Who Deserves to Reproduce?
Coercion, Choice, and Democracy in India’s Family Planning Program, 1951-Present

by

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For my father, Michael Koenig
In memory of his quiet brilliance
And contributions to the field of reproductive health
PREFACE

“We must now act decisively and bring down the birth rate speedily. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be kept in abeyance for the human rights of the nation.”

-Prime Minister Indira Gandhi, 1976

Reproduction, despite being considered a private affair, frequently falls under the jurisdiction of state power. Governments often attempt to impact the reproduction of their citizens, engineering fertility trends in an effort to attain population growth goals that contribute to the survival of the nation. Although this takes the form of pro-natalist policies in many developed nations whose populations are shrinking, in developing countries governments often aim to reduce high fertility by increasing access to and use of family planning services. Government programs that aim to control fertility may be associated with the principles of autocratic regimes—such as China’s “One-Child” policy of birth planning— but this role is less comfortable for democratic states. State policies that interact with citizens in an authoritarian manner—such as with coercive family planning programs—signify a disruption of the regulatory mechanisms of liberal democracy, as liberal regimes hold central the protection of the individual’s rights. In this light, India, as a developing democracy hoping to curb population growth, offers an interesting example of the dilemma between state coercion and liberal democracy. This thesis examines the strategies employed in India’s national family planning programs, which, for the past 60 years, have aimed simultaneously to address citizens’ need for reproductive health services and to limit population growth.
These programs allow state programs the disconcerting power of deciding the question: who deserves to reproduce? This question elicits a sensitive reaction, in part because of the consideration of sex and reproduction as intensely private. Such a question is irrevocably tied to a disturbing eugenic sentiment, and the attempt to “kill poverty by killing the poor”. Further, it calls into question the narrative of contraception as a universally benevolent development, and forces one to confront the complex relationships with reproductive technologies that define the experience of many individuals.

This project is grounded in a discussion of three theoretical frameworks of democratic governance: liberal democracy, participatory democracy, and communitarian democracy. Each form features its own approach to mediating the tensions between public and private—and between the state and individuals—so central to policies addressing reproductive health and population control. By examining the institutions and objectives of each of these modes of democracy, this project seeks insight as to how these various democratic values allow for or counteract the ability of a state to violate its citizens’ human rights.

The central objective of this thesis is to explore the impact of family planning and population control programs on the relationship between individuals and their governments through the framework of the coercive legacy of India’s National Family Planning Program. This project explores the potential of family planning programs to serve as a measure by which to clarify the normative limitations of the Indian government’s efforts to regulate the highly intimate sphere of sexuality and reproduction. Lastly, this project seeks to understand the extent to which the state

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may involve itself in family planning before violating the reproductive rights of its citizens. Through this project, I will demonstrate that it is in the best interest of Indian citizens for the state to intervene in reproduction only so far as to expand reproductive choice.

I seek to accomplish this goal by focusing on the moments in the history of India’s family planning program where major changes in policy occurred. By examining the political circumstances—both within India and between the state and the international community—at the time of these shifts, I hope to gain insight into the mechanisms by which coercive family planning tactics developed and grew to become pervasive throughout the program.

Furthermore, I use this framework in order to examine reproductive health NGOs as agents of civil society in India. In this regard, this project benefitted greatly from primary research made possible by the generosity of the Davenport committee in the spring of 2012. In August of 2012, I traveled to New Delhi in order to conduct interviews at autonomous, locally established NGOs that address issues of family planning and reproductive and sexual health and rights. These interviews focused both on participant perspectives on the history of family planning programs in India, and on each organization’s approach to asserting reproductive health, rights, and empowerment among marginalized Indian citizens, particularly women. This project will highlight the in-depth interviews I conducted with six participants at three organizations.

This thesis is organized in three chapters. The introduction assists the reader in understanding the harm of coercive family planning programs by outlining the
cultural context of fertility in India, the coercion employed throughout the program, and the effects of this coercion, and subsequently presents a brief overview of the history of India’s family planning program. Chapter I proposes a theoretical platform that outlines three forms of democracy—liberal democracy, communitarian democracy, and participatory democracy—focusing specifically on how each regime type accounts for the protection of human rights.

This theoretical platform is employed in Chapter II in order to inspect the history of India’s family planning policies. Beginning with the establishment of India’s independent democracy in 1947, I have identified four key time periods, and this chapter analyzes the policy and political forces at play during each period using the framework of democratic form established in the previous chapter. Ultimately this chapter uses the course of India’s family planning program to demonstrate that India’s structural democracy was insufficient in safeguarding its citizens’ human rights in this case, and that, while a purposeful shift in policy occurred in India’s family planning program, concrete change in practice failed to occur.

Finally, Chapter III discusses a body of theory on the role of civil society in democracy, as well as a summary of the evolution of civil society organizations in India’s reproductive health field since 1951, highlighting in particular the increasing presence of such organizations since 1994. Chapter III also introduces the three organizations I examined in my primary research and provides an analysis of these in-depth interviews within the framework of the existing body of theory concerning civil society. This chapter subsequently uses the insights gained from this research to construct an understanding of the responsibilities that are currently being shouldered
by local reproductive health NGOs in India. Ultimately, this thesis uses the theoretical framework of democratic form, the history of India’s family planning programs, and my investigation of reproductive health NGOs in order to highlight the importance of just reproductive healthcare programs to not only the health and political experience of Indian citizens, but also the welfare of the democratic nation.
INTRODUCTION

CONSIDERING COERCIVE FAMILY PLANNING

Understanding the Causes of High Fertility and Population Growth

Population growth in developing nations cannot simply be understood as the result of a lack of access to contraception, although it is a key component. A more nuanced approach recognizes that population growth is the result of multiple factors: the “population momentum” that invariably results when death rates decrease, when there is high unwanted fertility, and when individuals desire a large family, with this last characteristic often a result of chronic poverty. Programs such as India’s National Family Planning Program often disregard these complex factors, focusing exclusively on access to contraception without a comprehensive understanding of the factors contributing to population growth. Such programs often develop inefficiencies, and can fail to account for important ethical considerations.

A primary component of population growth results from the phenomenon of population momentum. Population momentum occurs, commonly in developing countries, when death rates decrease as the result of advancements in medicine and hygiene. Because death rates in developing nations generally decline prior to birth rates—which result in a larger population of reproductive age—this demographic shift results in population growth. Therefore, even if a nation’s fertility rate falls to replacement level—the level required to maintain a constant population growth rate

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in the absence of changes in mortality—itits population may still expand due to decreased death rates.

High fertility can also, to some extent, be attributed to unwanted fertility. In this context, undesired pregnancies result from insufficient education, a lack of access to contraception, or failure to properly employ contraceptive technologies. Yet this unmet need for contraception also implies that the adequate provision of the relevant education and coercion-free family planning services promises a reduction in population growth. However, the assumption that insufficient education and contraceptive access are the primary causes of overpopulation is conducive to the implementation of programs that are erroneously predicated on the belief that improved education and access will completely resolve the problem. Education and contraceptive services, while necessary components of family planning programs, are unfortunately insufficient to ensure a reduction in population growth.

A third determinant of population growth is high desired family size among impoverished populations, which is in large part a symptom of chronic poverty. High levels of infant or child mortality are common in societies where the standard of living is low, and families are thus motivated to increase the number of children they have with the understanding that some may not survive.³ Counter-intuitively, a decrease in infant mortality—or general increase in the standard of living—leads to a decline in population growth by encouraging a lower birth rate. Additionally,

³ Infant mortality rate is the number of deaths of infants under one year of age per thousand live births annually
Child mortality rate is the number of deaths of children aged 1 to 4 per thousand children in this age group annually
The World Bank, “Mortality Rate, Infant (per 1,000 live births)” and “Mortality Rate, Children Age 1-4 (per 1,000 children in age group annually)”
children born into impoverished families themselves begin working at a very young age, and often become integral actors in the family’s economy, further increasing the motivation to have larger families. In her book, *Reproductive Rights and Wrongs: The Global Politics of Population Control*, Betsy Hartmann states, “quite early in life, children’s labor make them an asset rather than a drain on family income.” For the impoverished, children are seen as a form of security, rather than financial burden, for an otherwise uncertain future. Children in this case are not a financial burden, as they might be for families in a high-income setting. A family planning program seeking to reduce population growth must also address the role that poverty plays in structuring reproductive choices. As a result, combating poverty is an important component of programs that aim to reduce population growth.

**Coercion employed in India’ National Family Planning Program**

During the course of India’s National Family Planning Programs, the central government’s Planning Commission employed various forms of coercion in an effort to control population growth. Most prominently, financial incentives were used throughout the program’s history to motivate impoverished clients to accept a family planning method. At vasectomy camps, men were offered compensation amounting to the equivalent of one month’s income for the vasectomy acceptor. During the early 1970s, Subrahmanyan Chandrasekar, the secretary of state for health and family

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5 Ibid, 7.
planning under Prime Minister Indira Gandhi, created an incentive scheme promising a transistor radio to any man who underwent a vasectomy.\(^7\)

The implementation of incentives in India’s Family Planning Program raises several ethical questions. The use of an incentive structure in motivating individuals to accept family planning methods is not necessarily an act of coercion. Yet the program largely targeted rural, undereducated, and impoverished individuals. Offering cash incentives in exchange for a permanent medical procedure distorts the individual’s ability to rationally weigh the consequences of that decision, and can cause them to do something to which they could otherwise be strongly averse.\(^8\) Due to the resource constraints of the individuals in question, any offer that motivates an alteration to their reproduction decision-making becomes coercive. While a motivational scheme such as an incentive structure allows an individual choice in whether or not to accept the offer, it is not a free choice if the person in question has no satisfactory alternatives.

Between 1975 and 1977, Indira Gandhi declared a State of Emergency, which allowed her the political power to suspend even those rights and freedoms guaranteed in the constitution.\(^9\) During this period, the program was characterized by increasingly coercive measures. Men were collected and forcibly sterilized in vasectomy camps, without adequate information about the procedure and without having given consent.\(^10\) In the period following the Emergency, similarly coercive

\(^7\) Ibid, 309.
\(^10\) Hartmann, \textit{Reproductive Rights and Wrongs}, 258
means were used to sterilize women. Sterilization camps performed tubal ligations on women who were not fully informed about alternative options, the procedure’s risks, and its irreversibility. Further, these women rarely gave informed consent for the procedures provided to them. Sterilization camps commonly used fingerprints as consent signatures for illiterate women, and this consent was frequently “obtained” after patients were anesthetized. Some patients reported being drugged by medical personnel and sterilized against their will.

Additionally, the adoption of family planning methods became a requirement in order to obtain salary or other public services. Women were required to agree to sterilization or IUD insertion in order to obtain maternal care, abortion services, or publically provided food rations. During the 1970s in Uttar Pradesh, a region in North India, married teachers faced the loss of one month’s pay if they did not undergo sterilization. This motivational structure was also applied to health workers involved in the Family Planning Program. Workers at every level of the Indian bureaucracy faced pay docks if they failed to meet the state quotas for contraceptive acceptance set by the central government. Such threats ensured that health care workers met these targets, and encouraged coercive measures to ensure contraceptive “acceptance” throughout the program.

**The Implications of Coercion**

Coercive family planning practices are violations of human rights. The World Health Organization considers reproductive rights in and of themselves as human

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11 Dhanraj, *Something Like a War*.
12 Dhanraj, *Something Like a War*.
14 *Dhanraj, Something Like a War*
rights, asserting the right for all couples and individuals to autonomously plan their families, free from coercion and discrimination.\textsuperscript{15} The Indian family planning program’s coercive features exclusively targeted rural, impoverished, and undereducated populations. Therefore, coercive family planning programs in the Indian context violate citizens’ human rights both to compulsory incentive structures and a discriminatory targeting of marginalized individuals.

Coercive sterilization is also simply ineffective in the long run. Rather than targeting the true causes behind high fertility, namely chronic poverty, coercive population control mechanisms assume that the “provision” of contraception will lead the way to the eradication of poverty. These programs fail to address the factors that cause a desire for high fertility, and instead assume that high fertility is unintentional and uncontrolled. As K. Shanthi asserts in her article, “Feminist Bioethics and Reproductive Rights of Women in India,” women’s reproductive rights will never be realized until other social factors—their economic disadvantage, social marginalization, and political disempowerment—are rectified.\textsuperscript{16} She explains, “Unless such issues as poverty, inequality, unemployment, and environmental degradation are addressed first, women’s rights and human rights will remain abstract concepts. They will only exist on paper.”\textsuperscript{17} Therefore, population control policies, in addition to being unethical, are ineffective in truly treating the root causes of high fertility.

\textsuperscript{15} World Health Organization, “Gender and Reproductive Rights.”
\textsuperscript{17} Ibid, 120.
Furthermore, coercive family planning programs promote ill health among the patients whose health they are in theory protecting. The harmful effects of the coercive measures to encourage family planning echo within and beyond the health care system. Coercion causes individuals to distrust family planning programs more broadly. They are less likely to seek reproductive and general health care when they are in need of medical attention.\(^{18}\) Rather than relieving the ill health effects of poverty, coercive family planning tactics promote a cycle of ill health by making impoverished individuals distrustful of publically provided health care.

An understanding of the importance of fertility in Indian culture is essential in order to fully comprehend the implications of sterilization for those citizens who became victims of the forced sterilization of India’s National Family Planning Program. The ability to bear children is of particular importance for deprived, oppressed, and impoverished women. Although there has been universal adult suffrage in India since Independence, norms in India’s highly patriarchal society place women in a socially subordinate role and prevent them from asserting their rights. For women who occupy a subordinate role in their families and societies at large, the ability to bear children is a form of social capital. Hartmann states, “Children are a woman’s constituency within the narrow political world of the family; the more she has, the stronger her clout. If she is infertile, her status plummets, and she often falls victim to polygamy, desertion, or divorce.”\(^{19}\) The ability to produce children, particularly male children, may allow women greater autonomy and

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\(^{19}\) Hartmann, *Reproductive Rights and Wrongs* 43
decision-making power within the family. In Deepa Dhanraj’s documentary

Something Like a War, a female victim of coercive sterilization stated: “We need children because we have no other resources. So our children are our wealth, our land, our only source of income. That is why the poor need children.”20 Forcing sterilization denies impoverished women a crucial source of power that they derive from the ability to leverage their fertility.

Of the concerns addressed above, the one of most relevance to this project is the distrust of government that spreads among citizens when the state acts violently against them, such as in coercive family planning programs. Rather than implementing policy that serves citizens, individuals become objectified as the means to achieving policy goals.

INDIA’S NATIONAL FAMILY PLANNING PROGRAM

1951-1971: Program Development and Implementation

In 1951, India became the first nation to adopt an official national program dedicated to concerns about population control and family planning.21 After achieving independence from Britain in 1947 and subsequently establishing the Republic of India, an independent and democratic state, the government set its goals on rapid modernization and development. At the time of Independence, the standard of living in India was dire. Eighty-five percent of the population resided in villages,

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20 Dhanraj, Something Like a War.
and 70% were employed in traditional, low-productivity agriculture.\textsuperscript{22} Less than a quarter of Indians at the time were literate, and mortality rates were extremely high.\textsuperscript{23} Therefore, the impetus for economic development was necessary and urgent.

The motivation for a national family planning scheme arose out of the central Planning Commission, established in 1950, which aimed to promote a rapid increase in standards of living.\textsuperscript{24} The Planning Commission determined that economic growth and opportunities necessitated a reduction in fertility rates.\textsuperscript{25} These concerns were reactions to India’s burgeoning population at the time. At the time of the program’s conception, India’s population was expanding at a rate of 1 million births per month, with the 1951 national population consensus predicting a population increase of 100 million between 1945 and 1960.\textsuperscript{26} The Commission decided that this program would have three aims: to understand the causes and patterns of high fertility in India, to understand which family planning methods would be suitable and easily distributable, and to integrate such services in the public hospital, clinic and health systems.\textsuperscript{27}

The family planning program was cautious during its First Five-Year Plan (1951-1956), initially allocating only 6.5 million rupees for issues of population and family planning.\textsuperscript{28} Traditional methods of contraception, such as the “rhythm” method—a method of contraception that involves abstinence during the period in which ovulation is most likely to occur—were researched and promoted alongside modern contraceptive technologies, but were later deemed too risky, and unsuitable

\textsuperscript{22} Uma Kapila, \textit{Indian Economic Development Since 1947}, (New Delhi, the Academic Foundation, 2008), 26
\textsuperscript{23} Ibid.
\textsuperscript{24} Ibid.
\textsuperscript{26} Harkavy and Roy, “The Emergence of the Indian National Family Planning Program”, 303.
for the rural and undereducated populations targeted by the family planning efforts.\textsuperscript{29} At the conclusion of the first plan in 1956, while the population’s awareness of the need for family planning had certainly increased, tangible program implementation had progressed minimally in the areas of education, service, or research.\textsuperscript{30}

During the Second Five-Year Plan, the central government established a network of public clinics to provide free or heavily subsidized family planning services to both rural populations and the urban poor. By 1961, more than four thousand clinics were publically providing free family planning services.\textsuperscript{31} While the program initially attempted to provide a range of contraceptive methods, funding for and access to supplies like condoms, diaphragms, and hormonal contraception were unreliable. The central government then began to propagate sterilization methods. While it was not a suitable contraceptive method for couples that sought only to space the births of their children, the government promoted sterilization after the birth of three to four children as beneficial to the family, as it eliminated all possibility of unplanned pregnancies, and to the nation, as it limited population growth rates. Limited access to efficient, cost-effective tubal ligation technology, in conjunction with cultural norms that prevent women from making autonomous decisions within their families, caused the government to focus its family planning efforts on men. The state attempted to convince men to undergo vasectomy by advertising the procedure as the patriotic duty of Indian men.

Frustrated with the lack of concrete results in population reduction and family planning service acceptance, and motivated by an intensification of global and

\textsuperscript{29} Savitri Thapar, “Family Planning in India”, 9.
\textsuperscript{30} Savitri Thapar, “Family Planning in India”, 9.
\textsuperscript{31} Harkavy and Roy, “The Emergence of the Indian National Family Planning Program”, 303.
national concerns about population growth, the state intensified its efforts during the early 1960s by implementing an extension approach. In the extension approach, a clinic in each village was staffed with educators, surgeons, and auxiliary nurse-midwives, while family welfare workers made house calls to encourage contraceptive acceptance. Although vasectomy was considered to be a highly effective and appropriate family planning method, men were practicing vasectomy at a lower rate than the state would have liked. An outright compulsory sterilization law was out of the question, as it violated the Constitution of India’s preamble, which assured for “the preservation of the dignity of the individual”. Therefore, beginning in the late 1950s, various states began enacting “motivational schemes” wherein family planning programs compensate the sterilization “acceptor” with a cash incentive. Such motivational schemes soon became commonplace throughout the program’s regions, which were gaining greater autonomy in the implementation of family planning services. The central government also strengthened medical campaigns, and mandated that education about population control be integrated into the school curriculum.

During the mid-1960s, the National Family Planning Program set official goals for contraceptive “acceptance” by method, which was then pursued by grassroots workers on a local level. In 1962, the central government set a target to

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reduce the birth rate from 41 live births per 1,000 to 25 per 1,000 by 1970.\textsuperscript{36} The establishment of such methods as the “target-centered” approach had significant negative effects on the quality of contraceptive services being delivered. In addition to the problems most large-scale health programs in developing countries face\textsuperscript{37}, the pressure to achieve these targets warped providers’ ability and motivation to respond directly to the needs of patients. In her book, \textit{Women’s Empowerment in South Asia: Concepts and Practice}, Srilatha Batliwala asserted that these coercive policies led to:

> “Unimaginable atrocities committed on the poor, backward castes and minorities, to force them to undergo sterilization. Government employees faced salary cuts; children were barred from school if their parents were not sterilized, irrigation water was withheld from villages that did not fill their sterilization quotas.”\textsuperscript{38}

Often, this meant that providers offered less choice of method, provided a lower quality of care, supplied clients with less information, and reduced follow-up care.\textsuperscript{39}

Nevertheless, an estimated 20 million births were averted in India between 1956 and 1975.\textsuperscript{40}

\textbf{1975-1977: State of Emergency}

The drive towards male sterilization accelerated through the 1970’s under the rule of Indira Gandhi, who served as Prime Minister from 1966-1977 and again from

\textsuperscript{36} Planning Commission, Five Year Plans, Third Five Year Plan, Article 59.
\textsuperscript{37} Donaldson defines these problems as “logistical difficulties, a poorly functioning personnel system; frequent changes in leadership; difficulty coordinating with external donors; a weak research and evaluation system; confused responsibility for implementation on the field; difficulties achieving a workable partnership between the health and family planning branches of the Ministry; and until recently, a reluctance to accept the organizations of civil society in to full partnership or allow competition between the government and the private sector for the provision of contraceptive services.” Donaldson, “The Elimination of Contraceptive Acceptor Targets and the Evolution of Population Policy in India”, 99.
\textsuperscript{40} Harkavy and Roy, “The Emergence of the Indian National Family Planning Program”, 304.
1980 until her assassination in 1984. Between 1971 and 1973, nearly 5 million sterilizations were performed in India, just under half of those performed worldwide during this period. Mrs. Gandhi delegated the task of overseeing family planning programs to her son Sanjay Gandhi, who employed highly violent coercive tactics to increase the number of men who underwent vasectomies. The program between 1969 and 1974 aimed to achieve a 60 percent contraceptive prevalence rate and a net reproductive rate of one daughter per mother.

In June of 1975, as a result of great social unrest, Indira Gandhi issued a State of Emergency, which allowed her to rule by decree, suspending civil liberties and elections. During the Emergency, Sanjay Gandhi’s family planning efforts grew increasingly violent and coercive. Poor, rural men in North India were taken off roads, forcibly or unknowingly sterilized in clinics, and promptly returned to their villages without any semblance of care. In fact, 1.7 million sterilizations were performed during the month of September 1977; a number equivalent to the annual sterilization rate for the previous decade. In their article, “India’s Family Planning Challenges: From Rhetoric to Action,” Shanti R. Conly and Sharon L. Camp state: “[Sanjay Gandhi] encouraged state governments to mobilize their entire

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41 Ibid, 311.
45 Dhanraj, Something Like a War.
administrative machinery to carry out family planning activities.”  

This campaign indiscriminately targeted married men who had already produced several children, as well as young and unmarried men, poor men, and political opponents. When she finally held a free election in 1977, Gandhi and her Congress Party were voted out of office, largely due to the scandal of this sterilization campaign.  

1977-1990’s: Post-Emergency

After Gandhi’s electoral defeat and the subsequent empowerment of the Janata party, who stood in opposition of Emergency Rule, these new officials were hesitant to address the issue of population control and family planning. They established the new title “family welfare” program and claimed to promote family planning as one part of comprehensive health care. They stressed the voluntary nature of family planning programs, but did little to actively provide services on the ground.

In 1980, Gandhi’s Congress party was voted back into power. Under this regime, the central government once again developed a targeted method, this time concentrating on the sterilization of women. Gandhi had learned from her party’s mistakes, and realized that coercively sterilizing women did not pose the same political threat as sterilizing men. While women held equal voting power, they retained less political power within the family and, therefore, in society more broadly.

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48 Dhanraj, *Something Like a War*.

49 Shanthi “Feminist Bioethics and Reproductive Rights of Women in India; Myth and Reality”, 122.


This new program phase focused primarily on tubal ligation and, to a lesser extent, IUD insertion. ²²

The number of sterilization camps established in rural areas grew rapidly during this period. These camps were designed for maximum efficiency, aiming to sterilize or insert IUDs in as many women as possible daily. They failed to involve patients in decisions regarding their reproductive health, and often ignored conditions that could be harmful to a patient using a certain type of contraception, “assigning” sterilization and IUDs to patients at disproportionate rates. Of the few women who were screened prior to contraceptive “delivery”, those who were deemed unfit for the procedure were frequently not turned away, for providers were unwilling to lose the financial benefit of reaching their target. ²³ Both providers and patients admitted that in most cases, the medical staff, not the patient, dictated the choice of method.

Ninety three percent of midwives felt that they controlled their client’s contraceptive choice. ²⁴ Sterilization camps in rural areas frequently lacked adequate light, clean water, privacy, electricity, and toilets. ²⁵ Furthermore, problems of inadequate follow-up care were common after these procedures, and frequently resulted in infection, post-procedural bleeding, and even death. ²⁶ The 1988-1989 All-India Family

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²⁴ Ibid, 4.
²⁵ Ibid, 6.
²⁶ Ibid, 9.
Planning Survey recognized that thirty-six percent of sterilization acceptors reported post-operative complications.\(^{57}\)

**1990s: The ICPD and Reproductive Rights**

The 1990s represent a major shift in the policies of India’s family planning program. This development of a target-free approach came about through a convergence of four factors: the increased presence and vociferousness of women’s health advocates, the influence of international sponsors of India’s family planning program, research highlighting the inefficacy of target-oriented methods, and the outcomes of the United Nation’s International Conferences on Population and Development.

During this time human, women’s, and reproductive rights activists began to recognize and speak out in opposition to the coercive population control tactics that were running rampant globally, and called for a re-conception of family planning programs. Women’s health advocates and women-centered non-governmental organizations (NGOs) were vital in achieving this shift in India. The international aid organizations that were once the largest proponents and funders of population-concerned policies now joined the reproductive justice movement.

This movement culminated at the International Conference on Population and Development (ICPD) in Cairo in 1994, which called attention to the injustices of coercive family planning programs. At the conference, representatives from 180 nations concurred that “population policies should address social development beyond family planning, especially the advancement of women, and that the family

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planning services should be provided in the context of comprehensive reproductive health care.” This was a massive shift in the goals of national family planning policies such as India’s. This conference was also representative of a substantial change in the attitudes of major international organizations such as the United Nations and the World Bank away from issues of population control and towards the achievement of reproductive rights for all.

Additionally, as early as 1992, the Indian government recognized that results from the target-focused program had stagnated. The state realized that centralized planning and a targeted-approach were inflexible and therefore ineffective at both providing health care and lower fertility rates in the program’s highly diverse targeted regions. The Indian government, under global scrutiny, was also pressured to respond to the demands of civil service groups and women’s groups, and it became a signatory on an international agreement that vowed to pursue only voluntary, coercion-free, and fully informed family planning care. Language surrounding population control was deemed unethical, and was replaced by that of a “target-free,” “rights-based” approach to family planning.

On paper, these changes were impressive: a full range of coercion-free contraception, broader reproductive health care services, a focus on individual care and counseling, and more. The program was decentralized in order to designate even more autonomy to the regional governments in terms of program implementation,

59 KG Santhya, “Changing family planning scenario in India: An overview of recent evidence”,.
61 KG Santhya, “Changing family planning scenario in India: An overview of recent evidence”,
which theoretically allowed increasing control to individual public health centers. Policymakers considered decentralization to be key to awarding increased control to the patient. Yet much skepticism remained about how program performance would be measured. As a result, many states imposed their own targets, restoring the coercive tactics that preceded this “rights-based” approach. Family planning health workers remained in their positions with little adjustment in instruction or additional training, further hindering tangible changes. Progress thus occurred largely in rhetoric only, and established no adequate model for the provision of comprehensive reproductive health care. Therefore, the establishment of a rights-based, target-free approach in India’s family planning program prompted minimal change in concrete outcomes for women.

These same coercive tactics persist in the program to date. In July 2012, the medical health and family welfare department of Jaipur, a major city in Rajasthan, set a target to sterilize 100,000 people between July 11 and July 14. In April 2012 in Bhopal, Madhya Pradesh, a 35 year-old man committed suicide after a plot of land, which his wife had been promised in exchange for her sterilization, never materialized. Since 2005, Britain has sponsored NGOs through which the state governments implement sterilization programs, citing concerns about the environmental impacts of India’s population. While donors expressed heightened concerns about environmental degradation, they appear to have completely disregarded obvious human rights violations. Though the language and policies of

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62 Visaria and Visaria, “Reproductive Health in Policy and Practice: India”, 10.
61 Ibid, 25.
64 “Health Department Sets 1 Lakh Target for Sterilization”, Times of India, Jun 29, 2012.
targeted population control have ceased, it is clear that, in practice, injustices persist throughout India today.
CHAPTER I: DEMOCRACY AND HUMAN RIGHTS

“The value of democracy includes its intrinsic importance in human life, its instrumental role in generating political incentives, and its constructive function in the formation of values.”

-Amartya Sen, “Democracy as a Universal Value”

Democracy has become the aim of every developing country and the global achievement of democracy the goal of the international community. Democracy is assumed to stand in opposition to tyranny, political exploitation, and the abuse of citizens. The structure of the Indian government is staunchly democratic. Yet India’s family planning program exemplifies that the systematic, widespread, and long-standing coercion of citizens by their government is a real possibility in Indian democracy. The pervasive nature of this coercion hints that this is not a failure of India’s democracy, but rather a malfunction by which systematic coercion can be conducted within the system. In order to illuminate India’s case, this project necessitates a theoretical explanation of different manifestations of democracy, and of each of their motivations, objectives, and institutions.

DEMOCRATIC OBJECTIVES

The goals, definitions, and objectives of democracy have long been debated. Therefore, the question of what constitutes “true” democracy stands to date. Definitions of democracy tend to be nebulous and often contradictory in order to apply to multiple forms of democracy. Thereby, it becomes difficult to draw the line between a democratic and a non-democratic regime. At a most basic level, democracy is a procedure by which to make collective decision for a group; that is,
democracy is a political system. In *Democracy and Human Rights*, David Beetham asserts that: “A system of collective decision-making can be said to be democratic to the extent that it is subject to control by all members of the relevant association, or all those under its authority, considered as equals.” This section aims to demonstrate that, while there exists a basic core meaning of democracy, which can apply to a multitude of democratic manifestations and definitions, the divergent objectives of various forms of democracy reveal that democracy cannot be assumed to be a universal good, and further that no singular model within democracy is best or a universal fit.

**What constitutes democracy?**

In *What Political Institutions Does Large-Scale Democracy Require?* Robert Dahl outlines his requirements for democracy which entail: 1) elected officials; 2) free, fair, and frequent elections; 3) freedom of expression; 4) alternative sources of information; 5) associational autonomy; and 6) inclusive citizenship. For the purposes of this project, this chapter will highlight the two democratic values that are central for the protection of human rights. First, all citizens, by whatever means, must have equal say in all political decisions. Second, a regime is considered to be democratic if political power is ultimately held with the populous. Thereby, a democratic regime rules by popular sovereignty, wherein governance is empowered by the people.

Idealistically, democracy could take a direct form, in which all individuals are able to debate and vote on initiatives directly. With negligible exceptions, direct

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68 Robert Dahl, "What Political Institutions Does Large-Scale Democracy Require?" *Political Science Quarterly* 120, no. 2 (Summer 2005), Table 1.
democracy becomes logistically infeasible once a nation reaches a certain size. Second, a participation problem emerges when the population grows to a point where institutions that allow for direct expression, like town hall forums, become unrealistic. Otherwise, democracy must assure that any policy implemented accurately represents the will of the people.  

Therefore, alternative channels of popular expression must be explored in order to achieve popular sovereignty. First, the state may empower a random sampling of the population by using a lottery ballot system. This eliminates the voting biases inherent in free elections. Yet a random ballot may not be truly representative of the popular will, as another random drawing would be highly likely to yield a different outcome. In Democracy and Elections, Richard Katz proposes the possibility of the expression of public opinion through random sample surveys. However, random surveys do not allow for political discourse among respondents, and may thereby favor individuals’ private interests rather than the general will. Furthermore, unlike a random ballot system, random surveys ultimately leave the decision in the hands of empowered officials, who are free to choose whether or not to honor the popular opinion.

Elections have become the singular procedure that designates a regime as democratic. Most regimes have adopted systems of elected representatives, who are imbued with the power to express the will of the people. The role of elections differs between various forms of democracy. In Democracy and Elections, Richard Katz explains how elections can legitimate a regime’s rule. He states:

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70 Ibid, 28
Because democracy is taken virtually to be the only acceptable form of government, this becomes a general argument about the legitimacy of a political system, which is legitimate because it’s democratic, and democratic because it holds elections.71 Elections are able to legitimate rule because they are taken to represent the consent of the people to be ruled by the elected authority. Thereby, free democratic elections are valued because they allow the greatest opportunity for individuals to assert their own choice, control, and political agency in a system of governance. Elections empower the populous to choose their own representatives. In order for a representative election to be democratic, a representative should theoretically act according to their constituents’ interests.

The discourse involved in an electoral campaign allows individuals the opportunity to become informed about their nations’ politics, and they are therefore more likely to make informed decisions when voting. Katz states, “Opportunities for expressing demands and proposing solutions to problems cannot transform subjects into citizens so long as responsibility lies elsewhere.”72 Elections allow individuals to take responsibility for their own governance. Thereby, popular sovereignty and political equality manifested through fair and free elections may be considered the overarching indicators that a government can be designated democratic.

Yet the regular occurrence of elections alone is not enough to legitimate a regime’s rule. A regime that is legitimately elected could take its empowerment as entitlement to act by its own accord, without consideration of its citizens’ best interests. In *The Third Wave: Democratization in the Late Twentieth Century*, Samuel 71 Ibid, 102. 72 Ibid, 105.
Huntington recognizes that while an electoral system dictates how a regime accumulates and uses its power, it does not necessarily guide its goals. He asserts:

Governments produced by elections may be inefficient, corrupt, shortsighted, irresponsible, dominated by special interests, and incapable of adopting policies demanded by the public good. These qualities make such governments undesirable but they do not make them undemocratic. Democracy is one public virtue, not the only one, and the relation of democracy to other public virtues and vices can only be understood if democracy is clearly distinguished from the other characteristics of political systems.⁷³

Therefore, elections do not guarantee against tyrannical rule. Further, in *Democracy and Human Rights*, David Beetham articulates: “although elections form a key mechanism for the popular control of government, they are of limited effectiveness on their own without institutions that secure a government’s continuous accountability to the public.”⁷⁴ Electoral empowerment should not be assumed to be congruent popular consent, and do not necessarily constitute a limit over state power.

**DEmOCRATIC FORMS**

Even given the practically universal requirements of popular sovereignty and elections for democratic regimes, democratic structure can take on several forms, each with its own objectives, values, and set of institutions. This section examines three such models: liberal democracy, participatory democracy, and communitarian democracy.

**Liberal Democracy**

The study of democracy has mistakenly assumed the mutual assurance of democracy and liberalism. In reality, the liberal strain is only one of democracy’s

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forms. Most broadly, the value of liberalism aims to preserve the freedoms of individuals by limiting the power and actions of the state. Liberal democracy holds central a defense of rights, which in the liberal sense are negative. Policies exist to protect individuals from an “unjustified deprivation of rights”.75 Here, it is important to note that in a liberal democracy, individual rights are not absolute, for the state must reserve the right to justly deprive a citizen of rights in order to defend the rights of others or the state as a whole.76 Examples of such just deprivation would include fair imprisonment and the collection of tax revenue. Severe limits, however, must be placed on this conception of the justified deprivation of rights of citizens by the state.

Liberalism, therefore, values democracy because it is the political process which best protects individual freedom.77 While liberalism limits state power, democracy dictates how this power is accumulated and used. The institutions that characterize liberal democracy therefore function to protect individual liberty by placing limits on the actions and power of the state. Aside from just and free elections, liberal institutions may feature any of several formal institutions: constitutions, legislatures, executive powers, and federalism. These institutions limit state power by separating government branches. Additionally, these institutions hold central the rule of law, and ideally, through this constriction of power, protect human rights and civil liberties.

Due to the historical Western idealization of liberal democracy, the disadvantages of liberal democracy, while real, are rarely recognized. First, the individualist values of liberal democracy assume an antagonism between individuals,

75 Richard Katz, *Democracy and Elections*, 47.
76 Ibid, 47.
77 Ibid, 46.
which complicates the singular objectives of a political community. Second, liberal democracy’s restrictions on state power generally provide for an equality of opportunity, rather than an equality of outcome. Therefore, existing inequalities between religions, ethnicities, genders, and classes may be unimproved, or even exacerbated, by liberal democratic rule.

In *The Disorder of Women: Democracy, Feminism, and Political Theory*, Carole Pateman explicates the failures of liberal democracy from a feminist perspective. She asserts that historically, liberal democratic theorists have assumed that the individuals whose rights are in question within liberal democracy, are men. Pateman argues that while liberalism holds central the political equality of all citizens, the exclusion of women, or any other social minority, does not disqualify a government from being considered a liberal democracy. Liberal democracy takes for granted that political equality is possible in societies without social equality. Pateman states,

> Democratic citizenship, even if interpreted in the minimal sense of universal suffrage in the context of liberal civil rights, presupposes the solid foundation of a practical, universal recognition that all members of the polity are social equals and independent ‘individuals’, having all the capacities implied by this status.\(^7^8\)

The formal political establishment of liberal individualism therefore only truly protects the liberties of those who already have the means—the social or political agency—to assert it, and therefore can easily exclude those who are politically disempowered to begin with. Liberal democracy fails to recognize and account for the structural inequality that prevents disadvantaged members of society from

exercising their political autonomy. While liberal democratic assertions of rights are important, one must question how substantive these individual rights are in practice in a liberal democracy; that is, whether liberal democracy best ensures the equality of political actors.

**Participatory Democracy**

Participatory democracy focuses on reconciling the consent of the populous with the process of elections by maximizing the participation of constituents in political processes more broadly. In participatory democracy, legitimacy is derived from a full consideration of all political interests, which should lead both politicians and the people to a better understanding of their own political objectives.79

Participatory democracy fuses ideas from direct and representative modes of democracy. While the decision about policy proposals ultimately rests with the people, politicians assume only the role of implementing this policy, as compared to most representative democracy, where policy is decided by elected representatives and the electorate asserts its will by endorsing or rejecting the choice in future elections.80 Therefore, the effectiveness of a participatory democracy can be measured by how closely implemented policy reflects citizens’ policy proposals.81 A participatory democratic regime’s legitimacy is dependent on the continuous and active political participation of its citizens. The actions of politicians in a participatory democracy are highly constrained by the will of the people. In participatory democracy, the electorate votes directly on the perceived ability of a

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79 Richard Katz, *Democracy and Elections*, 73
81 Ibid, 4.
politician to implement unadulterated policy, rather than on how that politician’s decisions lines up with the voter, as is the case in most representative democracies. Therefore, such a regime leaves little opportunity for discrepancy between the will of the people and the actions of politicians. Further, this process of participation aims to open political decision-making to a broader range of people.

In *Liberalism and Social Action*, John Dewey states, “The method of democracy—insofar as it is that of organized intelligence—is to bring these conflicts out into the open where their special claims can be discussed and judged in the light of more inclusive interests than are represented by either of them separately.”

Participatory democracy aims to achieve social inclusion, and avoid individual isolation. In *Participation and Democratic Theory*, Carole Pateman argues that the structure of governance has direct sway over how individuals view themselves as political actors. Participatory democracy should therefore be structured in order to ensure that “each individual member of a decision-making body has equal power to determine the outcome of decisions.” It benefits the individual by holding individual input central to the political decision making process, and involves individuals in their society by demanding cooperation in an effort to avoid any coercion, and partaking in an exercise of discourse to reach decisions, rather than having decisions imposed on them by an authoritarian figure.

Yet participatory democracy has several significant shortcomings. First, its critics argue that participatory democracy is essentially direct democracy—and

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82 Dewey, Liberalism and Social Action, 56
therefore brings about the same logistical problems. In order to truly achieve meaningful participation of citizens in participatory democracy, the system must sacrifice its efficiency. For example, referenda are much more inefficient and costly than decisions made by elected representatives. Further, this inefficiency cannot be corrected with representation because participatory democracies by nature dictate that representation constricts the political agency of the individual. Additionally, in participatory democracy, group participation threatens to deteriorate into a tyranny of the majority.

**Communitarian Democracy**

Like participatory democracy, communitarian democracy considers individual participation in communal political life to be central to achieving human fulfillment. Yet in communitarian democracy, maintaining and strengthening the connection between the individual and community is the central function of political life.84 While communitarian democracy considers individuals to be highly important to the political process, individual potential is recognized through their participation in and membership to communities.85 Therefore, strong individuals are created through strong communities. Rather than aiming to protect the interests of individuals out of context, in communitarian democracy, individual will is considered to consistently be congruent with the will of the community.

Communitarian democracy requires a strong sense of solidarity. Individuals must uphold the tenets of reciprocity, loyalty, and shared commitment.

Communitarian democracy requires the development of a common identity, through

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84 Katz, *Democracy and Elections*, 78.
85 Katz, *Democracy and Elections*, 78.
which citizenship becomes a source of pride for individuals, rather than a default attribute. Communitarian democracy necessitates a boundary that delineates membership to this community. Thus, individuals become compatriots, with collective obligations to internalize and provide for each other’s needs and interests.\textsuperscript{86} The social reinforcement resulting from strengthened relationships—between individuals, and thus between individuals and their community—will inherently facilitate cooperation and coordination within the political sphere.

Further, communitarian democracy prevents the development of opposed interest groups by assuming that each individual will belong to a multitude of communities.\textsuperscript{87} Ultimately, this web of overlapping communities can create a singular community, the members of whom are able to act effectively in its interest. Communitarian democracy inevitably involves some form of conformity, although theoretically this conformity avoids encroaching on the will of the individual.

Several features of communitarian democracy threaten its democratic function. When compared to other forms of democracy, communitarian democracy allows the greatest opportunity for individual rights or interests to be violated or constricted, as its ultimate objective is centered on the communal will. Therefore, corrupt leadership could more easily manipulate this collective will against individual interests. Alternately, corrupt leadership in a communitarian democracy could engineer an obedient and well-controlled, rather than responsive and politically engaged public, in the name of the collective. This scenario would restrict individual autonomy and

\textsuperscript{86} Amitai Etzioni, “Citizenship in a Communitarian Perspective”, \textit{Ethnicities}, September 2011 vol. 11 no. 3, 336-349
\textsuperscript{87} Katz, \textit{Democracy and Elections}, 79.
choice, and compromise the ability of citizens to genuinely participate in political processes.

**DEMOCRACY AND HUMAN RIGHTS**

Over the past century, the international arena has begun to view democracy as a requirement for a nation’s legitimacy and participation in the global political sphere. This has occurred because democracy is considered to allow the greatest opportunity to uphold the integrity of individual interests in the political decision making process, and further provides individuals the best opportunity to resist when their rights are being violated. Yet democracy itself does not guarantee this. If democracy continues to be the standard by which regimes are designated benevolent, the objective of a democracy must ultimately be a commitment to the human rights of its citizens by the state.

The question thereby arises as to how democracy may be formed in order to allocate state power in a way that is effective and efficient both in achieving national goals and in respecting the desires and needs of its citizens. An ideal democracy should hold central the duty of protecting the welfare of its citizens, from external forces, but particularly, from other groups in society, from other individuals, and from the state itself. This section aims to identify the aspects of each form of democracy that best provide for the protections of citizens.

When considering the objective of protecting human rights, Western thought praises liberal democracy as the strain of democracy that best provides for the protection of individual rights. In actuality, it is its formal institutions that are most effective in protecting citizens of liberal democratic states from their own
governments. A separation of state power, checks and balances, federalism, and an official commitment to the preservation of civil liberties, all prevent government abuses of the people by limiting how much power is accumulated by any singular government actor, and by dictating how this power may be used. Yet the mechanisms of liberal democracy that attempt to safeguard individual liberty can exacerbate existing societal inequalities when applied to states outside of the tradition of Western liberal democracy. Therefore, liberal democracy cannot be assumed to be the universal ideal form of democracy in order to protect individual rights.

Meanwhile, the methods by which communitarian democracy addresses relationships between individuals may be more effective than liberal democracy at preventing abuses of minority rights and ensuring political equality. This is particularly true if this democracy is being applied to an existing context of high socio-political inequality. Communitarian democracy promotes political equality by creating an environment that encourages and even requires individual decision-making to consider and absorb the needs of their compatriots. Thereby, individuals in a communitarian democracy are less likely to be tolerant of government actions that abuse or disadvantage other citizens. Yet communitarian democracies, as previously stated, provide greater opportunity for corrupt leadership to violate human rights by subverting the needs of the individual under the common good.

The political processes of participatory democracies are most effective in upholding human rights by giving voice to the political will of each individual. Policy created in participatory democracies should directly reflect the will of the people, with minimal chance that politicians could corrupt this will. Yet participatory
democracy also threatens human rights by failing to prevent a tyranny of the majority when considering the process of policy development and implementation.

In order to protect human rights worldwide, human rights and democracy must become interdependent. These three imperfect forms of democracy each feature attributes that protect and attributes that fail to uphold human rights. An ideal form of democracy would therefore provide for the protection of the human rights of citizens, from their state, from their society and from other individuals. A model democracy should dictate that it cannot function without a commitment to safeguarding human rights, and additionally that human rights cannot be guaranteed without democracy.
CHAPTER II: INDIA’S FAMILY PLANNING POLICY
FROM 1951-PRESENT

“If some excesses appear, don’t blame me. You must consider it something like a war. There has been pressure to show results. Whether you like it or not, there will be a few dead people”

-D.N. Pai, 1976, Director of Family Planning, Maharashtra

In order to gain insight into the development and application of coercion within the Indian Family Planning Program, it is necessary to analyze not only the program itself, but also the political circumstances from which it arose. Therefore, this chapter examines the program through four distinct time periods: the establishment of Indian democracy (1947-1951), the initial development of the family planning program (1951-1971), Indira Gandhi’s Rule, the Emergency, and its aftermath (1971-1994), and the contemporary period (1994-present). This chapter will contextualize this analysis within the framework of India’s democratic establishment, thereby attempting to understand the implications that Indian democracy has for individual choice in family planning.

PERIOD I: 1947-1951, THE ESTABLISHMENT OF INDIAN DEMOCRACY

“We the People of India, having solemnly resolved to constitute India into a sovereign socialist secular democratic republic and secure to all its citizens...

JUSTICE, social, economic and political;

LIBERTY of thought, expression, belief, faith and worship;

EQUALITY of status and of opportunity;

And to promote among them all
FRATERNITY assuring the dignity of the individual and the unity and integrity of the Nation.”

-Preamble to the Constitution of the Republic of India

The establishment of India’s independent democracy reflected the political climate of the period—an outgrowth of a colonial legacy, a powerful nationalist movement, and ambitious and diverse ideas about India’s political potential. In a procedural sense, India is commonly understood to be a liberal democracy due to its form of government: a federal constitutional parliamentary republic. This system grew directly out of the political institutions established during Britain’s colonial rule. Several liberal institutions characterize the Indian state: a separation of powers, adherence to a rule of law, and competitive elections. This liberal influence was codified in India’s constitution, the longest in the world. The preamble to the constitution broadly guarantees citizens justice, freedom, equality, and fraternity, namely by “assuring the dignity of the individual and the unity and integrity of the Nation.”

In Part III, entitled Fundamental Rights, India’s constitution asserts that “the State shall make any law which takes away or abridges the rights conferred by this Part and any law made in contravention of this clause, to the extent of the contravention, be void”. Part III goes on to outline citizen rights of: equality before the law; prohibition of discrimination based on religion, race, caste, sex, descent, place of birth, or residence; certain individual freedoms; and protection against exploitation. The articles concerning individual freedoms from exploitation are

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88 Preamble to the Constitution of India.
89 Preamble to the Constitution of India.
90 Constitution of India, Part III “Fundamental Rights”
particularly notable for the purposes of this project, as they seem to ignore the possibility of this transgression originating from the state. The Indian constitution asserts as its duty the protection of certain rights such as freedom of speech and expression, freedom of peaceful and unarmed assembly, and freedom of association.91 Clauses 23 and 24, meanwhile promise protection against exploitation in the cases of forced labor and trafficking.92

Yet the entire section addressing rights in India’s constitution features a major stipulation. Each assertion of rights is followed by a phrase that states:

*Nothing in sub-clause [x] of clause [x] shall affect the operation of any existing law, or prevent the state from making any law, in so far as such law imposes reasonable restrictions on the exercise of the right conferred by the said sub-clause in the interests of the sovereignty and integrity of India, the security of the State, friendly relations with foreign States, public order, decency or morality, or in relation to contempt of court, defamation or incitement to an offence.*93

These sweeping generalizations of justified restrictions on citizen freedoms in the Indian constitution are threatening to individual rights. Therefore, while Indian democracy is characterized as liberal for its political institutions, the inadequate assertions of freedoms in India’s constitution threaten a failure to guarantee these individual rights in a liberal sense. Specifically, this precondition threatens a failure of the constitution to protect Indian citizens from their government.

Perhaps most commonly, India is lauded as democratic for its achievements in smoothly implementing a universal electoral system in which all citizens genuinely have the opportunity to vote. Directly after independence, India established universal adult suffrage in elections, a feat that was considered progressive for any nation at the

91 Constitution of India, Part III “Fundamental Rights”.
93 Following phrase to Articles 19 in Part III, “Fundamental Rights”.
time, and particularly impressive for a country with such strong cultural conceptions of gender and class involvement in politics. Article 326 of India’s constitution reads: “The elections to the House of the People and to the Legislative Assembly of every State shall be on the basis of adult suffrage; that is to say, every person who is a citizen of India and who is not less than eighteen years of age.” The government has been admirably effective in its attempt to overcome the difficulties faced in creating a universal electoral system in a nation as diverse, populous, and vast as India. Both the central and state governments have pursued major initiatives that attempt to facilitate voting for illiterate Indian citizens. The establishment of universal suffrage in free democratic elections was the state’s attempt to allow all its citizens to participate in the massive process that is government in India.

Yet the political and scholarly community has recently begun to question the assumption that free and fair democratic elections assure legitimacy and adequate political participation for the masses. In “The Rise of Illiberal Democracy”, Fareed Zakaria warns of the dangerous trend of developing nations adopting the structural components of democracy—like elections—without taking on its substantive ideals. He states: “Democratically elected regimes, often ones that have been reelected or reaffirmed through referenda, are routinely ignoring constitutional limits on their power and depriving their citizens of basic freedoms.” Zakaria also asserts that elections have become the price of entrance into the global democratic arena.

Similarly, in Indian Democracy: Problems and Prospects, Sharmila Mitra Deb and

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94 Constitution of India, Article 326.
95 Recently, the Indian Government has undertaken an initiative to spread the use of electronic voting machines, which claim to facilitate the voting process for illiterate voters.
97 Ibid, 1.
Madhav Manisha state, “That elections forge a nation into a political community is undoubted. However, they should also reflect the moral community if the spirit of democracy is to prevail. As an institutional mechanism they are expected to ensure this end, failing which the utility of elections as democratic can be questioned.”98 These scholars assert that substantive democratic values—such as a true reflection of the will of the people—should count for as much or more than the presence of democratic structural institutions, like elections.

Many of the political values reflected in India's democratic founding drew from the nationalist movements that had engendered India's independence. Many of these nationalist tenets reflected a rejection of liberal Western values, in favor of communitarian democratic notions, which nationalist leaders thought to be truer to traditional Indian values independent of colonial influence. Democratizing nations often recognize that, while it is inarguably a product of the West, democracy must be adjusted and rearticulated to fit each nation's specific context. For India, this meant the adoption of socialist features within the liberal democratic structure of government.

The Indian nationalist movement originated from group demands for social reform against the oppression caused by both native structures and from the Colonial government during its rule.99 In order to unite the diverse and disparate Indian population as much as possible, the movement—spearheaded by Gandhi and Nehru—garnered support based on the sentiment that the advancement of the Indian state as a whole would lead directly to an improvement in individual quality of life. Moreover,

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99 Ibid, 2.
communitarian values of the nationalist movement fit well with traditional ideas that understood the Indian nation as a singular family, and individual sacrifice for the whole as the duty of the citizen.

Further, the Indian government used communitarian notions to garner public support for development programs. The Indian government took as its democratic duty the elimination of poverty. These development efforts took the form of socialist programs on a national scale, which were established within the limits of India’s democratic structure, and incorporated aspects from both communism and capitalism. The central government created a Planning Commission in order to carry out these programs, which developed five-year plans that aimed to improve various societal problems in India. The communitarian idea of individual sacrifice for the objective of social equity became prominent and threatened to dilute individual rights in India’s development programs.

It is clear that India faced a complex dilemma during the establishment of its independent democracy. The state was riddled with a multitude of challenges including: conflicting political aspirations, significant diversity in its population, high levels of inequality, and the breadth of the nation, which together made defining a democratic public will and forging a national ideology extremely difficult. In an effort to account for the challenges caused by this diversity, the Indian state was founded on the ideals of democracy, federalism, and secularism.

Yet inconsistencies emerged between India’s democracy in theory and in practice. These discrepancies facilitated gaps in the Indian government, spaces which opened the Indian state to undemocratic injustices such as the dire human rights
abuses that occurred and became commonplace in India’s National Family Planning Program.

**PERIOD II: 1952-1971, INTRODUCTION OF THE NATIONAL FAMILY PLANNING PROGRAM**

The development of the National Family Planning Program was a prominent undertaking of the Indian government’s Planning Commission. Because the state considered overpopulation to be at the root of such societal ills as hunger, poverty, and national economic distress, it prioritized this increasingly aggressive program that aimed to curb fertility. Thus, the state created the Ministry for Health and Family Welfare, and expected to develop a series of Five-Year Plans in order to address population control. Each plan offered quantitative objectives, as well as strategies by which to achieve them.

The First Five-Year Plan (1951-1956) introduced the idea of family planning and population growth as aspects central to the health and welfare not only of Indian citizens but also to the nation as a whole. The plan asserted that a reduction in the country’s birth rate was important in order to achieve a sustainable level of resource-use, and to optimize the health and welfare of the family. The first plan was responsible for establishing standards of tactics in India’s population control efforts. This plan rejected the idea of development as a method to lower fertility rates, as the state considered population growth to stand in the way of development. Article 105 of the First Five-Year Plan asserted, “While a lowering of the birth-rate may occur as a result of improvements in standards of living, such improvements are not likely to

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100 Planning Commission, Five Year Plans, First Five Year Plan, Health and Family Planning, Article 105.
materialize if there is a concurrent increase of population.\textsuperscript{101} Therefore, active state intervention to control population was necessary in order to achieve development.

The first plan also asserted that this reduction could be secured only by “the realization of the need for family limitation on a wide scale by the people.”\textsuperscript{102} This consciousness could only be achieved by changing popular attitudes about reproduction and family planning through an “extension education approach.” This approach aimed first to motivate families to adopt fertility-limiting practices through education, and subsequently to provide “the necessary advice and service based on acceptable, efficient, and harmless economic methods.”\textsuperscript{103} Further, this plan noted that while education was the cheapest first step towards encouraging family limitation awareness, the program would require extension and evolution in its subsequent stages.

The Second Five-Year Plan (1957-1961) aimed to build upon what it considered to be the limited successes of the first plan. It reflected on its previous progress, stating, “The family planning program was primarily directed to the building up of an active public opinion in favor of family planning and the promotion of family planning advice and serve on the basis of existing knowledge.”\textsuperscript{104} Now, the second plan required “further systematic development” of existing family planning programs. These new developments in India’s Family Planning Program were centered on a “clinic extension approach” which stressed the free or subsidized provision of family planning services through hospitals, health centers, and especially

\textsuperscript{101} Ibid, Article 105.
\textsuperscript{102} Ibid, Article 105.
\textsuperscript{103} Ibid, Article 106.
\textsuperscript{104} Planning Commission, Five Year Plans, Second Five Year Plan, Health and Family Planning, Article 54.
through the rapid development of family planning clinics.¹⁰⁵ Between 1956 and 1961, the plan outlined a major expansion of family planning-focused health clinics, with an objective of establishing one clinic to serve every 50,000 people.¹⁰⁶ This second plan continued to function on the belief that creating awareness would lead to increased demand for family planning services among the populous.

The Third Plan Five-Year Plan (1961-1966) continued to promote as its objective a steady expansion of family planning activities, with the recommendation that family planning should become central to the Planning Commission’s development program. The plan aimed to transform family planning from a government-directed development plan into a socially driven movement.¹⁰⁷ To achieve this, the third plan called for an intensification of existing education and service provision efforts. Additionally, this Plan first suggested the development of sterilization centers, with the objective of “sterilization undertaken on the basis of voluntary choice.”¹⁰⁸ Notably, the third plan continued to intensify family planning efforts, though it acknowledged that there already existed widespread awareness of family-limitation information, despite the failure of such efforts to make a meaningful impact on fertility behavior.

This review of objectives, methods, and results of family planning programs over the course of India’s first three five-year plans calls to attention several issues pertinent to ideas of democracy, human rights, and coercion. The faults of these plans are reflected in Betsy Hartmann’s book, *Reproductive Rights and Wrongs*, where she

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¹⁰⁵ Ibid, Article 54.
¹⁰⁶ Ibid, Article 56.
¹⁰⁷ Planning Commission, Five Year Plans, Third Five Year Plan, Health and Family Planning, Article 59.
¹⁰⁸ Ibid, Article 66.
outlines several assumptions made by population experts about fertility and population in the developing world.

First, Hartmann asserts that such experts assume that there exists a high demand for family planning services among their recipient population. The initiatives of India’s Family Planning Program were indeed predicated on the belief that low adoption of family-planning practice in India was a problem of supply, not of demand, and that such initiatives were serving an existing demand for contraceptive services that the people were either oblivious to or unable to articulate. This is particularly problematic for a democracy because rather than responding to a demand for family planning services from its people, the state is acting in a paternalistic fashion, assuming its ultimate knowledge of the societal rather than consulting its populous. Such action is symptomatic of a democratic malfunction, and is reminiscent of autocratic rule.

Second, Hartmann states that population control programs reveal the expectation that the targeted group can be easily motivated to accept family planning initiatives. This is visible in the evolution of the Family Planning Program through these three five-year plans. After an extensive education approach in the First Five-Year Plan failed to significantly alter fertility behavior, policymakers continued efforts to increase availability of services through clinics, which grew towards an incentive-based approach.

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109 Hartmann, Reproductive Rights and Wrongs, 58
110 Hartmann, Reproductive Rights and Wrongs, 59.
111 The HITTS (health system based incentive driven time-bound target-orientated schemes) approach used efficiency-promoting means such as sterilization camps and financial incentives in order to achieve demographic pre-determined by the Planning Commission.
This evolution of approaches calls to attention the issue of incentives and coercion in and beyond India’s family planning program. Notably, these plans never officially or intentionally sanctioned coercion in their policy. Policymakers assumed that incentives could be employed in order to avoid compulsion, and did not consider the possibility that incentives could, in fact, become coercive. In her article, “Coercion in a Soft State: The Family-Planning Program of India”, Marika Vicziany states, “Persuasion and incentives were seen by the Indian politicians as an alternative to compulsion which, in the cold-war climate of the 1950s and 1960s, had become identified with the communist method of modernization.”112 Therefore, because the Family Planning Program rejected compulsion, no body, political or otherwise, sufficiently questioned the actual methods by which the Indian government was realizing population control, and instead assumed that the government was successfully altering human behavior by voluntary means. Instead, the efficacy of the allegedly voluntary initiatives employed in India’s family planning period justified their use and escaped questioning.

Third, Hartmann contends that experts assume that the large-scale goals of population control necessarily reflect the values and desires of individuals.113 Such an assertion calls to attention problems of individual choice and agency in a democracy. The liberal and communitarian forms of democracy discussed in the previous chapter—address this relationship between the individual and the democratic whole. Certainly, liberal democracy stands the most in opposition to any policy that assumes this congruence, as it would consider such an assumption

113 Hartmann, Reproductive Rights and Wrongs, 60.
threatening to individual rights. Meanwhile, communitarian democratic norms support the idea that the best course of action for the whole inherently reflects the optimum outcome for the individual. Given the plural forms of democracy that feature in India’s political structure, India has not prescribed an expected relationship between its citizens and the state.

Development programs further complicate this relationship between the individual and the whole, as they often require some form of constriction of individual liberties for the advancement of the nation, which will ultimately be compensated by an improvement in the standard of living for individuals. The rhetoric of the first three plans speaks to this relationship between individual and common good by addressing the motivations for and beneficiaries of family planning efforts. The third plan stated, “In the circumstances of the country, family planning has to be undertaken, not merely as a major development program, but as a nation-wide movement which embodies a basic attitude towards a better life for the individual, the family, and the community.” Although these plans initially addressed family planning as an imperative due to the benefits they offer for both the collective and for the individual, over time, the language of these plans shifts away from an emphasis on the advantages of family planning practices for individuals, and towards a discussion focused nearly exclusively on the necessity of population growth for the whole. These original plans established the attitude that Indian citizens would and should comply with population control programs that restricted their reproductive decisions due to their benefits for the Indian nation as a whole.

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114 Planning Commission, Five Year Plans, Third Five Year Plan, Health and Family Planning, Article 59.
This discussion therefore calls into question the extent to which individual liberty can be constricted in efforts to improve the whole in a democracy, as well as the best means by which to protect human rights in a nation facing the same challenges to its democracy as India.


This period, beginning in 1971, contains the most infamous era of the Indian Family Planning Program, the State of Emergency. When scholars address coercive practices within India’s Indian Family Planning Program, it is nearly exclusively in the context of India’s Emergency period. Certainly, the Emergency, which featured an extensive restriction of civil liberties, was a horrific abuse of many Indian citizens by their government. Historically, the contrast drawn between the Emergency and other eras in India’s family planning program has been unmerited, as the Emergency is erroneously considered to be a disruption of an otherwise voluntary program. This section aims to disprove this assumption by framing the coercive family planning activities of the Emergency as an outgrowth of the existing programs and tactics of the Program.

**The Pre-Emergency Period**

Indira Gandhi rose to power as India’s Prime Minister in 1966, following the sudden death of Lal Bahadur Shastri, then-leader of the Congress Party. Gandhi was reelected by a narrow margin in 1967, and became highly popular with the success of
the Indo-Pakistani War in 1971 and her aggressive policy of economic growth, subsequently winning the 1971 national elections by a huge majority.  

When it came to family planning, Gandhi’s rule was marked by a colossal expansion of the national program. In the Fourth Five-Year Plan (1969-1974), family planning was designated a highest priority program within the Planning Commission. It was during this period when the “target and time-bound approach” was first introduced into the Family Planning Program. This approach set specific goals for markers such as clinic establishment, family planning practitioners, and most notably, contraceptive acceptance.

Although the fourth plan described the program’s successes as having roused “widespread public interest”, the birth rate remained largely unchanged in the period leading up to Gandhi’s rule. This new policy called for an intensification of the program through several major changes. First, the fourth plan integrated family planning with maternal and child health services in an effort to make family planning more agreeable to the public. During this period, the government focused on developing and emphasizing long-acting contraceptive methods—mainly vasectomy, and later IUD and tubectomy. Although the program celebrated its achievement of 1.8 million “voluntary” sterilizations from 1967 to 1968, it subsequently suffered from a “temporary set-back” in sterilization and IUD acceptance from 1968 to 1969 due to

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116 The HITTS (health system based incentive driven time-bound target–oriented schemes) approach used efficiency-promoting means such as sterilization camps and financial incentives in order to achieve demographic pre-determined by the Planning Commission. Planning Commission, Five Year Plans, Fourth Five Year Plan, Health and Family Planning.
117 Planning Commission, Five Year Plans, Fourth Five Year Plan, Health and Family Planning.
118 Gwatkin, “Political Will and Family Planning,” 36.
“reported side effects like bleeding and pain.”  

Further, in order to facilitate this increase in acceptance, sterilization camps were placed under the jurisdiction of central government policy and rapidly established throughout the country.  

This period also featured the beginning of policy that called for incentive plans that financially remunerated the user for their contraceptive use. The Fourth Five-Year Plan states: “The facilities for IUD insertions and sterilizations were provided not only free but also with some compensation to the individuals for out-of-pocket expenses, conveyance, and loss of wages.”  

As time went on, this program evolved from financial compensation for the wages lost during the week after sterilization, when the patient was expected to rest, to financial incentives, which aimed to alter the payoff structure of the individual towards choosing sterilization.  

In 1973 and 1974, the program was forced to abandon the mass-vasectomy-camp and incentive approaches due to financial constraints.  

As a result, this period featured a significant dip in sterilization acceptance. This lag in “progress” reveals that the latent and pervasive demand upon which the Family Planning Program was predicated may not have actually existed. To counteract this setback, financial incentives for sterilization were coupled with or eclipsed by financial repercussions for families that had more than two children. Additionally, the incentive plans implemented during this era grew to include intermediate “motivator” incentives,

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119 Planning Commission, Five Year Plans, Fourth Five Year Plan, Health and Family Planning, Article 18.23.
120 Gwatkin, “Political Will and Family Planning: The Implications of India's Emergency Experience”, 33.
121 Planning Commission, Five Year Plans, Fourth Five Year Plan, Health and Family Planning, Article 18.21.
122 Ibid, Article 18.22.
which compensated workers at various levels of the Indian bureaucratic system for recruiting individual sterilization “cases”.  

The development of these incentive programs calls for a distinction between an incentive and a bribe in family planning. In her article, “Coercion in a Soft State: The Family Planning Program of India”, Marika Vicziany articulates two features that distinguish incentives from bribes. First, an incentive should offer compensation only after the individual has been given all accurate information about the effects of the procedure, as well as a full and unbiased description of a range of alternatives. Second, with an incentive, the candidate for sterilization should ultimately decide to accept sterilization because she or he believes that the procedure will improve their lives, not because the incentive is valuable enough that the money promises improvement and prevents the individual from thinking beyond financial gain.

Directly prior to the Emergency, India participated in World Population Conference in Bucharest, in 1974. Dr. Karan Singh, Minister of Health and Family Planning, coined the phrase, “Development is the best contraceptive”. Through this declaration, Singh signaled both his rejection of the coercive population control tactics that the Indian government had been practicing for years, and his call for a shift in family planning policy towards programs that aimed to improve the root causes of high fertility. Yet Singh’s progressive assertions would be pushed aside only a year later, when Prime Minister Indira Gandhi decreed a state of Emergency rule.

124 Ibid, 394.
125 Ibid, 394.
126 Ibid, 395.
The Emergency

India’s Emergency is understood by scholars in retrospect as the climax of the coercion involved in India’s family planning program. By the end of the Emergency, which lasted 21 months, from 1975-1977, officials of the family planning program had ordered for the sterilization of millions of Indian citizens, most commonly by force and against their will.

From 1973 to 1974, Gandhi fell from popularity as North India was overcome with riots protesting government corruption, substandard living conditions, and the struggling economy overall. In fear of losing her office due to widespread calls for her resignation, Gandhi declared a state of Emergency, which restricted constitutional rights and eliminated her political opponents under the guise of national stability.

Indira Gandhi entrusted control of the family planning program to her son, Sanjay Gandhi, who implemented an aggressive sterilization campaign that targeted men in North India. He justified such drastic actions by saying; “All our industrial, economic, and agricultural progress would be of no use if the population continued to rise at the present rate.” The Fifth Five-Year Plan called for the employment of “firm and bold steps envisioned in the National Population Policy to improve the tempo of the program.”

While it may appear senseless to dissect the seemingly sui generis forcible policies that characterized India’s Family Planning Program during the Emergency, such analysis is necessary both in order to understand Emergency policies as

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128 Manas History and Politics, “Indira Gandhi.”
130 Planning Commission, Five Year Plans, Fifth Five Year Plan, Health and Family Planning.
outgrowths of the previous decade’s programs, and to understand the impact of Emergency policy on the relationship between Indian citizens and their governments. Between 1976-1977, over eight million people were sterilized, a rate over four times higher than any previous year in the Family Planning Program’s history.¹³¹

The Emergency appears to stand apart from the previous eras of the family planning program due to its sanctioning of outright and unapologetic forcible sterilization. The atrocities of this mass sterilization campaign included the gross inadequacies in care that resulted in the injury or death of many Indian men. Seven hundred deaths were officially attributed to post-surgical complications from sterilization during the two years of the Emergency.¹³² Yet this inadequate medical treatment, both surgically and in terms of post-operative care, predated the Emergency and continued to be a problem long after it ended. These human rights abuses gained the additional attention they did because of the scale on which such abuses were implemented. While the actual number of sterilizations accomplished during the Emergency stands apart from previous eras, the policy targets for sterilization during the Emergency cannot be considered a huge departure from targets for contraceptive acceptance that had been set in previous policy.

Additionally, more than 20 deaths between 1975 and 1977 have been recognized as the result of from police brutality in response to civilian resistance of forcible family planning.¹³³ Sizeable populations of men in Haryana, Rajasthan, and Uttar Pradesh were reported to have hid in their fields during the fall of 1976, in an

¹³² Ibid, 35.
¹³³ Ibid, 47.
attempt to avoid being brought in for sterilization. The fear of being “captured” for sterilization created disruptions in ordinary life on a significant scale. In “Political Will and Family Planning”, Davidson Gwatkin attested, “Attendance at the November 1976 Pushkar Rajasthan camel fair, an annual religious and commercial event that draws huge crowds, was only one-half to two-thirds what it had been in previous years. Merchants at the festival were unanimous in attributing the reduced attendance to popular fear of entrapment for sterilization.”

The police brutality that both directly “recruited” sterilization acceptors and that pressured other members of the bureaucracy to produce sterilization cases was a direct manifestation of state violence against its citizens. While the Emergency period was inarguably autocratic, these violent measures had lasting implications for the citizens who experienced such brutalities, particularly on how they perceived their relationships with their government. The insufficient protection of civil liberties within India’s liberal democratic structures became apparent in the wake of the Emergency, and roused notions of distrust of the state among citizens, particularly in the area of family planning.

In 1977, once Gandhi was confident that she had settled India with her Emergency rule, she held free elections, in which she was voted out of office—an expression of the people’s outrage about such coercive programs like her family planning policy. Ultimately, whatever “progress” in population control was achieved using forcible measures during the Emergency was lost in the following years, when

134 Ibid, 47.
135 Ibid, 48.
Indian citizens expressed a major rejection of government-sponsored family planning programs.

The coercion and violence involved in Family Planning Programs during the Emergency can therefore be understood as extensions of the strategy used in the years leading up to the Emergency. The periods before and during India’s Emergency period serve as evidence that substantiates the claim that incentives are problematic because they are conducive to, rather than preventative of, coercion. Further, as articulated by Dr. Karan Singh in 1974, coercive tactics are ineffective at reducing birth rates because they fail to treat the real causes behind high fertility. Therefore, incentives will not create a sufficient rate of contraceptive acceptance in order to satisfy the desire to sharply curb population growth.

These violations were in actuality reinforced by aspects of all three democratic models involved in India’s governmental structure. First, communitarian norms served as somewhat of a justification of violent family planning practices, due to the idea of individual sacrifice for the greater good. Second, liberal democratic values facilitated the disadvantaging of the marginalized groups targeted by these coercive measures. Last, participatory democratic practice validated the violence in family planning under Indira Gandhi’s rule, as her electoral empowerment served as the people’s consent for her actions.

Political instability during this period was closely tied to issues in family planning, as coercive family planning programs caused citizens to lose their trust in the state. A central value of democracy should be its commitment to the protection of its citizens. Yet the coercion in family planning policy that withstood several
different changes in leadership demonstrates that India’s democratic structure was insufficient in protecting human rights. It should not have been so easy for the state to commit such egregious and pervasive violations against its citizens.

**Post-Emergency Period**

The Emergency ended when Indira Gandhi was voted out of office in early 1977. Gandhi’s electoral defeat also meant the rise to power of the Janata Party, India’s first non-Congress ruling party, which had spoken out actively against the Emergency Rule. The Janata party vowed to restore the civil liberties of those who had been oppressed during the Emergency, and also to make the process of implementing an emergency rule more difficult in the future.\(^{136}\) The party’s campaign slogan encouraged the Indian people to choose between “democracy and dictatorship.”\(^{137}\)

In the wake of the Emergency’s massive human rights and civil liberty violations in the realm of family planning, the Janata party had no option but to distinguish itself from the Congress Party by declaring an entirely new population policy in June of 1977.\(^{138}\) This new policy was renamed “family welfare” in an effort to both distance itself from the negative aspects of previous population plans, and to assert this new program’s focus on welfare. This new policy held central its assertion of family planning as strictly voluntary by stating: “We wish to make it abundantly clear that in this task there is no room for compulsion, coercion, or pressure of any

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\(^{137}\)“Janata Party Family Planning Programme”, Cultural Studies and Humanities, Cochin University of Science and Technology.

\(^{138}\)Ibid.
Further the policy asserted: “Family planning has, however, to be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare…it must become a part of the total concept of positive health.” This rhetoric demonstrated policymakers’ awareness that in order to be acceptable for the people, the new family planning policy had to conform more to liberal democratic values. Part four of the Janata party’s 1977 family planning policy states:

> The government attaches the highest importance to that dignity of the citizen and to his right to determine the size of his family. We have no doubt that by and large the people of India are conscious of the importance of responsible parenthood; given the necessary information and adequate services, they will accept the small family norms. We will promote all methods with equal emphasis and it will be left to every family to decide what method of contraception it would like to adopt.  

While the Janata party’s assertion of coercion-free family planning in 1977 was a promising step towards a family planning program, part of its language reflects vestiges of the “motivational” practices of previous incarnations of Indian family planning policy. As it continues, the policy states, “Employees of the Union Government, State Government, autonomous bodies, local bodies, etc. will be expected to set an example and to adopt the small family norm.” While the Janata party declared that all couples should be autonomous in their reproductive decisions, they retained hold over the reproductive decision of government employees and their families. This subtle caveat seems to be a remnant of earlier population policy, a hint that perhaps, the Janata party had been unsuccessful at abandoning the legacy of previous coercive family planning policies.

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139 Ibid.
140 Ibid.
141 Ibid.
142 Ibid.
Soon after its rise to power, divisions within the Janata party, whose cohesion rested on its various members’ opposition to the Emergency, began to fracture and reveal themselves. These divisions ultimately led to worsening economic conditions, and quickly thereafter, the decline of the party’s popularity. During this period, the Janata party also failed to conduct the prosecution of abuses during the Emergency in a timely and rigorous manner. In particular, its allegations against Indira Gandhi lacked substantive evidence. During this period, Gandhi embarked on a nationwide campaign of speeches, garnering the people’s sympathy by apologizing for her mistakes during her rule. Through this campaign, Gandhi successfully engineered her comeback behind the curtain of the Janata party’s crumbling authority. In January of 1980, Indira Gandhi was reinstated as Prime Minister when the Congress party once again swept national elections. This declaration of voluntary family planning—however lacking—never had a chance to materialize, as the Janata party only remained in power for two years.

Therefore, drawing from the free and fair nature of these elections, the decision of the Indian people to re-elect a leader and party that had transgressed so greatly against their civil liberties comes into question. It is apparent that the earlier discussion on democratic theory is pertinent here. Perhaps unexpectedly, liberal democracy may not protect against a harmful decision made by an aggregate of individual voters. Meanwhile, other forms of democracy may provide institutions that safeguard against harmful cumulative decisions. For example, the discourse required by participatory democracy could have prevented the apparent deception and

144 Ibid, 48.
145 Ibid, 48.
manipulation of the people by Gandhi. Further, a communitarian democracy could recognize and account for the threat that Gandhi again posed to India.

Yet, Indian voters did re-elect the Congress party, and thereby, Indira Gandhi. The logic by which individual voters chose to reelect Gandhi may be summarized by the claim from a participant that “civil liberties do not fill your stomach.”¹⁴⁶ For Indian voters, while Indira Gandhi’s rule was associated with autocracy, the severe restriction of civil liberties, and human rights abuses, it also proved highly effective in the improvement of the Indian economy, and thereby of individual standards of living. The converse had also proved true—while the Janata party promised to uphold civil liberties, it also delivered a weak economy, weak nation, and thereby a lower standard of living.

Such a rationalization could reflect either communitarian or liberal democratic values. First, following communitarian thought, Indian voters appeared to be convinced that the advancement of the entire economy would ultimately benefit society as a whole, what is beneficial for the whole is inherently optimal for the individual. Second, the individual could weigh his or her civil liberties against the trickle-down benefits of national economic advancement, and decide that the latter is ultimately more advantageous for his or her self, which reflects the individualist values of liberal democracy. This discussion would suggest that the two are not always as paradoxical as they appear.

The Sixth Five-Year Plan (1980-1985), initiated directly following Gandhi’s reelection, reflected a return to many of the themes of pre-Emergency family planning policies. The plan states, “the non-attainment of the birth rate targets

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adopted in the plans is largely on account of our inability to carry forward the program throughout the country with the active involvement of the people.”

Further, because the previous plans’ set targets had not been achieved—largely due to what the program termed an inadequate generation of “public enthusiasm and community participation”—the program expressed a need to advertise itself as “a people’s program backed by support from governmental and non-governmental agencies.” These statements demonstrate that family planning officials continued to attribute the shortcomings in contraceptive target achievement to a failure to motivate the Indian people to articulate their need for family planning services, which officials presumed to exist.

During this time, India’s Family Planning Program shifted its focus for contraceptive acceptance from men to women. A March 1982 New York Times article entitled “In India, Birth Control Focus Shifts to Women”, outlined the tactics employed in women-centered family planning campaigns in the first years of the 1980’s. After the 1981 census revealed that India’s population had expanded to 12 million more people than expected, Indira Gandhi designated February of 1982 “family welfare month”. This campaign featured countrywide “small family, happy family” billboard campaigns, radio programs, and, once again, mass sterilization drives.

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147 Government of India, 6th 5-Year Plan, 22.60
148 Government of India, 6th 5-Year Plan, 22.60
150 Ibid.
The article explains that the Sixth Five-Year Plan acknowledged for the first time the vital role that women play in India’s economic development. The government asserted that a large component of the solution to India’s economic woes is to “reduce the number of children women bear, thus enabling them to work more productively.” While the campaign subsidized condoms and oral contraception, its emphasis remained on sterilization, this time for Indian women. During the February 1982 sterilization drive, women who underwent sterilization were awarded the equivalent of 22 USD, while men were offered 15 USD for sterilization. This payment discrepancy reflected the state’s stress on women’s contraceptive access as the key to success in population control. Further, the government invested considerably in the development of other birth control devices—namely the IUD—for women during this time.

This change in focus towards women as the targeted recipients of India’s family planning programs meant that women now bore the brunt of the program’s human rights abuses that had previously fallen on men. Theoretically, if women are able to vote, this shift should not have been any more politically permissible than forcibly sterilizing men. The state’s ability to move its coercion to women without significant resistance seems to suggest a social—and therefore political—disadvantage for women. Therefore, while the political framework of gender equality existed, the societal value of equality did not exist to ensure such political rights for women.

151 Ibid.
152 Ibid.
153 Ibid.
154 Ibid.
155 Ibid.
PERIOD IV: 1990s, THE ICPD AND REPRODUCTIVE RIGHTS

The 1990s brought with them a major overhaul in attitudes and policies about family planning in India. The Eighth and Ninth Five-Year Plans, as well as India’s participation in and response to the International Conference on Population and Development (ICPD) in Cairo reflected a growing recognition on the part of policymakers of necessity of adjusting family planning strategies to focus on individual health provision rather than national population rates. Few scholarly works have analyzed how this change in policy and rhetoric has transpired in practice.

The Eighth Five-Year Plan recognized for the first time the importance of social factors on fertility rates. Specifically, the plan referenced the association of female literacy and higher age at marriage with fertility decline. Further, this plan acknowledged for the first time that lower infant mortality rates make couples more confident about their children’s survival, and therefore willing to use contraception to limit the size of their families. The plan asserts: “Fertility rates have declined in many parts of the country where, apart from family planning program, substantial progress has been made towards female education and improve health status for women and children, and areas where job opportunities for women have increased.” Therefore, the eighth plan serves as the first of India’s family planning program that acknowledges and holds central the importance of factors other than contraceptive acceptance that affect birth rates, namely female empowerment and employment, infant mortality, and marriage age.

156 Government of India, Eighth Five-Year Plan, Health and Family Planning.
157 Government of India, Eighth Five-Year Plan, Health and Family Planning, 2.3.5
158 Government of India, Eighth 5-Year Plan, Health and Family Planning, 2.3.5
The eighth plan suggests that the state assumes the paternalistic role of caring for its citizens’ well being, specifically regarding improvements in the standard of living. In a justification of population control efforts, the plan states: “The country is committed to social and economic justice to the millions of people living under conditions of poverty and deprivation.” Yet while the state claims responsibility for this improvement, it does not claim accountability for the protection of its citizens’ civil rights. The existence of this perceived dichotomy is troubling for a democratic regime, resonating the sentiment that India’s leaders seem to consider civil rights to stand in the way of economic growth and progress.

Further, the eighth plan first emphasized the importance of not only government programs, but also non-governmental organizations in collaborations on family planning efforts. The plan states: “There is a need to incorporate family planning as a major objective of all voluntary organizations concerned with health and/or education-related activities. Substantially increased amounts of funds will be channeled through these agencies.” This increased consideration of NGOs reflects a shift away from the previously centralized nature of family planning programs.

While the eighth plan acknowledges that centralized and targeted tactics have impaired the family planning program, it also perpetuates the attitude that incentives are only unfavorable because they are ineffective. The plan states: “Incentives and awards have not been unequivocally shown to be very effective in the promotion of small family norms… The element of disincentives is also missing from the

159 Government of India, Eighth 5-Year Plan, Health and Family Planning, 12.3.3
160 Government of India, Eighth 5-Year Plan, Health and Family Planning, xii
161 Government of India, Eighth 5-Year Plan, Health and Family Planning, xii.
program.” Further, policymakers considered targets to be vital to the program’s success, and even called for a restructuring and reinforcement of the incentive and award aspects in order to improve the plan’s efficacy. While the nineties are generally recognized as the time when family planning was rearticulated to reject any notion of targeted goals, the eighth plan reveals that this change occurred far later than is initially thought.

In 1994, two years into the Eighth Five-Year Plan, the International Conference on Population and Development (ICPD) was held in Cairo. The conference called for increased state efforts towards the empowerment of women, as well as the elimination of coercion from all family planning and population programs. Chapter Seven of the conference’s Program of Action (PoA), entitled Reproductive Rights and Reproductive Health, asserts:

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

The ICPD relegated targets, coercion, and population-focused family planning programs to outside of the realm of what was considered ethical reproductive health policy.

Yet this position raises several questions. First, it allows individuals to make autonomous childbearing decisions so long as their decisions are made “freely and

163 Government of India, Eighth 5-Year Plan, Health and Family Planning, xi.
responsibly”. This statement implies that acceptable reproductive decisions are ultimately determined not by the prospective parents concerned, but by a larger, collective entity. Second, it rejects “discrimination, coercion and violence”, but fails to reject incentives. Perhaps this omission has served as a subtle sanctioning of the continuation of incentive-based family planning programs.

In addition to the global pressure culminating from the ICPD, local and international women’s groups, NGOs, and donors pressured India to move away from targeted family planning programs. Women’s groups objected to the family planning program, accusing the government of blindly and aggressively promoting contraception without concerns for quality of care. These groups considered the abuses of the family planning program to be major human rights abuses against Indian women. Further, major donors to the program such as the Ford Foundation and the Population Council who had formerly endorsed aggressive and coercive family planning policy now urged India to abolish such practices. Between 1992 and 1994, these groups, along with demographers, primary health care advocates, and family planning service providers collaborated to advocate for heightened ethical considerations in family planning, proper procedures, and higher-quality care.

After the Cairo conference, the Ministry of Health and Family Welfare implemented several major adjustments in family planning policy. First, and perhaps most prominently, the ministry announced the development of a “target-free approach” to family planning. In Reproductive Health in Policy and Practice: India, Leela

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165 Visaria and Visaria, Reproductive Health in Policy and Practice: India, 9.
166 Ibid, 9.
167 Ibid, 9.
168 Ibid, 9.
Visaria and Pravin Visaria explain that the establishment of a target-free approach meant that the targets for family planning acceptance that had been determined by the central government since the 1960s were no longer the impetus behind the program. Instead, national policy dictated that family planning would now be determined by community demand for services. Further, India’s family planning program after 1994 expanded the notion of family planning to include an understanding of reproductive health beyond just the provision of contraception.

Further, a statement from Dalit Ezhilmalai, India’s Union Minister for Health and Family Welfare, to the Hague Forum in 1999, entitled On Review of Progress in the Implementation of ICPD Program-of-Action, elucidates the Indian government’s self-perception of the shifts in family planning policy that occurred after the ICPD. First, Ezhilmalai emphasizes the liberal democratic values that ground the new population policy by stating: “India being a democratic country in the real sense, individual’s freedom for decision making takes a prominent place while implementing any program. So, the emphasis has been to popularize the policies and program to promote informed decision making.” Next, he reflects on the justification of the population policy based on communitarian ideas of the good of the whole, and praises these policies for being socially progressive due to their consideration of women and other marginalized groups. He states:

The policy has clearly reflected the concerns for gender perspective as a vital aspect for contraceptive technology and achievement of population goals with the aim of continuous improvement in quality of life; capacity of supporting the eco-system; decentralized action through empowered local governments

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169 Ibid, 10.
170 Ibid, 10.
with elected local representatives supported by centralized services. The draft Population Policy—that in short is a statement that is pro-nature, pro-poor, pro-women—has been debated at length and is under serious consideration for approval by the Parliament.\footnote{172}{Ibid.}

Further, Ezhilmalai notes the program’s move from a targeted to its “target-free” approach, later to be replaced by a “community-need based approach”. This new approach focused on “decentralized, need-based, participatory planning and a monitoring system with emphasis on quality of care and delivery of essential reproductive health services.”\footnote{173}{Ibid 2-3.}

The Ninth Five-Year Plan, 1997-2002, had two objectives; “to meet all felt needs for contraception,” and “to reduce infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility.”\footnote{174}{Government of India, Ninth 5-Year Plan, Health and Family Planning.} In order to achieve these goals, the plan advocated for certain strategies, which, in summary, aimed to “provide need-based, demand-driven high quality, integrated reproductive and child health care.”\footnote{175}{Ibid.} Overall, family planning policy in India in the 1990’s (and 2000’s, subsequently) is evidence of a significant change in orientation of family planning policy.

**CONCLUSION**

The development of India’s family planning policy since 1951 pales in comparison to the significance of its inaction. With a longstanding legacy of a targeted approach, the incentive-based system became practically indivisible from the idea of family planning programs. Although it generated a widespread distrust of

\footnote{172}{Ibid.}
\footnote{173}{Ibid 2-3.}
\footnote{174}{Government of India, Ninth 5-Year Plan, Health and Family Planning.}
\footnote{175}{Ibid.}
government-sponsored family planning programs, the system of targets nevertheless proved difficult to move past, as most family planning workers had been trained under an incentive-based system, and these targets permeated a multitude of levels within the Indian bureaucracy.

The trajectory of family planning policy in India over the past sixty years has been a fluid reaffirmation of the use of coercive tactics. Until recently—and perhaps still—coercion has been characteristic of the Indian government’s family planning programs, regardless of its leadership. Although Indira Gandhi serves as a prominent example of a leader who employed particularly extreme policies and violent tactics, her regime does not, in fact represent a departure from the periods prior to and following the Emergency.

Due to the highly personal and private nature of family planning and reproductive health, it would follow that liberal democratic regimes would be highly effective in protecting individuals’ reproductive rights. Yet the case of coercive family planning practices in India indicates that the various features of liberal, communitarian, and participatory democracy (of which Indian democracy features aspects from all three), are insufficient in protecting reproductive rights. Another political mechanism, therefore, is necessary to protect individuals from state violence. The following chapter explores civil society—reproductive health non-governmental organizations in particular—as a means by which to provide such an intermediary force.
CHAPTER III: CIVIL SOCIETY AND THE REPRODUCTIVE HEALTH NGO IN INDIA

“What is happening now is wherever services are improving, they’re improving because of some kind of partnership, or donor funding from outside, in partnership with the NGO sector. There is a lot happening, but there is no easy solution to this because there is so much that has not happened, and there is so much history.”

-Anonymous Participant, August 2012

The role of Non-Governmental Organizations (NGOs) and civil society has evolved throughout the course of India’s Family Planning Program. While international organizations initially contributed much of the program’s funding and program designs, the field of reproductive health in India has seen a recent increase in local advocacy and service-focused organizations. This chapter seeks to analyze the emergence of local reproductive health NGOs in India in order to describe the diverse and complex network of relationships between these organizations and local communities, the state, and the international reproductive health field. This chapter also addresses the extent to which the development of locally operated reproductive health NGOs has facilitated greater decentralization—and therefore participation—in India’s family planning program, asserting that these new NGOs provide crucial safeguards against incursions on individual reproductive rights.

THEORY ON CIVIL SOCIETY

In the following pages, I attempt to situate my analysis of the unique relationships between Indian reproductive health NGOs, individuals, and the state within broader theories of civil society. In *Democracy in America*, Alexis De
Tocqueville presents a theory that highlights the importance of civil society to liberal democracy. Tocqueville takes a stance that is highly wary of the growth of individualism so characteristic of liberal democratic societies. He understands the establishment of political equality in a highly individualized society to be hazardous because it prompts citizens to isolate themselves from one another. \(^{176}\) Once societal equality is achieved, people become progressively individualistic as they grow convinced that they are no longer dependent on each other. Tocqueville posits: “Despotism sees the isolation of men as the best guarantee of its own permanence.”\(^{177}\) He cautions that the dark side of democracy is the risk of the development of a “soft” despotism, a situation characterized by increasing isolation of individuals within society and an associated risk of a loss of control over democratic governments.\(^ {178}\)

Tocqueville argues that society can protect liberal democracies from this despotism that threatens individual liberties. He asserts, “Freedom of association has become a necessary guarantee against the tyranny of the majority.”\(^ {179}\) Civil society, by providing a vehicle for association, maintains a degree of collectivism in the face of increasing individualism. Through civil society, minorities are more able to easily and effectively advocate for themselves, and to have their preferences heard. Further, Tocqueville believes that associations act as a counterweight to the tendency of democracies to develop large central governments by facilitating federalism, or a balance between the political center and peripheries more broadly.\(^ {180}\)

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\(^{177}\) Ibid, 509.

\(^{178}\) Ibid.

\(^{179}\) Ibid, 192.

\(^{180}\) Ibid, 515.
Tocqueville considered civil society to be distinct from—but essential to—the development of an active realm of political society, in that it entails a sphere of private entrepreneurship and civil affairs that exists separately from the state. Civic associations therefore act as a means by which a divergent populous and democratic state may be reconciled. Tocqueville suggests that civil society and government should support each other’s distinct but related functions. The interests of individuals, of civil society, and of the state can all be fulfilled through these relations.

Civil society, therefore, acts as a means by which individuals overcome their self-interest to unite for a common purpose. Tocqueville explains: “As soon as common affairs are treated in common, each man notices that he is not as independent of his fellows as he used to suppose, and that to get their help he must often offer his aid to them.” Civic association prevents societal fragmentation, and forces individuals to collaborate with and internalize the interests of their fellow citizens. Tocqueville believes that civil societies prompts small sacrifices that discipline citizens, and make them more virtuous in their relationships with their fellow citizens.

Civil society’s voluntary associations can also be understood in terms of the degree to which they foster reciprocal social norms that engender trust and cooperation between citizens, allowing people to make full use of their liberties independent from the political system. Following Tocqueville, political scientist Robert D. Putnam defines civil society as “features of social life—networks, norm and

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181 Ibid, 515
182 Ibid, 518.
183 Ibid, 510.
184 Ibid, 527.
trust that enable participants to act together more effectively to pursue shared objectives.”\textsuperscript{185} Civil society promotes individual participation and engagement in community issues and initiatives, which influences government by making citizens’ demands more nuanced and vocal. It encourages citizens to be more active participants in political processes, and allows them to accomplish collectively that which would be arduous or impossible through individual action alone. For Putnam, democratic functionality comes to rely on trust among individuals. Therefore, civil society instills amongst individuals the leadership skills necessary to develop strong and effective leaders for representative democracy. Civil society associations, like NGOs, are able to ensure the accountability of political leaders, and are therefore vital to democracy. Putnam asserts that those societies that have successfully developed dense associational networks through civil society are able to “reduce incentives to defect, reduce uncertainty, and provide models for future cooperation.”\textsuperscript{186}

In “To Empower People: From State to Civil Society,” Peter Berger and Richard Neuhaus articulate their own theory of the importance of civil society in democracy. While Tocqueville and Putnam emphasize the beneficial effects of civil society on relationships among citizens, Berger and Neuhaus understand civil society organizations like NGOs as social institutions that act as intermediaries between citizens and the state. They define these mediating structures as:

…Those institutions that stand between the private world of individuals and the large impersonal structures of modern society. They ‘mediated’ by constituting a vehicle by which personal beliefs and values could be transmitted into the mega-institution. They were thus ‘Janus-faced’

institutions, facing both ‘upward’ and ‘downward’. Their mediations were then of benefit to both levels of societal life: the individual was protected from the alienations and ‘anomie’ of modern life, while the large institutions, including the state, gained legitimacy by being related to values that governed the actual lives of ordinary people.  

For Berger and Neuhaus, the health of a democracy rests on this mediation between individuals and state institutions. The authors address such impersonal state institutions as “megastructures.” Using this framework, the authors interpret contemporary anti-government sentiments as a result of the perceived impersonality, unresponsiveness, and excessive intervention of government. They further hold that the populous understands these megastructures to be devoid of personal meaning, and as having excessive costs for the insufficient services they offer. Berger and Neuhaus warn:

Without institutionally reliable processes of mediation, the political order becomes detached from the values and realities of individual life. Deprived of its moral foundation, the political order is ‘delegitimated’. When that happens, the political order must be secured by coercion rather than by consent. And when that happens, democracy disappears.

They posit that the integrity of democracy is threatened when the meaning of its institutions corrodes. The mediating structures of which civil society is comprised are essential to a democratic society. Additionally, public policy, whenever possible, should foster and utilize these mediating structures for the realization of social purposes. Berger and Neuhaus, like Tocqueville, argue that mediating civil society institutions give meaning to state institutions by rectifying both individual anomie

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188 Ibid, 143.
189 Ibid, 144.
190 Ibid, 144.
191 Ibid, 145.
192 Ibid, 145.
193 Ibid, 147.
resulting from the individual’s isolation from society and, more broadly, relieving citizens’ alienation from the public order.194

However, in order to truly serve the purposes Berger and Neuhaus require of such mediating institutions, civil society groups must avoid devolving into tools of the state. They assert:

There is a real danger that such structures be ‘co-opted’ by the government in a too eager embrace that would destroy the very distinctiveness of their function…The goal in utilizing mediating structures is to expand government services without producing government oppressiveness. Indeed it might be argued that the achievement of that goal is one of the acid tests of democracy.195

This claim relates directly to Tocqueville’s insistence that civil society remain separate from formal political institutions. Berger and Neuhaus are not, however, promoting mediating institutions as a means to decentralize government responsibility, but rather as a means to reconsider the institutions through which government responsibilities are channeled. Civil society should not replace government responsibilities, but rather they should inform and assist government actions by more accurately reflecting the values and needs of the people.196 For Berger and Neuhaus, civil society’s mediating organizations should ideally function as agents for public policy, mediating the gap between the private individual and the public state in order to hold the government accountable, to more accurately articulate the public will, and to facilitate a connection between the individual and society.

194 Ibid, 145.
196 Berger and Neuhaus state, “The paradigm of mediating structures aims at empowering poor people to do the things the more affluent can already do, aims at spreading the power around a bit more—and to do so where it matters, in people’s control over their own lives.” Ibid, 148.
It is important to note that the aforementioned theorists have based their writing nearly exclusively on civil society in the context of the United States. Mary Alice Haddad calls to attention the exceptionality of American civil society. She explains that while Americans mostly make use of “overtly political” methods of advocacy, citizens of most countries make use of “embedded” forms of organizations that “work closely with bureaucrats in making and implementing policy.” Here, the embedded organizations Haddad discusses are ones that have closer relationships with the state and are more localized, such as volunteer firefighting and parent-teacher conferences. Such “traditional” organizations are contrasted with Haddad’s concept of the “newer” organizations commonly employed by Americans, such as Greenpeace, and Amnesty International. Attitudes about the role of government in other nations differ greatly from the circumstances of the United States. Citizen perceptions about the role of government strongly influence the types of volunteer organizations that are supported and fostered in that nation’s civil society. Therefore, a discussion of the particularities of civil society outside of the United States becomes necessary.

In “The Social Requisites of Democracy Revisited,” Seymour Lipset explores the role of civil society in democratizing nations, a category under which the Indian state falls during the earlier stages of its Family Planning Program. He identifies civil society—not merely electoral rules—as the prime requisite for the development of strong and stable democracies. Lipset asserts that if a democratizing society seeks

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197 Mary Alice Haddad "Civic Responsibility and Patterns of Voluntary Participation around the World." *Comparative Political Studies* 39, no. 10 (2006), 1220.
to effectively align state action with social demands, its civil society should be able to oppose and countervail state power.\textsuperscript{199} He states, “Civil organizations reduce resistance to unanticipated changes because they prevent the isolation of political institutions from the polity and can smooth over, or at least recognize, interest differences early on.”\textsuperscript{200} He also explains that civil society’s groups become the basis and support for institutionalized political parties, which he considers a necessary condition for the attainment of modern democracy.\textsuperscript{201} By promoting a constant discourse among divergent ideologies, Lipset believes that civil society groups form an alternative entity to the state that is powerful and that can effect change in society. Lipset’s concept of civil society in democracy is an important complement to Tocqueville, Putnam, and Berger and Neuhaus due to its examination of democracies that are new or in the process of being established—a process that Lipset emphasizes is long and arduous.

Together, these theories provide a rubric of the potential range of civil society’s functions. First, according to Tocqueville, civil society and the state should act as mutually supportive and affirming institutions. Second, both Tocqueville and Putnam assert that civil society should promote association, which prevents societal isolation and empowers individuals to recognize their common objectives, thereby developing and articulating the popular will. Third, Berger and Neuhaus maintain that civil society should act as an intermediary force between individuals and state megastructures. Last, Lipset argues that the purpose of civil society is to empower

\textsuperscript{199} Ibid, 12.  
\textsuperscript{200} Ibid, 13.  
\textsuperscript{201} Ibid, 12.
otherwise marginalized individuals to unite into groups that are powerful enough to stand up to the state if it is not functioning in a proper and democratic fashion.

Yet the assertion that civil society is always beneficial for democratization must not be taken uncritically. Although civil society is intended to act as an intermediary sector, it remains vulnerable to appropriation by the state in democratizing regimes that retain some authoritarian features. While the development of civil society is conducive to democratization, it cannot guarantee a democratic outcome. Civil society in a highly liberal and individualized society is vital to democratic functionality because it strengthens the relationships among individuals and their state, yet one must also consider the function of civil society in democracies that are not purely liberal. Most existing theories of civil society are not easily applied to developing democracies that are less liberal than their developed counterparts. Therefore, a consideration of civil society outside of Western developed nations is important and necessary in order to develop an understanding of the applicability of civil society to developing democracies. The following sections explore the evolving role of civil society in India, specifically with regard to family planning and reproductive health.

**CIVIL SOCIETY IN INDIA**

Civil society has been a prominent feature of Indian society since Independence, drawing originally from Gandhian ideas of volunteerism. In “Civil Society in India: A Necessary Corrective in a Representative Democracy, Patralekha Chatterjee explains, “In independent India, the initial role played by the voluntary organizations started by Gandhi and his disciples was to fill in the gaps left by the
government in the development process.” While India has a long-standing tradition of civil society, such institutions have evolved from charitable social welfare programs into highly politicized and critical roles only in recent years.

While Indian civil society has an established history of volunteerism, it is only since the 1980s that the forms of civil society in India have begun to grow and diversify. Non-governmental organizations (NGOs) became a buzzword, and Chatterjee argues that such organizations generally specialized in one of three forms of civil societal intervention. First, so-called “traditional NGOs” approach social interventions by becoming involved in the community of a chosen area to implement development programs. The second faction of NGOs research and evaluate a particular social issue in depth. Third, and perhaps most prominently, a group of NGOs in India take on an activist role, lobbying bureaucrats for certain social issues and alerting the media of unfavorable policymaking decisions.

Because there is no tradition of referenda in Indian democracy, Chatterjee claims that citizens voice their opinions on policy to the government through NGOs. India’s democracy, like all regimes, features shortcomings that its NGOs attempt to make up for, whether they stem from intentionality, a lack of resources, or a lack of awareness. For example, the Jal Lokpal Bill of 2011 is an anti-corruption bill that was the result of a widespread “India Against Corruption” movement spearheaded by Anna Hazare. Movements such as these gain sweeping popularity

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203 Ibid.
204 Ibid.
205 Prakash Karat, “For An Effective Lokpal, Government Must Respond”, Pragoti: Progress and Struggle.
and signify the existence of a prominent and active civil society in India. The popularity of such movements also suggests that activism is the dominant form of civil society intervention in India. Yet this movement it also calls into question what effect such activist interventions actually have on policy, because the fact that such a protest was necessary at all suggests that activism in the past perhaps been insufficient in fully eliminating corruption, despite the gains each small movement may have accomplished. The existing pattern of inadequate government service provision coupled with reactionary citizen protests seems to suggest that this lively activism-centered civil society may not accomplish the concrete policy change for which it aims.

Meanwhile, in “Our Civil Society as an Instrument of Social Change,” Lokantha Suar places NGOs in a more active role of mobilizing the Indian public. Yet Suar also calls attention to the effects such mobilization has on the relationships between citizens and their governments. He states:

> The consequent development of India’s civil society has made Indians less confident of the transformative power of the state and more confident of the power of the individual and local community. The development is shifting a larger share of the initiative for resolving India’s social problems from the state to society.  

In some aspects, it seems that civil society is replacing the state by taking on some of what were previously designated as the state’s responsibilities. Suar’s article calls into question whether the assumption of responsibilities formerly shouldered by the government by civil society is hazardous, and whether an overzealous activist civil society could actually threaten to alienate individuals from their state.

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A more optimistic theory of the relationship between civil society and the Indian government is proposed by, Niraja Gopal Jayal, a professor at the Center for the Study of Law and Governance at New Delhi’s Jawaharlal Nehru University. She states, “A democratic state needs a strong civil society, but a strong civil society can only exist within a democratic framework guaranteed by the state. This is a symbiotic relationship, which should also mean that one does not trespass into the other’s domain.” Her assertion, however, calls to attention the limits of the respective roles of the state and civil society are in India, particularly pertaining to initiatives that provide services for citizens.

These perspectives of Indian scholars of the role of civil society in India indicate that citizens expect civil society to fulfill a function that is critical and regulatory of the Indian state. Yet the presence of a strong civil society that exists largely in this critical role points to a distrust of the state by the Indian people. While this distrust is not surprising in the wake of coercive family planning policy, it also highlights the presence of a democratic malfunction in India’s government.

INTERNATIONAL NGOs

Although the theorists cited in this chapter thus far stress the importance of the development of an active civil society to democratic functionality, these scholars neglect to consider the distinct role of international groups and organizations in the civil societal sector. In India, especially in the field of reproductive health,

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international NGOs have become intimately involved in the design and implementation of government policies related to development initiatives.

International NGOs and aid organizations have relationships with national governments that are distinct from those between local NGOs and their states. International NGOs commonly originate and are operated from developed countries, which disseminate programs and interventions, as well as funding for such initiatives. Western-originated international organizations are also able to circulate western values through these programs. Additionally, these international organizations generally possess more resources—and thus more influence—than local civil society organizations.

Due to their positions of power, internationally operated civil service organizations are frequently more influential over and directly involved in the government policy they seek to address. Yet the influence of international organizations within civil society challenges the notion of what makes a civil service organization effective. While international NGOs may have a global perspective on the issues at hand, this knowledge certainly comes at the cost of a local understanding of the matters on the ground. International organizations in civil society enjoy the resources and influence to effect change in the fields in which they work, but paradoxically can lack the specific local knowledge essential to the implementation of their programs.

International organizations tend to focus broadly on population issues, while local initiatives concern themselves more with individual reproductive healthcare decisions. India’s concerns about population growth stemmed largely from
international panic about overpopulation, which prompted Western population
alarmists to push for family planning and population programs in developing nations. These leaders and organizations took a particular interest in India as a prime example of an overpopulated developing nation. Concurrently, several major western
organizations—namely the Population Council, the Ford Foundation, and the
Rockefeller Foundation—focused on attaining population stabilization in developing
nations through the mass provision of Western contraceptive technologies. These
organizations initially became involved in the Indian Family Planning Program
through the development and implementation of demographic research centers, which
sent Western demographers and other population experts to India in order to gain an
understanding of the nation’s high fertility rates. While these organizations claimed
to defer to government objectives and preferences in regard to their own program
implementation, the resources, attention, and international backing that these
organizations possessed certainly held sway over both the government’s perceptions
of the population problem and their resulting programs. For example, these
international organizations often deferred to one another for program approval rather
than to the state. These organizations were the source of much of the funding—
and pressure—for the intensification of family planning efforts in India.

In the period following India’s rapid development—after the economic
liberalization policies of 1991—many international NGOs began to extract

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209 Visaria, “From Contraceptive Targets to Informed Choice: The Indian Experience.”
themselves from their initiatives in India in order to focus their efforts in areas with more perceived need. The flight of these international organizations suggests another potential shortcoming of international NGOs: that their behavior is unpredictable. Yet this mass exodus of international NGOs has also allowed for the emergence of local NGOs as dominant forces in Indian civil society.

THE EMERGENCE OF LOCAL NGOS IN INDIA’S FAMILY PLANNING PROGRAM

In 1994, the International Conference on Population and Development (ICPD) held in Cairo called for a reconsideration of family planning policies in order to achieve an improvement in quality of family planning services. The ICPD’s Programme of Action (PoA) was shaped significantly by the presence of the NGOs that participated in the conference. The PoA considers NGOs to be essential to the formulation and implementation of national family planning programs.212 While civil society had participated in family planning activities prior to the ICPD, the conference officially empowered them with the responsibility of implementing the PoA. NGOs are recognized by the ICPD as grassroots-level players in family planning; they work most closely with communities and therefore most accurately represent the voice of the people.

In the past two decades, the Indian government has more eagerly incorporated the work of domestic non-governmental organizations into the family planning program. Prompted by the ICPD’s PoA, the central government officially recognized the important role that NGOs played in achieving its mission of demographic

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212 UNFPA, Civil Society, and the Programme of Action ICPD, 27 July 1998
stabilization. In the Planning Commission’s article addressing “The Role of NGOs” in India’s population and family planning programs, the policy declares that successful nation-wide contraceptive acceptance rests on the involvement of both domestic and international NGOs. It asserts that NGOs will be hugely effective in improving sterilization and Couple Protection Rates (CPR). Further, the policy states, “NGOs should be given a multi-sector orientation and vision so that the linkages between the success of sectoral programmes and achievement of larger objectives like demographic stabilization is not missed.” These statements reveal the Indian government’s acceptance of the ICPD’s endorsement of NGOs, due specifically to what the state perceived as the integral role of NGOs in achieving population control.

The Indian Government—its Ministry of Family Health and Welfare more particularly—realized that the executive involvement of NGOs in family planning programs was important for two reasons. First, the incorporation of NGOs coincided with a period of liberalization and decentralization, both within family planning and in government programs more broadly. This process of decentralization was thought to make programs like family planning more palatable to the people and more efficient in producing the results the central government desired. The policy states:

A semi-autonomous framework will help channelize resources directly to needy districts. Funding from sources like the NCP through normal Governmental channels involves delays and uncertainty about the resources reaching the target areas. The process of decentralization of formulation and

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214 Ibid.
215 Such as the 1991 economic liberalization and decentralization
implementation of developmental projects has to reach lower levels up to the village.\textsuperscript{216}

Second, the central government supported the incorporation of NGOs into family planning programs because of their ability to have direct access to the target populations both entities were addressing. The Policy notes,

> Involving NGOs in population stabilization programmes can indeed be a positive step since through NGOs, big or small, the Government may be able to reach out far more effectively to the people. The vigorous people’s movement involving the civil society with the active participation of Panchayati Raj Institutions, NGOs, Self Help Groups and the Youth Clubs necessary for the implementation of programmes crucial for early population stabilization.\textsuperscript{217}

NGO workers are often living and directly interacting with the communities with which they are working, and they therefore are often able to attain a greater level of insight into local practices and behavior than are more removed government workers would not have. Through partnerships with NGOs, the central government hoped to reach a “marked improvement” in family planning rates.\textsuperscript{218}

The policy is, however, careful to assert the dominance of centrally planned schemes over the activities of NGOs. It reads, “In the view of the limited organizational, managerial and financial capacities of NGOs, they cannot, in any way, supplant the normal government machinery in addressing the various development problems of the social sector.”\textsuperscript{219} While the central government asserts the importance of NGOs in serving the ends of the state, it also stresses the limitation of their capabilities.

\textsuperscript{216} “Role of NGO: Making Population Stabilization a People’s Programme”, National Commission on Population.
\textsuperscript{217} Ibid.
\textsuperscript{218} Ibid.
\textsuperscript{219} Ibid.
The conscious decision to incorporate NGOs into India’s National Family Planning Program represents a cooperative shift towards international standards of reproductive justice. However, the language of this policy also suggests an attempt by the state to appropriate NGOs as tools for the central government’s objectives. Rather than praising NGOs for their ability to serve individual healthcare needs, the government recognizes the importance of NGOs in contributing to the achievement of the state’s own goals of population control.

Further, this attempt by the Indian government to appropriate NGOs for its own goals is not congruent with the role the international reproductive health sector considered for NGOs. In his retrospective evaluation of the ICPD’s PoA, titled “The ICPD Programme of Action: Pious Hope or A Workable Guide,” Fred T. Sai states, “Traditionally NGOs have played an important role in providing information and services to groups in society not well served by government programs.”220 It remains unclear whether the international reproductive health field envisions this role as one that is subservient to or defiant of the state’s agenda. Yet the Indian government—and perhaps the ICPD—failed to realize one of the most vital functions that NGOs alone are able to serve; the ability to articulate and defend the reproductive health and rights demands of the people, most importantly when they run contrary to the objectives and actions of the state.

REPRODUCTIVE HEALTH NGOs IN INDIA: PRIMARY RESEARCH

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Reproductive health NGOs are able to effect change in family planning in a multitude of ways, whether by influencing reproductive health on a policy level, or by impacting individual family planning choices. During my research this summer, I conducted eight interviews with workers at five New Delhi-based non-governmental organizations that address issues of reproductive health and rights. I will highlight the work of three of these NGOs, each of which interacts with individuals and the state in a different fashion and takes a unique approach to rectifying the problems they consider pervasive in the family planning field in India. I chose to focus on these three organizations because their activities represent a range of the potential roles that civil society organizations may adopt.

For each organization, this section will first provide an explanation of the organization’s perceived problems in the field of reproductive health in India, as well as its objectives, and central projects. Next, this analysis will address each organization’s perception of the history of family planning policies, and provide a discussion of the organization’s relationship with the state. Finally, the connection between the organization’s activities and the aforementioned prescriptions of the role of civil society by theorists will be considered.

**Indian Family Planning Initiative—IFPI**

The first organization investigated was the Indian Family Planning Initiative. The organization’s objective is to reposition family planning within a framework of human rights and reproductive rights. In order to do so, IFPI engages in six key areas: family planning, maternal and child health, adolescent reproductive and sexual health and education, the child sex ratio, urban health, and HIV/AIDS. One staff

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221 The names of all organizations have been changed.
member explained: “IFPI has aligned its strategy to the government and ICPD’s context of reproductive health and rights. So, now we look at family planning as a human right to which every person should have access so that they can make their own reproductive choices, without these decisions being forced upon them.” IFPI collaborates with central and state governments, as well as with other civil society organizations.

To achieve its mission, IFPI has created initiatives that aim to address the aforementioned issues by employing such strategies as: delaying age at first marriage, delaying first pregnancy, promoting birth spacing, preventing sex selection, and improving quality of care in family planning services. The organization’s programs fall into three types of intervention: advocacy; accountability; and organizational innovation, expansion, and capacity building. First, IFPI works with the central government to ensure that the rhetoric of reproductive rights is being followed in practice. One employee stated, “We are totally against coercive family planning, and have been advocating so that the entire discourse of family planning is repositioned towards reproductive and human rights. We must now work to expand choices.” In this regard, IFPI works directly with the Planning Commission by leading orientation workshops with various government entities. Second, the organization supports new reproductive health initiatives by providing technical and financial support to scale-up successful programs. In a complementary fashion, part of IFPI’s government advocacy includes building government capacity to expand successful programs. Together, these efforts aim to develop the agency of smaller organizations working directly on-the-ground by incorporating capacity building and program development
as integral components of family planning policy. Third, through partnerships with local innovative NGOs, IFPI aims to improve the accountability of state programs by incorporating the community into reproductive health programs. These local organizations are able to collect data, sensitize the community to these issues, and share this information with the government. A staff member explained, “Then, the community is involved in designing its village health plan. Local bodies will be trained as change agents, and they will promote our messages.” The organization aims to support such pilot programs by identifying models with the potential of impacting large-scale change, and arranging programming and funding partnerships with larger established organizations. IFPI’s projects work on three planes: on a policy level, with smaller NGOs in order to support innovative pilot programs, and with individuals to improve the incorporation of individual needs into state programs.

When reflecting on the coercion of past phases of the family planning program, IFPI employees admitted that actual change has been slow and unsteady. One stated, “We advocate with the government because it is still following the target-oriented approach to some extent.” One staff member noted regretfully, “Family planning policy too often becomes a tool of political decision.” This notion of the politicization of fertility is related to many moments in the history of the program when the fertility of Indian citizens was used for state ends, such as the international pressure for India to curb its population’s growth, and the post-Emergency change in the National Family Planning Program to focus on the sterilization of women.

IFPI’s multifaceted mission is linked to three theoretical descriptions of civil society activity. IFPI works closely with the Planning Commission on a policy level
in order to ensure the implementation of effective and just state family planning programs. In this way, IFPI fulfills Berger and Neuhaus’s understanding of civil society organizations as intermediary forces. Additionally, IFPI’s efforts to involve communities in reproductive health programs on a local level reflect Tocqueville’s position that civil society should work to prevent the isolation of society from the actions of the state. Lastly, IFPI’s work fulfills Lipset’s requirement that civil society should politically empower individuals so that they may advocate for their own needs to the state, through the organization’s support of small-scale innovations in reproductive health care.

Of the three organizations considered in this project, IFPI works most closely with the state, and therefore seems to pose the greatest threat to Berger and Neuhaus’s concern of NGOs being co-opted by state. This concern is exemplified in IFPI’s attitudinal shift regarding population control that has evolved in a parallel fashion to the state. At the time of its inception, IFPI was supportive of a coercive program, indicating that, at the time, many theorists may not have considered it to be a civil society organization. Yet over time, the organization seems to have grown increasingly independent of the state, to the point that it is able to hold the state accountable to ensure that individuals are able to make private and autonomous reproductive choices. Perhaps IFPI’s growing independence from the state was a matter of happenstance—it adapted to the demands of the ICPD and other, more independent radical NGOs that were highly critical of existing family planning programs. An organization such as IFPI that is so entwined with the state may have remained in support of coercive policy.
While an organization like IFPI that works closely with the state government has the resources and power to influence state policy, it also operates at a level that is more removed from the individuals whose reproductive health and rights they are attempting to safeguard, in a similar fashion to international organizations. An analysis of an organization like IFPI—whose actions were initially under the sway of central government policies, and has now distanced itself to a place that is more critical of the state—is important for this project because it is telling of the relationship between states and NGOs in India’s reproductive health field. Civil society organizations that work directly with the state must maintain a careful balance of power so that they are able to effectively advocate the central government for citizens’ interests.

**Women’s and Sexuality Empowerment Initiatives--WSEI**

The second organization with which I conducted interviews is Women’s and Sexuality Empowerment Initiatives (WSEI). The organization labels itself as a feminist and human rights organization, one that seeks to contribute to the protection of these rights both within India and globally. WSEI acts as a tool for building leadership capacity with its female employees by creating a line of leadership within the organization. In addition to such internal goals, WSEI works on sexuality, sexual and reproductive health and rights, and women’s rights. These are issues that the organization believes have been marginalized or underserved in the field of family planning in India. One employee stated, “We’re talking about a woman, or a young girl, who should have control over her body. She should have the right to make the
decision about choosing her partner, whether to marry, when to have kids, whether to have kids.”

The organization posits that much of this must be achieved by addressing sexual and reproductive health and rights (SRHR) issues beyond just family planning and contraception. Central to this objective is WSEI’s concept of sexual and reproductive health and rights, the scope of which the organization stresses extends beyond just family planning or contraception to include issues of abortion, menstruation, body image, puberty-related changes, consent, and emotional well-being surrounding sex and reproduction. The broader scope of WSEI’s mission comes from its founder’s perception of the reproductive health and rights field at the time of the organization’s inception, which they perceived as having major gaps. WSEI aims to provide services and training that helped to address these gaps in a way that would achieve meaningful change within the existing power structures of India’s family planning program.

WSEI has thoughtfully decided which groups to work with in order to best achieve its objectives. First, the organization consciously avoids working directly with policymakers. However, WSEI aims instead to build the capacity of those who do work directly with policymakers. This group includes other small NGOs, and with women employed by the National Rural Health Mission (NRHM) as care providers at the village level, as well as with women directly on issues concerning their health care, in order to change their attitudes towards key topics in SRHR. The organization aims to promote discourse that calls attentions to the connections between reproductive health, sexuality, and human rights.
In order to achieve this, WSEI conducts several initiatives. First, the organization runs a series of SRHR trainings and institutes, where academics, health practitioners, activists, and other who work in the field attend workshops with experiential training in order to raise awareness about the existing problems in national healthcare and education programs surrounding these issues. WSEI also works directly with adolescents in an attempt to foster positive attitudes about sex from an early age. This includes discussions and information about body image, menstruation, bodily changes, sex and sexuality, relationships, and consent. As a part of this program, the organization creates fact sheets for adolescent girls, with practical information about SRHR issues, but also that take on more abstract concepts, such as relationships and consent. WSEI hopes that this information and training will promote a dialogue so that girls are more able to raise these issues with their peers, mentors, and within their families, ultimately contributing to change in attitudes towards SRHR issues for the next generation. Additionally, WSEI publishes an annual translation of Reproductive Health Matters, a peer-review journal published out of London, into Hindi. This is the only material of its kind available in Hindi, and it is a vital resource for local workers in the field. The employees of WSEI are convinced that their work to change attitudes on the ground will help impact policy, or perhaps that policy is no longer what is important in family planning.

When asked for their perception of government reproductive health programs, employees at WSEI provided constructive suggestions from their experiences working directly with women or with grassroots organizations. One staff member stated:
It is not as if all grassroots programs are also the best, especially if they don’t have a focus on rights. But if it is a community or grassroots initiative, it tends to be more accessible, have a bigger outreach in their communities also. Whereas, the government programs, there is no accountability. There is a lot of absence on the part of employees who are talking about these issues or providing these services.

WSEI staffers also stressed the importance of civil society reinforcing government programs. One employee stated: “Where civil society health and rights groups have been really strong, there they have been able to push the government to have some kind of accountability.” WSEI employees offered several specific criticisms of government-sponsored reproductive health programs based on their experiences in the field. First, interviewees criticized government programs for their overly narrow focus on family planning, pregnancy, and delivery within the context of marriage. Second, WSEI staff highlighted the infrastructural shortcomings of central government programs. In reference to these infrastructural barriers—which include inadequate clinic staff and supplies, and difficulty with transportation to access rural clinics—one employee asked, “Where are the health centers nearby? Everyone has trouble getting there. Many people avoid going because it’s such a hassle. How do you expect them to go if you have not set up a better system?” Further, participants emphasized that the combination of such infrastructural insufficiencies with an incentive-based system has proven highly problematic. In reference to state-employed health workers’ motivations in an incentive-based system, one interviewee stated,

These programs use incentives. They encourage women to register themselves during pregnancy and delivery. But the local health workers were told, for example, ‘If you register 3 women, you will receive this much money.’ So these workers are not concerned about the woman or her pregnancy, instead they’re just trying to register the number of cases assigned
to them in order to receive that sum. The government has not thought enough in designing these programs, and many women have complained. Further, other individuals—such as village officials, or even families and husbands—may pocket these sums, thereby preventing this money from being spent on care, as intended. These testimonies highlight some of the problems that arise in an incentive-based reproductive health program. According to respondents from WSEI, any of the schemes within India’s Family Planning Program are rendered ineffective due to a combination of corruption in the incentive-based structure of the program and infrastructural weakness that makes this care difficult to access.

When asked about their perception of WSEI’s impact, one employee stated, “I know many women who have participated in a workshop, who have made a decision to have or not have children, and they have also started to use this language within their families, with their sisters or other family members, to talk about these issues. Now women are also talking about these issues in local panchayat.”222 Overall, the employees of WSEI seem confident that if even a small group of women develop the positive attitudes about SRHR issues, this movement will spread.

WSEI represents an NGO that conducts activities that may be considered moderate within the range of civil society organizations considered in this research. WSEI focuses on empowering its target audience, which includes not only individuals but also other educators and reproductive rights activists. While the organization does not interact directly with the state, it pursues its projects with the expectation that its activities will indirectly have an impact on policy. Therefore, WSEI’s activities fit two theoretical prescriptions for civil society activity. First, WSEI’s

222 The Panchayat is the village council system, the smallest political unit of Indian government.
workshops that aim to train healthcare providers, educators, and other reproductive rights activists reflect both Tocqueville and Putnam’s assertions that civil society must promote societal association and therefore enable people to more effectively come together to implore the state to pursue societal goals. WSEI also fits Berger and Neuhaus’s description of civil society organizations as intermediary institutions between individuals and state megastructures, as it aims to educate and train actors that work with both citizens and the state. WSEI aims to empower citizens independently of the state, and to impact policy. Its intermediary relationships with individuals and with the government put WSEI both at an advantage and a disadvantage, when compared with other civil society organizations. While WSEI is able to address both groups indirectly, it is unable to work in-depth with either group, and therefore its impact on both remains relatively remote and limited.

**IRSHC-Improving Reproductive and Sexual Health Communication**

The third organization that I interviewed was a small organization named Improving Reproductive and Sexual Health Community (IRSHC). IRSHC is founded on the belief that “All people have a right to sexual well-being and a self-affirming and enjoyable sexuality.” The organization strives to “expand reproductive and sexual choices in people’s lives,” and its activities are based on the notion that supplying individuals with accurate information is the best way to achieve this.

IRSHC aims to educate individuals to reduce misinformation, and to expand discourse about sex and sexuality through a variety of informational services. The organization is perhaps most well known for its popular telephone helpline, which was active from its founding in 1996 to 2009. A program officer at IRSHC stated:
“We founded the helpline because we realized there was really very little information that people had access to that was easy to understand and that was accurate.” This service provided information, counseling, and referrals on sexual and reproductive health and rights (SRHR). In total, the hotline received about 60,000 calls from individuals throughout the country. While callers ranged from twelve to seventy-two years old, most inquiries came from individuals between the ages of eighteen and thirty-five, and pertained to issues of body maturation, menstruation, conception, and contraception. The hotline service allowed IRSHC to not only answer questions, but also to collect data on the prevalence of sexual and reproductive health related issues and questions. A staffer stated, “Since we don’t directly work on the ground, our information is really based on what we hear in the helpline.” IRSHC has recognized that, while in-person work with individuals regarding their reproductive health is invaluable, the breadth of the impact of such work is severely limited. The helpline is the organization’s solution to this problem of scope, as it is able to overcome obstacles—such as the enormity and diversity of India—in order to impact a broader population that it would be able to reach with on-the-ground work. Since the helpline went off-line in 2009, it has been replaced with an automated version of the same service, which uses an interactive voice response system to provide the same comprehensive standard of information.

In addition to the helpline, IRSHC has published a Red Book and a Blue Book, materials that supply age-appropriate information about sexuality and reproductive health for ages ten to fourteen, and fifteen and older, respectively. Further, the organization is often commissioned to create informational publications for other
NGOs. In recent years IRSHC has conducted workshops on sexuality and reproductive health and rights. These trainings are aimed at teachers, other NGOs, activists, and counselors. The range of informational services that IRSHC provides reflects the organization’s belief that in order to make a substantial impact, it must aim to improve information and discourse at multiple levels of India’s reproductive health field—for individuals, other NGO workers, educators, healthcare providers, and policymakers.

During interviews at IRSHC, I also broached the subject of current barriers to sexual and reproductive health, and justice. Clearly, the organization considers a lack of accurate and accessible information to be an obstacle to individual health, which may be rectified through more informational initiatives like those of IRSHC. Additionally, staff cited attitudinal and social problems as barriers to reproductive health, which are more difficult to address. First, dialogue about sex in India is thwarted because sexuality is only ever acceptable to discuss within the context of a heterosexual marriage, and even then, is relatively prohibited. Second, domineering gender roles create challenges for both women and men in sexuality and reproductive health. Social norms prevent women from taking the initiative with their sexual health—should they seem too forward or sexual—and limit women’s mobility, and thereby their ability to access SRHR services. Further, one staff member cited the high premium that continues to be put on parenthood and motherhood. She stated, “If [women] are able to get married and have sons, then they may have an element of choice.” Meanwhile, men are hesitant to seek out sexual and reproductive health care
for fear of appearing sexually inexperienced or insecure, as asking for help may be considered a sign of weakness or naivety.

Lastly, I asked the interviewees at IRSHC for their perception of change in the field of reproductive health in India since the organization’s founding. Their responses were far from optimistic. One staff member stated,

“I think more people are using and aware of the human rights language, and there is less target-focused language. But if you read newspapers there are articles of teenagers getting hysterectomies, of the sterilization of young men. So the whole targeted approach to family planning still seems to be operating on the ground although we are talking the language of rights.”

IRSHC has recognized that the shift in rhetoric that occurred in the reproductive health field in the 1990’s has not had an adequate impact on the ground.

IRSHC is the organization of the three that works the most outside of the system, as it attempts to independently provide a service—the helpline—that it considers the state to have failed to create for its citizens. IRSHC employees were the most critical of failures (coercion, incentives, and insufficient information) of state government programs. Instead, IRSHC’s project focuses on empowering citizens to make decisions about their health in a manner independent of state programs, by providing direct channels of reproductive health information that government is unable to or has not provided. While IRSHC may not be able to achieve the broad impact of an organization that works closely with the government—such as IFPI—the organization is able to effectively promote agency among the relatively small population of individuals it does reach by empowering their reproductive choices through referrals, advice, and information about their reproductive rights and health.
IRSHC’s projects seem to most closely reflect the role of civil society Lipset argues for—that civil society should empower individuals, who will therefore be better equipped to assert and articulate their needs to their state. IRSHC’s educational projects, therefore, may be considered an approach that extends beyond traditional concepts of civil society in their radical nature and their criticism of the state. These activities represent a function of civil society not considered by theorists: empowering citizens to act outside of the state. As reproductive health NGOs have out of state control and towards increasingly critical role in defense of individuals’ reproductive rights, they reflect the broader trend of civil society in India fighting the corruption pervasive at many levels of the Indian state. It seems that many organizations across multiple fields have lost faith in the system and instead work towards providing services independent of the state.

**CONCLUSION**

Through these interviews, I found that several prominent themes emerged with implications for this project’s consideration of democracy and civil society. These respondents often mentioned the coercive experience with family planning, drawing a clear connection between a history of coercive practices, and a need to advocate today for individual choice and agency. Overall, the employees of these three organizations are optimistic that the field had been and would continue improving. Yet participants emphasized that there still exist significant barriers, including infrastructural weakness, the vestiges of a target-oriented program, or cultural attitudes. When asked to evaluate the changes in family planning during their time working in the field of reproductive health, one participant stated:
If your metric is, ‘Has contraceptive prevalence improved?’ I don’t think we’ve seen that. But if your metric is: ‘Do women know more?’ ‘Do they talk about things more?’ ‘Are they able to communicate more?’ ‘Are we generally more aware?’ That has happened, on a significant scale. What hasn’t happened is the use. And the use can happen and will happen, as long as there are services everywhere, quality services everywhere. And the potential is there.

Most participants seemed confident that this shift in rhetoric and attitude would facilitate change in practice. It seems that much of these three organization’s projects are centered on bringing about a cultural shift in attitudes regarding family planning. They advocate that contraception is an individual healthcare choice that belongs wholly to the woman—not her husband, her family, her village, or her government—and this is a right that she must be able to assert. This focus on individual choice marries two opposing movements that seem to have existed at odds with one another throughout the course of family planning policy in India: meeting women’s need for contraception, and protecting them from coercive family planning programs.

Participants also stressed that coercive family planning programs persist today. Such injustices in family planning programs in India are able to continue for several reasons. First, the targeted approach to family planning is ingrained at all levels of the system, as the entire program was built, to some extent, on achieving extreme goals that necessitated a targeted approach. Second, norms governing gender and sexuality promote an environment in which reproductive information is hard to come by, and individuals—women in particular—lack the ability to both assert their reproductive choices and defend themselves politically. It is for these reasons that these organizations continue to concentrate on promoting a society-wide change in attitudes—about gender relations, sexuality, reproduction, and family planning.
practice. This coercion that has pervaded family planning programs may be classified as state violence, which is invariably harmful to its citizens. Yet state violence has particularly severe implications in a democracy. If individuals lose faith in their democratic government, they will withdraw their participation, threatening to render that regime no longer democratic.

From these theoretical discourses surrounding democratic form and civil society, one may understand that each form—liberal, communitarian, and participatory—of democracy features different expectations for civil society based on its values. First, because liberal democracy is primarily concerned with the protection of individual freedom, such regimes expect civil society to regulate state actions in order to protect civil liberties. Meanwhile, participatory democracy is centered on the alignment of the private and public spheres through mechanisms that promote citizen participation in political processes. Therefore, in participatory democracies, civil society is valued because it is considered to be the site of the democratic discourse and association that produces the public good. Lastly, communitarian democracies aim to mediate the isolation of individuals from society that often results from liberalism. Civil society is therefore useful to communitarian democracies so far as it promotes civic association. The projects of these three organizations represent a range of functions that draw from all three democratic forms’ expectations of civil society. While it appears that NGOs in India’s reproductive health field are becoming increasingly critical of—and even independent of—the state, their actions also highlight the importance of civil society as a means of promoting civic association, and participation as a means by which to safeguard reproductive rights. In India’s
case, civil society is an essential component of democracy for its various projects that protect individuals from the violent state actions that cause citizen to distrust their government, thereby contributing to the destruction of democratic functionality.
CONCLUSION

Today, India’s approach to family policy is once again at a crossroads. Surely, much progress has been made away from the population control-focused and violent practices of earlier eras of India’s National Family Planning Program. In response to pressure from the global reproductive health community and the 1994 International Conference on Population and Development, Indian family planning policy today rejects coercion and emphasizes individual autonomy and choice in reproductive health decisions. This advancement in policy towards the language of reproductive health and rights, however, has not translated smoothly in practice. The incentive-based configuration that was a central feature during most of the history of the family planning program has proved difficult to relinquish. Problematic financial incentives, motivational systems, and even forcible sterilizations, persist, and remain commonplace in many areas. While India’s progress in family planning policy is commendable, this failure to adequately change attitudes and values within the actual implementation of the program itself makes such progress precarious. Because these persistent coercive tactics threaten to pull the nation back into an environment wherein coercion and targeting remain permissible, it is imperative that the drive towards the attainment of reproductive health and rights for Indian citizens is not lost.

Global development scholars are nearly unanimous in the assertion that effective reproductive health programs are a vital component of the advancement and development of functional modern democratic societies. The advancement of women’s role in society—of which optimal reproductive health is a major
component—has proved to be a highly effective technique for achieving societal
development. In their article, “Response to Critics of Family Planning Programs,”
John Bongaarts and Steven W. Sinding explain that voluntary reproductive health
programs benefit not only individuals (allowing women increased autonomy and
improved health), but also benefit socioeconomic development, in so far as they
stimulate economic growth and democratic stability. 223 A government’s provision of
quality reproductive health care displays its commitment to optimizing its citizens’
lives, a key value of democracy. On the other hand, measures that deny individuals
control over what should be personal decisions, like coercive family planning
programs, disrupt many of the tenets of democratic functionality. Coercive family
planning policy represents a state’s disregard for its citizens’ individual rights.
Similarly, reproductive freedom is central to individual citizens’ experiences of their
democratic governments. While experiencing a just reproductive health program will
affirm an individual’s relationship with his or her state, being the target of to coercive
family planning tactics will cause an individual to lose trust in his or her government.
Due to their sensitive nature, reproductive health programs serve as an ideal example
of a policy issue indicative of a state’s consideration of human rights.

Further, this project has addressed the tension between the highly intimate
nature of reproductive choices and that of population control as a social issue. This
tension between the public and private sides of reproduction has caused a divide in
the discourse on reproductive health. The argument for population control policies
has long been based on the idea of ensuring the “greater good”. Yet family planning

223 John Bogaarts and Steven W. Sinding “A Response to the Critics of Family Planning Programs,”
policy has become the grounds upon which the greater good and individual good have come into conflict. In his article, “Population Policy: Authoritarianism versus Cooperation,” Amartya Sen explains the difficulty of measuring such outcomes. He states, “It is not a matter of just fine-tuning conventionally defined costs and benefits: comparing the ‘costs’ to the family members resulting from the violation of their reproductive freedom with the ‘benefits’ to others that would result from that violation. There are reasons to see the problem rather differently.”

Therefore, the “greater good” justification for coercive family planning does not hold because of the problematic nature of attempting to aggregate the effects of rights violations.

Supporters of population control policy rely on Malthusian concerns of resource shortages and sustainability. While Sen agrees that the population problem is certainly dire, he instead highlights the threat that high fertility places on the quality of human life. In his September 1994 lecture “Population: Delusion and Reality,” Sen explains:

There are strong reasons for concern about the adverse effects of high birth rates on the quality of life, especially of women. With greater opportunities for education (especially female education), reduction of mortality rates (especially of children), improvement in economic security (especially in old age), and greater participation of women in employment and in political action, fast reductions in birth rates can be expected to result through the decisions and actions of those whose lives depend on them.

Therefore, Sen argues that the main concerns of population control supporters should be the detrimental effect that high birth rates have on those individual lives, rather than the challenges they create at the population level. Sen also discredits justifications for coercion by affirming that the individuals involved will voluntarily

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adopt the family planning practice that is optimal for their lives—which will result in a decreased birth rate. Sen explains, “The route to rational family planning lies in supporting and empowering those whose lives and responsible agency are most directly involved.”226 Therefore, development initiatives that empower individuals—namely those that reduce poverty and enhance political agency—present a potentially effective and coercion-free means to achieve lowered birth rates.

This thesis has employed reproductive health and rights as a case study of the Indian state’s treatment of human rights. Chapter I explored three forms of democracy—liberal, participatory, and communitarian—as well as their respective efficacy in defending their citizens against human rights abuses from the state. Democratic scholars have historically presented a bias that liberal democracy, due to its commitment to upholding the integrity of individual rights, is the optimal means to protect individual citizens’ rights. Yet this project has questioned such an assumption, suggesting that the best means to protect human rights are not necessarily universal, and may vary between societies. Therefore, the existence and acceptance of varying forms of democracy is beneficial because different democratic manifestations are more effective in protecting human rights in various societal circumstances.

Furthermore, it is the values of a democratic regime, not its institutions that are indicative of a regime’s actions and priorities. Although India adopted a liberal democratic institutional framework that was based largely on the colonial state, the influence of its communitarian and participatory democratic values were perhaps more influential in protecting human rights. This may be attributed to India’s circumstance at the time of being a developing nation with high levels of inequality,

one in which exclusively liberal democratic values would have only exacerbated existing inequalities.

Although no regime serves as a pure exemplification of one such theoretical form of democracy, India’s political and historical circumstances at the time of its Independence produced a regime particularly filled with tensions about its democratic values—tensions that became significant factors in the justification of coercive family planning programs. Recently the state has pursued an increasingly decentralized format of family planning, in an attempt to offer individuals greater autonomy and participation in their reproductive and family planning decisions, an effort by the state to promote individual participation in their politics.

This thesis has also explored the relationships and tensions that exist between the international and local NGOs, whose actions and objectives are often at odds with one another. International NGOs are influential on a broad scale due to their extensive resources and influence. Yet these small NGOs are able to have a more in depth impact, on a small scale, a function of their close work with affected communities and local insight into key issues. These findings suggest that both international and local NGOs are important in implementing programs like family planning, and furthermore, that collaborative relationships between the two types of organizations should be pursued in order to most efficiently implement efficient, well-funded, innovative, and just reproductive health care programs.

Further, this project has investigated the efficacy of NGOs in fulfilling the functions expected of civil society. Theorists concerned with civil society have envisioned for it a range of functions including empowering individuals to politically
assert themselves to their states, promoting association—and therefore discourse—among individuals, mediating relations between individuals and the state, and acting as a mutually affirming body with the state. Throughout its history, civil society in India has undertaken a range of these prescribed roles. While the Indian government initially considered NGOs to be institutions through which they could further state goals, some NGOs in its reproductive health field have grown increasingly critical and regulatory of government programs, acting as political entities in their own rights. Other organizations also serve as intermediary institutions between individuals and states. In the context of reproductive health organizations, locally-operated NGOs in India have evolved into a multitude of roles, most of which are somewhat critical of the state, and focus on making accessible those resources and services that the state—and international organizations—are unable to provide for citizens. These activities are focused on impacting change in attitudes about reproductive health, family planning, and population control, as these organizations see such an attitudinal shift as imperative to ensuring citizens’ ability to demand just reproductive healthcare services from their states.

Who deserves to reproduce? In India, the question has existed under the authority of the government who, until recently, had been overwhelmingly concerned with the threat population growth has supposedly posed to the well-being of the nation as a whole at the cost of the assurance of individual reproductive health and freedom. The Indian Family Planning program has demonstrated violations of a range of India’s democratic. Today, while the state has altered its programs in order to fit the language of reproductive rights, concrete outcomes for individuals affected
by the national family planning program have been minimal. It is clear that reproductive health programs must respond directly to the demand and needs of the individuals they serve.

The activities of the NGOs examined in this thesis reflect a focus on projects that aim to impact widespread changes in attitudes regarding gender norms, sexuality, and reproductive health more broadly. Just as the adoption of a democratic political structure is of no utility without the centrality of democratic values, reproductive health programs will remain ineffective and unable to prompt a change in practice on the ground until reproductive health and rights are adopted universally as values and as human rights.
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Participants 1 & 2, Organization A (pseudonym WSEI), 16 August 2012, 41 m 31 s, New Delhi.

Participant 3, Organization B, 23 August 2012, 39m 43 s, New Delhi.

Participants 4 & 5, Organization C (pseudonym IFPI), 24 August 2012, 46 m 31 s, New Delhi.

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