



Reproductive Health, Population Control and Women's Sexuality: the Indian Experience

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(Received 14 January, 2015, Accepted 19 March, 2015)

(Published by Research Trend, Website: www.researchtrend.net)

ABSTRACT: Women's sexuality has always been viewed in a narrow sense, reducing it into mere reproductive health of future mothers who are expected to give birth to healthy children for the nation's growth and development. This paper traces the relationship of women's sexuality and their health and tries to see how it shapes their lives and perspective of well-being. Women's reproductive health has never been an independent concern except in relation to their reproductive capacities. It focuses on the linkages between women's choice, autonomy, voices, rights and state health policies imposed on them. This paper also explores the shaping of the 'motherhood' imagery used by leaders of so called nation building. It is argued here that women are viewed as mother goddesses and expected to fulfill their motherly roles for nation building rather than acknowledge their existence as an individual having independent choice and rights. The article locates the discourse of sexuality, fertility and population control in pre- and post-independence India and its impact over women's control of their body, fertility and access to basic health services through larger political debates and policy frameworks.

I. INTRODUCTION

For almost two decades now, the question of sexuality has assumed an important space in public debates in India. The effort to examine how sexuality affects women's health and women's understanding of it has been a recent phenomenon, particularly in societies like India. I would like to focus on women's sexuality to explore the ways in which it shapes their lives and health through some of the initial debates on birth control in pre-independence India and perspectives which influenced shaping the policies related to women's health post-independence. Sexuality, like all other aspects of social life, is shaped, mediated, and defined by the social milieu. The prevailing cultural norms, economic, and political organization of society and the power relations give meaning to the sexual experiences of individuals and of acceptable and unacceptable sexual behaviours. As Mishra and Chandramani (2005) argues:

“Cultures provide widely different categories, schema, and labels for framing sexual experiences. These construction not only influence individual subjectivity and behaviour, but they also organize and give meaning to collective sexual experience through, for example the impact of sexual identities, definitions, ideology and regulations”.

The socio-cultural construction of sexuality remains a political process deeply rooted in the historical evolution of the societies and the distribution, and redistribution of power between, and within society. Owing to these power relations and dominance of different social groups, some forms of sexuality emerge as socially 'acceptable' norms, while others are widely perceived (at least by the dominant power groups) as obscene, immoral, and against the social ethos. The process of emergence of the dichotomous notion of 'good' and 'bad' sexuality, and the resistance to any 'deviation' from the 'normal' sexuality is located, not merely in the 'passive' evolution of the society, but in the actual politics of it. At the same time, the ideologies that legitimize and ensure the dominance of the particular social groups play a crucial role in defining and concretizing this bipolar notion of sexuality.

Various state health policies in India such as inclusion of population control in the initial Five Year Plans, forced sterilisation during Emergency (1975-77), National Health Policy (1983) etc., also have been influenced by the societal approach towards seeing women as child producing machines. Global players also reduced women health into family planning policies. These players were believed to have technological answers for all the women's health

related problems. This technological fix have been further narrowed down by the World Bank which sees family planning services alone as a necessary input to improve women's health (Qadeer, 1998: 2679). Hence fertility control per se becomes the key to a public health package (World Bank, 1993, cited in Qadeer). Post independent national state's policies too reduced them into reproductive machines and do not consider them as a human being having independent choice over their body, sexuality and child birth.

The social construction of sexuality and the resultant gender relation plays a crucial role in shaping women's life and health conditions. The state uses the developments of medical sciences to gain support for the motherhood ideology and also for making inferior status of women in society seem natural. The ideology of motherhood, Badinter (1981) argues, was created with the advent of industrial capitalism in Western Europe. She asserts that the good woman was the motherly housewife whose sole purpose in the life was to sacrifice herself in the service of her husband and children, and thus to become foundation of the emerging nation state (Badinter, 1981). Therefore, women's reproductive organs were seen as the location of the personality characteristics of the women that qualified them only for childbearing, while also making them unfit for other activities. Rao (2000) noted, "we have today in our country a dominant ideology that seeks to reinforce dark tradition of Indian womanhood: that of sacrifice. Macroeconomic reforms, which are eroding the necessary conditions for women's health are complimenting this. As is, perhaps, health policy, with its focus on women as merely reproductive beings" (Rao, 2000: 4322).

The link between sexuality and women's health has been neglected for a very long time. It has come into the discourse after the panic created by the HIV/AIDS. It was right after the emergence of HIV/AIDS epidemic that the nation state started inclusion of sexuality education in schools, and general awareness about the sexually responsible behaviour through various modes such as advertisements. Policy makers viewed women and sexual minorities as a risk factor responsible for spreading the disease. The emphasis of all these efforts was not much onto giving control to women of their own bodies or empowering them to exercise choice but to put them in surveillance so that they will not be able to "spread" the disease. Sex workers/ people in prostitution were primarily seen responsible for spreading the epidemic that is why free condom distribution to prostitutes was done on a massive scale without taking into the consideration the role of customers.

II. CONTROLS OVER WOMEN' SEXUALITY

The term 'sexuality' generally refers to the sexual orientations (and behaviours) of individuals (Weeks, Jeffery (2003). It is often considered to be natural and essential characteristics of an individual and it finds expression through sexual activities and relationships. This common sense perception of sexuality is a misnomer. Sexuality incorporates not only the matters of body, the sexual pleasures attached to it, and the normative sexual behaviours acceptable in a culture, but also the question of power and its exercise through various channels in society. It transcends the private realm and is mediated, shaped and defined by the socio-economic organization of the society. Far from being a natural or a biological construct, sexuality is a social construct. It is a concept that encompasses the physical capacity for sexual arousal and pleasure (libido) as well as personalised and shared social meaning attached both to the sexual behaviour, and the formation of sexual and gender identities. It does not remain confined to the sexual orientation of men and women; it mediates with the control they exert over their respective bodies, their mobility, and their access to resources, and thus plays an important role in not only defining but also shaping their status in society. John and Nair emphasise that:

...far from signifying biological genitality, 'sexuality' must connote a way of addressing sexual relations, their spheres of legitimacy and illegitimacy, through the institutions and practices, as well as discourses and forms of representation, that have long been producing, distributing and controlling the subject of 'sex' (John & Nair, 1998:1).

The core instrument of control over human sexuality by society, state, religion and other forces has been patriarchy (Geetha, V. (2007). Patriarchy as a systemic ideology subordinates women in families in particular and in society in general. However, this is not to imply that patriarchy operates in a single way and women have the same experience of suffering. Women are not a homogenous group and so the experiences of the ideology of patriarchy and the consequent implications for their sexuality have been quite different for women belonging to different classes, castes and races. Patriarchal ideologies remains much more concerned with the inheritance of property rights and thus had the propertied classes under its main adherent. That is why we find that the norms and values for the social and sexual behaviour had been different for upper castes and classes than they were for the deprived sections of the society (Kolenda, 2003).

The discourse on sexuality has been influenced by the attempts of patriarchal structures like caste, kinship networks and religion to control women's sexuality. The attempts of the state to regulate the sexuality of its subjects by legitimizing only one of the sexual behaviours; and the resistance put up by women's movement as well as other progressive movements, particularly the Left forces. Other than the women's and other progressive movements, the different forces have had fluctuating relations with one another, from collaboration to confrontation. However, all of these forces have attempted to maintain and strengthen the subjugation of women, control their sexuality and use fertility in the service of the relevant ideologies. The subjugation of women under patriarchal structures and the control over their sexuality gets reflected in the recurrent incidents of sexual harassment, gender discrimination against women in public as well as private spaces, and targeting of women during communal and ethnic violence. Women often bear the brunt of the violence during conflicts because of being perceived as the site of the honour of the community.

The regulation of women's sexuality is also carried out by extra-constitutional bodies like caste panchayats, which deny women (and men) even the basic human rights like choosing one's life partner. The recurrent media reports of "honour murders" from many parts of the country, dissolution of marriages by the caste panchayats, and denying victims recourse to the state agencies by using brute force make it evident that even after sixty years of independence, the rule of law has no place at the grassroots. And women are the worst victims of the government's failure in doing so.

Medical Science is no exception to this patriarchal ideology. Despite giving women some control over their bodies, it soon become clear that the developments in reproductive technologies, like all other developments, were used by the ruling patriarchal forces to further their agenda, and to put women and their sexuality in continued subjugation. Now even certain physiological processes like pregnancy have gone in the hands of specialized medical professionals and women's bodies are becoming side of medical intervention on the name of research on contraceptives and new reproductive technologies etc. Targeting women's bodies served two purposes in one go - first, absolving men of any responsibility towards contraception and second, turning the exploration of joys by the women into a threatening thing. For this reason, population establishments, pharmaceuticals companies, governments, international agencies and other actors in reproductive health research have focused largely on women's bodies while ignoring research on developing male contraceptives (Hartmann 1995).

This was apparent in the family planning programmes taken up across the developing countries, with the 'target group' of these programmes being women. Most of the research in developing contraceptives was focused on women in the form of contraceptive pills, emergency pills, copper-T etc, as if implying that men have no role whatsoever in reproduction. Even those contraceptives which were developed for men like non-surgical vasectomy, permanent and temporary contraception by injection, we heat method and ultra sound methods, are nonhormonal methods and thus making it far safer for the man as compared to the women.

Furthermore, most of contraceptive techniques in the name of providing reproductive rights, do not take social-economic structures, women's autonomy and their decision-making capacities in the context of reproductive choice into consideration (Petchesky: 2000). Overemphasis on women's reproductive health denies the fact that reproduction is but only one part of women's overall personality and sexuality and thus reduces women into merely reproductive beings.

III. THE POLITICS OF BIRTH CONTROL IN INDIA—THE PRE-INDEPENDENCE ERA

The population question in India was brought into public discourse by the colonial rulers because of their preoccupation with the size of population and their ability to know and control its social and demographic contours, economic activities and settlement patterns.. Moreover as in all other cases, the agenda of population control to improve health conditions of the 'natives' conformed to the colonial 'civilizing mission' and gave legitimacy to the rule. The 1891 Census report for example, invoked Malthus to contend that overpopulation was responsible for poverty in India (Banerji, 1985:174). Especially with institutionalisation of Census, the colonial government started having a fair idea of its subjects, their socio-economic and demographic profile and then used the information to further its agenda of establishing control over it. However, their attempt of pushing the agenda forward was seen with great suspicion and was resented by the nationalist movement.

Furthermore, the colonial state's emphasis on using birth control techniques generated a huge deal of suspicion among the nationalist leadership and women alike, as it brought the 'private' question of sexuality and reproduction in 'public' discourse. The nationalist leadership, already skeptical about the intentions of the colonial state, saw this development as an attack on Indian culture and perceived it as an attempt of conquering the final frontier.

Birth control movement, however, received support from unlikely quarters: the eugenisists who consistently invoked the degeneration of the Aryan race that the Indian population supposedly represented and called for using scientific techniques to restore the purity and strength of 'race' (Hodges, 2006). They perceived overpopulation as the biggest and most immediate concern for the emerging nation and used the vocabulary of life sciences to press for their agenda. In fact, they succeed in giving a new language to that section of nationalist struggle, which was ingrained in the western values system and was amenable to the use of birth control as an effective technique of curbing societal problems. Most importantly, the eugenisists were instrumental in dragging one individual's sexual behaviour out of the domain of 'private' and linking it with the agenda of modernizing the nation as a whole (Hodges 2006).

Another important group that supported birth control movement and advocated the use of contraception was that of women medical professionals. Though quite many of them were cautious in their response to contraception techniques, their daily life experience with high maternal and infant mortalities shaped their support for these techniques. Furthermore, they were the single group that tried to bring in the question of sexuality and its relation to reproduction in the ongoing debate. Barbara N Ramusack (2006) underscores their contribution in bringing the question of sexuality and challenged the hegemonic position taken by the colonial rulers, the eugenisists and a section of the nationalist movement alike.

The connection with sexuality was a problematic site for even who supported birth control techniques for the improvement in the health of the nation. As the leadership of the nationalist movement was almost entirely constituted of urban, elite and upper caste bourgeoisie, engrained with the value system of new paternalist patriarchy, it was bound to get worried with this development. The possibility of women controlling their sexuality and as a consequence, their sexual behaviour, was totally incongruous with the painstakingly built asexual mother goddess imagery. Furthermore, it could alienate an important section of freedom struggle - the uppercaste upper-class propertied men. Assuaging these concerns, it seems, a section of the nationalist movement termed birth control techniques as being immoral and was perceived as having hidden agenda of insuring the access of British doctors to Indian 'homes'.

Gandhi was one of the most important leaders of the freedom struggle who opposed birth control by what he called 'artificial contraceptives' (Aryee, 2006) on moral grounds. He refused to buy any arguments in favour of it as for him any use of sex urge barring procreation was 'sinful' and against humanity. He, instead, advocated self-control and sexual abstinence, as the only effective and agreeable methods for birth control. Furthermore, birth control, as used by the British authorities, seldom expressed any concerns about improving the health of women. Rather, all justifications and arguments were rooted in using birth control techniques for curbing overpopulation and the problems like poverty and scarcity of resources caused by it.

Even within the nationalist movement the agenda of birth control was gathering momentum and a significant section of the Indian National Congress started supporting the notion. Thus, the 1932 Calcutta session of all India Women Conference passed a resolution urging the men and women to be responsible citizens and adopt birth control techniques. At the same time, it avoided confronting Gandhi and made adjustments to include his views, while arguing in support of birth control. Thus, National Planning Committees' Subcommittee on Women's Role in Planned Economy supported self-control as an effective tool of birth control but also observed that this is a method which can be taken recourse to by only strong people and so stressed on the need of providing scientific knowledge of birth control method to common people.

The most curious part of this whole debate was the absolute denial of agency of women. Contraception was not to be adopted for controlling one's sexuality but for contributing to the idea of nation as it emerged as a counter-view to colonialism. Thus, from the very beginning, there was no attempt to engage men in adopting any of the contraception techniques and the target group was only women. Moreover, the notion of autonomy was downplayed as it countered the chaste wife/mother notion and was believed to be a western degeneration brought out in Indian women's lives. Adding to that, the debate about fertility and its control did never see 'woman' as an individual. Since 1930s, policy makers, administrators and the supportive national bourgeoisies were well aware of the class differences in the fertility limitation. However, instead of addressing the basic factors like poverty, which gave birth to these differences, the administrators blamed the economically and socially underprivileged group for not only bearing too many children but also for reproducing poverty and thus foiling the modernization attempts. A major reason behind the apathy of the state machinery, and their failure in identifying the root issues laid not only in the ideological setup they operated in, but also in alienation of the bureaucracy from the masses. The administrators operated in a kind of a vacuum, completely alienated from the people it was supposedly serving. Instead, it created a

hierarchical autocracy, which relied not on convincing and winning people over but in coercing them (Katzenstein: 2000).

This bureaucratic autocracy formed a strategic alliance with the supportive national leaders, eugenics and the medical fraternity, to argue that fertility control was crucial for defining national development and solving many of the urgent problems. The focus of this alliance was the reproductive capacities of the women while completely ignoring them as human beings all together. The problems with this approach, as Mohan Rao argues, are twofold:

First, it focuses women primarily as reproducers, ignoring all their myriad productive activities that contribute to national development. Second, it serves to isolate reproduction from the socio-economic context within which it occurs (Rao, 2004:23).

In the process it created a discourse that made the women into active agents of population control and tried to convince them as if this was their moral and national duty. It did not conceptualise the young, about to be married women, as agents of change, but dealt largely with married women and aspired to control their fertility.

IV. POPULATION CONTROL AND WOMEN'S HEALTH IN POST-INDEPENDENCE INDIA

Women's health in the modern world has been believed to be shaped by the interconnections between their sexuality, morality, a perennial threat of getting sexually violated and their vulnerability to ill health and disease. The emergence of modern nation states made the question of interconnections between sexuality and health an important one, by turning the women's bodies into societal health. As women were seen as perpetuator of the race, and a strong nation required a concurrently strong and healthy race, women's health came under scrutiny with efforts made to improve mothers' health since they were the mothers of the nation.

With the identification of rapid increase in population as the cause of poverty and many other social evils by the ruling elites, attempts of controlling women's reproduction got legitimised and secured support of strong nation states. This is evident as Rao argues that "at a time when no nation in the world sponsored a family-planning programme, Laksmibai Rajwade argued the case for the inclusion of 'birth control, provision of goods, instructions, demonstrations and consultations' in maternal and child health services" (Rao, 2004: 19). During this period, development of health policies across the world focused only on the sexual (reproductive) capacities of women ignoring her personhood in all its other aspects, including sexuality. This is the understanding adopted and followed by the postcolonial Indian ruling elites as well.

The project of population control was vigorously pursued by the post-independence Indian state. The agenda was included in the first Five Year Plan and got emphasized more and more in successive Plans. The first decade of the family planning programme had a clinic centered approach. The government saw population control as an important vehicle for development. The operation strategy of the programme in the first two Five Year Plans was largely shaped by the international Planned Parenthood movement (Banerjee, 1976). However, the programme started getting prioritised only with the third Five Year Plan, when the government realised that the population growth had far exceeded its expectations. Now the government replaced the clinical approach by family planning extension education approach, introduced in 1963, and intensive education measures were introduced to motivate the population to adopt family planning methods (Kumar, 2006).

One important aspect of Indian family planning programme had been its voluntary character. However, with the third Plan, the voluntary nature of the programme started getting changed. The Minority Report, a supplement to the recommendations of Mudaliar Committee Report of 1961, showed a sense of urgency bordering on panic in tackling population question and recommended incentives and disincentives in order to bring the birth rate. It also recommended consideration of 'appropriate legislative and administrative measures' in order to achieve the goals of family planning programme (Rao, 2004).

In the coming years, many of the recommendations of the Minority Report entered the official discourse and programme of family planning discourse, albeit in veiled forms. The commission was formed after a sense of panic was felt during the third Five Year Plan period from the 'failure' to control population. Soon after, the programme shed all the facades of voluntarism and took to absolutely coercive measures. During the Emergency (1975-77) era, the Indian state cracked down brutally on its own citizens and unleashed the terror to forced sterilisations. As historical evidence shows, the character of the family planning programme has always remained coercive, and the

myth of its voluntary nature was consciously constructed by the ruling classes. Vicziany (1982) rightly observed, the foundations of the excesses carried out in 1977 were not the result of whims of an individual or the government, but were rooted in a growing disconnect between upper class, ruling elite and the masses.

In 1983, the National Health Policy envisaged long-term demographic goals to be achieved and started talking of the health of the mother and child. In 1992, the Child Survival and Safe Motherhood programme (CSSM) was introduced with the stated goal to address major causes of morbidity and mortality in women and children. The programme got a further boost with the International Conference on Population and Development (ICPD) held in Cairo in 1994. Following the Cairo summit, the Indian government took the initiatives to change its approach by removing demographic family planning targets and adopting a broader reproductive health approach. The Reproductive and Child health (RCH) programme was launched in 1977 and the government professed its support to the stated objectives of the ICPD. Despite changing its attitude in theory, the government stuck to the old line and molded the plan to accommodate family planning and to make population control the goal. In a booklet, to explain the programme to state and district level officials, the Ministry of Health and Family Welfare (MoHFW) wrote: "It is legitimate right of the citizen to be able to experience sound reproductive and child health and, therefore, the RCH programmes will seek to provide relevant services for assuring reproductive and child health to all citizens. However, RCH is even more relevant for obtaining the objective of stable population for the country. The overall objective since the beginning has been that the population of the country should be stabilized at a level consistent with the requirement of the national development. It is now well established that parents keep the family size small if they are assured about the health and longevity of the children and there is no better assurance of good health and longevity of the children than health care for the mother and for young children" (cited in Anand, 2004: 184).

It becomes evident, thus, that the votaries of population control in the Indian ruling classes were only trying to, successfully, appropriate the feminist jargon with no agenda of really 'empowering' them. The forces inimical to women's rights, like the religious Right, neo-Malthusians, neo-liberal forces starting using the vocabulary of the movement for furthering the agenda of population control, by controlling women's fertility. The protagonists of population control refused to accept the role of macro-economic changes and their serious implications for women's health. The focus on reproductive health gave the authorities an excuse to ignore the urgent issues of equity and equality in development. Furthermore, appropriation of the reproductive rights agenda by these forces effectively reversed the gains made by the progressive forces in the Third World countries by emphasising the role of structural determinants in health care and shaping the Alma Ata Declaration. The Alma Ata Declaration of Health For All (1978) questioned the role of medical-pharmaceutical industry and health bureaucracy, and made the linkages between overall and equitable development and health, especially in the Third World. Apart from linking health and development, contribution of Alma Ata Declaration were immense and multifaceted.

Bolstered by the collapse of Soviet Union and the capitalist dominance over global political economy, neoliberal forces appropriated the reproductive rights agenda for reversing this development. Women's access to resources, which were already limited, was further reduced due to new liberal economic policies and rapid privatization of basic services took place. Access to health services themselves being curtailed under the rubric of structural adjustment programmes. This process was actively supported by the religious Rights across the globe. It led to marginalisation of women's overall health and helped in re-converting them into mere reproductive beings. The ICPD conference on one hand established women's reproductive rights and control over their sexual lives, but on the other it failed to address their different health needs in a holistic way (Qadeer 1995). The so-called paradigm shift of the Indian Family Welfare Policy (concerned with meeting targets for population control) to Reproductive and Child Health programme (adopted from the principles of ICPD conference) was part of an overall change in policy outlook – from the family planning framework towards that of reproductive health. Under the RCH regime, specific targets given to the health workers were removed, and STDs, RTIs and HIV/AIDS were seen as part of overall issue of reproductive health. These were seen as women's reproductive rights and the 'cafeteria approach' was introduced for family planning, where couples were allowed to opt for a suitable family planning method of their choice. The RCH programme came at the time when neo-liberalisation was taking place in the form of Structural Adjustment Programmes and governments were preparing to entrust delivery of basic services to the hand of private sector. On the name of providing rights, contraceptive were made available in the market and advertised heavily in the name of 'free choice'. As Rachel Simon-Kumar (2006) points out, the neoliberal agenda of the government is revealed in the efforts of the government in cutting down its expenditure in health-care provisioning and also in promoting market forces in delivery of public health services, in the name of public-private partnership (Kumar, 2006).

The national state adopted the reproductive rights framework in principle, accepting the ICPD conference recommendations that located reproductive health and rights within a broader context of women's self determination and control over their reproductive and sexual lives. In effect, however, what the state did was an appropriation of feminist rhetoric to pursue conservative development goals of policy driven promotion of market-based solutions. The change in the so-called policy shift was nothing much than putting old wine in a new bottle. In the name of giving choice to the women in the form of new reproductive technologies and methods, it actually served the state's interest of population control. In a country like India, where even the most basic needs like food is denied to a sizable section of the population (women being the majority of them), reproductive health cannot be ensured in the absence of livelihood rights. Similarly, in a country where women are confined under the yoke of patriarchy and are not allowed to take even simple decisions regarding their daily lives, expecting them to be the decision makers on the reproductive matters is simply too much.

V. LINKAGES BETWEEN THE STATE AND PATRIARCHAL IDEOLOGIES

The construction of womanhood in national imagination has always been shaped by patriarchal ideologies since colonial times. The notion of women as citizens in the modern liberal democratic state has always been mediated by social construction of their 'cultural' roles, as emblems of national (and primarily upper caste-Hindu) identity and tradition. The state has always perceived aspects of women's lives within contours of a host of issues, including being perpetrators of the nation. Thus, the emphasis on the notion of individuality, the hallmark of the liberal democratic tradition, in the development ideology taken up by the post-independence Indian state has always excluded 'women' as equal partners and have seen them as appendages to broader caste/kinship/religious/ethnic groups. Chaudhuri (1995) underlines the emphasis of the national bourgeoisie in asserting the differences between men and women and cautioning women against becoming 'cheap imitation' of men as the role of women as mother was crucial in the task of nation building. She points out that *Women's Role in Planned Economy*, a document brought out in 1938, stated that a women's responsibility would include not becoming a man since a 'cheap imitation of men render her useless for the great tasks of motherhood and nation building' (Chaudhuri, 1995: 224).

The patriarchal structures, which perpetuate women's inferior status in the society, have been strengthened over decades because of the state's refusal to intervene in the internal matters of cultural networks, in the name of safeguarding Indian culture. The Indian state, Bina Agarwal argues (1988), reproduces patriarchal relations to domesticate women and control their sexuality (Agarwal, 1988). The state's non-committal approach in dealing with violence on women, both within family and community and in religious, ethnic or caste conflicts, affects women's everyday lives and shapes their control over their bodies or the lack of it. The widespread prevalence of domestic violence indicates serious shortcomings of reproductive right approach in India; as it highlights the distribution of power within families and that women cannot exercise 'choice' in any aspect of their lives, including reproduction.

Health conditions of women are also determined by the ubiquity of gender-discrimination in Indian society. In many societies, women's social status is entirely linked to her reproductive role. For many women, especially young married women, having children is the only source of power, whereas, failure to bear children in general and sons in particular means deterioration of women's status and even the threat of getting abandoned. The introduction and easy availability of sex-selection technologies has further weakened the little control women had over their bodies. The use of these technologies have resulted in killings of female fetuses and sex selective abortion and the one hand, and increased pressure of getting pregnant again and again on wives till they bear a male child (Croll, 2000). The neo-liberal market forces have tried their best to foil the attempts to ban sex-selective abortions on the ground that reproductive choices includes the freedom of spouses to choose the sex of the child while completely ignoring the fact that this choice, too, is socially constructed and results in complete devaluation of women's status in society (Eriksson, 2000). In arguing that choosing the sex of the child is logical extension of family planning, the complicity of the neo-liberal market forces in perpetuating patriarchal control over women's sexuality becomes obvious. Furthermore, the contribution of gender discrimination curtails the girl's access to food, health and education and thus derails the whole notion of reproductive rights.

Interestingly, the ascending Hindu Right supported the neo-liberal forces in furthering the market outreach of reproductive technologies, while simultaneously opposing any moves that could help in restoring women's right over their sexuality. This seemingly unusual and conflicting alliance worked together in reversing many of the decisions of earlier governments. For example, despite promising to make anti-retroviral treatment available, the BJP-led National Democratic Alliance government moved away from what it called 'condom-centric' public education campaign to control HIV/AIDS to a more 'holistic' one (Waldman, 2003). The minister for the MoHFW, Sushma Swaraj opposed condom advertisements on television fearing it would lead to 'public sex'. The government

started a campaign based on the message that if the husband and wife remain loyal to each other, there would be no space for HIV/AIDS in India, thus reinforcing the burden, especially on women, to practice monogamy and the stigmatization of the people leaving with HIV/AIDS (Joshi, Poornima 2003).

As the state kept speaking the language of feminist rhetoric of reproductive right framework in principle, it actually used it to further its own conservative agenda of population control. In doing so, the state drew its legitimacy from the ideology of patriarchy, and class-based regressive notions of sexuality, which views the dangerous sexuality and the irresponsible promiscuity of the poor as a hindrance in the nation's march to progress. Thus the state emphatically argues that fertility control is crucial for national development and solving many an urgent problem. It perceives women as vectors of population control and tries to convince them that it is their moral and national duty to keep population in check. The Indian state has ignored the fact that reproductive health cannot be achieved without ensuring general health to women, and ensuring that they are capable of controlling their own body. In a country like India, where more girls die before reaching the reproductive age than during it, where they are discriminated against in their own families, and even during the reproductive age suffer more with malnutrition or infectious diseases rather than pregnancy and child birth complications, the emphasis of the state should be more on ensuring overall economic development and access to health services, though continuing to ensure reproductive health services.

The notions, which dominated the discourse in the colonial times, continued to inform and shape the politics of the post-independence Indian state. Despite professing its belief in the socialist values and for the upliftment of the downtrodden and the poor, the post-independence 'bureaucratic autocracy' formed a strategic alliance with supportive national leaders, eugenics and the medical fraternity, to argue that fertility control was crucial for defining national development and solving many of the urgent problems. In perceiving overpopulation as the root cause of many of the social problems, the state endeavored to control the reproductive capacities of the women while completely ignoring them as human beings. Indian state's population policies have largely been shaped by the influence of the population control establishment, and have vigorously followed policies suggested by them. In doing that, Indian government's family planning program have given little importance to women's autonomy or empowerment. It has, also, failed singularly in removing the structural impediments rooted in the patriarchal ideology, which restrict women from exercising control over their fertility and sexuality. Interestingly, even after adopting the reproductive rights framework in principle, in effect what the state did was to use the language of feminist ideology for pursuing its agenda of population control. The Indian state has ignored the fact that reproductive health cannot be achieved without ensuring general health to the women and ensuring that they are capable of controlling their own body.

VI. CONCLUSION

The Indian state has ignored the fact that reproductive health cannot be achieved without ensuring general health to women and ensuring that they are able to control their own bodies. An overemphasis on just the physiological aspect of a woman's reproductive health hides the fact that reproduction is but only one aspect of her overall personality and sexuality and reduces women into merely reproductive beings. It needs to be understood that reproductive health is closely linked with the social structures within the society and the status given to women therein. Without taking these issues into consideration, reproductive health and choices cannot be ensured. Thus, in addition to ensuring the availability of reproductive health services to women, the emphasis of the state should be on ensuring overall economic development, social equality and access to general health services.

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