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Seventh
Krishna Raj Memorial Lecture on
Contemporary Issues in Health and Social Sciences
Instituted by Anusandhan Trust

Rethinking Population Education:

Challenging the Gender and Structural Violence of Prevailing Norms

Betsy Hartmann
Professor Emerita of Development Studies
Senior Policy Analyst, Population and Development Program
Hampshire College
Amherst, MA USA
2015 Fulbright-Nehru Distinguished Chair

Hosted by

Centre for Enquiry into Health and Allied Themes, Mumbai
With
eSocial Sciences, Department of Economics and Department of Civics & Politics, University of Mumbai, P.G. Department of Economics, SNDT Women's University and Tata Institute of Social Sciences (TISS)

Anusandhan Trust has instituted the Krishna Raj Memorial Lecture Annual Series on Contemporary Issues in Health and Social Sciences to honour the intellectual and academic traditions that Krishna Raj set in place, and in his memory. This is a humble tribute to the memory of the visionary editor of the *Economic and Political Weekly (EPW)*.

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I am extremely honored to have been asked to give the Anusandhan Trust's Krishna Raj Seventh Memorial Lecture on Contemporary Issues in Health and Social Sciences. I met Krishna Raj only once, in the early 1980s in the offices of *EPW*. Though I was young and only beginning my career as a political writer, researcher and activist, I remember how Krishna Raj took me seriously and that made all the difference. I know that many other young people had a similar experience. Encouraging and nurturing the next generation was one of his many considerable talents.

I admired Krishna Raj for many reasons, but for the purposes of this lecture, one in particular stands out. Under his leadership, the *EPW* took the lead in exposing India's harsh population control policies. As his obituary in the *Guardian* newspaper notes, during the 1977 Emergency, Krishna Raj "wriggled past the censor the first horrifying details of Sanjay Gandhi's forced sterilization plan". For his courage and outspokenness, he was accused by the government of sedition, charges which were later dropped. Over the years, it was in the pages of *EPW* where population policies came under close scrutiny by scholars and activists in the women's and people's health movements. More broadly, the *EPW* played, and continues to play a key role on the national and international stage in developing and promoting cutting edge work in women's and gender studies. I know of

no other magazine like it in the English-speaking world. It bridges so many divides: between theory and praxis; research, policy and activism, and different and competing political perspectives. At its heart always remains Krishna Raj's deep commitment to social, economic and political equality and his radical humanism. He never lost sight of the concrete impact dominant ideologies and policies have on the lives and livelihoods of India's poorest people.

Betsy Hartmann is a Professor Emerita of Development Studies Senior Policy Analyst, Population and Development Program, Hampshire College, Amherst, MA USA, received her B.A. from Yale University and her Ph.D. from the London School of Economics. Her research, teaching and activism focus on the intersections between population, health, migration, environment and security issues. She is the author of Reproductive Rights and Wrongs: The Global Politics of Population Control and two political thrillers about the Far Right, The Truth about Fire and Deadly Election. She is the co-author of A Quiet Violence: View from a Bangladesh Village and co-editor of the anthology Making Threats: Biofears and Environmental Anxieties. She is currently writing a book on apocalyptic thinking in the U.S. and received a Fulbright-Nehru Distinguished Chair Award to spend spring semester 2015 in New Delhi, India.

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Abstract

The way population issues are taught in schools, colleges and universities can have a profound impact on the development of students' worldviews, particularly regarding the root causes of poverty, malnutrition, ill health, and environmental degradation. In the United States as well as India, surveys of textbooks reveal extreme bias against poor people and poor women in particular, blaming their reproduction for a long catalogue of social and environmental problems. Limiting fertility is then put forward as the solution. Left unexamined are powerful structures of economic, political and gender inequality. In the case of medical education, such biases shape clinical practices that view women's bodies as objects that must be controlled, distorting, among other things, the delivery of family planning and other reproductive and sexual health services. Gender violence is often the result, as in the recent sterilization tragedy in Chattissgarh. Neo-Malthusian understandings of population also legitimize other punitive measures such as the two-child norm, contributing to structural violence in food distribution, employment and electoral schemes as well as skewed sex ratios. This lecture will address ways educators, researchers, activists and policy advocates can intervene in the process of population education to challenge neo-Malthusian views and promote justice-centered approaches to improving women's health and reducing inequality.

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Rethinking Population Education:
Challenging the Gender and Structural Violence of Prevailing Norms

Today I will talk about how his kind of radical humanism is required to challenge and transform the ways in which population is conventionally taught in Indian high school and medical textbooks. While I focus on the Indian context, I first want to describe how we face similar challenges in the US. In fact, I first became interested in population education at the high school level when my daughter brought home her biology text book. I skipped to the section on human population. Side by side were two photographs depicting the impact of population growth in Third World countries: one a picture of a herd of cattle overgrazing the land, the other an image of a starving African child. The authors warned ominously, "Either we will voluntarily reduce our birth rate or various forms of environmental resistance will increase our death rate. Facing the problem of how to limit births is politically and emotionally difficult but continued failure to do so will be disastrous." The book even counseled against lenient immigration policies in the U.S. since they would delay national population stabilization.

My students at Hampshire College, where I have taught for over 25 years, frequently tell me that this is what they learned in high school too. They come to college believing that world population is still growing exponentially, and that population growth is the main cause of hunger, poverty, environmental degradation and political instability in the developing world.

To help counter these myths, we initially did two surveys of the treatment of population in American biology and social studies textbooks. The results were dismal – my daughter's biology textbook was not an outlier. We also compared the US approach with UK textbooks, which tend to have

a more nuanced presentation of population issues, encouraging students to consider and debate different positions. Ultimately, we decided what was needed was a curricular resource for teachers, students and activists that presents multifaceted, gender sensitive, and rights and justice-centered approaches towards population education. Our curriculum, *Population in Perspective*, is now in its second edition, with chapters on basic demography, food and hunger, environment and climate change. The first edition has been adapted and translated into Spanish for the Bolivian context by the Bolivian environmental NGO Lidema. Both the English and Spanish versions are available free online.[1]

Has this effort transformed population education in the US? I wish I could say yes. Given the economic power of the textbook industry, increasing pressure on teachers to teach the standardized test, and state standards that still mandate teaching about the so-called "population explosion," it is a mammoth task to change the dominant ideology. But we believe in the old proverb: Nothing ventured, nothing gained. Especially in an age of electronic media, teachers and students find us. People come to know that there is an *alternative*.

Why is it, one might ask, that population education has changed so little with the times? In the US case, and in the Indian case as we shall see, the analysis provided by many mainstream textbooks harkens back over two centuries ago to the ideas of the Reverend Thomas Robert Malthus, the famous father of the principle of population as well as the 'dismal science' of economics. His intellectual trajectory has much to tell us about the reasons why his ideas are enshrined in our respective nations' schools. In the last decade of the 18th century, Malthus took his first job as a curate in the ancient Okewood church, located in a small village in the southeast of England. Most of the parishioners he served there were poor and illiterate, living in cramped thatched huts and surviving on a diet of bread and little else. Their children suffered from stunted growth. Yet despite these miserable conditions, Malthus noted from studying church

[1] To download the English or Spanish-language editions of *Population in Perspective*, visit http://popdev.hampshire.edu/pip

records that the number of baptisms was much larger than the number of burials - in other words there was a surplus of births over deaths. This disparity evidently sparked his concern about the evils of population growth (Avery, 1997).

In 1798, he published the first version of *An Essay on the Principle of Population*. As many of you know, Malthus maintained that if left unchecked, human populations grow geometrically while food production at best follows a linear arithmetic path. This condemns humanity to a constant battle to provide sustenance for its growing numbers. "The race of plants and the race of animals shrink under this great restrictive law," Malthus wrote, "and man cannot by any efforts of reason escape from it." (Malthus, 1914). Only the ensuing misery of hunger, poverty, disease and war keep human numbers in check by increasing death rates, along with some help from moral restraint and vice (infertility caused by venereal diseases) in keeping birth rates down. Even though forms of birth control existed, the conservative Malthus had little truck with it. In his eyes, the poor especially were perpetually doomed to have too many babies, making them responsible for their own misery.

Malthus took on the prominent progressive thinkers of his time, men like Marquis de Condorcet and William Godwin, who had more faith in human reason, altruism and agency and believed that it was possible to build a more equitable and peaceful world. Malthus lashed out at them for locating the causes of misery and vice in human institutions, insisting that the "deeper-seated causes of evil" result from "the laws of nature and the passions of mankind." (Avery, 1997). For Malthus, this meant the rich owed nothing to the poor, and the poor in turn had no real rights. This passage from his *Essay* sums it up well:

> That the principal and most permanent cause of poverty has little or no *direct* relation to forms of government, or the unequal division of property; and that, as the rich do not in reality possess the *power* of finding employment and maintenance for the poor, the poor cannot, in the nature of things, possess the *right* to demand

them; are important truths flowing from the principle of population… (Malthus, 1914).

Malthus also drew a distinction between the industrious, worthy rich and the lazy, undeserving poor. The latter's distress, he wrote, is "an evil so deeply seated that no human ingenuity can reach it." (Malthus work as cited in Harvey, 1996).

Malthusian ideas of course have changed over time. In particular, neo-Malthusians came to embrace contraception as a means to lower the fertility rates of the poor. But Malthus' basic principle that overpopulation is a major cause, if not *the* major cause, of hunger, poverty, scarcity and even war remains a virtual article of faith in many quarters. It does so because it is tremendously useful to those in power. In one stroke it obscures the political economy of inequality, naturalizes scarcity and war, and stereotypes and stigmatizes poor people, turning them into faceless numbers in an archaic mathematical equation. It also performs a certain gender magic, since it is women's sexuality and fertility that are the scourge.

Ten years ago I made a political pilgrimage to the Okewood church. As I stood inside the small chapel, I wondered if Malthus might have come to different conclusions if he had bothered to really talk to his parishioners. What if he had inquired more deeply into the real causes of their hunger and distress and had seriously considered the oppressive forces ranged against them during that particular period of British history: the enclosure of the commons, land dispossession, indecent wages, poorhouses that made a mockery of Christian charity? Maybe then he would have seen that their plight was not as simple as a surplus of births over deaths. Instead his contempt for the poor traveled far and wide, helped along by the fact that he went on to educate colonial officers of the East India Company.

It is not surprising then that his principle of population later echoed in the Malthusian views of British authorities in India who failed to prevent a severe drought from turning into the massive famine of 1877. Previous

shipments of food surpluses to Britain, failure to regulate grain speculation and hoarding, and lack of relief efforts led to dire conditions in the Indian countryside. A staggering 5-12 million people died. A few years afterwards, British finance minister Sir Evelyn Baring told Parliament, "Every benevolent attempt made to mitigate the effects of famine and defective sanitation serves but to enhance the evils resulting from overpopulation."[2] (Davis, 2002).

Unfortunately, Malthusian ideas came to flourish not only in pre-independence but also post-independent India, in part because they intersected so well with existing caste, class and communal prejudices on the part of Indian elite. In 1952, India became the first country in the world to launch an official population control program. The impetus came from both within the country and from abroad, with rapid population growth viewed as an impediment to modernization by government officials as well as international actors such as the US based Ford and Rockefeller Foundations (Rao, 2004).

Today, Malthusian ideas permeate the pages of high school textbooks here in a manner strikingly similar to those in the US.

A recent report by Sama Resource Group for Women and Health, *Spectres of Malthus: A Study of Representation of Population in School Textbooks in India*, reviews 110 social studies textbooks for classes 7-12 across India in 2012-13. It includes textbooks published by the National Council of Educational Research and Training (NCERT), the Indian Certificate of Secondary Education (ICSE), Delhi's State Council of Educational Research and Training (SCERT), and the Uttar Pradesh, Madhya Pradesh, Maharashtra and other state educational boards. Sama also reviewed a number of private publishers. The books selected were adopted after the introduction of the National Curriculum Framework of 2005 and are still in use.

[2] See also Corner House, "The Origins of the Third World: Markets, States and Climate," Briefing 27, Sturminster Newton, U.K., December 2002. Baring quote is from "Famine Commission – Financial Statement," Parliamentary Papers 181, 68, cited in Corner House, "The Origins of the Third World," 8.

Sama's review clearly reveals the overwhelming presence of neo-Malthusian discourses in school curricula. The textbooks view 'overpopulation' as the root cause of poverty, unemployment, food scarcity, environmental degradation, inflation and conflict. They mainly blame poor people, women and other marginalized sections for high population growth rates. The emphasis is on population control as a precondition for national socioeconomic development. Many books advocate coercive methods of population control.

Here is a short sample of quotes:

> *Implications of Population Growth to [for] Development: Fast growing population has its own implications as it nullifies all achievement in economic and social spheres and is largely responsible for environmental degradation. It is a herculean task to provide food, clothing, shelter, health, education and other facilities to a population, which grows at a rapid pace* (Class XII Geography textbook as cited in Sama, 2015).

> *Suggestions for eradicating poverty in India: Population Control: Rapidly increasing population cripples economic development. Thus, the population growth should be controlled. For the purpose of controlling population family planning measures should be effectively implemented* (Class XI Yogbodh Arthshastra Textbook as cited in Sama, 2015).

And another along the same lines:

> *For population control, the government should give up political opportunism; make stringent laws; and ensure punishments for those not following them.*

Even eugenics is embraced:

> *In India, apart from family planning programmes, birth improvement programmes should also be implemented. Under this, people who are epileptic, hysterical, physically disabled, mentally challenged, morally degenerate, and with genetic and/or hereditary chronic diseases should be prohibited from getting married and producing children* (Class X Samajik vigyan Textbook as cited in Sama, 2015).

And widows are targeted:

> *Widow marriages are on an increase in India. This has also increased our birth rate* (Class IX Economic Applications as cited in Sama, 2015).

Nor are medical textbooks much better when it comes to teaching about gender and population issues. In 2005, *EPW* ran a series of articles analyzing the role of gender in major preventive and social medicine textbooks. The authors uncovered gender bias in a number of fields. Some of the texts were not only gender-blind, but cast aspersions on women. The approaches toward population and family planning are particularly striking. Family planning is primarily seen as an instrument of population control, not as a basic reproductive right. Women are the target, and the role of male responsibility for birth control is ignored. Park's widely used *Textbook of Preventive and Social Medicine*, moreover, paints family planning as a quick and easy intervention: Family planning programmes can be initiated rapidly and require only limited resources, as compared to other factors (Parks work as cited in Gaitonde, 2005).

Another textbook on the same themes by Mahajan and Gupta reveals a cavalier approach to postpartum IUCD insertion: "It is advisable to insert the loop after a child has been born. Retroverted uterus is no contraindication. Slight discharge does not matter. Mild erosion results in no harm and prolapse can be ignored. Cervical tear, infection, caesarean section, myomectomy and lactation alamenorrhoea are not contraindications." Moreover, the book advises that women with more two or more children should be "motivated" for sterilization (Mahajan & Gupta work as cited in Bhate & Acharya, 2005). Here is a disturbing example of how an individual woman's health needs and conditions are

totally ignored; her body is a simply a vessel for medical intervention in the service of state prerogatives.

The surveyed texts do not address the ethics of informed consent, the need for counselling, or quality of services. When sterilization incentives and camps are mentioned, it is without criticism. The *Textbook of Gynaecology and Contraception* by C. S. Dawn goes so far as to suggest the "One child policy for the next 30 years to stabilize India's population". It reinforces stereotypes of the poor and disenfranchised as irresponsible breeders with the claim that the IUCD is "the most effective and suitable contraceptive for less motivated women, particularly in rural and slum areas in India"(Dawn work as cited in Khanna, 2005).

Ten years have passed since this survey of medical textbooks. It would be interesting to know if anything has improved since that time and perhaps a new survey is in order. However, if the reality on the ground is anything to go by, it would seem that not much has changed.

Dr. Mohan Rao at JNU's Centre for Social Medicine and Community Health reports that:

> Interviewing medical students for the MPH programme in our Centre, it is almost invariable that when asked about the major health problems in India, the answers are overpopulation, cancer and diabetes. Forgotten are hunger, infant, child and maternal mortality or communicable diseases. It is not surprising that overpopulation comes first, because if I remember Park's *Textbook of Preventive and Social Medicine*, generation after generation of medical students has been taught India contains 2.4 per cent of the total land area and "supports 16 per cent of the population of the world" (Rao, 2015).

Given the way gender and population issues are taught to medical students, who are already imbued with Malthusian thinking from high school texts, it isn't surprising that the delivery of family planning services remains rooted in a population control paradigm, with grave consequences for

women's health, rights and bodily integrity. In the same way that Malthus viewed his parishioners as less than human, so too have many Indian health providers been trained to view the poor women they are supposed to serve as unworthy of basic rights. "First, do no harm," or in Latin *primum non nocere*, has from the Hippocratic Oath onwards served as a central precept of medical ethics. The Malthusianism version distorts the meaning: "To prevent overpopulation from harming the nation, harming poor people is justified."

Or in the words of former Prime Minister Indira Gandhi, justifying the coercive population control campaign of Emergency Rule, "We must now act decisively and bring down the birth rate. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation..." (Rao, 2004). Those drastic steps led to the forced sterilization of an estimated seven million people, mainly poor men.

While forced sterilization is no longer government practice, many family planning clinics and camps are the scene of less dramatic and more routinized forms of medical violence, directed now at poor women. The recent deaths of 13 women in a sterilization camp in Bilaspur, Chhattisgarh are the tip of a much larger iceberg. Two excellent fact-finding reports, *Robbed of Choice and Dignity: Indian Women Dead after Mass Sterilization* by a team led by the Population Foundation of India, and *Camp of Wrongs: The Mourning Afterwards* by a team led by Sama, reveal how the Chhattisgarh tragedy must be situated within the larger context of state and national government population control strategies that systematically *dehumanize* poor women by turning them into the faceless numbers behind sterilization targets. These policies also dehumanize health care providers by turning them into cogs in the wheel of a vast population control machine.

India was a signatory to the 1994 Program of Action of the International Conference on Population and Development, which came out against top-down, target-driven family planning programs and advocated for a broader agenda of women's empowerment and comprehensive

reproductive health programs as the way to address population issues. In 2000, the government announced a new National Population Policy based on free and informed consent and critical of coercion. Yet India still relies overwhelmingly on female sterilization, and states are essentially given free rein to impose sterilization targets – now euphemistically called Expected Levels of Achievement. In 2013-4, the country spent 85% of government family planning expenditure on female sterilization, and only 1.45 percent on spacing methods. Male sterilization, though safer, is almost totally ignored. The pressure of meeting targets has led to widespread disregard of quality of care standards in sterilization operations, placing a large burden of morbidity and mortality on women.[3] Meanwhile, access to temporary methods of contraception is seriously curtailed, and there is a high level of sterilization regret among women (Singh, Ogallah, Ram, & Pallikadavath, 2012).

The Chhattisgarh tragedy reveals how these policies play out in practice. The state has high targets for sterilizations, but severe shortages in staff. Family planning is an isolated entity within the overall public health services, and practitioners receive virtually no training. Monitoring and supervision are severely lacking and standards for informed consent are not adhered to. Community health workers are under pressure to motivate women for sterilizations and are financially incentivized to bring in clients. Doctors are under similar pressures to meet targets. Poor women are paid incentives to be sterilized. Although by middle class standards the amount seems small – Rs. 600 – this compensation money is an attraction.

Sterilization operations routinely take place outside of regular clinics and hospitals. This was the case with the Bilaspur camp responsible for the deaths of 13 women. The camp was set up in an abandoned private hospital. As *Camp of Wrongs* describes, "The place was rife with cobwebs, thick dust, and rusted frames. The biomedical waste was thrown

[3] See *Robbed of Choice and Dignity: Indian Women Dead after Mass Sterilization*, Report by a Multi-organizational Team (New Delhi: Population Foundation of India, November 2014), and *Camp of Wrongs: The Mourning Afterwards* (New Delhi: Sama, Jan SwasthyaAbhiyan, and National Alliance for Maternal Health and Human Rights, November 2014).

at many places on campus" (Sama, 2014). The building was not properly disinfected before the operations. In this sordid environment, women were treated like objects on an assembly line. One doctor sterilized 83 women in one and a half hours. This translates into roughly one to one and a half minutes per surgery, when it should take a minimum of 5-6 minutes. None of the staff changed gloves in between procedures, and the same needles were used for all cases. While government standards mandate that three laparoscopes should be used for a maximum of 30 patients, only one laparoscope was used for all 83 patients. It was not properly sterilized between operations (Population Foundation of India, 2014). Is it any wonder then that women developed severe sepsis?

Both reports document the consequences of the women's deaths on their families. Children, including nursing infants, were robbed of their mothers; grief-stricken fathers and other family members found it difficult to cope. The state government's payment of compensation cannot possibly make up for their loss. And so the medical violence, gender violence and dehumanization at the clinical level spreads outwards, affecting entire families and communities. These are not isolated deaths.

In the wake of the Chhattisgarh tragedy, and others like it, there is now a push to introduce more temporary methods of contraception into the national family planning program. Certainly, women and men deserve more non-permanent contraceptive options. But as long as the Malthusian imperative remains a centerpiece of family planning delivery, medical education is biased against women, and public and primary health care services are defunded and in dismal shape, there is a danger that non-permanent methods will be abused as well. For example, post-partum IUD insertion has taken place without women's knowledge or full informed consent.

There are also worrying developments on the global population stage. Today we are witnessing renewed alarm over the dangers and threats posed by population growth in international policy circles, the media and Western, particularly US, environmental movements. In many ways this is reminiscent of the population bomb scare of the 1960s, 70s, and 80s,

though demographically the world is in a very different place. As measured by Total Fertility Rate, the average global family size is now 2.53 children, (United Nations, 2013). and the demographic transition to replacement level fertility or below has occurred or is occurring in most countries, including India. In 33 sub-Saharan Africa birth rates remain relatively high because of the persistence of high rates of mortality, poverty and social, economic and gender inequalities.

The so-called 'population explosion' is now over; though in absolute terms world population is still growing and could reach between 9-11 billion people before it stabilizes. This is because a large share of the population, especially in the global South, is young and in or approaching childbearing age. However, this youthful momentum will peter out as birth rates continue to decline. In fact, many demographers now worry about the phenomenon of population aging – how will a shrinking supply of young people support a growing elderly population?

Yet, despite the near ubiquity of demographic transition, there is a return to the old pre-ICPD paradigm with the promotion of the injectable Depo-Provera and long-acting, reversible contraceptives like implants and IUDS – now called by the acronym LARCs, as the technical contraceptive fix for the population problem. Family planning is once again being promoted as the centerpiece of reproductive health services.

In part, this is due to the entry and now growing dominance of the Bill and Melinda Gates Foundation in the population field. The foundation played a key role in Family Planning 2020, which aims to get 120 million more women – note men are missing - using contraception by 2020. The Gates foundation's position is highly problematic, combining neo-Malthusian reasoning with an anti-abortion bias. Melinda Gates refuses to support safe abortion, and there is growing concern in the SRHR field about Gates' undermining of the safe abortion agenda.[4]

[4] See Marlene Gerber Fried and Anne Hendrixson, "More than One Direction: Beyond the Exclusion of Abortion from Family Planning," and "Down a Garden Path: The Folly of Pitting Contraception against Abortion," in *Conscience*, 35 (3), 2014.

To (theoretically) minimize the need for abortion *and* reduce population growth, Gates and its partners have developed the Depo Provera and LARC strategy. They claim the contraceptives will liberate women and reduce maternal mortality too. While the population control imperative often remains hidden, it sometimes rises to the surface. For example, the Long Acting and Permanent Methods toolkit produced by USAID and Knowledge for Health asserts, "Wider availability and use of LA/PMs would reduce fertility rates more than wider use of other contraceptive methods, and countries would be able to meet their fertility goals more cost-effectively ("Long-Acting and Permanent Methods (LA/PMs) of Contraception | K4Health," n.d.). Note it is *countries'* fertility goals, not women's.

At the moment, the main tool in the Gates tool box is the three month injectable contraceptive Depo-Provera. Depo-Provera has long been the subject of considerable medical controversy. Its known side effects include prolonged and irregular bleeding, suppression of immune response, loss of bone mineral density in young women, significant weight gain, depression and loss of libido. There are clear racial disparities in its use, both in the US where it is mainly promoted to women of color, and globally where sub-Saharan Africa is a primary target (Volscho, 2011; USAID, 2012).

In July 2012, at the London Summit on Family Planning, a public-private partnership of the Bill & Melinda Gates Foundation, USAID, the UK Department for International Development (DFID), UNFPA, Pfizer, and the medical non-profit PATH announced a new initiative to reach three million women in sub-Saharan Africa and South Asia over the next three years with 12 million doses of a new subcutaneous delivery form of Depo-Provera called Sayana Press. Their program is designed explicitly to reduce the need for clinics and to bring Depo-Provera "to women living in some of the world's most remote regions" (Bill & Melinda Gates Foundation, 2012). The hope is that women will eventually inject themselves.

For over a decade now, medical studies have provided compelling evidence that Depo-Provera may increase the risk of women and their partners becoming infected with HIV.[5] A recent study in *The Lancet Infectious Diseases* found a 31 percent heightened risk for the general population and a 40 percent heightened risk for sex workers and other women at greater risk of acquiring HIV (Ralph, McCoy, Shiu, & Padian, 2015,). So why one might ask is the Gates coalition vigorously promoting Depo-Provera in sub-Saharan Africa, a region where most of the 16 million women living with HIV are located? Furthermore, don't women in high HIV-endemic areas need more access, not less to reproductive health clinics where they can receive much needed HIV/AIDS prevention and treatment services in addition to contraceptive access? From both an ethical and public health standpoint, the decision to promote Depo-Provera and the Sayana Press delivery system is dubious, to put it nicely.

South Asia is also a major focus. The Sayana Press is currently being introduced into Bangladesh. There is growing pressure on India to accept Depo-Provera into its national family planning program as well. Women's groups in India fought long and hard to keep injectable contraceptives out of the public program. Shouldn't there at least be a vigorous public debate about Depo-Provera's safety?

If Depo-Provera is ultimately phased out because of HIV risk, LARCs will become even more prominent. Critical scrutiny of them is thus also needed. In the Indian case, the absence of a functioning primary health care system, as well as the continuing dominance of population control and prejudices against the poor, mean that many poor women are unlikely to be adequately informed of LARC risks, or screened and followed-up. India has made a commitment to FP 2020 that 48 million more women

[5] For example, see R. Heffron et al, 'Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study', *The Lancet* 12/1 (Jan. 2012) pp. 19-26. For discussion of previous studies, see N. Visvanathan, 'Hormonal Contraception and HIV Disease Acquisition: A Limited Review and Assessment of Findings', Discussion Paper (Amherst, MA: Hampshire College Population and Development Program 2009) accessed March 6, 2013 at http://popdev.hampshire.edu/sites/default/files/uploads/u4763/Visvanathan%202008.pdf

and girls will have access to contraception by 2020 – but which contraceptives and how will they be distributed?

The contraceptive technical fix approach essentially obscures the larger context in which such interventions take place. Here it is important to note the *structural violence* of current population policies that occurs outside the immediate clinical context, in particular the impact of the two child norm. Proposed in 1992 by a National Development Council committee, ten states initially barred people with more than two children from running in local panchayat elections. The negative effects have been well documented. Since poor families tend to have more children than wealthier ones, the two-child norm effectively skews elections toward more powerful classes and castes, with a disproportionate impact on women. In a context of son preference, the two child norm pressures women to abort female fetuses in order to comply with it, one of the contributing factors to India's seriously declining child sex-ratio. In the face of these severe consequences, four states have revoked the two-child norm with regard to local elections. Yet it continues to be applied in other domains, notably maternal and child benefit schemes at both the central government and state levels.[6]

Many Indian scholars and activists have argued forcefully that ever since 1952, the government's focus on population control has diverted resources away from public health and social welfare programs.[7] This too contributes to structural violence against the poor in the form of unnecessary morbidity

[6] For more on the two child norm, see Sama Resource Group for Women and Health (2005). *Beyond Numbers: Implications of the Two-Child Norm*, New Delhi: Sama; Cole, C.B. (2009). *Responding to the Two-Child Norm: Barriers and Opportunities in the Campaign to Combat Target-Oriented Population Policies in the Post-ICPD India.* Collaborative study by the Centre for Health and Social Justice and the Community-Oriented Public Health Practice Program at the University of Washington School of Public Health. New Delhi: Centre for Health and Social Justice; "The Two-Child Norm: A Coercive Population Control Measure in India," Briefing Paper, National Coalition Against the Two-Child Norm and Coercive Population Policies, Coalition Secretariat, Centre for Health and Social Justice, New Delhi; Visaria, L., Acharya, A., & F. Raj. (2006). Two-Child Norm: Victimising the Vulnerable. *Economic and Political Weekly*, Vol. 41(1), 41-48.
[7] See, for example, Rao, *From Population Control to Reproductive Health.*

and mortality. Despite the best efforts of those trying to reform the system, it has been an uphill battle to meet people's needs for a broad array of sexual and reproductive health services, in which maternity care and safe contraception and abortion figure *along with* sex education and age and gender-sensitive services, including those for LGBTQ communities. There are many excellent SRHR efforts underway – many of the people in this room are among those undertaking them - but the population control imperative continues to thwart progress.

The Hindu Right's most recent communalization of differential fertility rates between Muslims and Hindus also makes the job harder, as does the continuing manufacturing of economic scarcity by powerful interests. The current phase of capitalism, characterized by grotesque wealth concentration – the US and India being perfect examples - dominance of the financial sector, accelerated privatization of public services, and huge resources devoted to the military - the US and India again being perfect examples - is clearly not up to the task of meeting the needs of the present population, much less a future, larger one. This creates the illusion of economic scarcity. Sip this scarcity cocktail and you come to believe there is just not enough to go around and population growth rates must be forced down – never mind the fact that the demographic transition is already well underway. Women want birth control, but instead they get population control.

So what is the way forward? In the spirit of Krishna Raj's radical humanism, the moment is ripe for ending the dehumanizing stranglehold Malthusian and neo-Malthusian ideologies have had over Indian population education, medical training, and the provision of health and family planning services. Malthus died over two centuries ago – isn't it time to lay his ghost finally to rest? Isn't it time to stop targeting and stereotyping poor people, especially poor women, and blaming their fertility for the nation's ills? The way population is taught naturalizes and depoliticizes the state's problematic development logics – in the name of educating the next generation, it spreads false consciousness among the population.

Free the national imagination of Malthus, and another world, a world where justice and equity are the central values becomes more possible. Population and medical education are a good place to start. What if young people and medical students all over the country were to read in their textbooks that India's experiment with population control was a colossal error, with unnecessary and tragic outcomes? What if they were to come to understand that it isn't the fertility of the poor preventing or slowing national development, but the concentration of wealth and power in the hands of the country's ruling elite and their transnational allies? What if they were exposed to a broad, gender-sensitive SRHR agenda, including early and effective sex education? What if they came to see all people as human beings like themselves, worthy of basic rights, respect, dignity and bodily integrity?

A tall order, yes, but the inspiring example of Krishna Raj's life's work shows how much can be accomplished if one sets not only one's mind, but also one's heart to the task of transforming consciousness and building a better nation and a better world.

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