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BIO-POLITICS OF THE POPULATION IN THE INDIAN POPULATION POLICIES

Nandini Sahay * & Prof. (Dr.) Sukhwant S. Bindra **

*PhD Scholar and Visiting Faculty (Social Work) Amity Institute of Social Sciences D Block, 2nd Floor Amity University Uttar Pradesh Sector-125, Expressway, Noida-201313 Name of the second author:

**Head of Institution Amity Institute of International Studies (AIIS) E-2 Block, 2nd Floor, Room #209 Amity University, Uttar Pradesh Sector-125, Expressway Noida-201313

Abstract

India launched a nation-wide Family Planning Programme in 1952, which was dominated by demographic goals since its inception. In this paper the aim is to understand the bio-politics of the population in Indian family planning policies which is done by evaluating the process of implementation of family planning policies in India. A modest attempt has been made to explore writings on empowerment discourse to consider how it might be useful in the context of family planning practices in India. Michael Foucault coined the term "bio-power" to refer to the ways in which power manifests itself in the form of daily practices and routines through which individuals engage in self-surveillance and self-discipline and thereby subjugate themselves. In the present paper, an attempt has been made to understand how bio power can be useful to explore as to how the promise of empowerment could be used by family planning associations, development agencies and governments to encourage women to control their fertility.

Keywords: *Bio-politics, Population, Policies, India*

INTRODUCTION

Contrary to the theories of power which focus on the domination of one group by another, Michal Foucault coined the term **"bio-power"** to refer to the ways in which power manifests itself in the form of daily practices and routines through which individuals engage in **self-surveillance and self-discipline** and thereby subjugate themselves. Bio-power is a wide-ranging concept for Foucault sparring from sexuality to how prisons are arranged.

In this paper the aim is to concentrate on certain aspects of this thought. Also the objective is to understand the bio-politics of the population in Indian family planning policies.Firstly, an attempt has been made to evaluate the family planning policies. This would be done by recalling different incidents which happened while implementing family planning programme in India. These incidents have been quoted here to understand how these programmes have adversely affected the individual's sexual and reproductive rights. Secondly, a modest attempt has been made to explore writings on empowerment discourse to consider how it might be useful in the context of family planning practices in India.

India launched a nation wide Family Planning Programme in 1952[1]. India was the first country in the developing world to initiate a state sponsored family planning programme with the goal of lowering fertility and slowing the population growth rate.Since its inception in 1951, the National Family Planning Program has been dominated by Demographic goals.Sterilization is the most popular method of contraception in India. As the demand for sterilization services remains very high with large unmet need, the country has continued with the camp mode (mobile clinic) to reach the people in under-served and under-reached areas. District Level Household and Facility Survey from 2008[2] shows that of the 54 percent of the population that reported using any method of contraception, female sterilization accounted for 34 percent and male sterilization accounted for 1 percent of contraceptive use. Although the Family Welfare Programme has begun to give higher priority to spacing methods than to permanent methods, sterilization is expected to remain the most popular method for the foreseeable future**.**From the introduction of targets and incentives in the mid-60s to the mass vasectomy camps of early 1970s, India's family planning programme, one of the first and largest in the world, consistently treated poor recipient of its services as second-class citizens. In 1975, during the emergency period variety of laws and regulation were enacted to solve the problem of overpopulation. Public employees' salaries were made contingent on the number of acceptors they brought for sterilization. Fines and imprisonment threatened couples who failed to be sterilized after three children, and food rations and other government services were withheld from the unsterilized.In the last six months of 1976, 6.5 million people were sterilized; four times the rate of any previous period. Meanwhile hundreds died from infections associated with the operation, and in riots and protest against the programme.[3]

[1]www.medindia.net>general>family-planning in India-2011
[2]District Level Household and Facility Survey from 2008,Ministry of Health and Family Welfare,Government of India,2010
[3]Hartmann, Betsy, Reproductive Rights and Wrongs (Revised Edition): The Global Politics of Population Control (And Addie D. Averitt Lecture Series; 3),Harper and Row publisher, New York,1987

During Emergency[4], people were sterilized as punishment. In October, 1976 riots broke at Muzaffarnagar, Uttar Pradesh when people were protesting against these policies implemented during emergency (including sterilization). In response to the protest, the state police started seizing rickshaw pullers and stall owners. They were forced to go for sterilization.

Similar type of incident happened in the village of Uttamar, Haryana. Around hundreds of villagers protested against these polices. The state police raided the village with arms and tear gas[5]. They took the villagers for 'interrogation' and took a further one hundred and eighty to nearby family planning centres at Mandkola for sterilization. The final report from the Shah Commission[6] concluded that these activities were 'planned deliberately' by officials because of the local populations' refusal to submit to state programmes (Government of India, August, 1978, 32).

In the year 2014, about 4.2 million sterilization operations took place and 98% of these were carried out on women[7]. India is only country in the world where profoundly regressive practice of female sterilization predominates amongst the various birth control measures. The theory of "population bomb" has been emphasized while actual health concerns of a large number of women were neglected in the process.

Another example was shared by demographer John and Pat Caldwell and P.H.Reddy who saw these pressures first hand. Although the rural elite preferred to use IUD, poor villagers were offered no other birth control measures but sterilization in the belief that they were too ignorant to cope with anything else and their fertility had to be controlled at any cost.[8] Even India's tribal minorities faced the same pressure. Tribal villagers in the Indian state of West Bengal were forced to go for sterilization in 1982. According to Hartman[9] police officers were putting pressure on village leaders to send women"10 to 15 at a time" to the hospital to be sterilized.

COERCIVE NATURE OF POPULATION POLICIES

Coercive nature of the population programmes was also evident in the following policies:

- The National Population Policy of 1976 which called for a "frontal attack on the problems of population" and inspired state governments to "pass suitable legislation to make family planning compulsory for citizens" and to stop childbearing after three children, if the "state so desires" (Srinivasan 1998). The backlash of the coercive approach compelled subsequent governments to stress the voluntary nature of family planning acceptance.

[4] Mehta Vinod, The Sanjay Story. 2nd ed. London: Harper Collins, 2012, Omar, Imtiaz, Emergency Powers and the Courts in India and Pakistan. London: Kluwer Law International : 2002

[5]Government of India, The Shah Commission of Inquiry: Interim Report two. Delhi April, 1978, 28

[6] Government of India, The Shah Commission of Inquiry: Final Report. Delhi August, 1978

[7]VarmaSubodh, women undergo 98% of sterilization in India, The Times of India dated 12th November2014

[8] Caldwell, C,John, Reddy.P.H, and Pat Caldwell, "Demographic change in Rural South India," Population and Development Review, vol.8, no.4 (December 1982), p.712

[9]Hartmann, Betsy, Reproductive Rights and Wrongs (Revised Edition): The Global Politics of Population Control (And Addie D. Averitt Lecture Series; 3),Harper and Row publisher, New York,1987

- During mid-70s The National Population Policy called for a frontal attack on the "problem of population" and inspired state government to "pass suitable legislation to make family planning compulsory for citizens".
- The child bearing was expected to "State so desires" (Srinivasan.1998).

PRIVATE SECTOR

The ICPD Plan of Action clearly warns against administrative excesses and abuses. However no clear mechanisms were instituted to guard against these. The private sector, which provides a significant proportion of contraceptive services continues to be poorly regulated in India. A set of guidelines were once issued for ensuring quality of care of sterilization services, however no directions were given regarding what should be done if these were not being followed. The performance audit review conducted by the Comptroller and Auditor General noted that only 9 states have reported a total of eight hundred contraceptive failures but no procedure existed to deal with these. Using the most conservative estimates roughly 22,000 women (0.5%) face contraceptive failure each year, though local studies indicate a much higher rate of failure.[10]

INCENTIVES AND DISINCENTIVES

Supporter of the incentives argues that they are a neutral tool of social engineering, designed as "inducements to change behavior". According to them, the use of incentives in family planning programmes help to spread information about contraceptive techniques, acts as a trigger-mechanism to start people using contraception who are already interested in limiting births, and encourage those not yet interested to accept family planning through financial benefits that alter their "taste" for children. Ostensibly, incentives are voluntary, since people can either choose to accept them or refuse them if they want. These kinds of attitudes ignore the social context in which these incentives are introduced.

MarikaVicziany in her classic study of the Indian Family Planning programmes wrote "What is remarkable is that none of them make room for a more down to earth explanation of effectiveness of incentives in a culture of poverty namely, that the main reason a material incentive work is that it provides an immediate gain." A starving person is much less likely to make an informed decision about sterilization if he or she is offered cash and food as a reward. Thus, in practice incentives often have more to do with coercion than with choice.

A Selection Of Incentives And Disincentives In Different State Population Policies[11]

[10]BOOKLET 3-Changing Paradigms : RH Policy and Advocacywww.chsj.org/.../booklet_3-_changing_paradigms __ *rh _policy_and_advocacy...*

[11]Dak,T.M,Application of two child norm for contesting or holding office in panchayati raj institutions in Fifth Scheduled Areas States of Rajasthan, Madhya Pradesh and Gujarat: A study of its impact on women,Research Report,2009,Institute of Social Development,Udaipur

The states which adopted the two child norm at one stage or the other sought population control and stabilisation through incentives and disincentives such as enhancing minimum age of marriage, education about enacted legislation, preventing people with more than two children from contesting elections to PRIs or to hold office in panchayats, making the norm as minimum criteria for availing government facilities, denial of free education to the third child etc (Visaria)[12]. These states included Rajasthan, Madhya Pradesh, Haryana, Gujarat, Andhra Pradesh, Orissa and Himachal Pradesh. Some of the incentives and disincentives are discussed below:

- The two-child norm was made applicable not only for contesting elections for or holding office in PRIs but also for entry and promotion of employees in public services.
- Two child norm was applicable also for the eligibility of persons to avail benefits of government welfare programmes and services.
- At the community level, performance in RCH and rates of couple protection were to determine the construction of school buildings, public works and funding for rural development programmes.
- Performance in RCH was also made the criterion for full coverage under programmes like TRYSEM, DWCRA, Weaker Section Housing Scheme and Low Cost Sanitation Scheme. Allotment of surplus agricultural land, housing sites, as well as benefits under IRDP, SC Action Plan, and BC Action Plan were to be given in preference to acceptors of terminal methods of contraception.
- Educational concessions, subsidies and promotions as well as government jobs were to be restricted to those who accept the small family norm.
- A lottery with an award of Rs. 10,000 were to be given to three couples to be selected from every district on the basis of a lucky dip. The eligible included three couples per district with two girl children - adopting permanent methods of family planning, three couples per district with one child - adopting permanent methods of family planning and three couples per district with two or less children - adopting vasectomy.
- Women with more than two children were barred from contesting elections to the panchayati raj institutions.
- The Uttar Pradesh population policy also disqualified persons married before the legal age of marriage from government jobs, as if children were responsible for child marriages.
- Further, 10 per cent of financial assistance to panchayats were to be based on family planning performance.
- The assessment of the performance of medical officers and other health workers was linked to performance in the RCH programme. (Mohan Rao,2003)

IMPACT OF DISINCENTIVES

[12]VisariaLeela, AcharyaAkash, and Francis Raj (2006) 'Two-Child Norm: Victimising the Vulnerable', Economic and Political Weekly, XL (1) January 7-13

- When disincentives are applied at the level of the health service providers, the health functionaries start applying pressure on the community, and engage in coercion. The quality of family planning services which is not too good to start with, becomes worse. This poor quality has tremendous implications in terms of core health concerns like maternal mortality and morbidity.

- When disincentives are applied to the community, the impact is squarely upon the women. Men persuade or force women to undergo sterilization operations. The woman also stands to be deserted, if she has a third child. If a woman with three children becomes a widow she could have to face the burden of disincentives (no job, no loans etc.) even though she is already extremely vulnerable.

- The impact of disincentives was also disproportionately borne by the dalits, OBCs/ STs who were already vulnerable, because they had more children. So instead of creating opportunities for the vulnerable which is the mandate of the state (according to the Indian Constitution), a scheme of disincentives ended up doing just the opposite.

IMPACT OF INCENTIVES

- Most incentives that were being provided were linked with undergoing sterilization after two children. This was similar to promoting a two-child norm, in a less coercive way. The impact of such an incentive was to promote sex selective abortion, as well as the pressure on the woman to undergo sterilization operation. At another level, when people were economically very vulnerable, incentives became coercion because the people could not afford to refuse the incentive. It is clear that whichever way one looks at it, incentives and disincentives ended up being disadvantageous to women.

- There is an important aspect which was ignored in these programmes and policies, that in the matter of fertility decisions, the multiple forms of power converge. Women do not have the right to choose when to marry, when to have children, spacing between children and number of children to be produced. There are people including husband, family, the community and the religion who are involved in controlling women's bodies.

- India's family planning programme has traditionally and exclusively targeted women and women sterilization had been the most acceptable form of use of family planning services. This is because male sterilization is not acceptable in a patriarchal society. Instead of addressing misapprehension of sterilization affecting male virility, sterilization is being promoted among female. Such practices result in gender injustice and inequity.

- Sterilization was pursued through other programs that are entirely funded by state governments. For example, five states have introduced "girl child promotion" programs. This scheme would provide

monetary benefits to parents of girls, with a final cash benefit if she reaches the age of 18 unmarried. But the couple must produce a sterilization certificate if they want to receive the benefit[13].

The emphasis on achievement of decreasing the average family size is also dependent on technical and managerial elements. According to the family planning programmes, the decrease in the family size can be achieved by right technical and administrative methods, added with the latest medical knowledge. Effectiveness of this kind of approach can be questioned on the ground that in the given socio-cultural context of our nation, women do not make individual personal decisions about their fertility. Men and elderly women play a decisive role in shaping these 'choices' outside the household, within the 'public' sphere and the thrust of population control polices dictate the options and choices available to women. Thus 'choices' no longer remain choices, rather these become compulsions dictated by factors which are beyond the control of individual women.

BIO POWER AND THE EMPOWERMENT DISCOURSE

Empowerment discourse can be used as the principal component for implementing family planning programmes in India. In this paper, discussions about empowerment has been identified as a discourse. The discourse on 'women's empowerment' has been used in the advocacy of family planning. This discourse integrates a number of earlier justifications of promoting family planning as a strategy to enhance women's access to higher standards of living and improved health.

The empowerment discourse was first mainstreamed in 1994 at the United Nations International Conference on Population and Development (ICPD) in Cairo. In this discourse, women empowerment was considered important in addressing the reproductive health 'needs' of women and the provision of family planning.

As mentioned in the first paragraph of this paper, Biopower explores the importance of population to political and economic power. It provides a framework for analysing how government bodies can evoke 'desire' as a tool to control population without coercive measures. In the present context, biopower can be useful to explore how the promise of empowerment could be used by family planning associations, development agencies and governments to encourage women to reduce their fertility. There are two components of Foucault's 'bio-power'.

(i) Disciplinary power and
(ii) Regulatory power.

Disciplinary power: Disciplinary practices aim to "render the individual both more powerful, productive, useful and docile"[14] and in doing so achieve control. In this case, birth control technologies might represent a form of disciplinary practice, as they are the measures individuals take to control their bodies. Birth control technologies make women's reproductive capacities 'docile' in an attempt to make women more powerful, productive and

[13]India: Target-Driven Sterilization Harming Women,retrieved from https://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women

[14] Price Janet, Shildrick Margrit , Feminist Theory and the Body: A Reader, 1999

useful to themselves and the society at large, for it allows them to participate in paid work and engage in activities outside of the home.

Regulatory power: Population control policies, health initiatives & the empowerment discourses regulate population by creating governing policies and interventions (Sawicki 1991).

In this paper empowerment discourse is taken as a version of Foucault's biopower in exercising disciplinary and regulatory control over women's fertility. The empowerment discourse associates the use of modern methods of contraception with many positive outcomes for women, their households, their communities and the nation state. These positive outcomes include control over the number of children they will conceive as well as choice as to when they would have the children, personal ownership of their bodies, and enhancement of their civil rights and equality with men. Family planning and modern contraceptives provide the means of disciplining women's bodies to become 'empowered'.

The need of the hour is to have a form of government that attempts to invest in women, the final authority to make judgments about having children. Kerala[15] can be seen as a model in this regard. Kerala had a population density three times of the average Indian state, but the state government invested in universal education (an important dimension of empowerment) and provided greater access to family planning and, by 1989, the fertility rates there had fallen to the second lowest in the country.

It is from this perspective that the uptake of women's empowerment within the administrative logic of the population apparatus becomes particularly acute. Hence, instead of adopting coercive measures, it is important to understand that population control measures can become more successful if social and cultural factors are given more importance. Equal educational, health and employment opportunities can empower women to take care of herself and her family in a better way.

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[15]http://newint.org/blog/2014/07/08/education-women-fertility/#sthash.4bfU52Q8.dpuf

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