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Population Control in India: Prologue to the Emergency Period

MATTHEW CONNELLY

SOME 30 YEARS after the event, the Emergency Period remains the one episode in the history of family planning in India that would appear to require no introduction. It has become emblematic of everything that can go wrong in a program premised on “population control” rather than on reproductive rights and health. This included time-bound performance targets; a preference for methods that minimized the need for sustained motivation; disregard for basic medical standards; incentive payments that, for the very poorest, constituted a form of coercion; disincentives that punished non-participation; and official consideration of compulsory sterilization, which, even if never enacted into law, signaled that achieving national population targets might override individual dignity and welfare.*¹

Yet, even now, we know little about how and why such policies were first developed. Early accounts pointed out that there were precedents for these abuses, and Marika Vicziany was particularly persuasive in critiquing the already pervasive belief that coercion was unique to the Emergency Period.² Yet these accounts were never followed up in the ensuing decades. Moreover, even these authors did not investigate the role of international organizations and foreign advisors or probe the motives behind the policies. Instead, the Emergency Period is remembered as a singular episode,

*Sources cited in footnotes are primarily of two types: unpublished material from archives and published articles and books. A list of archives consulted and a reference list appear at the end of the article.

¹ This article describes how “family planning” became a strategy and a slogan to achieve specified population targets, which helps explain why, for Indians, it became synonymous with “population control.” For Americans, on the other hand, the latter term is pejorative. Nevertheless, it accurately describes India’s program in the 1950s and 1960s. Avoiding it would further confuse the distinction that most people in the field now strive to uphold.

² Gwatkin, “Political will and family planning,” 1979; Vicziany, “Coercion in a soft state,” Part I, 1982; Part II, 1982–83.

part of an individual country's domestic political crisis dominated by a few personalities, above all Indira and Sanjay Gandhi.³

With the opening of important new archives—most notably, those of United Nations agencies, the World Bank, the Ford Foundation, the International Planned Parenthood Federation, the Population Council, and India's Ministry of Health and Family Welfare—a different picture has begun to emerge. The very richness of these materials precludes a definitive account, especially since they reveal the need for both a wide-angle lens and a long historical perspective. They show how, in the 1950s and 1960s, increasingly coercive policies with grievous health consequences were undertaken in India with the full cognizance of foreign consultants, and often at their explicit recommendation. Coercion was countenanced not just at the level of clinics and their clients, but between countries, especially when the United States could use food aid as leverage. This practice led to a disastrous campaign in 1965–67 to induce 29 million women to accept intrauterine contraceptive devices (IUDs). Shifting the focus back in time shows that the key policies thought to distinguish the Emergency Period had a long gestation, during which the advice and support Indians received from population control proponents abroad played a crucial role. Working together, they succeeded in making India an example of a *worldwide* population emergency requiring ever-more extreme measures.

Some of this history is already known from the public record, which makes the misplaced focus on the Emergency Period all the more striking. But the present account highlights the evidence emerging from recently opened archives. To explain how and why policymakers made particular decisions, historians consider confidential communications to be more revealing and reliable than what is said and written for public consumption.⁴ In this case, most participants in the decisionmaking process were prepared to support policies susceptible to abuse because they believed that reducing population growth would alleviate poverty. But the archives show that both

³ Even while citing Gwatkin's research, Oscar Harkavy of the Ford Foundation insists the Emergency Period was "a unique phase of the Indian program," at the same time criticizing India's use of targets and incentives without acknowledging any role for outside consultants in their development: *Curbing Population Growth*, 1995, pp. 157–158. Sheldon Segal claims that the Population Council's position was always "absolute and unalterable opposition to the use of coercion"—even "the perception of coercion" created by incentive payments was unacceptable. He regrets that Indira and Sanjay Gandhi did not heed such advice: *Under the Banyan Tree*, 2003, p. xxvii.

⁴ As the distinguished historian Marc Trachtenberg writes, "the documentary record—the body of material generated at the time and kept under wraps for many years—is far and away the best source there is. Yes, you sometimes need to read the open sources—that is, the sort of material that entered the public record at the time—but you can't be too quick to take what someone said in public as representative of his or her real thinking. Everyone knows that people tend to express themselves more freely in private, and everyone knows why. When speaking in public, people tend to concern themselves more with how other people will react. They know what constitutes acceptable public discourse and what is expected of them. Being familiar with the conventions of their own political culture, they know they cannot be too frank.... The real thinking is more likely to be revealed by what people say in private, as recorded in documents they believe will not become publicly available for many years": *The Craft of International History*, 2006, pp. 153–154. In such a politically charged field as family planning, this distinction between "acceptable public discourse" and "real thinking" is likely to be especially pronounced.

in India and elsewhere there was also a persistent concern about preserving the “quality” of populations by reducing differential fertility—whether between different castes and religious communities or between different countries and “civilizations.”

Of course, decades later it is difficult to establish motive with certainty, and other historians may go to the same archives and come away with different conclusions. Historical research, like any kind of research, sometimes produces surprising findings that call for verification. While the present account may not be definitive, it should serve as an invitation for more evidence-based debate about the international origins of coercive population control than we have had until now.⁵

How the population control movement came to focus on India

India has for centuries had a rich intellectual tradition concerning both the quantitative and qualitative aspects of population, as well as practical experience in controlling fertility since time immemorial.⁶ But Westerners preferred to make an example of India when developing their own theories and deriving lessons for policy—whether T. R. Malthus, who taught colonial administrators at Haileybury that alleviating famines in India would only compound the evils of overpopulation, or the first neo-Malthusians like Annie Besant, who cited these same famines as proving that poor people everywhere should practice contraception.⁷ In the 1920s, when American and British authors began to warn of a “Rising Tide of Color,” India was once again the most oft-cited example—even though there was not yet any evidence that its population was growing rapidly.⁸ In the 1930s Margaret Sanger and her Birth Control International Information Center focused on opening clinics in India. “So many white people returning from there are keen on birth control and see in it the only solution for India’s problems,” as one activist noted in 1933. “But that does not necessarily mean, unfortunately, that Indians will be of the same opinion.”⁹

In fact, Indians had for many years been participating in international debates about population. As in Europe and the United States, the cause of fertility regulation could serve various agendas, including gender equality and maternal health, but also neo-Malthusianism and eugenics. Indeed, the

5 A fuller version of my argument, including the Emergency Period itself, will appear as part of a history of the rise and demise of the population control movement to be published by Harvard University Press.

6 Raina, *Planning Family in India*, 1990, pp. 12–79, passim.

7 Ambirajan, “Malthusian population theory and Indian famine policy in the nineteenth century,” 1976; Caldwell, “Malthus and the less developed world,” 1998, pp. 684–686; “Mrs. Annie Besant’s appeal,” 1879.

8 Stoddard, *The Rising Tide of Color Against White World-Supremacy*, 1920; East, *Mankind at the Crossroads*, 1923, pp. 88–90; Wright, *Population*, 1923, p. 66; Ross, *Standing Room Only?*, 1927, pp. 295–296.

9 Marjorie Martin to Edith How-Martyn, 19 December 1933, Archives of the International Planned Parenthood Federation, London (hereafter IPPF), series B, reel 214, frame 424.

most vocal proponents were upper-caste Hindus concerned that differential fertility would increase the relative size and power of lower-caste and Muslim communities.¹⁰

The Congress Party, which dominated Indian politics until the end of the Emergency Period, evinced concern about population “quality” even before Independence. In 1940 its National Planning Committee commissioned a report from a working group under Radhakamal Mukherjee, a Bengali Brahman already on record for his concern about lower-caste and Muslim fertility. Warning of the “gradual predominance of the inferior social strata,” the report urged removing barriers to intermarriage among upper castes as well as directing birth control propaganda at the rest of the population to prevent “deterioration of the racial makeup.” The report estimated that 8 million insane and feeble-minded people were “at large and producing abnormals and subnormals”—indeed, reproducing more rapidly than normal parents. Citing precedents from the United States and Europe, including Nazi eugenic courts, the authors called for “selectively sterilising the entire group of hereditary defectives.”¹¹

The National Planning Committee was chaired by future prime minister Jawaharlal Nehru. He had long favored birth control, even while pointing out that other measures, like improving nutrition, might also reduce fertility. Nehru emphasized that population control could not, by itself, cure poverty.¹² His committee finally passed a set of recommendations that emphasized broad-based economic progress as “the basic solution.” But it also acknowledged that “measures for the improvement of the quality of the population and limiting excessive population pressure are necessary.” It backed fertility limitation, cheaper contraceptives, and, as part of a “eugenic programme,” removal of barriers to inter-caste marriage along with sterilization of epileptics and the insane.¹³

Following Independence, and after the 1951 census showed continued population growth despite a decade of war, famine, and sectarian strife, Nehru called for the new Planning Commission to convene another population committee. Their report recommended fertility limitation both for the sake of mothers’ and children’s health and to stabilize population “consistent with the requirements of national economy.” It called for free sterilization and contraception when recommended on medical grounds, and suggested that where feasible these methods should be adopted for social and economic reasons as well.¹⁴ Officials were still concerned about popu-

10 Ahluwalia, “Controlling births, policing sexualities,” 2000, pp. 37–38, 41–43, 46–47, 53–55. See also Ramusack, “Embattled advocates,” 1989.

11 Mukherjee, *Population*, 1947, pp. 64–67, 87–88.

12 IPPF, *The Third International Conference on Planned Parenthood*, 1952, pp. 143–145.

13 Mukherjee, *Population*, 1947, pp. 129–131, 134–135.

14 Raina, *Population Policy*, 1988, pp. 5–7; and “Recommendations of the Committee...on Population Growth and Family Planning,” 14 April 1951, reprinted as appendix A2 in Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme in India*, Vol. 1, 1992.

lation “quality.” When India invited the first field study by the UN Population Commission, it was charged with ascertaining whether people were already planning their families and “whether fertility differentials exist between different social and economic groups.”¹⁵ India was also the first country to obtain family planning advice from the World Health Organization. Indian representatives continued to press for family planning aid in international forums, although Catholic and Communist countries blocked any more such missions for the following decade.¹⁶

India’s government was slow to implement a family planning program. In the 1930s Gandhi had spoken out against contraception on moral grounds—most notably during a famous debate with Sanger—although he accepted periodic abstinence. In the 1950s and 1960s two of his disciples, Rajkumari Amrit Kaur and Sushila Nayar, took turns leading the Ministry of Health, an institution that was overstretched and reluctant to take on a new mandate. For almost 15 years, they waged a rear-guard action against birth control.¹⁷ Officials at the Planning Commission, on the other hand, were powerful and persistent advocates, urging “family limitation” in their first five-year plan 1951–56 “to promote the health and welfare of the people and development of the national economy.” Continuous data collection and analysis should inform population policy, the authors advised, “in view of the intimate connection which exists between the numbers, sex composition, age structure, physical and mental health and general quality of the people.”¹⁸ They called for state-funded research centers to develop “birth control suitable for all classes of people.” But Kaur continued to insist that only the rhythm method was acceptable.¹⁹

With such divisions among Indian officials and with no possibility of UN support, nongovernmental organizations came to play a crucial role in sustaining interest in family planning. Among the most important was the New York–based Population Council. The organization developed out of a 1952 meeting John D. Rockefeller 3rd organized in Williamsburg, Virginia to bring together demographers, scientists, academic administrators, and population activists. According to the Population Council’s own history, for Rockefeller “the reason to care about population was ‘to improve the quality of people’s lives, to help make it possible for individuals everywhere to

15 Alva Myrdal to Director-General, 15 May 1951, UNESCO Archives, Paris, 312 A 06(45) 54; “Document Presented to the Regional Committee for South-East Asia at Its Fourth Session,” 28 November 1951, World Health Organization, Official Records, no. 40 (Geneva, 1952), pp. 135–136.

16 World Health Organization, “Pilot Study on the Voluntary Limitation of Families in India,” *Official Records*, no. 42 (Geneva, 1952), p. 140.

17 Douglas Ensminger Oral History, 1 November 1971, Part B1, Ford Foundation Archives, New York, NY (hereafter FFA).

18 “Recommendations of the Committee Appointed by the Panel of Health Programmes of the Planning Commission,” 1951 Appendix V to “Report of the Family Planning Third Five Year Plan Committee,” National Institute of Health and Family Welfare, Documentation Centre, New Delhi (hereafter NIHFW), Depository, 204 IND.

19 Quoted in S. Chandrasekhar, “Demographic Disarmament for India: A Plea for Family Planning,” 30 November 1951, Planning Commission Archives, New Delhi.

develop their full potential.”²⁰ But in the verbatim transcript participants offered many different reasons to care about population, including economic development, but also geopolitics, conservation, and eugenics.²¹

The demographers in attendance, including Frank Notestein, Kingsley Davis, Irene Taueber, and Warren Thompson, had long been concerned that rapid population growth would impede the economic development of poor countries. The intensification of the Cold War with the “loss” of China and the ongoing conflict in Korea made this worry even more acute.²² When making their points and proposing action, many of the participants at Williamsburg used India as an example, undoubtedly because it was the largest, poorest country still uncommitted in the struggle between the superpowers. They asked, for instance, whether it was feasible to produce estrogen doses in such large numbers, and whether enough Indian women could be “inoculated” against pregnancy.²³

The most sensitive and contentious debates—with participants going off the record and accusing each other of “being provocative”—came when conservationists like William Vogt and Fairfield Osborn suggested that “industrial development should be withheld” from poor, agrarian countries.²⁴ Vogt had been appointed national director of the Planned Parenthood Federation of America (PPFA) after writing a best-selling book, *Road to Survival*. It opposed foreign aid and even trade that might “subsidize the unchecked spawning of India.” Instead, he called for “sterilization bonuses.” “Since such a bonus would appeal primarily to the world’s shiftless,” Vogt wrote, “it would probably have a favorable selective influence.”²⁵ The idea of paying incentives to encourage lower fertility would frequently recur over the following decades.

Warren Weaver of the Rockefeller Foundation along with most other participants considered the conservationists to be too pessimistic about the prospects for development to lift growing populations out of poverty. But he also suggested that foreign aid would only make Indians “nigger rich.” Weaver elaborated: “a man who finds out that he has a little income.—And what does he do? Well, at that moment he just stops working four days or a week, and he just sits there. I do not think that is what we want to bring to India.”

20 “About the Population Council,” «<http://www.popcouncil.org/about/history.html>» (accessed 21 June 2006). The quotation is from a speech Rockefeller gave 22 years later at the Bucharest World Population Conference. At the time, Population Council president Bernard Berelson viewed the speech as a repudiation of the Council’s work: Critchlow, *Intended Consequences*, 1999, pp. 185–186. The speech is reprinted in “Population growth: The role of the developed world,” 1978.

21 “National Academy of Sciences: Conference on Population Problems,” 20–22 June 1952, Rockefeller Archive Center, Tarrytown, NY (hereafter RAC), RG 5, John D. Rockefeller 3rd Papers, series 1, sub-series 5, box 85, folders 720–723. The following account and quotations are from this transcript. A summary account is reprinted in “On the origins of the Population Council,” 1977.

22 Szreter, “The idea of demographic transition and the study of fertility change,” 1993.

23 “National Academy of Sciences: Conference on Population Problems,” Evening Session, 20 June 1952.

24 “National Academy of Sciences: Conference on Population Problems,” Morning Session, 21 June 1952, pp. 17, 24.

25 Vogt, *Road to Survival*, 1948, pp. xvi, 14, 48, 77, 257, 280–283.

"I hesitate to use this language," Weaver had said, "but I guess it's all right at the moment." The Williamsburg Inn admitted only white patrons.²⁶

Indians were represented at this meeting, but they did not represent themselves. Instead, participants projected their prejudices onto the subcontinent as they speculated about its future. The only one who had actually published research on India, Kingsley Davis, had visited the country for the first time six months earlier. Consequently, Weaver was not the only one who fell back on his experience of divisions in American society to understand relations between rich and poor countries, particularly regarding "the potential degradation of the genetic quality of the human race"—as Detlev Bronk, head of the National Academy of Sciences, described it. Bronk pointed to the interaction of diverging fertility and improving public health, "making it possible for individuals to survive, who would not under natural conditions be able to survive." Summarizing the first day's discussion, he said that "there was the recognition of the fact that a very great obstacle to the achievement of much that was defined as being desirable is the level of intelligence in those areas of the world where these controls and these developments are most needed." Frederick Osborn, future president of the Population Council, warned that one could not "preserve the freedom of the human mind" in situations of high mortality and high fertility. It also required "a certain quality of human mind...I mean, a potential of intelligence considerably above the average." Repeating and rephrasing a point of Warren Thompson's about the danger of having to compete with rapidly growing populations, Osborn painted an apocalyptic picture: "this little group of three or four hundred people, who produce most of the freedom of the human mind, may be engulfed—and who have the low birth rate, and this death rate—may be engulfed by a great mass of people to whom these conceptions are largely alien."²⁷

Who were these "three or four hundred people"? It is difficult to discern whether the threat Osborn perceived was to people like those present at the Williamsburg Inn or to national elites worldwide. Some of those in the room, such as Irene Taeuber, considered that throughout the Middle East and Asia "the political survival of westernized groups is at stake." In January 1954, she observed that these elites understood the population problem "not as a theory but as a nightmare."²⁸ But at Williamsburg some may have felt that the danger was that elite *societies*—distinguished by condi-

26 "National Academy of Sciences: Conference on Population Problems," Morning Session, 21 June 1952, pp. 56–57. On Rockefeller's failed effort to desegregate Colonial Williamsburg see Harr and Johnson, *The Rockefeller Century*, 1988, pp. 494–495. This was an ongoing source of controversy at meetings of the Population Association of America, most recently at the May 1951 meeting in Chapel Hill, North Carolina. See van der Tak, *Demographic Destinies*, 1991, pp. 38, 55.

27 "National Academy of Sciences: Conference on Population Problems," Morning Session, 21 June 1952, pp. 7–9, 68–69.

28 "Excerpt from remarks by Dr. Irene Taeuber regarding her trip to the Orient," 16 January 1954, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 1, folder 3.

tions of low fertility and low mortality permitting “freedom of the human mind”—would be engulfed by those peoples with a lower “level of intelligence” and no elite to speak of. Even discussions about the quality of America’s population kept coming back to India. On the afternoon of the second day the economist Isador Lubin tried to explain why:

At luncheon today I raised the question as to why it was that almost everybody who spoke this morning talked about India. What is there about India that makes this situation so acute? And I think unconsciously we are scared, and I think we have a right to be. In other words, that is where the ferment is taking place. That is where the pressure is the greatest.

Communists were filtering in, he said, promising India easier solutions that need not await technological advance. “If that part of the world accepts another political philosophy of life then the pressure on us will be such that we will have less time and less men and less interest—I am talking about the Western civilization—to do these things that we are talking about.”²⁹ Similarly, Davis warned that “the advanced countries, the places where the scientific developments are being made, are beginning to be leveled down by the tremendous demands of the rest of the world for sheer subsistence, at low levels of living.” Thus, “Western Civilization” along with its technocratic elites would be dragged down through the diversion of energies to emergency aid, or even to self-defense, before most of the world’s population could be raised to the point where they could stand on their own.³⁰

Conference participants agreed that Asian elites had to want population control for themselves. Even Vogt understood that appearing to impose it risked provoking a backlash. “It is commonly said in the Orient that we want to cut their population because we are afraid of them,” he noted. “But the program can be sold on the basis of the mother’s health and the health of the other children....There will be no trouble getting into foreign countries on that basis.” Notestein thought that “there is a considerable opportunity to influence opinion and policy, perhaps directly, to channel such influence through international agencies.” He therefore urged training local scholars and setting up research centers, while admitting that “some of the research, of course, would be pretty bad.”³¹

The Population Council’s first major program was to provide fellowships, most of which went to Indians and Americans.³² And the first time the Coun-

29 “National Academy of Sciences: Conference on Population Problems,” Afternoon Session, 21 June 1952.

30 “National Academy of Sciences: Conference on Population Problems,” Afternoon Session, 21 June 1952, p. 76.

31 “National Academy of Sciences: Conference on Population Problems,” Afternoon Session, 21 June 1952, pp. 103–104; Morning Session, 21 June 1952, p. 21 ff.

32 Caldwell and Caldwell, *Limiting Population Growth and the Ford Foundation Contribution*, 1986, p. 44.

cil received money from anyone but Rockefeller—a Ford Foundation grant in February 1954—it used it to create the first UN population research center in Bombay.³³ These regional centers would serve a political as much as a scientific function. Directors were to “combine the qualities of scientist, pioneer, diplomat, and salesman,” as a Ford-sponsored meeting agreed.³⁴ They were not expected to contribute to the understanding of population problems outside their particular regions, much less in Europe or North America.

In its first three years, the Council provided grants for studies of twins and of differential fertility among social classes, and also made direct contributions to the American Eugenics Society that would continue for more than two decades.³⁵ Indeed, in 1959, shortly before Notestein succeeded to the presidency of the Council, he wrote that “all of us were convinced that, so far as the western world was concerned, the important issues were likely to be qualitative rather than quantitative.”³⁶

Why did Notestein and others in the Population Council consider qualitative issues in poor countries to be relatively unimportant compared to quantitative issues? And why did they never support eugenic research in places like India? It is not because they would have had no willing partners, as a Council representative, Pascal Whelpton, discovered during a 1954 visit. India’s first official research program included studies of differential fertility between caste, class, and religious groups, as well as the development of intelligence tests appropriate for each one. One of the “main goals,” Whelpton learned, was to gather data about the present quality of population, and determine whether a program to reduce fertility “will reduce family size in much greater degree among the more desirable than among the less desirable groups of the population.”³⁷

American researchers were not entirely uninterested in differential fertility in poor countries. They speculated that promoting education and access to paid work, especially for women, might reduce preferred family size.³⁸ Eugenists in Europe and the United States had long worried that educated and employed women were not contributing to the gene pool. In 1957 Osborn

33 Frederick Osborn application to Ford Foundation, 10 February 1954, FFA, 1953 Grant Files, PA 54-20, The Population Council.

34 Bernard Berelson, “Summary Report of Discussions of Informal Consultative Group,” 18–19 April 1953, FFA, 1953 General Correspondence, C-1165A, “Population.”

35 “Proposed Establishment of Population Council,” 20 November 1952; and Frederick Osborn, “Population Council: Philosophy of the Rational Control of Family Life,” 9 June 1954, RAC, RG 5, John D. Rockefeller 3rd Papers, series 1, sub-series 5, box 82, folders 683–684. On the persistence of eugenics in the Population Council see also Mesner, “Engineering global population,” 2001, and Ramsden, “Between quality and quantity,” 2001.

36 Frank Notestein to Caryl Haskins, 17 April 1959, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 34, folder 489.

37 “Minutes of a Meeting of the Subcommittee on the Quality Aspects of Population,” 13 March 1954, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 32, folder 470.

38 Balfour et al., *Public Health and Demography in the Far East*, 1950, pp. 83, 116; Frank Notestein, “Gaps in the Existing knowledge of the Relationships Between Population Trends and Economic and Social Conditions,” circa June 1954, UNESCO Archives, Paris, 312 A 06(45) 54; “Conference on Study of Motivation Relevant to Fertility Control,” 29 May 1959, RAC, RG 5, John D. Rockefeller 3rd Papers, series 1, sub-series 5, box 82, folder 680.

observed that “those who have only a grade school education have more children than those who have gone to high school...the socially handicapped are contributing more than their share of children.” He asked whether the Council should consider more direct action to “reduce or reverse present socio-economic differentials in fertility.”³⁹ Ironically, what some considered a problem affecting the “quality” of Western populations was seen as an opportunity to reduce the quantity of “Third World” peoples.

One can ask why the Population Council had different priorities in different countries without doubting that its leaders had good intentions. For Notestein, the danger of differential fertility was unproven, whereas the effects of a poor environment in places like India were palpable. He believed that controlling fertility would enhance the health and productivity of both poor people and poor countries. Moreover, both Notestein and Osborn were sensitive to the charge that family planning was intended to preserve white supremacy. For that reason, in the Council’s own work and when advising others, they urged close cooperation with Third World researchers and a primary emphasis on economic factors, not geopolitics or eugenics. It was their advice, for instance, that led the World Bank to give its first grant for population research to Ansley J. Coale and Edgar M. Hoover for their seminal study, *Population Growth and Economic Development in Low-Income Countries*. The book made India a case study of how feeding, housing, and educating a fast-growing population could prevent the capital accumulation necessary for industrial development, and it had a major influence in Delhi.⁴⁰

Yet Notestein was also concerned about the geopolitical aspects of population growth. Thus, he considered economic policies that met minimal needs as “worse than useless,” since they were “expanding the base populations,” and the situation was already causing “political explosions.”⁴¹ While Davis differed from Notestein on many issues, he too warned that expanding food aid would have the effect of “building up ever larger populations on the basis of charity.” Leaders of impoverished, overpopulated countries would resort to blackmail, especially if some industrial power supplied these “youthful hordes” with weapons of war.⁴² Population control proponents, for their part, increasingly viewed foreign aid as providing leverage to demand that poor countries control fertility.

39 “Concluding Statement by Chairman,” 4 April 1957, and Frederick Osborn to members of Ad Hoc committee, 15 April 1957, RAC, Population Council Papers, Record Group IV3B4.2, General File Series, box 2, folders 12–13.

40 Richard Demuth to Robert Garner, 26 October 1953, World Bank Group Archives, Washington, DC, Central Files 1947–1968, General Files—Projects and Studies, box 35, “Population,” vol. 1: Coale and Hoover, *Population Growth and Economic Development in Low-Income Countries*, 1958.

41 Notestein, “The economics of population and food supplies, 1953, pp. 24–25.

42 Kingsley Davis, “World Population Trends and American Policy,” November 1956, RAC, Rockefeller Brothers Fund, RG V4C, Special Studies Project, box 21, folder 237.

Some observers completely dismissed the “humanitarian aspects of birth control,” viewing it simply as a weapon to win the Cold War. Foremost among them was Hugh Moore, founder of the Dixie Cup Corporation, who produced over 1.5 million copies of a pamphlet that coined the term “Population Bomb.” He took out full-page advertisements in major newspapers, and his views were endorsed by establishment figures like Ellsworth Bunker, soon to become ambassador to India.⁴³ Dudley Kirk, who headed the Population Council’s demographic division and who recruited and selected its first fellows, acknowledged in a 1989 interview that he was motivated, at least in part, by a concern for “the supremacy of Western civilization.”⁴⁴ While he was still with the organization, Kirk emphasized that the Council “should advocate birth control as a humanitarian gesture and not because there are too many Asians, too many Arabs.”⁴⁵

Suspicion of American motives created tensions in the new International Planned Parenthood Committee, which was composed of the leading birth control activists from the United States and Europe. Many of its members considered the Americans to be “obsessed” with “attacking population problems, and especially those of coloured people.”⁴⁶ Margaret Sanger complained that emphasizing maternal health and sex education would not inspire potential American contributors. In 1951 she grew worried that if the Dutch were permitted to host the Committee’s next international meeting, population control would drop from the agenda. At this critical juncture, she decided that India would actually be the ideal site for such a meeting, even though its newly established Family Planning Association was not even a member of the International Committee.⁴⁷ Sanger could count on her hosts to pack the meeting, aside from those few foreign participants she selected for travel grants.

Those who disagreed with Sanger’s priorities but came to Delhi anyway heard a series of messages from Indian leaders pleading the case for family planning.⁴⁸ This belied the impression that planned parenthood was just a way for wealthy, insecure Americans to keep down poor, dark-skinned people—something that the influential head of the Swedish delegation, Elise Ottesen-Jensen, had long suspected. For her, the most persuasive message was that delivered by Dr. Sarvepalli Radhakrishnan, a noted philosopher, vice

43 See Critchlow, *Intended Consequences*, 1999, pp. 30–33; Sharpless, “Population science, private foundations, and development aid,” 1997, pp. 191–193.

44 Jean van der Tak interview with Kirk, 29 April 1989, Population Association of America Archives, Silver Spring, MD, Box 4A, folder 65.

45 Frederick Osborn, “Notes on Ad Hoc Meeting,” 7 March 1956, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 1, folder 7.

46 Suitters, *Be Brave and Angry*, 1973, p. 42.

47 “Draft Reply to Mrs. Sanger’s letter,” 9 January 1950, IPPF, series B, reel 117, frames 1208–1210; Sanger to Vera Houghton, 25 January 1951, IPPF, series B, reel 717, frames 1643–1644; Houghton to Sanger, 11 June 1951, IPPF, series B, reel 717, frames 1625–1627.

48 One of them, the governor of Uttar Pradesh, declared it “essential that decrepit, diseased, infirm and incurable adults should be prevented, by enforced surgical treatment, from adding an unhealthy and infirm element in our national composition”: IPPF, *The Third International Conference*, 1952, pp. 2–4.

president, and future president of India. He patiently and thoughtfully demonstrated how the cause of planned parenthood was a crucial theater in the struggle for human rights, a safeguard for women's and children's health, a cornerstone of the welfare state, consistent with Gandhi's teaching on self-control, and a fulfillment of God's wish that people use their intelligence to alleviate suffering. Ottesen-Jensen was so impressed that she quoted from the speech for years afterward and reprinted it in full in her autobiography.⁴⁹ While for Ottesen-Jensen and like-minded activists family planning was a way to empower people and improve general welfare, their support permitted Sanger and her allies to draw up plans for an international federation that would make controlling population growth a top priority.

Increasingly coercive measures: International origins and intellectual justifications

Even after the incorporation of the Population Council in November 1952 and the founding of the International Planned Parenthood Federation three weeks later, a family planning movement could not really get moving without the official backing of at least one government. Field workers and funds for field experiments were useless without a field of operations, preferably one made free and accessible through the backing of local officials. On 7 December 1952, this final element fell into place, when Nehru presented to parliament the first five-year plan, which included the world's first explicit policy of population limitation.

The plan did not specify targets, unlike many that would follow, but called only for reducing birth rates to "a level consistent with the requirements of national economy." At the same time, it acknowledged that family planning's "main appeal" was the improvement of individual welfare, and therefore recommended that it be part of the public health program. While the plan urged provision of birth control advice in hospitals and health centers, it allocated just 6.5 million rupees, or \$480,000 a year—an annual budget of \$3.3 million in today's dollars.⁵⁰

More than a year earlier, Notestein had reported that India was moving toward a family planning policy with "remarkable" speed. In fact, the program that was finally presented was far less ambitious than the one the Congress Party had proposed back in 1947.⁵¹ Nevertheless, the long-anticipated news "profoundly influenced" John D. Rockefeller 3rd, helping to convince him to fund the Population Council with \$100,000, and to pledge another \$1.3 million within a year. Up to this point, the five centers of demographic

49 Radhakrishnan, "Inaugural Address," in IPPF, *The Third International Conference*, 1952, pp. 10–13; Linder, *Crusader for Sex Education*, 1996, pp. 177, 185.

50 Srinivasan, *Regulating Reproduction in India's Population*, 1995, pp. 30–32.

51 Notestein, "Policy of the Indian government on family limitation," 1951, p. 254.

research in the United States had a combined annual budget of only \$160,000.⁵² Officials from the Ford Foundation were also encouraged to award the Council \$600,000, the Foundation's first grant for population research.⁵³ The Rockefeller Foundation set aside almost a quarter of a million dollars between 1953 and 1956 for a single family planning project in Punjab.⁵⁴

All along, demographers pointed to India's leadership as they appealed for support from foundations. Davis proclaimed that "India had a chance to be the first country to achieve a major revolution in human life—the planned diffusion of fertility control in a peasant population prior to, and for the benefit of, the urban-industrial transition"—quite a return on investment, considering the size of its family planning budget.⁵⁵ By 1956 India had spent only a fraction of the small sum allocated: 1.5 million rupees, or about \$110,000 a year.⁵⁶ International financial assistance for population control therefore exceeded monies expended by India's own government, though much of it supported researchers in Princeton and New York.⁵⁷ Ironically, while demographers had urged the foundations to play a "pump-priming role," encouraging governments to take a greater interest, they used India to prime the pumps of foundation support.⁵⁸

Nehru's government still gave priority to rural development and rapid industrialization, and Nehru himself professed optimism that food production could keep pace with population growth, no matter how rapid.⁵⁹ Even the small sums allocated to family planning went unused because officials at the Ministry of Health decided whether and how states would receive them. They made the approval process cumbersome and attached onerous conditions, a problem that would continue to plague the national program.⁶⁰ But some Indian officials, such as V. T. Krishnamachari in the Planning Commission, increasingly viewed population limitation as not merely helpful, but essential for raising standards of living. They feared falling into what came to be known as the "low-level equilibrium trap."⁶¹ The head of the

52 Caldwell and Caldwell, *Limiting Population Growth*, 1986, p. 25; Harr and Johnson, *The Rockefeller Conscience*, 1991, pp. 40–41; "Population Presentation to the Trustees," February 1953, FFA, 1953 General Correspondence, C-1165A, "Population."

53 "Research and Training in the Field of Population," 19 February 1954, FFA, 1953 Grant Files, PA 54-20, The Population Council.

54 "Grant in Aid to Harvard University," 27 October 1953, and subsequent grants in RAC, Rockefeller Foundation, RG 1.2, Projects, 200 United States, Harvard University—Indian Population 1953–1955, box 45, folder 369.

55 Quoted in Hodgson, "Demography as social science and policy science," 1983, pp. 19–20.

56 Srinivasan, *Regulating Reproduction*, 1995, pp. 31–32.

57 Docket Item, "The Population Council," 22 March 1957, FFA, 1953 Grant Files, PA 54-20, "The Population Council."

58 Waldemar Nielsen–Pascal Whelpton, memorandum of conversation, 28 January 1953, FFA, 1953 General Correspondence, C-1165A, "Population."

59 Nehru to Julian Huxley, 14 January 1955, IPPF, series B, frame 1879; Nehru to Chief Ministers, 28 May 1959, in Parthasarathi (ed.), *Jawaharlal Nehru Letters to Chief Ministers 1947–1964*, vol. 5, 1989, pp. 256–257.

60 Ministry of Health circular to all state governments, 27 February 1954, in Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, Vol. 1, 1992, appendix A4.

61 India, Planning Commission, *Second Five Year Plan*, 1956, pp. 7, 21–22; Caldwell and Caldwell, *Limiting Population Growth*, 1986, p. 29; Nelson, "A theory of the low-level equilibrium trap," 1956.

Ford Foundation's office in India, Douglas Ensminger, worked with these officials to persuade Nehru and Rajkumari Kaur to give population control higher priority. Kaur agreed to invite Notestein and Leona Baumgartner, commissioner of the New York City Department of Health, to spend several months in India in 1955 and help develop a new program.⁶²

With its second five-year plan in 1956 the government established a Central Family Planning Board presided over by the minister of health, and sometimes by Nehru himself. A new director of family planning, Lieutenant Colonel B. L. Raina of the Army Medical Corps, took charge of the program, and the Population Council's Sheldon Segal served as his advisor on contraceptive methods. While population control was still a tiny part of the plan budget, an annual allocation of 10 million rupees represented an almost fivefold increase.⁶³ Ensminger assisted Raina in his running battles with the Ministry of Health to see that more of the budgeted money was actually spent.⁶⁴ The Population Council, for its part, cited its influence in India when it successfully applied for another \$1 million in Ford support.⁶⁵

India's new plan called for establishing 2,500 clinics nationwide to provide free contraceptives for low-income clients. By 1959 Raina had a staff of 20 and was subsidizing family planning boards and full-time directors in most of India's states. Together they had established 473 rural and 202 urban clinics. At the same time, they launched a nationwide publicity campaign, printing almost half a million posters and broadcasting hundreds of radio programs a year in multiple languages. On average, each of India's 26 radio stations produced a family planning talk, discussion, dialogue, or feature every two weeks.⁶⁶

All this seemed impressive on paper, but what happened on the ground was another story. In rural areas, where 82 percent of India's population lived, opening a clinic usually meant that just one additional worker was hired at an already overburdened primary health center. Each center was responsible for serving a population averaging 66,000 people. With no more than two months of training—and sometimes none at all—workers were expected to provide everything from motivation to education, screening their clients while also supplying them. Because it proved impossible to recruit sufficient numbers with degrees in health care or social work to serve in rural areas, officials stressed personal qualities rather than professional credentials, including "infinite patience."⁶⁷

62 Ensminger Oral History, FFA, B.1.

63 Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 1, 1992, pp. 54–55, 98–99; Sheldon Segal interview, 18 January 2005.

64 Ensminger Oral History, 1 November 1971, FFA, B1.

65 Frederick Osborn grant application, 25 January 1957, FFA, 1953 Grant Files, PA 54-20, The Population Council.

66 "Report of the Family Planning Third Five Year Plan Committee," NIHF, Depository, 204 IND.

67 "Family Planning in India: A Review of the Progress in Family Planning Programme, April 1956–November 1958," NIHF, 204/83 IND; Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 1, 1992, p. 71.

Officials themselves began to lose patience, and some concluded that sterilization provided the only long-term solution. In 1959 R. Gopaldaswami, chief secretary of Madras, resolved to pay people 30 rupees (\$6.30 in 1959 dollars) to undergo sterilization and to pay “motivators” 15 rupees for each person they delivered to the clinic door. These were not insignificant sums, considering that per capita gross national product was less than \$70 a year. He declared that only sterilization would work for “the large mass of the people who will not space their pregnancies or limit their number except as a result of Governmental action.”⁶⁸ In February 1959 the Central Family Planning Board decided to follow Gopaldaswami’s lead, strengthening the staff at 3,000 hospitals and maternity homes to enable them to conduct more sterilization operations free of charge while compensating low-income patients for travel expenses and lost wages. Public-sector employees who underwent sterilization were offered a week’s vacation.⁶⁹

It is not clear whether Gopaldaswami and others started offering incentives for sterilization out of eugenic or Malthusian concerns. In a survey conducted at the time among government officials, academics, activists, and medical workers involved in family planning, only 15 percent supported compulsory sterilization. But a “striking majority” called for research on the “qualitative aspects of population and sterility under [a] family planning programme.”⁷⁰ In 1958 the Indian Council for Child Welfare resolved that, “where no provision exists for the rearing of children away from contagion, and grave emotional disturbances, steps should be taken to encourage sterilization of cases such as cretins, mongols, those suffering from serious mental or nervous disorders and those suffering from serious communicable diseases such as leprosy, tuberculosis etc.”⁷¹

The Population Council closely monitored these developments. Incentive payments had been discussed inside the organization since it was founded.⁷² While surveys suggested people wanted birth control—and such data would be used to persuade many more governments to provide it—they had failed to predict actual use. “Respondents to interviews typically favor small families,” Notestein and J. Mayone Stycos pointed out to a Ford-sponsored meeting on motivation in 1959, “while in other contexts they indicate their desire for large families.”⁷³

68 “Introduction to the Memorandum on Administrative Implementation of Family Planning Policy,” in IPPF, *The Sixth International Conference on Planned Parenthood*, 1959, p. 288.

69 “Agenda for the Sixth Meeting of the Central Family Planning Board,” 1 February 1959, IPPF, series B, reel 156, frames 1805–1811; Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 2, 1992, p. 4.

70 “Report of the Family Planning Third Five Year Plan Committee,” appendix III, as cited in note 66.

71 “Family Planning in India: A Review of the Progress,” as cited in note 67.

72 “National Academy of Sciences: Conference on Population Problems,” 20–22 June 1952; “Implications of Population Policies,” 29 February 1956, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 1, folder 6.

73 “Conference on Study of Motivation Relevant to Fertility Control,” 29 May 1959, RAC, RG 5, John D. Rockefeller 3rd Papers, series 1, sub-series 5, box 82, folder 680.

The Council was no less ambivalent in its response to this challenge. Members of the board had just affirmed their belief that “individual and family choices and decisions are ultimate in all matters pertaining to the size of families.” But they also worried that in India “population problems have become so pressing as to require heroic measures.”⁷⁴ W. Parker Mauldin argued for investment in education, citing research indicating a negative correlation with fertility. But the economist Stephen Enke, just back from India, considered the correlation weak and “a questionable basis for a policy.” He favored providing aid that would enable India to offer much larger payments for sterilization. Ansley Coale warned that “under no circumstances should money inducements be offered by outside groups.” Notestein, now president of the Council, believed that “the economic motivation must be subtle and indirect and might include ‘some forms of price and tax discrimination.’” He too was “dubious about the effectiveness of a ‘direct bribe.’” Some suggested that it might be possible “to show that if a family foregoes another child it might afford a radio.”⁷⁵

The sensitivity surrounding the role of “outside groups,” especially when it came to measures intended to boost motivation, made membership associations like the IPPF all the more important. Gatherings of volunteers, the PPFA’s Frances Ferguson pointed out, “are better than these [Population Council] meetings, for they are full of actual representatives of all these Asian countries.”⁷⁶ Council staff criticized what they called the “feminist orientation” of birth control activists and chose not to follow up research suggesting a relationship with education and employment that might have revealed why more women did not use contraception.⁷⁷ They also failed to see a rather striking correlation between the strength of IPPF affiliates in places like India and Pakistan and official backing for population control. The president of India’s Family Planning Association, Lady Dhanvanthi Rama Rau, was married to the governor of the Bank of India, had been privy to the early planning, and was now a member of the Central Family Planning Board. She was therefore in a position not only to press for a more vigorous program, but also to ensure that the Family Planning Association received a portion of the board’s growing budget.⁷⁸ Countries with weak or non-existent voluntary associations, like Egypt and Kenya, received Population Council missions but declined to follow their advice. Thus, public-private networks proved crucial in the development of the family planning move-

74 “Report of the Committee on Program and Succession,” 9 January 1959, RAC, RG5, John D. Rockefeller 3rd Papers, series 1, sub-series 5, box 82, folder 680.

75 “Conference on Study of Motivation,” 29 May 1959, as cited in note 73.

76 Frederick Osborn, “Notes on Ad Hoc Meeting,” 7 March 1956, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 1, folder 7.

77 “Conference on Study of Motivation,” 29 May 1959, as cited in note 73; Chesler, *Woman of Valor*, 1992, p. 451.

78 “Family Planning in India: A Review of the Progress,” as cited in note 67.

ment within countries as well as at the international level. But as these organizations became mutually dependent, even intertwined, their values and goals also grew alike, tending toward control of populations rather than promotion of reproductive rights and health.

In 1960 Indian officials elevated the family planning program to “the very centre of planned development.”⁷⁹ The third five-year plan provided for a sixfold increase in funding and projected a fivefold increase in the number of clinics. But there was also a shift to an “extension approach,” based on the idea that waiting for people to come to clinics would not yield results. Raina defined the approach as a strategy “whereby the forces of group pressure can be mobilized.” Thus, every village and town was directed to form a family planning committee, and “natural group leaders” were paid an “honorarium” of 4,000 rupees (≈\$800) to develop the “small family norm among their group.”⁸⁰

The most dramatic example of the new approach first appeared in the state of Maharashtra. During a five-week “intensive Family Planning campaign” in 1960 more than 10,000 men were vasectomized in camps designed to create a carnival-like atmosphere and maximize group pressure. This was held up as a model for other states.⁸¹ Sterilizing men rather than women was preferred because a competent surgeon could perform the operation in ten or fifteen minutes under local anesthetic. But the drive to reduce fertility rapidly and at minimal cost made it difficult to maintain standards, including medical screening and sterile instruments.⁸² In 1962, 158,000 Indians (more than 70 percent of them males) were sterilized as the Ministry of Health began to encourage the use of mobile units to reach people institutionalized for tuberculosis, leprosy, and mental illness.⁸³

India was now committed to the goal of reducing the birth rate by 40 percent by 1972. No government since wartime Japan had pursued a population program with specific demographic goals, and this was the first in history aimed at *reducing* population growth. All of this was done in close cooperation with nongovernmental organizations. The Ford Foundation alone employed hundreds of staff in India, more even than the US Agency for International Development. Anticipating objections in the Indian parliament, Ford participated in the fiction that its consultants were not actually “working within the government.” In fact, they worked side by side with Indian officials, typically for five years or more.⁸⁴ By 1966, Ford had

79 India, Planning Commission, *Third Five Year Plan*, 1961, pp. 25, 72.

80 Raina, “Family Planning Program: Report for 1962–63,” 1962, pp. 7, 46, NIHFW, 204/83 RAI: Central Bureau of Health Intelligence, *Annual Report of the Directorate General: 1962*, 1962, p. 151.

81 Central Bureau of Health Intelligence, *Annual Report of the Directorate General: 1960*, 1960, p. 181; Raina, “Family Planning Program: Report for 1962–63,” pp. 33–34, as cited in note 80.

82 “Population Control and Family Planning: Report of the Indian Parliamentary and Scientific Committee,” 1963, Planning Commission Archives, New Delhi.

83 Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 2, 1992, p. 6.

84 Ensminger Oral History, FFA, B.1; A.38.

17 long-term population consultants advising India's program.⁸⁵ These consultants were also expected to monitor Ford projects and identify new funding opportunities, giving them leverage with their Indian colleagues. Indian officials, for their part, competed for fellowships. Even before matters reached this point, a senior Ministry of External Affairs official noted that they were "watching with anxiety the increasing penetration and power of foundations like the Ford, Rockefeller, and Nuffield in governmental spheres."⁸⁶

Yet, from the NGOs' point of view, the penetration sometimes seemed to be coming from the other direction. The Population Council, for instance, found that Indian officials were able to override its recommendations and see to it that fellowships were awarded according to seniority.⁸⁷ The Health Ministry also won the right to approve all Ford consultants in family planning—the first time the foundation agreed to such a procedure—and attempted to divert Ford money to strengthen public health efforts. The local Ford representative, Douglas Ensminger, was incensed when some of his consultants began to defend Nayar's position that family planning funds should be used for maternal health care. Rather than penetrating the Indian government and propelling a more intensive family planning program, Ford consultants had to choose sides in a war among Indian bureaucrats.⁸⁸

Of the foreign consultants who worked in India, Stephen Enke was the most vigorous in pressing for a more direct approach to population control. He calculated that preventing births could increase India's per capita GNP by redirecting money spent on the health, education, and welfare of surplus population to more productive investments, while at the same time reducing the number who would share in the proceeds. Since children were deemed to have a negative economic value, he thought Ford should help India pay young parents \$250 for agreeing to sterilization—a small fortune at the time. Raina said he was "very much shocked" at the idea. The Ford Foundation demurred, but one of Enke's studies soon landed on the desk of Robert Komer, who would shortly become national security advisor to President Lyndon Johnson.⁸⁹

Presidents Dwight Eisenhower and John F. Kennedy had privately favored population control but declined to make it a part of US foreign aid, fearing it would spark a political firestorm. Johnson would not even meet with John D. Rockefeller 3rd to discuss the topic. A close Johnson aide, Jack

85 Minkler, "Consultants or colleagues: The role of US population advisors in India," 1977, p. 413.

86 Ensminger Oral History, FFA, A.38; Naid minute to file, 1 July 1958, National Archives of India, New Delhi (hereafter NAI), Ministry of External Affairs, American Division, File no. 67(4)-AMS/58.

87 "Agenda, Meeting of Board of Trustees," 19 October 1960, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 36, folder 507.

88 Radhika Ramasubban and Bhanwar Singh Rishyasringa, "From Population Control to Reproductive Health and Sexual Rights: Fifty Years of the Ford Foundation Program in India," 2001, unpublished manuscript in FFA," pp. 22–24; Ensminger Oral History, FFA, B.1; A.38.

89 "Proceedings of the First International Conference on Voluntary Sterilization," 16 April 1964, NIHFW, 247 INT.

Valenti, explained that it was “not a matter that the President wants to visibly touch at this time.”⁹⁰ But Johnson had grown dissatisfied with how little US aid seemed to achieve. In 1965, India and Pakistan, its two largest recipients, were on the brink of war. Neither country supported US policy toward China and Vietnam, yet both seemed to expect American aid would continue indefinitely. India had just requested another 14 million tons of grain.⁹¹

Komer passed Enke’s study on to McGeorge Bundy. “Here’s a little flank attack that I think might just penetrate LBJ’s defenses,” he wrote. “It’s a hard dollar and cents argument for taking a more serious view of birth control in the [less developed countries].” Assigning a negative value to an individual life allowed Enke to argue that paying people to undergo vasectomy would have a greater impact boosting per capita GNP than if the same money were directly invested in industry or infrastructure—250 times as great.⁹²

Komer then took his case to the president, arguing that Enke’s research had “immense significance” for India, Pakistan, and other recipients of US aid. “The process of getting these countries to the stage of self-sustaining growth, *and thus reducing the longer term foreign aid burden on us*—could be greatly foreshortened.”⁹³ He did not mention Enke’s proposal to use money as an incentive for poor people to undergo sterilization. He suggested instead “using our foreign aid more as an incentive to major efforts in this field by the less developed countries themselves.”⁹⁴

Two months later Johnson publicly declared that less than five dollars invested in population control was worth a hundred dollars directly invested in economic growth.⁹⁵ Without necessarily understanding the basis for this claim, the president had signed off on the idea that children in poor countries could be a net liability. Even more important, he now insisted on personally approving every new food shipment to India, typically a month’s supply, in a policy that came to be known as “the short leash.”⁹⁶

A large number of issues divided the United States and India. But “wise men” like Dean Acheson advised Johnson that India could not be starved into submission on issues like Kashmir, the Vietnam War, or nuclear weap-

90 McGeorge Bundy to Jack Valenti, 7 March 1965, and Valenti to Johnson, 9 March 1965, Lyndon Baines Johnson Library, Austin, TX (hereafter LBJ Library), LBJ Papers, Welfare, EX WE 11/22/1963, box 1.

91 Brands, *The Wages of Globalism*, 1995, pp. 131–133; Hammond, *LBJ and the Presidential Management of Foreign Relations*, 1992, pp. 63–67, 73–74.

92 Robert Komer to McGeorge Bundy, 27 April 1965, and Stephen Enke, “Lower Birth Rates—Some Economic Aspects,” 12 February 1965, LBJ Library, LBJ Papers, National Security File, Files of Robert W. Komer, box 48, Population Control 1965–March 1966.

93 Robert Komer to Johnson, 27 April 1965, LBJ Library, LBJ Papers, National Security File, Files of Robert W. Komer, box 48, Population Control 1965–March 1966, emphasis in the original.

94 Robert Komer to Johnson, 27 April 1965, in Patterson, Duncan, and Yee (eds.), *Foreign Relations of the United States*, 1997, pp. 95–96.

95 “Address in San Francisco at the 20th Anniversary Commemorative Session of the United Nations,” 25 June 1965, *The American Presidency Project* «<http://www.presidency.ucsb.edu/ws/?pid=27054>» (accessed 15 October 2006).

96 Brands, *The Wages of Globalism*, 1995, pp. 133–134; Hammond, *LBJ and the Presidential Management of Foreign Relations*, 1992, p. 74. Neither of these accounts notes India’s population policies as a factor in the ensuing negotiations.

ons development. Instead, the United States should use its leverage only in matters where its interests ran parallel, but where Delhi needed a push in the right direction. The president and his advisors therefore began to focus on the idea of “self help,” compelling India to develop an economic program that would reduce its need for US aid, and that included population control.⁹⁷

The United States was only one member of a “consortium” of donors, including the United Nations, the World Bank, and the Ford Foundation. In 1965 the latter three had teams working in India preparing recommendations on family planning. “Much time is spent telling visitors and one another what is wrong with the program,” one Ford consultant observed. “Everyone has a diagnosis!”⁹⁸ Officials had hardly begun to implement all of the changes recommended after the last major evaluation, not least because the Ministry of Health was resisting the idea of extending family planning services beyond medical clinics. Even with total unity of purpose, merely hiring and training enough personnel to reach the remotest areas was a Herculean task. For instance, the plan called for training 49,000 auxiliary nurse midwives by 1967.⁹⁹ Some state programs were already cutting corners. In Kerala, for instance, physicians received two days of training before they started performing sterilizations.¹⁰⁰ A “substantial percentage” of their patients reported complications such as pain, weight change, or lessening of sexual desire in a follow-up study.¹⁰¹

By the end of the third five-year plan, in 1966, 42,000 people had received some kind of training in family planning, including 7,000 physicians. But this was still far short of the goal, and many areas were woefully understaffed.¹⁰² Given India’s federal structure, officials in Delhi could do little if state health departments did not share their goals. Although responsible for a budget that was 300 times larger than in 1957, the family planning staff in Delhi had grown hardly at all. New personnel seemed to “sink in the murky waters of papers which should long ago have been disposed of.”¹⁰³ The entire office was weighed down by the bureaucratic traditions of the Indian civil service. No request, however small, was answered quickly.¹⁰⁴ The World Bank team asked for many reports on the family planning program while they were in India. Commissioner Raina was unable to produce a single one.¹⁰⁵

97 Hammond, *LBJ and the Presidential Management of Foreign Relations*, 1992, pp. 74–75.

98 Reuben Hill, “Comments on Programs in India,” 18 October 1965, FFA, Report Number 003684.

99 Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 2, 1992, p. 8.

100 “Evaluation of the Family Planning Programme, Reports of Assessment Teams and the Panel of Consultants,” 25 June 1965, NIHFWD, Depository, 06/213.8/IND.

101 “Report on Demographic Training and Research in India Under the Guidance of the Demographic Advisory Committee,” n.d., but circa March 1965, NAI, Ministry of External Affairs, U.I. Section, file no. UI/3532-01/65.

102 Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 1, 1992, pp. 119–120.

103 “Evaluation of the Family Planning Programme, Reports of Assessment Teams,” 25 June 1965, as cited in note 100.

104 Reuben Hill, “Comments on Programs in India,” 18 October 1965, as cited in note 98.

105 “Conversation with Sam Keeney [sic],” 16 March 1965, RAC, Population Council Papers, RG IV3B4.8, Foreign Correspondence, box 48.

Everyone had a different diagnosis for what was wrong with India's family planning program because there were so many reasons to choose from. But there was little disagreement among these experts about what should be done. Above all, they advised creating within the Ministry of Health an independent power center that would control budgets and staff and concentrate solely on family planning. For the World Bank committee—Sheldon Segal, Sam Keeny, and Conrad Taeuber—that meant relieving the director of family planning of responsibility for maternal and child health, even while ensuring his access to all health care facilities. Family planning had to be his “unconditional first priority.”¹⁰⁶ The UN team agreed, since “the programme may otherwise be used in some States to expand the much needed and neglected maternal and child health services.” It was led by IPPF Director-General Colville Deverell and included Leona Baumgartner, by then with the US Agency for International Development, as well as the Population Council's Howard Taylor.¹⁰⁷

The expert reports all emphasized the need to abandon the medical model of family planning. India should move training programs out of medical colleges, a joint Ford Foundation–Planning Commission team advised. Everyone endorsed the use of camps and mobile clinics. Of course, some methods, like female sterilization, still required physicians, many physicians still worked in hospitals, and hospitals still had to treat sick people. So both the Ford and UN committees called for a “strong policy” requiring large hospitals to reserve beds for sterilization.¹⁰⁸ This would “avoid delay and consequently possible loss of motivation.”¹⁰⁹ Considering that in most Indian hospitals maternity beds were the only ones available to women, this would further reduce the scant resources devoted to their health—notwithstanding the fact that they already had lower life expectancy than their male counterparts.¹¹⁰

While they advised against an over-reliance on any one method and the UN team called for a tenfold increase in the rate of sterilizations, all of the expert committees insisted on the importance of the IUD. This was a foregone conclusion, in light of the fact that the Population Council was already promoting the IUD all over the world and had coordinated with Ford and the World Bank in reinforcing both of their teams with the Council's own consultants.¹¹¹ The contraceptive pill seemed too expensive

106 “Report to the President of the International Bank for Reconstruction and Development and the International Development Association on India's Economic Development Effort, Volume XI: Family Planning,” 1 October 1965, p. 51, Economic Growth Center, Yale University, New Haven, CT.

107 United Nations Advisory Mission, “Report on the Family Planning Programme in India,” 20 February 1966, pp. 8–9, NIHFW, 204 UNI.

108 “Evaluation of the Family Planning Programme, Reports of Assessment Teams,” 25 June 1965, as cited in note 100.

109 “United Nations Family Planning Mission to India: Main Draft Recommendations,” n.d., but circa December 1965, United Nations Archives and Records Centre, New York (hereafter UNARC), S[eries]-0291-[box] 0009, Chef de Cabinet, Unnumbered files, 1958–1973, India Family Planning, Sep. 64–March 1970.

110 Committee on the Status of Women in India, *Towards Equality*, 1974, pp. 16, 317–318.

111 Bernard Berelson memo to files, 14 September 1964, RAC, Population Council Papers, Record Group IV3B4.5, General File Series, box 29, folder 425.

and too dependent on women's motivation. For Alan Guttmacher, head of the Population Council's medical committee, the pill was "birth control for the individual, not birth control for a nation." In view of the risks of high fertility, including maternal mortality, he judged that the IUD's side effects were less important than the fact that it could be promoted in a mass program with few medical personnel.¹¹² The Council's lead investigator, Christopher Tietze, later recalled that there "was such a feeling of urgency among professional people, not among the masses, but something had to be done. And this was something that you could do to people rather than something people could do for themselves. So it made it very attractive to the doers."¹¹³

Guttmacher was instrumental in persuading Nayar to accept the IUD, and she subsequently overruled Health Ministry researchers who wanted to complete their studies before its mass introduction.¹¹⁴ For the UN mission as well, the IUD was "a break-through which should be fully exploited." For that purpose, "Initial training for the Reinforced Programme should be reduced to the bare minimum, and staff should be sent into the field to gain experience, and return for further training later on."¹¹⁵ Similarly, the World Bank consultants advised that "district staffs should be instructed to organize, carry out, and report on a mobile team IUCD insertion sortie within a specified, short period of time (60 days), using whatever facilities are available."¹¹⁶

India's Ministry of Health had not, up until this point, given family planning workers performance targets or incentive payments, only paying those undergoing sterilization, ostensibly for travel and lost wages. But the expert committees agreed on the need to set targets not only for the end goal of reducing fertility, but for everything needed to achieve it—namely, averting 40 million births in ten years, according to the UN estimate. "No mass program," the World Bank team insisted, "has reached its target without defining it in terms of quotas. The targets must be related to money and manpower appointed, in the field, and at work on the job for which they were intended."¹¹⁷

To meet these targets, the committees also endorsed the "emergency need for promotional incentives," as the Ford Foundation–Planning Com-

112 Warren O. Nelson and Alan F. Guttmacher, "Introduction," in Tietze and Lewit (eds.), *Intra-Uterine Contraceptive Devices*, 1962, p. 7; see also pp. 122–125.

113 Quoted in Reed, *From Private Vice to Public Virtue*, 1978, p. 307. Tietze's "Cooperative Statistical Program" was often cited as demonstrating the IUD's safety, even though he emphasized that the "CSP is primarily designed to furnish data on effectiveness and acceptability in terms of pregnancy rates, expulsion rates, and removal rates. The CSP, as it is now set up, should not be expected to furnish the required information on [pelvic inflammatory disease] and exfoliative cytology"—i.e., tumors: Tietze to Sheldon Segal, 16 September 1964, RAC, Population Council Papers, RG IV3B4.4b, National Committee on Maternal Health, box 94, folder 1764.

114 Segal, *Under the Banyan Tree*, 2003, pp. 81–82; Ensminger Oral History, FFA, B.1.

115 United Nations Advisory Mission, "Report on the Family Planning Programme in India," 20 February 1966, as cited in note 107.

116 "Report to the President of the International Bank for Reconstruction and Development," p. 52, as cited in note 106.

117 "Report to the President of the International Bank for Reconstruction and Development," p. 47, as cited in note 106.

mission report put it, especially considering that every “birth averted” represented a “saving to the nation.”¹¹⁸ The UN mission advised that incentive programs “be further developed if necessary, in order to obtain the maximum degree of cooperation from all concerned.”¹¹⁹ The World Bank team suggested that two rupees for women who agreed to have IUDs inserted would cover meals and transport, while the same amount should be paid to *dhais*—midwives—for every woman they escorted for an insertion. The amount might seem trivial, but at the time two rupees was a decent wage for a day’s work, and many people earned less.¹²⁰

Incentives and disincentives: The price Indians paid for population control

The Indian government had a compelling incentive to accept this advice, which came from committees composed of officials from USAID, the World Bank, the United Nations, and the Ford Foundation. Together they provided most of India’s annual \$1.5 billion aid package.¹²¹ India was already the World Bank’s biggest debtor, and, as leader of the India consortium, the Bank’s president, George D. Woods, would play a key role in determining what kind of aid it would receive in the future. He was convinced that the IUD had the potential to control excessive population growth “in countries where the problem can be attacked without restraints, reservations or inhibitions.”¹²² India’s willingness to make “immediate and strong decisions” to cut its population growth rate in half, his personal representative observed, would be “a very essential element, in the presentation to the aid-giving countries.”¹²³

Lyndon Johnson was already “using food as leverage,” as Robert Komer put it, “by only dribbling it out slowly.” By September 1965, when India and Pakistan went to war over Kashmir, officials in Delhi had grown unnerved by their vulnerability. Daily rations in Calcutta had already been cut. “Right now 40 million Indians, most of them low income people living in large cities, are wholly dependent upon US foodgrains,” Ambassador Chester Bowles reported. Any interruption of supply threatened famine.¹²⁴

118 “Evaluation of the Family Planning Programme, Reports of Assessment Teams,” 25 June 1965, as cited in note 100.

119 United Nations Advisory Mission, “Report on the Family Planning Programme in India,” 20 February 1966, as cited in note 107.

120 “Report to the President of the International Bank for Reconstruction and Development,” pp. 49–50, as cited in note 106.

121 Figure from Cargill, “Efforts to influence recipient performance,” 1973, p. 94.

122 Shirley Boskey to J. Burke Knapp, 30 August 1966, World Bank Group Archives, Washington, DC, Central Files 1947–1968, General Files—Projects and Studies, box 35, “Population,” Vol. 3.

123 André de Lattre, “Report of Mission,” 6 August 1965, Columbia University, Rare Books and Manuscripts Library, New York, NY, George D. Woods Papers, box 19.

124 Robert Komer to McGeorge Bundy, 13 September 1965, and Chester Bowles to Robert Komer, 21 September 1965, in Mallon and Smith (eds.), *Foreign Relations of the United States*, 2000, pp. 393, 420.

A more effective population control program was only one of a number of responses that Washington and the World Bank wanted from India. But the other desiderata—devaluing the rupee, easing import controls, shifting investment from industry to agriculture—required agonizing reappraisal of national plans and priorities, whereas India already accepted reducing fertility as integral to its development. A revitalized program seemed merely to involve reshuffling the staff and budget of a single ministry. Minister of Finance V. T. Krishnamachari, Minister of Agriculture Chidambaram Subramaniam, and Minister of Planning Asoka Mehta all favored a more forceful population control policy. Foreign pressure now gave them leverage to move decisively against Nayar and the Health Ministry.

The cabinet first created a committee on family planning, where in monthly meetings Krishnamachari, Subramaniam, and Mehta could isolate Nayar. Planning Commission official Asok Mitra took the lead in spelling out what she had to do. To meet the World Bank's targets, Mitra emphasized, "the guts of the matter is administration."

Where the Planning Commission should insist would be to hold the Ministry to its proclaimed time and physical targets. To be able to fulfill them, very large scale expansion of the entire machinery all down the line, an enormous widening of the base, and real stiffening of the administrative machinery will be required. The [Family Planning] Commissioner's writ must run swiftly and unimpeded all down the line.¹²⁵

Although the ministry had only begun IUD insertions a few months earlier, Mitra expected that by 1970–71 19.7 million people would be using them. Mobile units and camps would be the mainstay of the program. "It should be possible for [the] IUCD campaign to forge ahead of the [Rural Health Centre] programme and not depend upon it," Mitra wrote.¹²⁶ This recalled the World Bank consultants' recommendation for "an immediate and vigorous" IUD program "without waiting for the necessary and laudable undertaking of developing rural health services."¹²⁷ Perhaps anticipating the consequences, Mitra noted that, while studies had shown some people would spontaneously expel IUDs or request their removal, "With the expansion of the programme, these rates will be higher." The Population Council, at least, was ready. It had already sent to India one million loop IUDs with 20,000 inserters.¹²⁸

125 Asok Mitra to B. Mukherjee, 22 October 1965, Nehru Memorial Museum and Library, New Delhi, Asok Mitra Papers, National Planning Commission, box 152 (provisional box number).

126 Asok Mitra to B. Mukherjee, 22 October 1965, as cited in note 125.

127 "Report to the President of the International Bank for Reconstruction and Development," p. 23, as cited in note 106.

128 Asok Mitra to B. Mukherjee, 22 October 1965, as cited in note 125; "Technical Assistance Authorization," 10 August 1965, RAC, Population Council Papers, RG IV3B4.2, General File Series, box 34, folder 490.

Waging war became the favored metaphor for India's new approach to population control. Officials in Punjab, which had the highest rate of sterilization, announced that they considered themselves "on a war footing." While fighting raged across the border with Pakistan, IUD insertions continued, totaling 60,000 by December 1965 in just this one state.¹²⁹ Martial metaphors also meant that some portion of the population would be sacrificed. As Mehta put it, population growth was "the enemy within the gate.... It is war that we have to wage, and, as in all wars, we can not be choosy, some will get hurt, something will go wrong. What is needed is the will to wage the war so as to win it."¹³⁰

At the time, most people were less concerned about the family planning program than an impending food crisis. "Frankly, what worries me, as a planner," senior State Department official Walt Rostow wrote, "is that a good many human beings may starve in those critical months before the next harvest." When Indira Gandhi became prime minister in January 1966, Agriculture Secretary Orville Freeman suggested that Johnson might pledge 1.5 million tons of food as a goodwill gesture. The president told Komer "to get Freeman to quit giving stuff away."¹³¹

Johnson would be pleased to discover that the new prime minister had a longstanding interest in family planning. Indeed, according to Sanger's notes from her 1935 visit to India, Indira had asked her father at the time whether she would ever have been born had he met Sanger first.¹³² Gandhi had donated her family's ancestral home in Allahabad so that it could become an Institute for Family Planning. As information minister, she had pressed a plan to distribute hundreds of thousands of radios across rural India to disseminate family planning information. And Gandhi, together with Dhanvanthi Rama Rau of the Family Planning Association, had been pressuring Nayar to pay women to accept IUD insertions.¹³³ The day after she was formally sworn into office, the Ministry of Health was renamed the Ministry of Health and Family Planning, including a separate department with its own permanent secretary and minister of state for family planning.

Nevertheless, Johnson would not relent until Gandhi came to Washington and made a personal commitment to a more forceful population con-

129 "Evaluation of the Family Planning Programme, Reports of Assessment Teams," 25 June 1965, as cited in note 100; "Summary Record of the First Meeting of the Central Family Planning Council," 31 December 1965, attached to "Central Family Planning Council 2nd Meeting Agenda," 27 June 1966, NIHFW, Depository, 204 IND.

130 "The Problem—Some Broad Conclusions," n.d., but circa April 1965, UNARC, S[eries]-0175-[box] 0627-06, Family Planning—India (210-1A).

131 Robert Komer to Johnson, 4 January 1966; Walt Rostow to Johnson, 6 January 1966; Komer to Johnson, 18 January 1966, all in Mallon and Smith (eds.), *Foreign Relations of the United States*, 2000, pp. 524, 526–527, 541–542.

132 "Notes on India," circa December 1935, Margaret Sanger Papers, The Smith College Collections, UPA, reel 70, frames 404–405.

133 Indira Gandhi to Chakravarthi Narasimhan, 13 September 1964 and 4 November 1965, UNARC, S[eries]-0291-[box] 0009, Chef de Cabinet, Unnumbered files, 1958–1973, India Family Planning, Sep. 64–March 1970; Bernard Berelson memo to files, 14 September 1964.

trol program. When one of his advisors, Joseph Califano, suggested the United States commit to a large food aid package before her arrival, Johnson “exploded,” asking “Are you out of your fucking mind?”¹³⁴ Johnson insisted he was “not going to piss away foreign aid in nations where they refuse to deal with their own population problems.”¹³⁵

For Komer, who had been the first to suggest that Johnson use food as leverage, Gandhi’s visit was the culmination of a year’s labor. “We finally have the Indians where you’ve wanted them ever since last April...coming to us asking for a new relationship on the terms we want.” Better still, “That tough-minded George Woods and the World Bank are with us.” Woods would be “a great ally” in conveying the clear message that “*from now on we hinge aid to performance.*”¹³⁶ In all the papers that Johnson’s advisors gave him to plough through before Gandhi’s arrival, population control was only one subject among many. But it was always there, and her moves to give the program “more punch” always counted in her favor.¹³⁷

There is no record of the conversation between Gandhi and Johnson when they met alone on the morning of 28 March 1966. But Johnson was apparently satisfied. When he sent a message to Congress two days later requesting it approve food aid for India, he reported that “The Indian government believes that there can be no effective solution of the Indian food problem that does not include population control. The choice is now between a comprehensive and humane program for limiting births and the brutal curb that is imposed by famine.”¹³⁸

In fact, India would suffer from both famine and a brutal program to curb population growth. Shortly after Gandhi returned from Washington, Nayar accepted a report and recommendations from a special committee under B. Mukerji, permanent secretary in the Ministry of Health, intended to reverse a decline in the number of IUD insertions. It made only oblique reference to the program’s growing problems. “Systematic follow-up of the cases is of utmost importance,” it affirmed, since neglecting complications “would give a serious set-back to the program eventually.” Yet, as in all of the foreign-expert reports that formed the basis for these recommendations, there was no provision to ensure such follow-up. Instead, physicians were given quotas for IUD insertions and incentive payments to meet them. Citing the World Bank experts, the Mukerji report called for the IUD program to “forge ahead” of rural health centers. Indeed, the ministry’s method of

134 Califano, *The Triumph and Tragedy of Lyndon Johnson*, 2000, pp. 154–155.

135 Califano, *Inside*, 2004, pp. 172–173.

136 Robert Komer to Johnson, 21 March and 27 March 1966, LBJ Library, LBJ Papers, National Security File, Files of Robert W. Komer, box 133, “Prime Minister Gandhi Visit Papers,” emphasis in original.

137 John Lewis to Robert Komer, 21 March 1966, and see also Dean Rusk to Johnson, 26 March 1966; “Visit of Prime Minister Indira Gandhi of India: Strategy Paper,” 21 March 1966, all in LBJ Papers, cited in note 136.

138 “Special Message to the Congress,” 30 March 1966, *The American Presidency Project* «<http://www.presidency.ucsb.edu/ws/?pid=27519>» (accessed 15 October 2006).

funding state family planning programs actually discouraged better care, requiring them to absorb the cost of treating those with contraindications—such as pelvic inflammatory disease—out of the three rupees they received for each IUD insertion. On the other hand, Nayar postponed a decision on whether to accept the Mukerji report's recommendation to pay individual "acceptors" of IUD insertions.¹³⁹

Indian officials were proud of the dynamism and boldness with which they pursued population control, and it was a favored theme in their public relations work abroad.¹⁴⁰ In a White House interview in May 1966, Minister of Planning Mehta regaled Johnson with their achievements and aspirations: "in 1965 there were more vasectomies than in the preceding 10 years. In five states targets for 'the loop' had been reached within five months. Twenty-nine million IUD's would be fitted within the next five years."¹⁴¹

The Population Council was in the best position to know that these targets were not merely unrealistic, but positively reckless. As the main backer and coordinator of IUD programs all over the world, it was receiving regular reports of mounting problems. In June 1966, for instance, a Singapore postpartum project discovered in follow-up exams that 20 women out of 3,400 fitted with IUDs had suffered a perforated uterus—a rate 15 times higher than anticipated. The women had access to better care and diagnostic procedures than most, so investigators were "sure that there must be many cases of undiagnosed perforations in other programs."¹⁴² The next month Guttmacher learned that the rate of IUD insertions in Hong Kong had fallen off "rather shockingly" because of side effects such as heavy bleeding and ectopic pregnancy.¹⁴³ By August it was obvious that this was a systemic problem, common to IUD programs in the United States, Puerto Rico, Taiwan, South Korea, and Pakistan.¹⁴⁴

Rather than publicize this finding, the Population Council privately circulated it to program administrators. To improve retention rates they suggested that physicians do a better job educating their patients and perhaps be paid for follow-up visits rather than just the initial insertion. "The strange

139 Mukerji Committee Report, 16 April 1966, and Govind Narain minutes to file, 20 and 21 April 1966, Department of Family Welfare Archives, Ministry of Health and Family Welfare, New Delhi (DFWA).

140 Ministry of Health and Family Planning, "A Danger Signal," in RAC, Rockefeller Foundation Papers, RG 1.2, Projects, series 200A, Harvard University—Population Studies in India, box 132, file 1173.

141 Memorandum of conversation Johnson—Asok Mehta, 4 May 1966 in Mallon and Smith (eds.), *Foreign Relations of the United States*, 2000, pp. 637–638.

142 Adaline Satterthwaite to Christopher Tietze, 21 June 1966, RAC, Population Council Papers, RG IV3B4.4b, National Committee on Maternal Health, box 95, folder 1773. Sheldon Segal maintains that one physician was responsible for most of these perforations: 18 January 2005 interview. If so, that should have underscored the importance of proper training and set off alarm bells about the pace of India's program. Segal's advisory committee expected the program to be "spreading with explosive rapidity": "Report to the President of the International Bank for Reconstruction and Development," p. 54, as cited in note 106.

143 Alan Guttmacher to Frank Notestein, 26 July 1966, RAC, Population Council Papers, RG IV3B4.4b, National Committee on Maternal Health, box 95, folder 1773.

144 W. Parker Mauldin, "Retention of IUD's," August 1966, RAC, Population Council Papers, as cited in note 143.

thing," Guttmacher remarked, "is that Nayar claims such magnificent results in India. Perhaps it is because follow-up is less complete."¹⁴⁵ In fact, the monthly rate of IUD insertions in India had fallen by half since March, from approximately 120,000 to 60,000. In June Delhi received reports that in some areas nearly half of all women fitted were complaining of prolonged bleeding, "creating a very bad reaction amongst women using the loop." Performance continued to decline throughout the summer until there were barely 50,000 IUD insertions in October 1966, one-tenth the rate required to meet the annual target. The rate of sterilizations was actually higher, contrary to all expectations, though it had begun to level off. India's family planning program was not only failing to meet its goals, it was turning into a fiasco.¹⁴⁶

A few states seemed to show the way forward. Punjab had been paying IUD acceptors, and it achieved 277 percent of its target for 1965–66. Madras instead concentrated on sterilization, with higher incentive payments for both acceptors and motivators than any other state—and the highest performance per capita. On 27 October 1966 the Health Ministry finally agreed with all those who had been urging that it provide funds to pay acceptors. Rather than set a nationwide pay scale, it provided states 11 rupees for every IUD insertion, 30 per vasectomy, and 40 per tubectomy (later increased to 90 rupees). Out of this sum, states could pay whatever incentives appeared necessary, whether to individuals, to staff, or to freelance "motivators."¹⁴⁷

Just a few weeks earlier the monsoon rains had failed to arrive in Bihar, Rajasthan, Madhya Pradesh, and parts of Uttar Pradesh. Over 100 million people were now at risk of famine. Bihar was particularly hard hit—it was the third year of drought. In moderately to severely affected areas, annual per capita income over the next year would range from 74 to 112 rupees (that is, \$10–\$15).¹⁴⁸ The possibility of receiving even a modest cash payment therefore had extraordinary importance.

At no point did anyone assert as a matter of policy that poor people would starve if they did not accept sterilization. Even when, that same month, President Johnson signed a "Food for Peace" act requiring that a country's family planning efforts be taken into account before granting food aid, he insisted in public that population programs be "freely and voluntarily undertaken."¹⁴⁹ At the same time, USAID officials were told "to exert

145 Alan Guttmacher to Frank Notestein, 26 July 1966, as cited in note 143; W. Parker Mauldin, "Retention of IUD's," August 1966, as cited in note 144.

146 "Considerations of Suggestions Made By the State Governments and other Members of the Central Family Planning Council," attached to "Central Family Planning Council 2nd Meeting Agenda," 27 June 1966, NIHFW, Depository, 204 IND; "India's Family Planning Programme: A Brief Analysis," Ford Foundation Report, April 1970, NIHFW, Depository, 291 FOR.

147 Govind Narain, "Note for the Cabinet Committee on Family Planning," 7 June 1966, DFWA; Ramachandran to B. P. Patel, 30 March 1970, DFWA, file number 1-1/71-PLY; Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 1, 1992, p. 31.

148 Drèze, "Famine prevention in India," 1990, p. 57.

149 "Statement of the President Upon Signing the Food for Peace Act of 1966," 12 November 1966, *The American Presidency Project* <<http://www.presidency.ucsb.edu/ws/?pid=28025>> (accessed 15 October 2006).

the maximum leverage and influence" to ensure that, where necessary, governments were meeting their obligation to "control population increases."¹⁵⁰ Similarly, Indian officials were reminded not to use the word "incentive" in public, maintaining the fiction that the payment was merely for travel and lost wages (even when there were no travel costs or lost wages).¹⁵¹ In fact, incentive payments were coercive even in the best of times, since many Indians were always at risk of malnutrition. Now some people in Bihar were subsisting on less than 900 calories a day.¹⁵²

Immediately after the incentive payments were announced there was a spike in the number of sterilizations and IUD insertions, particularly in the states that had started to go hungry. Bihar, for instance, had previously had the lowest rate of sterilization per capita of any state or union territory in India, performing just 2,355 such procedures in 1965. And, with 12,677 insertions, it had met only 12 percent of its IUD target. But in 1966–67, with some people eating leaves and bark, a total of 97,409 "acceptors" suddenly came forward. The next fiscal year's performance was even better: 185,605, with 78 percent opting for sterilization (and the higher incentive payment). As a Ministry of Health and Family Planning analysis concluded, it was "the famine and drought conditions in various parts of the country like Bihar, Madhya Pradesh and Orissa, which attracted large numbers of persons towards sterilizations." If it were not for these states together with Uttar Pradesh, there would have been no increase in the number of "acceptors." Because of them, and because of their plight, an additional 300,000 Indians agreed to IUD insertion or sterilization in 1966–67, or 1.8 million altogether.¹⁵³

Peace Corps volunteers who worked in Bihar recall how women in their villages were fitted with IUDs in clinics that lacked even soap to keep hands and instruments sterile. They also witnessed workers who would wipe bloody IUD inserters on their saris or with a cloth after each procedure, then reuse the inserter on other patients, spreading disease. In families with no other means of subsistence, the oldest member would volunteer to submit to sterilization so that the others could eat. In one case, when the volunteers shared their concerns with Ford Foundation consultants, they were told to stay focused on meeting program targets.¹⁵⁴ The physician who led the state in number of sterilizations asserted that "practically all were the result of famine—hungry men who needed the twenty-five rupees offered as incentive." Even

150 Piotrow, *World Population Crisis*, 1973, pp. 117, 127.

151 R. N. Madhok, "Note for the Committee of Cabinet...Suggestions for Incentives," 15 September 1967, DFWA, file number V 13011/4/75.

152 Drèze, "Famine prevention in India," 1990, p. 57.

153 These figures, as well as those for Madhya Pradesh and Uttar Pradesh, are from the following sources: B. Mukerji, "Note for the Cabinet Committee on Family Planning," 13 March 1966, DFWA; G. Ramachandran to B. P. Patel, 30 March, DFWA, file number 1-1/71-PLY; Gupta, Sinha, and Bardhan, *Evolution of Family Welfare Programme*, vol. 2, 1992, p. 74. Quotation is from Ramachandran to Patel, 30 March 1970.

154 Personal communication from Mary Chamie, 1 April 2005.

after the famine had ended, many poor women continued to have an IUD inserted for six rupees, then paid a midwife one rupee to remove it.¹⁵⁵

Eventually, when popular resistance became undeniable, independent researchers and India's own Planning Commission turned the tools of social science on the family planning program itself, asking "acceptors" what happened when they were "targeted" and questioning officials about why they felt compelled to do it. The interviews Robert Elder conducted in Uttar Pradesh for a Duke University dissertation were particularly revealing. He discovered that meeting targets meant "constant whipping of the staff," especially during periodic "family planning fortnights." District magistrates put the whole weight of the state behind these drives, and threatened to dismiss those who did not make their quota. Block development workers and revenue collectors offered acceptors even higher payments, free fertilizer, and land grants. As promises were made and broken, as motivators started to bring in the aged and infirm, and as poorly trained medical staff botched operations, the whole program fell into disrepute.¹⁵⁶

An evaluation by the Indian Planning Commission found much the same pattern in Punjab and Maharashtra. Although neither state was affected by drought, family planning campaigns were often coercive and sometimes appalling. Punjab, like Uttar Pradesh, enlisted revenue collectors, threatened to punish workers who underperformed, and paid "motivators" according to the number of people they brought in. "In this type of canvassing," the report's authors dryly noted, "the demarcation between persuasion and compulsion recedes."¹⁵⁷ With permission from Delhi, officials in Maharashtra abolished the positions of field workers and educators in order to free up more money for incentive payments for sterilization.¹⁵⁸ People of all backgrounds took on the role of "motivator," including private contractors who set up camps on their worksites and started leaning on employees. This spirit of "catching cases" was reported to have developed even among physicians in Punjab, who competed with each other to win larger shares of the incentive money.¹⁵⁹ Conversely, in May 1967 Delhi demanded disciplinary action against government physicians who did not meet their quota.¹⁶⁰

With no incentive to follow up patients, the Planning Commission found that the quality of postoperative care was "the weakest link."¹⁶¹ Elder related incidents in which sterilizations were performed on 80-year-old men,

155 Pope, *Sahib*, 1972, pp. 21–22, 42–44.

156 Elder, *Development Administration in a North Indian State*, 1972, pp. 21–22, 39, 40, 49, 77–78, 94–100, 106–107, 118–120.

157 "Family Planning Programme, An Evaluation: Punjab," 1971, Planning Commission Archives, New Delhi.

158 "Dept. of F.P.: Govt. of Maharashtra Proposals," 7 October 1967, DFWA, file number V 13011/4/75; Programme Evaluation Organization, "Family Planning Programme, An Evaluation: Maharashtra," 1971, Planning Commission Archives, New Delhi.

159 "Family Planning Programme, An Evaluation: Punjab," as cited in note 157.

160 "Statement Showing the Decisions Taken," 15 May 1967, DFWA, file number V 13011/4/75.

161 "Family Planning Programme, An Evaluation: Punjab," as cited in note 157.

uncomprehending subjects with mental problems, and some who died from untreated complications.¹⁶² The Maharashtra report found that just 5 percent of the men and 6 percent of the women were subsequently visited by program staff. More than half of these men complained of pain, and 16 percent had sepsis or unhealed wounds. As for the women, almost 58 percent experienced pain after IUD insertion, 24 percent severe pain, and 43 percent had severe and excessive bleeding.¹⁶³ Considering that iron deficiency was endemic in India, and would have been still worse in famine-affected areas, one can only imagine the toll the IUD program took on the health of Indian women.

Of course, some of these same men and women desperately wanted to avoid pregnancy, with or without any incentive payment. Most had not heard of state-sponsored family planning until 1966. It is therefore all the more unfortunate that they received such a poor first impression. In Maharashtra, for instance, three-quarters of husbands were initially happy with their wives' decision to use the IUD. But more than half changed their mind.¹⁶⁴ When monthly performance fell short, new "family planning fortnights" were launched with higher incentives, only to bring diminishing returns. People who might willingly have participated learned to wait. Belying all the urgency and high-pressure tactics, many of those rewarded for sterilization would never have had additional children in any event. A study from Uttar Pradesh found that the ages of those undergoing vasectomies had been systematically falsified in official records. On-the-spot verification showed that almost half were over 50 years old. Some 63 percent were either unmarried, separated, or had wives aged 45 and older. With villagers openly showing their distrust or even contempt, family planning officials began to see their assignment as a punishment. In Elder's study, 69 percent said that they would happily take another job if it were offered to them.¹⁶⁵

Oblivious to all of this, in January 1967 Lyndon Johnson told Indira Gandhi that "We count on the Government of India to become an example of what a determined people can do for themselves." He viewed its struggle against famine as emblematic of a global crisis. He therefore urged her to "take the lead in inspiring and urging all nations—rich and poor alike—to join a truly world wide effort to bring population and food production back into balance."¹⁶⁶

In fact, Gandhi was falling further and further behind. By September several states, including Madras, Uttar Pradesh, and Gujarat, were calling

162 Elder, *Development Administration in a North Indian State*, 1972, pp. 122–125.

163 "Family Planning Programme, An Evaluation: Maharashtra," as cited in note 158.

164 "Family Planning Programme, An Evaluation: Maharashtra," as cited in note 158.

165 Elder, *Development Administration in a North Indian State*, 1972, pp. 32, 121, 129; R. N. Madhok, "Note for the Committee of Cabinet...Suggestions for Incentives," 15 September 1967, as cited in note 151; "Family Planning Programme, An Evaluation: Punjab," as cited in note 157.

166 Johnson to Indira Gandhi, 16 January 1967, in Mallon and Smith (eds.), *Foreign Relations of the United States*, 2000, pp. 808–809.

for even higher incentive payments—up to 100 rupees.¹⁶⁷ At this time also, someone in the Ministry of Health and Family Planning recommended giving people a transistor radio if they agreed to be sterilized.¹⁶⁸ It was probably inevitable that others would instead call for the state to punish those who would not cooperate. At the end of 1966 both Kerala and Mysore had begun denying maternity leave to government employees with three or more children. In June 1967 the government of Maharashtra took what it admitted were “radical decisions,” recommending that India should not only deny free medical treatment and maternity benefits to those who gave birth to a third or higher child, but should actually make sterilization compulsory. To demonstrate its seriousness, Maharashtra announced that in 14 months all state employees who elected to have more than two children would henceforth be denied government scholarships, grants, loans, and maternity and housing benefits. Haryana and Uttar Pradesh soon announced they would introduce similar measures. In a conference of the chief ministers of Indian states, all but two said that they favored mandatory sterilization.¹⁶⁹

Now that India’s government was finding it impossible to persuade its population to reproduce itself according to plan, concerns about differential fertility resurfaced. A year earlier a new advisory group, the Central Family Planning Council, had taken up the sensitive question of whether Muslims were participating in the program, and just as quickly dropped it. Virtually everyone present agreed that religious differences presented no impediment to participation, but also that they had to try harder.¹⁷⁰ This included meeting with Muslim leaders and issuing *fatwas* endorsing birth control.¹⁷¹ But the concern persisted and, as the family planning program developed, seemed to find confirmation. Elder’s study, for instance, revealed that in every district examined far fewer Muslims submitted to sterilization than would be expected from their share of the population. In fact, some Muslim political leaders encouraged their followers to out-reproduce everyone else. It did not help matters that well over 90 percent of senior family planning officials—at least among those Elder interviewed in Uttar Pradesh—were high-caste Hindus.¹⁷²

The cabinet committee on family planning was warned that these “rumblings” might “snowball into large scale opposition.” It was agreed that some

167 R. N. Madhok, “Note for the Committee of Cabinet...Suggestions for Incentives,” 15 September 1967, as cited in note 151.

168 R. N. Madhok, “Note for the Committee...Pilot Project for Gift of Transistor Radio,” 15 September 1967, DFWA, file number V 13011/4/75.

169 R. N. Madhok, “Note for the Committee of Cabinet...Suggestions for Incentives,” 15 September 1967; V. P. Naik to Indira Gandhi, 27 June 1967, both in DFWA, file number V 13011/4/75.

170 “Summary Proceedings of the Central Family Planning Council,” 27 June 1966, NIHF, 204 IND.

171 “Minutes of the Meeting Held Under the Chairmanship of Mir Mushtaq Ahmed,” 23 November 1966, NAI, Ministry of Home Affairs, Delhi Section, file 11/29/68-Delhi.

172 Elder, *Development Administration in a North Indian State*, 1972, pp. 29–31, 110–116.

minorities were seeking to take advantage of the family planning program to gain a “larger say in the affairs of the country.”¹⁷³ Some officials were prepared to target particular groups, beginning with India’s “scheduled castes.” Ironically, they could start by stripping them of benefits to which their status had previously entitled them. Thus, Maharashtra and Uttar Pradesh announced that scholarships would be barred to families with more than three children, except for those awarded on individual merit (rather than caste membership).¹⁷⁴ At the grassroots level, population control programs already focused on scheduled castes. In Uttar Pradesh it was found that, while they made up 29 percent of the population, they constituted 41 percent of those vasectomized. They were an even larger proportion of those brought in by revenue collectors and block officials. Typically the most impoverished and powerless in any community, scheduled castes were the most vulnerable to local notables intent on achieving targets and reaping the rewards.¹⁷⁵ The new minister of health and family planning, the demographer Sripati Chandrasekhar, wanted to make sterilization compulsory for every man with three or more children. But since violators would merely have to pay a fine, the measure would be compulsory only for those who could not pay.¹⁷⁶

By the end of 1967 it was clear that, rather than accelerating, the rate of IUD insertions had entered into a long decline. While the monthly tally of sterilizations had briefly topped 300,000 during the summer, it too was now falling.¹⁷⁷ Yet after a prolonged debate the cabinet judged Chandrasekhar’s proposal for compulsory sterilization to be impractical. Legislators would never agree to it, and even if they did family planning services were unequal to the task. Some states continued to adopt more-limited measures to penalize large families, such as denying maternity benefits. Officials had to point out the obvious—that stripping scheduled castes of scholarships would cause hardship and that withdrawing free medical care and maternal leave would harm women and children. Asoka Mehta, now social welfare minister, admitted that “This has an element of inhumanity in it,” but that unrestrained population growth would be even more inhumane. “Here we have to wield the surgeon’s knife. It may hurt a little, at a point, for a while, but it will help to impart health ere long.”¹⁷⁸

173 K. N. Srivastava, “Note for the Committee of the Cabinet...Critical Analysis of the Family Planning Programme,” 29 March 1967; “Minutes of the Meeting of the Cabinet Committee on Family Planning,” 31 March 1967, both in DFWA, file number 4-4/67-C6-C.

174 “Note for the Committee of the Cabinet...Suggestions for Incentives and Disincentives,” 2 April 1968, DFWA, file number V 13011/4/75.

175 Elder, *Development Administration in a North Indian State*, 1972, pp. 141–142.

176 Lelyveld, “India: Is sterilization the answer?,” 1967.

177 “India’s Family Planning Programme: A Brief Analysis,” as cited in note 146.

178 “Meeting of the Cabinet Committee on Family Planning,” 25 November 1967, and “Extract from File...of Department of Social Welfare,” 3 November 1967, both in DFWA, file numbers V 16011/3/82 and V 13011/4/75.

India and the world in the Emergency Period

Any convincing account of coercive population control must begin and end with a recognition that proponents were in fact dealing with an unprecedented situation that posed excruciating dilemmas. Decades later, long after it had begun to slow, global population growth still inspired alarm, as well as a tendency to analyze complex social and political problems in terms of “us” and “them.”¹⁷⁹ But if historians must strive to be fair to those who, 40 years ago, felt a responsibility to act and lacked critical foresight, people who suffered from their mistakes also deserve consideration, as well as an investigation of what went wrong.

Critics of population control have often portrayed it as a conspiracy perpetrated by white elites on the rest of the world. A closer look at the case of India reveals a more complicated picture. The archives show that the population control movement focused on India at least partly because many Indian elites were eager to enlist. They too were concerned about differential fertility and population “quality,” albeit for reasons different from those of Americans worried about Western Civilization. Both elites pursued quantitative as well as qualitative goals for the purpose of alleviating poverty and spurring social and economic development. But other motives were papered over with slogans such as “bringing family planning” to “those who need it most”—whether they knew it or not—leaving buried such questions as who did the planning in family planning, and for whom.

When the Indian populace showed insufficient motivation to use contraception, scientists, activists, and officials both there and abroad worked together to overcome opposition and make population control a priority. They argued that India exemplified a global population emergency that required extreme measures. The failure of these measures reinforced a persistent tendency to “target” both poor people and poor countries, if necessary by resorting to outright compulsion. But it inspired others to question whether family planning programs really could or should try to shape reproductive behavior rather than seek to redress gender inequality, poverty, and poor health—not just in India, but in the United States as well.¹⁸⁰

This debate was well advanced when the Emergency Period began in 1975, which ensured that this episode would be more closely watched, and better remembered, than the one detailed in this article. But the earlier involvement of international and nongovernmental agencies in advocating targets and incentives and a heavy reliance on methods that did not require

179 The author’s own earlier work, alas, provides a case in point: Connelly and Kennedy, “Must it be the rest against the West?,” 1994.

180 The more influential contributions to this debate include Davis, “Population policy,” 1967; Hardin, “The tragedy of the commons,” 1968; Berelson, “Beyond family planning,” 1969; Blake, “Population policy for Americans,” 1969; Mamdani, *The Myth of Population Control*, 1972. An analysis appears in Connelly, “Population control is history,” 2003, pp. 145–147.

sustained motivation also help explain why these groups continued to support India's program when it pressed these policies even further.¹⁸¹ After the fact, commentators grew fond of quoting Frank Notestein's 1971 prediction that "efforts at coercion would be more likely to bring down the government than the birthrate."¹⁸² The many other—more mixed—messages that foreign advisors delivered to India were all but forgotten. Then as now, focusing on the Emergency Period as a domestic political crisis and ignoring the international origins of coercive population control serves a political purpose: in this way, it can be blamed on Indira and Sanjay Gandhi, yielding at most a cautionary tale for a movement ever eager to move on.

In fact, while the process has just begun, excavating newly opened archives of the IPPF, the Population Council, the Ford Foundation, and UN agencies has already shown not just how they cooperated in trying to control India's population, but how the experience profoundly affected each one of them. Much more work is required before we can recover all of these connections, and there are many leads to pursue. But all point to the fact that family planning in rich and poor countries shares a common history. Thus, contraceptives like the pill, initially developed as a "fool proof" means to reduce the fertility of poor people and poor countries, helped spark a sexual revolution that swept the globe. Fundraising campaigns focused on India subsidized family planning clinics in the United States. Conversely, proponents of these programs deemed them essential to demonstrate their good faith in urging family planning in other countries. But targeting India, and the reaction it provoked, also brought into focus the questions of how population policy might empower people, rather than control them, and whether women, in particular, had a stake in defending reproductive rights and health wherever they were threatened.¹⁸³

The family planning community must not shrink from this history, or leave it to polemicists who insist that nothing has changed. In fact, when

181 World Bank president Robert McNamara was "encouraged" by Gandhi's Emergency Period population policy when he visited India in November 1976, writing that, "At long last India is moving to effectively address its population problem": "Notes on Visit to India, 6–12 November, 1976," in World Bank Group Archives, 03-04, Office of the President, Records of President McNamara, Series 05. Contacts [Member Countries] files, Box 8, India (1976–1977). Nafis Sadik—then chief of the program division of the United Nations Fund for Population Activities (UNFPA), and later executive director—thought that countries which adopted a policy of compulsory sterilization should not receive UN funding. But she also believed that "compulsion may be needed at the expense of human rights," and it could be ethical provided people were given a choice of contraceptives: I. H. Kang to Files, 1 December 1976, World Bank Group Archives, Records of the Health Services Development Sector, Liaison with International and Other Organizations—UNFPA—Vol 5. The World Bank, the UNFPA, the IPPF, and the Swedish International Development Agency, among others, continued funding India's family planning program throughout the Emergency Period.

182 See, for instance, Landman, "Indians repudiate coercion, not family planning," 1977b, p. 5; Landman, "Birth control in India," 1977a, p. 101; Harkavy, "Birthspacing," 1986; Coale, review of *Regulating Reproduction in India's Population*, 1998, p. 444; Segal, *Under the Banyan Tree*, 2003, p. xxvii.

183 The influence of the IUD episode in raising these questions was not always acknowledged, but seems evident nonetheless. For instance, in 1971 Julia Henderson of the IPPF suggested that it had 75 clinics "that might be prepared to take on testing of somewhat more risky compounds." Sheldon Segal replied "forcefully" that the Population Council was "not prepared to push forward on methods that entail substantial medical risks": Oscar Harkavy, "Informal Notes on Bellagio Population Conference Discussion," 24 June 1971, FFA, Report Number 009549.

we examine the history carefully, it becomes clear that there were always some individuals who fought to defend family planning as a means to promote individual dignity and welfare, rather than to control population growth. The current consensus is not, therefore, just faddish or politically correct, but the fruit of a long struggle, one that is far from over.

Note

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Archives and acronyms

Columbia University, Rare Books and Manuscripts Library, New York, NY
 Department of Family Welfare Archives, Ministry of Health and Family Welfare, New Delhi (DFWA)

Economic Growth Center, Yale University, New Haven, CT

Ford Foundation Archives, New York, NY (FFA)

International Planned Parenthood Federation Archives, London (IPPF)

Lyndon Baines Johnson Library, Austin, TX (LBJ)

National Archives of India, New Delhi (NAI)

National Institute of Health and Family Welfare, Documentation Centre, New Delhi (NIHFW)

Nehru Memorial Museum and Library, New Delhi

Planning Commission Archives, New Delhi

Population Association of America Archives, Silver Spring, MD

Rockefeller Archive Center, Tarrytown, NY (RAC)

Margaret Sanger Papers, The Smith College Collections, University Publications of America (UPA) Microfilm

United Nations Archives and Records Centre, New York (UNARC)

UNESCO Archives, Paris

World Bank Group Archives, Washington, DC

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