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For reproductive justice in an era of Gates and Modi – the violence of India's population policies

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This article addresses India's contemporary population control policies and practices as a form of gender violence perpetrated by the state and transnational actors against poor, Adivasi and Dalit women. It argues that rather than meeting the needs and demands of these women for access to safe contraception which they can control, the Indian state has targeted them for coercive mass sterilizations and unsafe injectable contraceptives. This is made possible by the long-term construction of particular women's lives as devalued and disposable, and of their bodies as excessively fertile and therefore inimical to development and progress. It further considers how population policy is currently embedded in the neoliberal framework of development being pursued by the Indian state. In particular, it argues that the violence of population policies is being deepened as a result of three central and interrelated aspects of this framework: corporate dispossession and displacement, the intensification and extension of women's labour for global capital, and the discourses and embodied practices of Hindu supremacism. At the same time, India's population policies cannot be understood in isolation from the global population control establishment, which is increasingly corporate led, and from broader structures of racialised global capital accumulation. The violence of India's contemporary population policies and the practices they produce operates at several different scales, all of which involve the construction of certain bodies as unfit to reproduce and requiring intervention and control.

Keywords: population policies; sterilisations; long-acting hormonal contraceptives; Hindu supremacism; Gates Foundation; reproductive justice

Introduction

Union minister Giriraj Singh ...advocated sterilisation to control population growth at a function in his parliamentary constituency Nawada on Saturday. Singh said the India needs a strong population control act including sterilisation as the country was facing a population boom impeding development and social stability....He however insisted that it would be wrong to link his support for sterilisation as directed against any particular community....In October this year, the minister of state had said Hindus should seriously consider increasing their population in the country by producing more children. (Hindustan Times, 4 December 2016)

On February 15, the Bilaspur High Court ordered that all charges be dropped against the main accused in the sterilisation deaths case – the operating doctor, Dr RK Gupta – on a technicality. ..Gupta had performed laparoscopic tubectomies at a sterilisation camp held on November 8, 2014 at Nemichand Hospital, an abandoned private hospital in Takhatpur block...Earlier in the year, he had received an award for conducting over 50,000 laparoscopic tubectomies. On November 8, he did 83 laparoscopic tubectomies in just a few hours, using just one laparoscopic instrument. Subsequently, 13 women died and more than 130 women were hospitalised with serious complications from the surgeries... Gupta was arrested on November 12 and was in jail for less than a month, after which the Chhattisgarh High Court granted him bail. Two women survivors subsequently challenged his bail in court, but their petition was dismissed. (Nandi, 2017)

On 6th February around 600 Dalit and Lambadi (Adivasi) women ...gathered outside the office of the Kalaburagi Deputy Commissioner (DC)...6th February was the second time these women came together to protest this injustice and exploitation. Their first protest, also in front of the DC's office, had been a year-and-a-half earlier, demanding an enquiry into mass

unwarranted hysterectomies that had been performed in the area...98 percent of the 707 women spoken to reported undergoing hysterectomies in private hospitals...What was additionally shocking was how young these women were — 65 percent were less than 35 years old, while 25 percent were less than 30 years old....besides the unnecessary and cruel operations, no medical procedure was followed even in cases where women had died of hysterectomies. There was no post-mortem done, the body was cremated in a suspicious manner and families were bribed to stay silent (Ananya, 2017)

Appearing within a few weeks of each other in the winter of 2016-17, these news stories epitomize the intersecting forces which target the bodies – and more specifically the wombs - of poor, Dalit, Adivasi and religious minority women in India as sites of violent intervention. The statement by Giriraj Singh, one of several on the topic by the Union Minister in Narendra Modi's BJP government, barely conceals its moorings in increasingly dominant Hindu nationalist discourses in which the reproduction of the demonized Muslim other is continuously sought to be prevented, often through genocidal violence against women. Superficially however it invokes a set of ideas which have been mainstreamed by the Indian state for much longer, those which assume that the fertility of poor women represents an obstacle to India development, one which it is reasonable to seek to overcome through mass sterilizations. And indeed, as the second news story indicates, coercive sterilizations of women in camps under appalling conditions have been a central aspect of India's 'Family Planning' policies for several decades. The impunity of those responsible for the shockingly high levels of women's deaths which have inevitably resulted has been made possible by the deeply entrenched and systematic devaluation and dehumanization of the poor, overwhelmingly Dalit, oppressed caste and Adivasi women who are the main targets of attempts to control fertility. But as the protests by Dalit and Adivasi women reported in the third story make clear, the coercion

embedded in state and corporate interventions in fertility should not be assumed to preclude the collective agency of those targeted: coercion and agency should be understood as not mutually exclusive, but closely intertwined (Madhok, Phillips and Wilson, 2013). This story also starkly illustrates what happens when this devaluation and dehumanization informs profit-making strategies in a context of rampant marketisation of health care: in this profit-driven scandal, the women had been falsely told by doctors in private hospitals that they needed hysterectomies as a life-saving measure against cancer; elsewhere in India, unnecessary hysterectomies have been performed in private hospitals in order to take advantage of government schemes which cover healthcare costs of specific low income groups (Ananya, 2017). This article will explore the themes these stories highlight– the neo-Malthusian populationism of the Indian state’s development discourse, the targeting of particular bodies marked as ‘disposable’ for intervention and regulation, and the rise of a Hindu right wing nationalism which is simultaneously committed to neoliberal development – and examine how they are deeply co-implicated in population policies understood as a form of gender violence. But it also suggests that India’s population policies, along with its wider neoliberal transformations, cannot be understood in isolation from broader structures of racialised global capital accumulation. As we will see, this helps to explain why, although in the wake of the Chhattisgarh sterilisation deaths, the Indian Supreme Court directed state governments to move to end sterilization camps, large-scale sterilizations are expected to continue and why, simultaneously, the Indian government has adopted the long-acting injectable hormonal contraceptive Depo Provera into its ‘Family Planning’ programme despite the known risks associated with its use.

India’s population policies as gender violence

15 women died in the second week of November 2014 after undergoing sterilisation surgery under appalling conditions in camps in Bilaspur district of Chhattisgarh.

According to a fact-finding report by SAMA Resource Group for Women and Health (Sama, 2014), these women were all in their 20s and 30s and from Dalit, Adivasi (indigenous) and OBC (Other Backward Classes) communities. Most of them were from landless households and their main source of income was agricultural and other daily wage labour. Yet while their deaths made headlines, albeit briefly, these tragic events cannot be seen as an aberration. They are inevitable, and even expected, within approaches to 'Family Planning' which can be better understood as population control policies.

Coercive sterilizations in India are a form of violence against those marked by the intersections of gender, caste, class and community, perpetrated by the state and transnational actors. This violence can be understood both in the sense of direct embodied violence and in terms of the way it depends on the wider structural violence of social/economic inequality (which also has embodied effects).. Although a long term feature of Indian policy, this violence has, as we will see, been extended and intensified within a framework of neoliberal economic policies and patterns of global capital accumulation. Crucially, the violence of population control has been deepened in India in the context of the symbiotic relationships between neoliberal development, and the religious communal, Brahmanical and patriarchal discourse of the Hindu right which has risen to power in several states, and since 2014, at the Centre.

In the early 20th century, India came to be constructed within colonial discourse as the epitome of 'overpopulation', a concept located at the nexus of the Eugenicist and neo-Malthusian ideologies which were to generate population control policies (Mohan Rao, 1994; Hartmann, 1995; Connelly, 2008). As Connelly points out, 'India under the Raj remained open to inspection and instruction', and 'innumerable Americans and Europeans therefore traveled to India, witnessed "overpopulation" first hand, and returned ashen-faced, suitably appalled, to tell others of their experience.' (Connelly, 2008:89). With anti-colonial resistance intensifying, the idea of reproduction as a

threat to the racial order increasingly permeated the discourse of overpopulation, and this was reflected in a subtle change in the representation of racialised 'native' populations – whereas earlier the emphasis had been on 'apathy', 'indolence' and 'fatalism', tropes which were used to justify colonial inaction in the face of famine and starvation, these same populations now began to be more often portrayed as ominously hyperactive, incessantly 'swarming', 'teeming' and 'seething'.

Post-independence, in the changed global context of the reconfiguring of imperialism after formal colonialism, the Cold War in which, particularly after the Chinese Revolution in 1949, Asia was defined as a key battleground, and more generally the challenge to the existing global distribution of wealth and resources posed by communist movements in the global South, population growth in India as elsewhere was explicitly constructed in dominant development discourses as a geopolitical threat. As Laura Briggs puts it 'Third World women's sexual behavior was rendered dangerous and unreasonable, the cause of poverty and hence of communism, and needed to be made known, managed and regulated' (Briggs, 2002:117).¹

It was in this climate that in 1952, birth control advocate Margaret Sanger - who famously shifted from being a feminist and a socialist sympathizer to an active collaborator with the Eugenics movement (Gordon, 1976; Hartmann, 1995) - and Lady Dhanvanthi Rama Rau launched the International Planned Parenthood Federation (IPPF) in Bombay. The IPPF 'attracted funding from ... a veritable Who's Who of America's corporate and finance capital' (Rao, PE 49). In the same year, India became one of the first countries to initiate an official family planning programme. Between 1952 and 1975, the Ford Foundation spent 35 million dollars to finance family planning programmes, of which India received more than 20 million dollars (Rao, 1994).

The enthusiasm for family planning in India also reflected the presence of India's own established eugenics associations (Hodges, 2006) which, as elsewhere (Rao, 1994)

‘by the 1940s...had either renamed their societies or moved entirely into the growing field of family planning’ (Hodges, 2006:131). As Sarah Hodges notes, the distinctiveness of Indian eugenicist thinking was that it mobilized Hindu nationalist arguments that promoted caste endogamy (intra-caste marriage) and pointed to it as evidence of eugenicist practices in ancient Indian societies (Hodges, 2006:121-5). These caste supremacist eugenicist approaches, which defined Dalits, Adivasis and oppressed castes as by definition unfit to reproduce, were therefore arguably embedded in Post-Independence family planning policies in India from the outset.

The practice of sterilizations during the Emergency of 1975-77, in which men were forcibly taken to camps for vasectomies, is well known. This was one of few examples globally where men have been targeted on a mass scale, and the extensive opposition it generated contributed to the historic electoral defeat of the Congress Party in 1977 (Ahluwalia and Parmar, 2016). Subsequently however, sterilisation of women has been the main method used in India’s population policies since the late 1970s, and it is also the main form of contraception available in India.

Despite official claims that the Family Planning Programme provides a “cafeteria approach” with a “basket of choices” including five official methods — female sterilisation, male sterilisation, intrauterine contraceptive device (IUCD), oral contraceptives, and condoms – in 2005-2006, female sterilisation accounted for 66 per cent of contraceptive use. 77 % of women who underwent sterilisation had not used any method before they were sterilised and more than half of the women were aged under 26 when they were sterilised (Pachauri, 2014). Recent expenditure figures are also revealing: for the year 2013-14, India spent Rs 3960.97 million on female sterilisation, constituting 85 per cent of the total expenditure on family planning. Of this, Rs 3240.49 million was spent on incentives and compensation, and Rs 140.42 million on camps. For comparison 1.45 per cent of total family planning expenditure was spent on spacing methods (the remainder was spent on other family planning

related expenses like transportation, equipment and staff). (Population Foundation of India, 2014: 26).

The drive for female sterilisation has further intensified in the context of neoliberal reforms from the 1990s onwards. Since 2000, approximately 4.5 million tubectomies have been taking place every year in India. In Bilaspur district of Chhattisgarh, where the sterilization camp deaths occurred in November 2014, 47.2% of currently married women aged 15-49 had undergone sterilisation according to the 2012-13 Annual Health Survey (Sama, 2014).

In line with neoliberal policies in the health sector, ‘family planning’ programmes have also been increasingly privatized, with sterilisation surgeries outsourced to private clinics and hospitals. Doctors, private health centres and NGOs are paid ‘incentives’ for every woman sterilised (Population Foundation of India, 2014:27) .

Dr. R. K. Gupta, the doctor who single-handedly conducted 83 surgeries in less than three hours at one of the Chhattisgarh camps, and was subsequently arrested in connection with the sterilisation deaths, had received an award from the state Health Ministry for performing a record 50,000 surgeries during his career (Jaiswal, 2014).

This was not an aberration – in another case only three months later in January 2015, a doctor was found to have conducted 73 sterilisation operations in four hours in Varanasi, in Uttar Pradesh (Rai, 2015). At a camp near Bhubaneswar, Odisha, where 56 women were sterilised in one day, the doctor used a bicycle pump to introduce air into the women’s abdomens instead of an insufflator to introduce carbon dioxide at a controlled pressure and temperature. He insisted this was routine practice and claimed that he had carried out 60,000 tubectomies, many of them with bicycle pumps (Srinivasan, 2016). Clearly the system of marketisation and incentivisation of sterilisations ensures that basic rights will be routinely violated (Das et al, 2004).

Making such abuses possible however is a deeply rooted dehumanization of poor,

Dalit and Adivasi women who are constructed as disposable bodies whose 'excessive' fertility threatens the interests of the nation state.

A question asked in the Indian Parliament in 2012 revealed that on a national level, officially recorded deaths caused by sterilisation between 2003 and 2012 translate into 12 deaths a month on average, and actual figures are almost certainly much higher (Bhoumick, 2014). For example, a 2002 study found that an estimated 19 women in India die out of every 100,000 women sterilized (cited in Das et al, 2004:3876) suggesting that actual death rates are five times higher than those officially recorded; this compares to 3 per 100,000 internationally (op cit.). More recently a study of 5442 sterilisations of women which took place at a tertiary health care centre in Hubli, Karnataka between 2010 and 2014 found that a shocking 7 women had died, all from septicaemia (Mahadevappa et al, 2016). In some cases, women have died after being lied to about the nature of the operation, threatened with loss of ration cards or access to government welfare schemes, offered small amounts of cash or food as 'incentives', or forcibly taken to camps.

Equally significantly, many poor women who actively seek contraception are constrained to agree to sterilisation as a result of lack of access to other methods. This is an example of the way coercion is often also embedded in situations which are framed in terms of the exercise of 'choice', and underlines the need for an understanding of agency which does not assume an absence of coercion or structural oppression (Wilson, 2008; Madhok, Phillips and Wilson, 2013)².

At the same time, policies like the 'Two Child Norm'³ implemented in a number of states (Rao, 2003) have the effect of responsabilising and penalizing individual women for the failure to control their own fertility. Sheoran (2015:253) suggests that this can lead to poor and marginalized women policing the fertility of their peers, where women with a larger number of children may be shamed 'for not participating

in the one or two child norm that was propagated by ideas of contraceptive modernity’.

In a discussion of the growing disparities along class lines in access to contraception in India which focuses on the promotion of emergency contraceptive pills (ECPs) to middle class women, Sheoran (2015) uses the term ‘stratified contraception’ to describe how in an Indian context, ‘some women...experience a privileged contraceptive reality within the global South, while existing in close proximity to ‘contraceptive ghettos’ where information about, access to and the ability to purchase contraceptives, and to nutritionally support these contraceptives, is limited’ (Sheoran, 2015: 244) . However, the focus on unequal access can also risk obscuring both the implicit coercions of the market within which these more privileged women are interpellated as ‘consumers’, as well as the construction of poor and marginalized women as an emerging mass market for long acting hormonal contraceptives (as discussed below) and relatedly as a population needing to be controlled, subject to targets for acceptance of contraception.

Feminist reproductive health activists have long identified targets in population policy as one of the main drivers of abuses like those which led to the Chhattisgarh massacre. After the 1994 Cairo conference on population, the Indian government claimed to have abandoned targets. But in fact, these have simply been replaced with the euphemistically named ‘Expected Levels of Achievement’ at state level. As Human Rights Watch reported in 2012, ‘in much of the country, authorities aggressively pursue targets, especially for female sterilization, by threatening health workers with salary cuts or dismissals’ (Human Rights Watch, 2012; see also Population Foundation of India, 2014:16 for details of this practice in Bilaspur district of Chhattisgarh). The Indian government’s Programme Implementation Plan (PIP) 2014-2015 showed a target for Chhattisgarh state of 1,50,000 tubectomies (and 8,000

vasectomies) for the current financial year (which was to be achieved within only six months between October and March) and an increase in targets in subsequent years (Sama, 2014).

However, the recent evolution of India's 'family planning' initiatives, and their frequently devastating embodied effects, also need to be understood, I suggest, in the context of changes in global population policy. Particularly significant has been the FP2020 commitment made at the London Family Planning Summit hosted by the British government and the Bill and Melinda Gates Foundation in 2012. Along with USAID, UNFPA, and other international organizations, the hosts announced a \$2.6 billion global family planning strategy, 'FP2020', to get 120 million more girls and women in the poorest countries to use 'voluntary family planning' by 2020. The next day a Human Rights Watch report warned that the commitments made by the Indian government at the Summit in the framework of the FP2020 goal to get 48 million more women to use contraception by 2020 would lead to further abuses (Human Rights Watch, 2012). An October 10, 2014 letter from the National Rural Health Mission, under the aegis of the Indian Union Ministry of Health and Family Welfare, confirmed this. It stated that an increase in sterilizations was essential to meet the Family Planning 2020 commitment made by India at the Summit, especially for 11 "high focus" states, ruling out the importance of other possible methods of contraception. The letter ordered an increase in the payment given to all those involved in carrying out sterilization in these states (Singh, 2014). Meanwhile, aid from Britain's Department for International Development (DfID) was found to have helped to fund sterilization camps in the Indian states of Madhya Pradesh and Bihar in which a number of women died in 2012 (Chamberlain, 2012).

The main focus of FP2020 on a global level, however, has been the mass promotion of long-acting hormonal injectable and implantable contraceptives, in particular

Depo-Provera, Implanon, and Norplant 2 (Jadelle), produced by pharmaceutical giants Pfizer, Merck, and Bayer, respectively. Both Depo Provera and Norplant have historically been the focus of sustained opposition by feminist sexual and reproductive health and rights activists, who have argued that rather than giving poor women in the global South much needed access to safe contraception they can control, they potentially further undermine women's health and control over their bodies (see, for example, Akhter, 1992; Hartmann, 1995; Nair, 1989), while the more recently introduced Implanon has also raised significant safety concerns (MRHA, 2011; Wilson, 2013). Activists have also tracked and resisted the use of these drugs in neo-Eugenicist campaigns, documenting for example the current coercive administering of Depo-Provera to Ethiopian women in Israel (Hallgarten, 2013), along with numerous instances of the targeting of Black, indigenous and minority women, women with disabilities, incarcerated women, and women on welfare benefits in Europe and North America (Roberts, 1997; Silliman et al, 2004; Jackson, 2011).

In September 2015, the Indian Health Ministry announced the approval of the injectable contraceptive Depo Provera, for use in the National Family Planning Programme. This followed a pilot project financed by the Bill and Melinda Gates Foundation to introduce Depo-Provera into the public system in two districts in Haryana (Hartmann and Rao, 2015:11). A wide range of reproductive health and women's rights activists and scholars in India opposed its introduction. They argue that a number of serious side-effects are associated with the drug and that 'the use of Depo-Provera needs continuous medical follow-up by health staff in a well-functioning health system.... The health budget has stagnated while the salary and medicine costs have gone up. Health human power shortages are acute; the shortage of specialists trained in Obstetrics and Gynaecology is even more severe. Hence, the

health system remains incapable of dealing with the safe delivery of a contraceptive requiring intensive medical support' (Kafila, 2015). Studies of Indian women's experiences with Depo-Provera reveal high discontinuation rates due to side effects, especially menstrual disturbances such as intermittent or heavy bleeding, which interfere with women's ability to do even routine household tasks. The quality of information and counselling given about the method is poor (see for example, Sama, 2003). Further, medical studies for more than a decade have provided evidence that Depo-Provera increases the risk of women and their partners becoming infected with HIV (Polis et al, 2016; Hartmann et al, 2016:17 WHO, 2017)⁴.

Government approval for Depo Provera is argued to have been spurred on by the recent attention focused on the use of sterilizations in Indian government programmes, particularly after the Chhattisgarh deaths (Barry and Dugger, 2016). Indeed it has been followed one year later by a Supreme Court judgement directing the Government of India to "make efforts to ensure that sterilization camps are discontinued" by state governments within three years.. In response to complaints that government health workers with targets for sterilisation were forcing women to undergo the procedure, the court said that it would "leave it to the good sense" of state governments to ensure that targets were not fixed (Srinivasan, 2016). However, there is little indication that the newly introduced contraceptives will lead to a phasing out of sterilisation as the most widely available method of contraception in India, particularly in the context of the increased pressure of meeting globally set targets in the form of the commitments made by the Indian government under FP2020.

Both sterilization campaigns and the promotion of long-acting hormonal contraceptives are taking place in the context of further withdrawal of health provision, including reduced spending on reproductive health (Schultz & Bendix, 2015). This is also consistent with a wider trend which has been associated with the

growing dominance of the Bill and Melinda Gates Foundation in global health policy: the prioritization of ‘vertical’ single issue interventions over ‘horizontal’ investment in health systems (Harman, 2016; Sexton and Nair, 2010).. In India, the increased pressure of meeting FP2020 commitments has been accompanied by the further undermining of already inadequate health provision since the current government of Narendra Modi’s right wing Hindu nationalist Bharatiya Janata Party came to power in 2014, a crisis highlighted in a major study by Indian health experts published in the Lancet(Patel et al, 2015).. It is in this context, in which a model of shrinking health service provision and permanent shortage of trained staff is taken as a given, that Sayana Press, a new delivery method of Depo-Provera, is being extensively promoted in sub-Saharan Africa and South Asia by a collaboration between the Gates Foundation, USAID, DfID, UNFPA, pharmaceutical corporation Pfizer, and the US NGO PATH, with the claim that it requires minimal involvement of health professionals and can even be self- administered (PATH, 2016).

Malthus, Neoliberalism and Hindu supremacism

The global ‘neo-Malthusian resurgence’ which defines population growth as the cause of poverty, climate change and displacement (Hartmann and Rao, 2015; Hartmann, Hendrixson and Sasser, 2016), as well as the appropriation of feminist notions of reproductive rights and choice by corporate actors promoting long acting hormonal contraceptives and more broadly the rise of a ‘Smart Economics’⁵ approach based on the intensification and extension of women’s labour as the basis for sustaining global capital accumulation (Wilson, 2015) all contribute to the targeting of the fertility of women who are marked by their gender, class, caste and religion. However, these embodied and differentiated experiences are also shaped by the specificities of the Indian state at this moment when extensive neoliberal restructuring in the interests of

Indian and transnational corporate capital is combined with the hypernationalist project of building an exclusivist Hindu Rashtra (Hindu state).

Contemporary population control initiatives can be understood as part of the process of ‘accumulation as dispossession’ to which the intensification of women’s labour is central. Responsibility for household survival has been increasingly feminized, through both an extension of women’s unpaid labour (Chant, 2006; Molyneux, 2008) as well as the incorporation of increasing numbers of women into corporate-controlled global value chains. As in Puerto Rico in the 1950s, where mass sterilization drives were pioneered as part of one of the earliest experiments in increasing profits by outsourcing US manufacturing to low-paid women workers in the global South in ‘Operation Bootstrap’ (Briggs, 2002; Mass, 1976), a reduction in women’s fertility is being promoted within the ‘Smart Economics’ framework, primarily as it is regarded as facilitating women’s entry into labour markets and enhancing their productivity for global capital (see for example Grépin and Klugman, 2013, Elborgh-Woytek et al, 2013).

This approach has been incorporated in India in uneven and complex ways. While fertility rates are declining in India (Hartmann and Rao, 2015) and ‘predicted to converge to replacement levels in the medium run’ (Elborgh-Woytek et al, 2013:21), in contrast to Bangladesh which had adopted strategies of export-led growth based on predominantly female labour much earlier, India’s low female workforce participation rates (Chaudhary and Verick, 2014) have actually declined since the introduction in the 1990s of economic liberalization policies (Chandrashekhar and Ghosh, 2013).

This has been linked to women’s increased burden of unpaid work as a result of neoliberal reforms, as well as patriarchal rigidities which lead to women being ‘withdrawn’ from the labour market with even small increases in household income

(op cit; Ghosh, 2009). As a result, women's labour in India has been identified as an 'untapped resource' by the IMF, among others. Modi's current 'Make in India' policy, extending existing policy under previous Congress-Party led governments, involves the promotion of India as a location for investment based on the availability of low cost, efficient, 'flexible', largely female labour. This translates into insecure, low-paid temporary jobs in which even India's limited remaining labour laws are consistently flouted (Dutta, 2015; Mezzadri, 2017). As Krishnan explains (2015; this volume) patriarchal and caste-based restrictions on mobility and interaction are now central to the operation of factories which supply transnational value chains, suggesting that 'rather than challenging gender norms, the expansion of this form of employment actually builds on and reinforces patriarchal gender values' (Krishnan, 2015). It also gives an indication of the symbiotic relationship between the Hindu right (with its violent so-called 'moral policing' of gender norms), on the one hand, and the neoliberal economic project on the other, which are not only compatible but interdependent in contemporary India.

The labour of rural women from low income households is also being mobilized through the expansion and deepening financialisation of microfinance and Self-Help Groups (SHGs) (Aitken, 2013; Kalpana 2009; 2017) and through the recruitment of women as unpaid volunteers (receiving an 'honorarium' rather than a wage) in state schemes for social provision – notably ASHA (Accredited Social Health Activist) Anganwadi (childcare centre) and school Mid-Day Meal schemes. ASHA workers are in fact among those who are expected to recruit women for sterilisation as part of their tasks. But the population control initiatives of the Indian state, in partnership with global capital, can also be understood as directed at particular sections of the population who are constructed in the dominant discourses of 'development' as superfluous to capital accumulation, and therefore legitimately subject to multiple forms of displacement and dispossession. This is particularly the case with the

targeting for sterilisation of women in Adivasi (indigenous) communities who live on mineral rich land and are viewed as obstacles to its exploitation by corporate capital. The currently BJP-ruled state of Chhattisgarh, where the sterilization camp deaths took place in November 2014, exemplifies this. Chhattisgarh is one of India's poorest states, with abysmal health care provision. Unsurprisingly, given the model of predatory accumulation by dispossession which the Indian state has embraced, Chhattisgarh also had the highest large-scale investment of all states in 2014-16 (Kaur, 2016). Since the early 2000s, the Bastar and Dantewada districts have seen the influx of transnational mining corporations.. This has resulted in the appropriation of agricultural land, the uprooting of entire villages, and the displacement of thousands of Adivasi people (Sundar, 2006). State paramilitaries and armed vigilante groups, among them the relaunched 'Salwa Judum' set up with initial funding from steel companies Tata and Essar (Government of India, 2009), have played a key role in this displacement and in the militarization of the region. Women and girls have been targeted for appalling sexual violence at the hands of the police and paramilitaries (Subramaniam, 2015; Sundar, 2016). The case of activist Soni Sori, who was targeted for exposing police atrocities (Amnesty International, 2013), is the best known among many. It is within this framework, in which poor Adivasi and Dalit women, their bodies and their livelihoods are perceived primarily as an obstacle to development, that the intensification of population control violence against these women can be located. The felicitation of doctors who perform unsafe and abusive mass-scale sterilizations as heroes of development disturbingly echoes the medals for 'gallantry' which were awarded to Ankit Garg, the Chhattisgarh police superintendent who supervised the torture of Soni Sori, and SRP Kalluri, the Inspector General of Police who is accused of the rape of an Adivasi woman, Ledha Bai, in 2007 and is responsible for ordering the rape and torture of Adivasi women on a mass scale as part of a wider ongoing campaign of terror in the name of anti-insurgency (Poyam, 2016).

So far this article has addressed the impact of the Hindu right's ascendance to power and the formation of the Narendra Modi government in May 2014 primarily in terms of the intensification of the violence of 'Family Planning' policies, the appropriation of resources and the extension of women's precarious labour – the marked deepening and widening of processes already underway. But when considering population control, one must also think about the rise of Hindu supremacist ideology and in particular the mainstreaming of necropolitical discourses of population elimination.

The trope of higher population growth rates among India's minority Muslim community in relation to the Hindu majority⁶ is a central element in an arsenal of myths which are repeatedly mobilized by Hindu right wing groups in order to orchestrate communal (inter-religious) massacres which target women's bodies and those of their children for horrifying violence. As Tanika Sarkar has written in relation to the genocidal massacres which took place in Gujarat in 2002 (when Modi was Chief Minister of the state), these myths of 'allegedly ultra-virile Muslim male bodies and overfertile Muslim female ones...inspire and sustain the figures of paranoia and revenge' (Sarkar, 2002). Public discourse in India, as noted earlier, has become increasingly suffused with these tropes, with statements by political figures repeatedly reproducing them. For example, on August 26 2015, Yogi Adityanath, then an MP of the ruling Bharatiya Janata Party⁷, requested Prime Minister Modi to implement a population control 'law' specifically for Muslims (Express News Service, 2015); in October the same year, Mohan Bhagwat, leader of the Rashtriya Swayamsevak Sangh, the cadre-based organisation at the heart of the network of Hindu nationalist groups in India, stated that India needed to address population 'imbalances' between communities (PTI, 2015); these followed BJP MP Sakshi Maharaj's statement that 'Hindu women should have at least four children' (Ali, 2015). While this construction of 'exceptional' fertility among Indian Muslims is

deeply entrenched, the incitement to violence through invocation of the need to prevent the proliferation of the ‘other’ is reproduced in multiple contexts. For example, survivors of the massacres in the late 1990s of landless Dalits and Muslims in rural Bihar carried out to counter the growing influence of the Communist Party of India (Marxist-Leninist) testify how the killers from the Ranveer Sena – an armed landowners gang with close links to the Hindu right - talked of brutally murdering women who ‘would give birth to Naxalites (revolutionary communists)’ and children who would ‘grow up to be Naxalites’. The Ranveer Sena leader Brahmeshwar Singh has been chillingly quoted as telling a journalist that “the viper in the egg will one day hatch and come to bite you. There is no sin in crushing the egg” (Morrison, 2012).

These genocidal narratives are superficially a far cry from the technocratic language of India’s Family Programme, which according to the website of the National Health Mission ‘is currently being repositioned to not only achieve *population stabilization* but also to promote *reproductive health* and reduce *maternal, infant & child mortality and morbidity*’ (National Health Mission, 2017, emphasis in original). But I would argue that they are not in contradiction with, but rather complement and reinforce the neoliberal approach to population control rooted in Eugenicism (the Indian version of which was, as suggested earlier, already inflected with Hindu supremacist caste-based thinking) and Neo-Malthusianism. Within both, those women who are constituted as ‘not belonging’ to the nation in a variety of ways are targeted for ‘almost inexhaustible violence’ (Sarkar, 2002), while simultaneously those who ‘belong’ are constructed as having an obligation to reproduce the nation.

Conclusion

The gendered violence of India’s contemporary population policies and the practices they produce operates at several different scales, all of which involve the construction of certain bodies as excessively reproductive and requiring intervention and control.

Population policies promoted by neoliberal global capital in the 21st century construct the fertility of essentialised and racialised ‘poor women in the global South’ as exceptional, dangerous and threatening even as their discourse is reframed in terms of market-driven reproductive choice. Incorporated into Indian national ‘Family Planning’ programmes, they both mobilize and re-embed the structural subordination of women belonging to marginalized and demonized communities, legitimizing the embodied and sometimes fatal violence of day to day practices of population policy which these women encounter. This violence has been intensified by the ascendance of the far-right proponents of a ‘Hindu Rashtra’ whose hyper-nationalism remains consistent with corporate-led neoliberal globalization. In order to be effective, then, approaches to reproductive justice in the context of India’s population policies need to attend in particular to corporate dispossession, displacement, occupation and militarization, the intensification and extension of women’s labour for global capital, and the mainstreaming of the genocidal gender narratives of Hindu supremacism.

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¹ Attempts to regulate sexuality in the interests of imperialism have a long history with a plethora of colonial discourses, laws and practices including those relating to marriage, children of mixed race, prostitution and sexually transmitted infections.

² The denial of reproductive rights under India's population policies is further underlined by evidence that since the 2014 deaths, women in Chhattisgarh belonging to 'Particularly Vulnerable Tribal Groups' with high infant mortality rates are being prevented from accessing sterilisation under a 1979 government order aimed at 'preserving the community', while other forms of contraception remain unavailable (Lavtepatil and Sijwali, 2017)

³ The introduction of the 'Two Child Norm' involved a plethora of coercive incentives and disincentives in several Indian states, including exclusion from eligibility to contest Panchayat (local government) elections of women and men who have more than two children (Rao, 2003) .

⁴Implicit in the exclusive focus on long acting hormonal contraceptives despite the known risks is the emphasis on 'cost-effectiveness' and minimizing the risk of contraceptive failure, and hence the need for safe abortion. This is another consequence of the Gates Foundation's now dominant position in the field, since Melinda Gates does not support abortion rights (Fried and Hendixson, 2014). In 2017, Melinda Gates reiterated her position in support of the Mexico City policy that "US funding can never

go to an abortion organisation, ever” while criticizing President Trump’s broadening of the application of the rule for its impact on reducing funding for family planning (Revesz, 2017).

⁵ In recent years, globally dominant development institutions have been promoting an explicitly neoliberal approach to gender, epitomized by the World Bank’s slogan ‘Gender Equality as Smart Economics’ (World Bank, 2006; World Bank, 2011) and the current corporate-initiated global development focus on adolescent girls. Smart Economics is premised on highly gendered assumptions that women will always work harder, and be more productive, than their male counterparts; further, they will use additional income more productively than men would, and that this behaviour is inherent (Wilson, 2015). Therefore it argues that greater gender ‘equality’, understood as an increase in women’s participation in labour markets, will have a significant impact on economic growth.

⁶ The reality is that family size among Muslims saw a greater reduction between 2001 and 2011 than that in any other community, as recently released government census data reveals (see HT Correspondent, 2016)

⁷ Adityanath, who is notorious for his record of hate-mongering and violence, was appointed Chief Minister of the state of Uttar Pradesh after the BJP won state Assembly elections there in March 2017.