighty Adventure': Institutionalising the Idea of Planning in Postcolonial India, 1947–60," *Modern Asian Studies*, Vol 43, No 4, pp 939–78.

Ledbetter, Rosanna (1984): "Thirty Years of Family Planning in India," *Asian Survey*, Vol 24, No 7, pp 736–58.

Mudaliar Committee (1962): "Report of the Health Survey and Planning Committee," Ministry of Health, Government of India.

Murthy, Nirmala (ed) (1983): *Family Planning Programme in the Organized Sector: Case Studies*, New Delhi: Sterling Publishers.

Nair, Rahul (2006): "The Discourse on Population in India, 1870–1960," diss, University of Pennsylvania.

Pai Panandikar, V A, R N Bishnoi and O P Sharma (1978): *Family Planning under the Emergency: Policy Implications of Incentives and Disincentives*, New Delhi: Centre for Policy Research and Family Planning Foundation, Radiant Publishers.

Repetto, Robert (1968): "India: A Case Study of the Madras Vasectomy Program," *Studies in Family Planning*, Vol 1, No 31, pp 8–16.

Rogers, Everett (1971): "Incentives in the Diffusion of Family Planning Innovations," *Studies In Family Planning*, Vol 2, No 12, pp 241–48.

Sandel, Michael J (1998): "What Money Can't Buy: The Moral Limits of Markets," the Tanner Lecture of Human Values, Brasenose College, Oxford.

Satia, J K and R M Maru (1986): "Incentives and Disincentives in the Indian Family Welfare Program," *Studies in Family Planning*, Vol 17, No 3, pp 136–45.

Shah Commission of Inquiry (1978): "Third and Final Report," Delhi: Controller of Publications, Government of India.

Sinha, Mrinalini (2006): *Specters of Mother India: The Global Restructuring of an Empire*, Duke University Press.

Szreter, Simon (1993): "The Idea of Demographic Transition and the Study of Fertility Change: A Critical Intellectual History," *Population and Development Review*, Vol 19, No 4, pp 659–701.

Tarlo, Emma (2000): "Body and Space in a Time of Crisis. Sterilisation and Resettlement," *Violence and Subjectivity*, Veena Das et al (eds), Berkeley, California: University of California Press.

— (2003): *Unsettling Memories: Narratives of India's Emergency*, Berkeley, California: University of California Press.

Tomlinson, B R (1996): *The Economy of Modern India, 1860–1970,* Cambridge University Press.

Vicziany, Marika (1982): "Coercion in a Soft State: The Family Planning Program of India: Part 1: The Myth of Voluntarism," *Pacific Affairs*, Vol 55, No 3, pp 373–402.

— (1983): "Coercion in a Soft State: The Family Planning Program of India: Part 2: The Sources of Coercion," *Pacific Affairs*, Vol 55, No 4, pp 557–92.

Williams, Rebecca Jane (2014): "Storming the Citadels of Poverty: Family Planning under the Emergency in India, 1975–77," *Journal of Asian Studies*, Vol 73, No 2, pp 471–92.

Permission for Reproduction of Articles Published in *EPW*

No article published in EPW or part thereof should be reproduced in any form without prior permission of the author(s).

A soft/hard copy of the author(s)'s approval should be sent to EPW.

In cases where the email address of the author has not been published along with the articles, EPW can be contacted for help.