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## **Northern feminists and Southern women: Scandinavian aid to the Indian family planning programme**

Abstract:

The Scandinavian countries have played pioneering roles in the international debate on population growth in developing countries, raising the question of ‘the population explosion’ in international organisations such as the UN and the OECD. The Scandinavian countries have also been at the forefront as donors to family planning programmes in the Third World, providing substantial amounts of population aid to African and South Asian countries. In 1958, Sweden became the first country in the world to initiate a bilateral aid agreement on family planning, as they established a Swedish ‘pilot project’ in Sri Lanka. Norway initiated population aid in the early 1960s, and in 1971 the *Storting* decided to earmark as much as ten per cent of the country’s total aid budget for family planning activities.

The Scandinavian initiatives in family planning aid were taken partly as a result of a perception of a need to limit population growth in developing countries, which became especially urgent in the 1950s and –60s, and partly due to the fact that women became a particular target group for Scandinavian aid during the 1960s and –70s. Furthermore, within the aid agencies, there was a strong belief that the Scandinavian countries were particularly suited to providing this type of assistance, due to a lack of moral or religious reservations regarding the use of contraceptives. However the family planning aid should also be understood in relation to domestic Scandinavian population policies of the interwar period, and what seems to have been a firm belief in the possibilities of social engineering.

The Swedish and Norwegian interest in population programmes was initially directed at countries in the South Asian region, and this paper explores Scandinavian aid to the Indian family planning programme. In the 1960s, both Sweden and Norway received requests for population aid from India. Only limited technical assistance was provided at first, however in the 1970s the aid was increased dramatically and concentrated on larger projects. Sweden assisted the ‘India Population Project’ (IPP), and Norway funded the ‘Post Partum Programme’ (PPP). These projects ensured a strengthening of the facilities at more than 1500 hospitals all over India, and are some of the largest population control projects that Sweden and Norway have supported.

## Northern feminists and Southern women: Scandinavian aid to the Indian family planning programme<sup>1</sup>

The Scandinavian countries<sup>2</sup> have played pioneering roles in the international debate on Third World population growth, and they have been the first and most generous donors of population aid.<sup>3</sup> Their involvement took many forms. In 1958 Sweden became the first country in the world to provide bilateral population assistance to a developing country, after Swedish family planning<sup>4</sup> activists had co-operated with the Ceylonese family planning organisation from the late 1940s. Described as ‘something completely new and quite sensational,’<sup>5</sup> the project was understood as groundbreaking as other donors deemed family planning aid too controversial and unsuitable. In 1962, *Science* noted that Sweden was the only donor that ‘dares touch the subject’ of birth control. The Kennedy administration, in comparison, had ‘no inclination to incur the enormous political hazards involved in promoting birth control,’ and Sweden appeared likely to become ‘the most significant force for attempting to reverse the population explosion in the underdeveloped nations.’<sup>6</sup>

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<sup>1</sup> This paper is based on research done for my doctoral project. For the full thesis, see Engh, S., ‘Population Control in the 20<sup>th</sup> Century: Scandinavian Aid to the Indian Family Planning Programme’ (University of Oxford D.Phil. thesis, 2005).

<sup>2</sup> The Scandinavian countries are normally considered as Sweden, Denmark and Norway, however this paper uses the terms ‘Scandinavian’ and ‘Scandinavian countries’ to refer to Sweden and Norway only, as it focuses on these two countries. The omission of Denmark is due to a lack of relevance for the topic that is analysed, development aid to population control, particularly within an Indian context. Denmark did not provide population aid to India in the time period the paper examines.

<sup>3</sup> In this paper, the terms ‘population’ and ‘family planning’ assistance, aid or support are used to describe the same phenomenon; assistance extended from one country to another within the field of population, most often going to population control programmes in the recipient country. I use the term ‘population control’ to refer to attempts at influencing aggregate population characteristics, which may include both pronatalist and antinatalist policies.

<sup>4</sup> ‘Family planning’ is defined in the Oxford English Dictionary as ‘the use of various methods of birth control to limit the size of a family.’ Online edition at <http://dictionary.oed.com/>. It should be noted that the terms ‘family planning,’ and also the less specific ‘family welfare,’ have taken on political meaning, as they have been used, particularly within an Indian context, to downplay the population control aspects of the programmes. The Indian family planning programme was changed to ‘family welfare programme’ after the national Emergency in the mid-1970s, in order to avoid association with earlier coercive policies.

<sup>5</sup> Article by S. Heppling 30 April 1956, as quoted in S.Å. Nilsson, *Svenskt bistånd till den tredje världen – dess uppkomst under 1950-talet. En studie av SIDA:s och NIB:s föregångare: Centralkommittén för svenskt tekniskt bistånd till mindre utvecklade områden* (Hammerdal, 2004), p. 25.

<sup>6</sup> D.S. Greenberg, ‘Birth Control: Swedish Government Has Ambitious Program to Offer Help to Underdeveloped Nations’ in *Science* vol. 137, no. 3535 (28 September 1962), p. 1039.

Despite considerable international opposition, Sweden worked to place the population question on the agenda of a number of international organizations, particularly the UN, and did so with the support of Norway. From 1952 onwards, continued Scandinavian lobbying in the UN, with the increasing support of the USA, ensured the 1966 acceptance of the issue by the General Assembly, and the 1969 establishment of the UN fund for Population Activities (UNFPA). In addition, as a result of American, Swedish and Norwegian lobbying and outright pressure, family planning work was included and given a prominent place in the work of the Organization for Economic Cooperation and Development (OECD) from the mid-1960s. Another example is found in Norwegian development policy, as Norway supported population control in developing countries during the 1950s and 1960s, and population officially became a prioritised area of aid in 1971 when parliament designated ten per cent of the entire aid budget for family planning purposes. This was a remarkable allocation, making Norway the only donor country with a set target for population assistance, which the country consistently achieved, and often exceeded.

These are just a few examples of the pioneering role of the Scandinavian countries. Sweden and Norway were particularly active in the 1950s and 1960s, when Third World population growth gradually became a concern for development aid. Family planning was promoted with ‘missionary zeal,’<sup>7</sup> and the countries argued the salience of the population issue in international forums, creating a favourable opinion of the matter. An increasing number of Western donor countries reluctantly included population assistance in their aid programmes, and together with the USA Sweden and Norway became the most generous donors to Third World family planning.

This paper explores the particular Scandinavian commitment to the population issue, and it seeks to understand how these countries came to play a significant role in this field. A central question is why Sweden and Norway, with their small domestic populations and low birth rates, took a great interest in the population growth of the developing countries. Also why have these countries assumed the role of international

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<sup>7</sup> B. Ljunggren, ‘Swedish Goals and Priorities’ in P. Frühling (ed.), *Swedish Development Aid in Perspective. Policies, Problems and Results Since 1952* (Stockholm, 1986), p. 68.

advocates of Third World population control? There is no obvious reason why these countries should have seen it as their particular responsibility to create international interest for this policy area, particularly as family planning matters were unresolved and controversial within a domestic setting. This resulted in incoherent policies, for example when Sweden and Norway sponsored self-determined abortion in developing countries fifteen years before women were granted similar rights at home.

The Swedish and Norwegian interest in population programmes was initially directed at countries in the South Asian region, and this paper explores Scandinavian aid to the Indian family planning programme. Being a so-called 'priority country,' India received large amounts of development aid, and in the 1960s, both Sweden and Norway received requests for population aid from India. Only limited technical assistance was provided at first, however in the 1970s the aid was increased dramatically and concentrated on larger projects. Sweden assisted the 'India Population Project' (IPP), and Norway funded the 'Post Partum Programme' (PPP). These projects ensured a strengthening of the facilities at more than 1500 hospitals all over India, and are some of the largest population control projects that Sweden and Norway have supported.

### ***Development aid and population growth***

Third World population growth emerged as an issue in development aid from the 1950s, much due to Scandinavian interest and international promotion; however the initiatives would not have produced results without American interest in the matter, which began several decades earlier. The population work of American scientists, politicians and private philanthropic foundations has been the subject of several recent studies, many of which argue that a predominantly American 'network of knowledge,' or 'epistemic community,' reworked demographic knowledge into a politically acceptable message, at the same time propagating this internationally.<sup>8</sup>

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<sup>8</sup> See for example: J. Caldwell and P. Caldwell, *Limiting Population Growth and the Ford Foundation Contribution* (London, 1986), M. Connelly, 'Population Control is History: New Perspectives on the International Campaign to Limit Population Growth' in *Comparative Studies in Society and History* (2003), vol. 45, pp. 122-47, P.J. Donaldson, 'On the Origins of the United States Government's International Population Policy' in *Population Studies*, vol. 44, no. 3 (1990), pp. 358-99, S. Greenhalgh, 'The Social Construction of Population Science: An Intellectual, Institutional, and

Wealthy philanthropists were influential in the early population work, and the Rockefeller family played a particularly important part, through the Population Council and the Rockefeller Foundation. The Ford Foundation was also influential.<sup>9</sup> This work often focused on Asia, and India was a case in particular, the topic of works such as Kingsley Davis' *The Population of India and Pakistan* (1951). Population growth in Asia was understood as 'exploding,' both impeding development efforts, and creating 'a breeding ground for communism.'<sup>10</sup> The new discipline of demography embraced the family planning agenda, and through the benefits of close co-operation with policymakers, the field experienced a 'rapid institutionalization, professionalization, and socialization of a new generation.'<sup>11</sup>

As Matthew Connelly has pointed out, historical works on the topic tend to focus on US participants, implying that 'Americans monopolized agency and influence flowed only one way,'<sup>12</sup> leaving out an important international dimension. Firstly, support for population control measures was not unusual within ruling elites in the recipient countries and so it is not right to talk of a one-way influence.<sup>13</sup> Secondly, as this paper aims to show, influence did not only come from the US. Although admittedly decisive in producing research, disseminating information and knowledge, and taking crucial first initiatives, the very first bilateral population projects and the very first promotion of population aid through international

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Political History of Twentieth-Century Demography' in *Comparative Studies in Society and History* vol. 38, no. 1 (1996), pp. 26-66, D. Hodgson and S.C. Watkins, 'Feminists and Neo-Malthusians: Past and Present Alliances' in *Population and Development Review* vol. 23, no. 3 (1997), pp. 469-523, J. Sharpless, 'Population Science, Private Foundations, and Development Aid: The Transformation of Demographic Knowledge in the United States, 1945-1965' in F. Cooper and R. Packard (eds.), *International Development and the Social Sciences* (Berkeley, 1997), pp. 176-200.

<sup>9</sup> The role of American philanthropies such as the Rockefeller Foundation in promoting international health co-operation, relief work, social medicine, and the funding and establishment of social sciences has also been shown in M. Bulmer, 'Mobilising social knowledge for social welfare: intermediary institutions in the political systems of the United States and Great Britain between the First and Second World Wars', pp. 305-25, M.D. Dubin, 'The League of Nations Health Organisation', pp. 56-80, J. Farley, 'The International Health Division of the Rockefeller Foundation: the Russell Years, 1920-34', pp. 203-21, C. Miller, 'The Social Section and Advisory Committee on Social Questions of the League of Nations', pp. 154-75, P. Weindling, 'Social medicine at the League of Nations Health Organisation and the International Labour Office compared', pp. 134-53, and P. Weindling, 'Introduction: constructing international health between the wars', pp. 1-16, all in P. Weindling (ed.), *International Health Organisations and Movements, 1918-1939* (Cambridge, 1995).

<sup>10</sup> Hodgson and Watkins, 'Feminists and Neo-Malthusians', p. 479.

<sup>11</sup> Greenhalgh, 'The Social Construction of Population Science', p. 42.

<sup>12</sup> Connelly, 'Population Control is History', p. 128.

<sup>13</sup> This has been shown by for example Caldwell and Caldwell, *Limiting Population Growth*, pp. 37-41, and R. Symonds and M. Carder, *The United Nations and the Population Question* (London, 1973).

organisations were not taken by American, but by Scandinavian aid authorities. Furthermore it may be argued that an important part of the American participants' work was the dissemination of their ideas to a wider, international audience, and this aspect is lost unless the present bias is rectified and the topic explored more fully. The matter is also one of timing, as despite the early interest of American organisations, scientists and policymakers, the Swedish and Norwegian governments openly supported population control more than a decade before the US authorities. In addition, Swedish population experts were part of an attempt to convince the Senate of the need to include family planning in the American aid programme. It has been argued that by 1960, 'the American public was ready to support an overt neo-Malthusian movement,'<sup>14</sup> and this makes it important to ask the question why the Scandinavian public was ready ten years earlier. The framework within which Third World population control gained urgency, counting factors such as the Cold War and fears of communist expansion, the concern over food shortage and fears of famine, is not likely to have been felt more strongly in Scandinavia than in the rest of the world, and so explanations for the commitment to the matter must also be sought outside the standard framework.

### *Scandinavia and population control*

In order to explain the comparatively early Scandinavian attention to family planning and population, it is necessary to look at the countries' prior experiences with related fields such as family and population policy, welfare policies as well as policies relating to social and racial minorities such as single mothers, and the so-called *tater* group: gypsies, Romani, and other travellers. The existence of a tradition for the governments to influence the populations' reproductive rights, beginning in the 1930s, may help explain a disposition to becoming involved in other countries' domestic population policies, or at least support other governments' right to a similar influence upon their demographic development. Furthermore, some of the central decision-makers both in the first Swedish and Norwegian population aid initiatives had also been active in the formulation of domestic population policies of the earlier periods.

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<sup>14</sup> Hodgson and Watkins, 'Feminists and Neo-Malthusians', p. 483.

The Scandinavian experiences with population matters fits in with broader Western European and American developments in the early 20<sup>th</sup> century, within which population debate and policies gained importance. Falling birth rates were a cause of concern, and in many countries pronatalist measures were introduced, with the aim of influencing people to have more children. Although this interest would most often concern the numerical strength of a population, another important aspect was its quality, and this would often entail eugenic policies or legislation. Norwegian debate and legislation largely reflects the Swedish, and Swedish influence can also be traced.

In the early 20<sup>th</sup> century, information about birth control was abolished in Sweden on the basis of ‘moral and religious grounds’<sup>15</sup>, however allowed from 1938 onwards.<sup>16</sup> The declining Swedish birth rates were a cause of concern, and according to Kävlemark the political parties ‘defined the problem as concerning no less than the continued existence of the Swedish people.’<sup>17</sup> In Norway, the situation was similar, and advertisements for or informing about contraceptives could be punished through fines and imprisonment.<sup>18</sup> Opposition to birth control was found mainly within the organisation *Kristiania Sedelighetsforening*,<sup>19</sup> the Church and among medical professionals.<sup>20</sup> From the mid-1920s, the Labour Party’s women’s movement provided advice on contraceptives and health care for mothers, with the support of the Association for Socialist Physicians and their leader Karl Evang.

In both countries population debate took a radical turn after the 1934 publication of Gunnar and Alva Myrdal’s book *Kris i befolkningsfrågan*,<sup>21</sup> which argued the need to introduce pronatalist policies and also to ensure quality in the

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<sup>15</sup> A.S. Kävlemark, *More Children of Better Quality? Aspects on Swedish Population Policy in the 1930's* (Uppsala, 1980), p. 27.

<sup>16</sup> A.S. Ohlander, ‘The Invisible Child? The Struggle over Social Democratic Family Policy’ in K. Misgeld, K. Molin and K. Åmark (eds.), *Creating Social Democracy: a Century of the Social Democratic Labor Party in Sweden* (University Park, 1992), p. 217.

<sup>17</sup> Kävlemark, *More Children of Better Quality?*, p. 55.

<sup>18</sup> *Ibid.*, p. 173.

<sup>19</sup> Kristiania association for moral conduct. I. Blom, *Barnebegrensning – synd eller sunn fornuft?* (Oslo, 1980), p. 182.

<sup>20</sup> *Ibid.*, p. 214.

<sup>21</sup> *Crisis in the Population Question.*

population: ‘When the population fails to regenerate itself, the problem of how the human material may be preserved and improved becomes urgent.’<sup>22</sup> Based on the Myrdals’ proposals, Swedish authorities in the mid- to late-1930s introduced various pronatalist policies to encourage larger families and more births. The measures included housing loans to encourage earlier marriages, maternal aid and allowances for new mothers, and the building of apartments for large families.<sup>23</sup> The 1936 publication in Norway of the Myrdals’ book further sparked debate on population policies, and Evang, a close friend of the Myrdals, was a central participant in the debate. Their ideas fit with his views on public health, and the state’s responsibility for the health of individuals.<sup>24</sup>

Parallel with the introduction of pronatalist policies was the establishment of certain antinatalist policies, and legislation concerning sterilisation.<sup>25</sup> Maciej Zaremba describes how the interest in eugenic measures grew in Sweden in the early 20<sup>th</sup> century, and how influential women’s activists supported these. In the early 1920s, Elise Ottesen-Jensen ‘popularised racial hygiene,’ arguing that ‘racial elements of minor worth’ ought to be sterilised or isolated, as society should not be burdened with the care of these.<sup>26</sup> As a result of the increasing focus on population and eugenics Sweden in the mid-1930s introduced sterilisation laws that opened up for sterilisation without the patients’ consent, and these remained in place until the mid-1970s. According to Maija Runcis, the main motive behind the laws was to stop so-called

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<sup>22</sup> From A. Myrdal, *Nation and Family. The Swedish Experiment in Democratic Family and Population Policy* (London, 1941), as quoted in Kävlemark, *More Children of Better Quality?*, p. 16.

<sup>23</sup> Ohlander, ‘The Invisible Child?’, p. 224. Maternity benefits had already been propagated in 1911-12 by Ellen Sofia Key, a propagator of eugenic ideals. See M. Hawkins, *Social Darwinism in European and American Thought 1860-1945* (Cambridge 1997), pp. 265-71.

<sup>24</sup> S.F. Berg, *Den unge Karl Evang og utvidelsen av helsebegrepet* (Oslo, 2002), p. 65.

<sup>25</sup> The Swedish sterilisation laws and policies have been the focus of several recent historical studies, and was the topic of a much-publicised debate in Swedish and international media. A series of articles on the sterilisations in *Dagens Nyheter* in autumn 1997 by the journalist M. Zaremba placed the issue on the agenda. Central works are M. Runcis’ doctoral thesis *Steriliseringar i folkhemmet* (Stockholm, 1998), M. Tydén’s doctoral thesis *Från politik till praktik. De svenska steriliseringslagarna 1935 – 1975* (Stockholm, 2002), and M. Zaremba’s *De rena och de andra. Om tvångsteriliseringar, rashygien och arvsynd* (Stockholm, 1999). In 1999, Sweden offered compensation to people who had been sterilised against their consent.

<sup>26</sup> Zaremba, *De rena och de andra*, p. 34, footnote 13, based on M. Karlsson and L. Lennerhed, ‘Ottars vurm för rashygien har trängts bort’, *Svenska Dagbladet* 30 August 1998. Zaremba emphasises that Ottesen-Jensen in 1936 condemned the German sterilisation practice, however that she still supported the principles of racial hygiene, saying that ‘sterilisation could prevent much human misery, if carried out by responsible doctors in the service of science and humanity.’ Based on I. Svanberg and M. Tydén, *Sverige och Förintelsen* (Stockholm 1997).

‘feeble-minded,’ mentally ill and ‘anti-social’ individuals from having children. In the period 1935 – 1975, it is estimated that some 63 000 sterilisations were performed in Sweden, 95 per cent of which were performed on women.<sup>27</sup> The sterilisation laws had a class- and gender bias which in practice meant that single mothers, and mothers from ethnic minorities, were more likely to be sterilised than married women of Swedish ethnicity. According to Mattias Tydén, about fifty per cent of the sterilisations can be regarded as voluntary, with the remainder made under different degrees of duress,<sup>28</sup> and Runcis has argued that ‘completely voluntary sterilization scarcely occurred at all during the first two decades.’<sup>29</sup>

As in Sweden, a halt in the Norwegian population growth rates was connected to an anxiety for the number of mentally disabled and other groups with low social capabilities.<sup>30</sup> Norway introduced a sterilisation law in 1934, which remained in place until 1977, allowing sterilisation both with and without the patients’ consent, on what was called ‘social and eugenic basis.’<sup>31</sup> Per Haave argues that the Norwegian law was more restrictive than the Swedish, as it allowed forced sterilisation only if the patient was particularly lacking in mental capabilities, and did not include a clause on ‘anti-social behaviour’ as a cause for sterilisation.<sup>32</sup> Haave has found that the groups considered *tatere* were subjected to a heavy-handed policy of assimilation, and that some 130 were sterilised.<sup>33</sup> In total, more than 44 000 sterilisations were carried out,

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<sup>27</sup> Runcis, *Steriliseringar i folkhemmet*, p. 355.

<sup>28</sup> Tydén, *Från politik till praktik*, p. 586.

<sup>29</sup> Runcis, *Steriliseringar i folkhemmet*, p. 364.

<sup>30</sup> N. Roll-Hansen, ‘Norwegian Eugenics: Sterilization as Social Reform’ in N. Broberg and N. Roll-Hansen (eds.), *Eugenics and the Welfare State* (East Lansing 1996), p. 154.

<sup>31</sup> The Norwegian sterilisation policy received increased attention from Norwegian media and researchers from the 1990s onwards. The sterilisation of ‘tater’ was raised by *Verdens Gang* in 1991, which accused Norwegian authorities of having followed a policy of ethnic cleansing, which led several politicians to demand an investigation of the policies. The debate gained momentum after Zaremba’s articles in *Dagens Nyheter* in 1997, leading to a series of articles in the Norwegian *Dagbladet* in 1998. The organisations of Sami and Romani peoples in Norway reacted sharply, and demands for investigations were again voiced from politicians and medical associations. In 1998, the Norwegian government extended an official apology to the tater group, and a government committee in 2004 delivered a proposal for compensation to people who have been sterilised without their consent. A study on the Norwegian sterilisation policy and its relation to eugenics was carried out by P. Haave and Ø. Giæver, which resulted in the report *Sterilisering på medisinske indikasjoner og sammenhengen mellom eugenikk og humangenetik* (Oslo, 2000). Other central works relating to these themes are O. Bastrup and A. Sivertsen, *En landevei mot undergangen* (Oslo, 1996), B.K. Larsen, *En gang var vi som vinden* (Oslo, 1991), Roll-Hansen, ‘Norwegian Eugenics’ and P. Haave, *Sterilisering av tater 1934-1977. En historisk undersøkelse av lov og praksis* (Oslo 2000).

<sup>32</sup> Haave, *Sterilisering av tater*, p. 84.

<sup>33</sup> *Ibid.*, p. 10.

and like in Sweden, about half of these were carried out under different degrees of pressure.<sup>34</sup>

Karl Evang, responsible for the establishment and organisation of the Norwegian public health services through his position as Director of Health in the period 1938 – 72, saw sterilisation as a useful tool with which to reduce the number of ‘feble-minded’ in the population, and the policy was given a central place.<sup>35</sup> An additional factor was a firm belief in scientifically based social planning, which reached a peak in the period 1930-60, and eugenics and sterilisation fit in with the comprehensive social reform programme. It has been argued that the ‘scientizing of politics’ was a core principle in Evang’s ideology, which aimed towards the welfare state.<sup>36</sup>

Tydén has pointed out that a ‘determinant factor’ behind the Swedish sterilisation laws was the presence and influence of medical and eugenic professionals in the Swedish political system. Similarly, in the case of Norway Roll-Hansen has found that the role of experts was crucial: scientists were ‘prominent participants both in the public debate that set the political agenda and in the further decision making process,’ and highly influential in the formulation and later practice of the sterilisation law.<sup>37</sup>

### ***Population control and Scandinavian aid***

Another, and possibly more important link between the interwar population policy and post-war population aid is even more direct: many of the influential participants in the Scandinavian population control debates reappear in the early population aid, and the first Swedish and Norwegian support of Third World population control was carried out by well-known feminists and activists such as Alva Myrdal, Elise Ottesen-Jensen, Hanna Rydh, and Karl Evang. The Swedish – Ceylonese project was the result of the private connections, initiatives and interest of

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<sup>34</sup> F. Sejersted, *Sosialdemokratiets tidsalder. Norge og Sverige i det 20. århundre* (Oslo, 2005), p. 131.

<sup>35</sup> Haave, *Sterilisering av tatere*, p. 335.

<sup>36</sup> Roll-Hansen, ‘Norwegian Eugenics’, p. 188.

<sup>37</sup> *Ibid.*, pp. 183-4.

Ottesen-Jensen, Rydh and Myrdal. In 1949, Ottesen-Jensen lectured on family planning in Sri Lanka, and she and Rydh had established contact with the country's family planning association.<sup>38</sup> The two women forwarded a formal proposal for the establishment of a family planning project in Sri Lanka to the aid administration in 1954. Alva Myrdal became involved in the preparations when she was appointed ambassador to India in 1955, particularly as the project was discussed by Ottesen-Jensen, Rydh and Ceylonese representatives at a conference in Delhi the same year.<sup>39</sup> Myrdal also participated in project planning during trips to Sri Lanka in 1956. The project was established in 1958,<sup>40</sup> and the Swedish-Ceylonese co-operation continued until 1983.<sup>41</sup>

In studies of Norwegian aid, population aid has not been given much attention, despite it having received comparatively large proportions of the aid budget, and Norway's promotion of the matter internationally. Although the country did not extend 'pure' population control aid until the 1960s, the first Norwegian aid project, the Indo-Norwegian Fisheries Project (INP) became involved in the Indian population control effort. The INP developed the fishing industry and trade of the states of Kerala, Karnataka and Tamil Nadu, however the project also ran its own hospital near Quilon in Kerala, under the close supervision of Karl Evang. From 1955, the hospital offered consultation and advice on contraceptive methods for women, and employed an Indian birth attendant, or *dai*, as well as two family planning workers. From the mid-1960s, the hospital carried out vasectomies, and offered IUD (intrauterine device) insertions. The number of sterilisations carried out was relatively low, at 398 cases in 1965.<sup>42</sup> Norway ended its support to the health component of the INP in 1966, while the development of the fisheries continued until 1972.<sup>43</sup> The population control

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<sup>38</sup> *Ibid.*, p. 23.

<sup>39</sup> C. Wahren, 'The Crucial Family' in P. Frühling (ed.), *Swedish Development Aid in Perspective. Policies, Problems and Results Since 1952* (Stockholm, 1986), p. 188.

<sup>40</sup> Nilsson, *Svenskt bistånd*, p. 27.

<sup>41</sup> Wahren, 'The Crucial Family', pp. 188-9.

<sup>42</sup> NMFA: 37.4/24: 10: Memo 25 February 1967, Evang, for NU board meeting 28 February 1967.

<sup>43</sup> According to a Foreign Ministry memo, India and Norway agreed that the hospital and health centre should be taken over by India in 1966, and that the establishment of a similar health centre in other areas of the INP would be 'too complicated.' NMFA: 37.4/24: 10: NMFA memo to the cabinet members 27 January 1966.

work was not a result of a Norwegian initiative, however as the hospital was part of the Indian health system, it was included in the country's population control efforts.<sup>44</sup>

Another factor favouring Scandinavian support of population control was that both countries' aid administrations strongly backed the issue, and this had a decisive impact on the acceptance of population aid by the political authorities, particularly in Norway where the political parties differed on the matter. In the archival material from the aid administrations, it is common to find references to the idea that Sweden and Norway were particularly suited to providing this type of aid, and that the countries had an important role to play in the promotion of such assistance. The Swedish-Ceylonese project made Sweden the first country in the world to provide bilateral family planning assistance. Within Swedish aid circles, the project was seen as 'a pioneering effort, which (...) may have extraordinary meaningful consequences not only for Ceylon but also in other countries.'<sup>45</sup> The Swedish aid bureaucrats' idea of the project as groundbreaking illustrates their view of their own effort in the population field, and the importance that they accorded it.<sup>46</sup> Ernst Michanek, head of the Swedish aid administration NIB 1963-79, has described the Swedish work as 'playing a very significant role to give family planning a place in international co-operation.'<sup>47</sup> Indeed the Swedish promotion of population control has been characterised as carried out with fervour, with Sida wasting no opportunity to advocate it.<sup>48</sup> Anders Forsse, head of Sida 1979-85, has argued that Sweden was

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<sup>44</sup> The INP's birth control work became contested in 1967, when Bishop Fridtjof Birkeli, a member of the aid administration NU's board, questioned the INP's contribution to Indian population control, and demanded Evang provide an explanation. Birkeli also criticised the work publicly in *Morgenbladet*, saying it was 'deplorable,' that NU had never approved it, and that Norwegian taxpayers had the right to know what had happened. 'Har européerne innsikt nok til å kunne råde u-land i vesentlige livsspørsmål?' in *Morgenbladet* 20 January 1967. Evang was forced to account for the population work, and he argued that this had been carried out within the NU guidelines, and that the INP would have done better to do even more family planning work. NU's Secretary General Andresen supported Evang, who ended his explanation by demanding a public apology from Birkeli. NMFA: 37.4/24: 10: Memo 25 February 1967, Evang, for NU board meeting 28 February 1967.

<sup>45</sup> Article by S.Heppling 30 April 1956, as quoted in Nilsson, *Svenskt bistånd*, p. 25.

<sup>46</sup> This view is further perpetuated in writings by former Sida officers, see for example S.O. Döös, 'Tillbaka till rötterna' in P. Gumbel, B. Kärre and A. Wieslander (eds.), *...och världen växte* (Uppsala, 1999) pp. 44-55, S. Heppling, 'The Very First Years – Memories of an Insider' in P. Frühling (ed.), *Swedish Development Aid in Perspective. Policies, Problems and Results Since 1952* (Stockholm, 1986), pp. 13-26, E. Michanek, 'Solidaritet – från Sverige till världen' in P. Gumbel, B. Kärre and A. Wieslander (eds.), *...och världen växte* (Uppsala, 1999), pp. 224-38, and Wahren, 'The Crucial Family.'

<sup>47</sup> Michanek, 'Solidaritet – från Sverige till världen', p. 232.

<sup>48</sup> Ljunggren, 'Swedish Goals and Priorities', p. 68.

identified with family planning to the extent that the recipient countries had the impression that in order to receive Swedish aid at all, a country would also have to accept some population aid.<sup>49</sup>

In Sweden, political support of family planning ran all the way to the top, and the Minister with responsibility for development assistance, Ulla Lindström, personally supported the issue. Lindström initiated family planning co-operation with Pakistan, and she also promoted family planning matters in international organisations, particularly the UN. Sweden first argued the need for population control in an ECOSOC meeting in 1952, after which Belgian and WHO representatives dissuaded Sweden from mentioning the topic again, as they otherwise would make a counter-proposal.<sup>50</sup> The matter was raised again in 1955, when Lindström talked of the population explosion, and ended up in heated debate with other representatives. In 1959, Lindström introduced the matter in the General Assembly, with an appeal for donors to provide population aid.<sup>51</sup> In her memoirs, she argued she had ‘tickled the Catholics’ with mentioning the high birth rates in Catholic regions, questioning why none of the UN’s 1852 development experts worked with population questions.<sup>52</sup>

In 1960, Lindström raised the issue again, arguing that the UN should extend population assistance, and was afterwards told by Dag Hammarskjöld that ‘the UN blushed’ at the contents of her speech. Her own comment was that: ‘...the Catholic states may have turned red with anger. The rest was all prudishness.’<sup>53</sup> In 1961, Sweden and Denmark, with the support of Norway, put forward a resolution for the UN to extend technical assistance for ‘research, experimentation and action for

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<sup>49</sup> Interview A. Forsse 26 November 2003. Indeed this belief may have been well founded, as recent research has found that the existence of an official population control policy greatly increased developing countries’ likelihood of receiving aid, and that countries who pursued population control received greater amounts than those who did not. D. Barrett and A.O. Tsui, ‘Policy as Symbolic Statement: International Response to National Population Policies’ in *Social Forces* vol. 78, no. 1 (1999), pp. 213-33.

<sup>50</sup> S. Heppling, *Sverige och u-länderna i FN – en återblick* (Stockholm, 1991), p. 133.

<sup>51</sup> *Ibid.*

<sup>52</sup> U. Lindström, *I regeringen. Ur min politiska dagbok 1954-1959* (Stockholm, 1969), p. 334.

<sup>53</sup> U. Lindström, *Och regeringen sat kvar! Ur min politiska dagbok 1960-1967* (Stockholm, 1970), p. 50.

dealing with the problems of population.’<sup>54</sup> The resolution was accepted in the ECOSOC, however met with strong opposition, and the General Assembly later deleted the clause on technical assistance. The most vocal opposition in the ECOSOC debate came from France, Italy, Ireland, and Argentina, with the Vatican’s representative actively co-ordinating the resistance. Lindström was disappointed in the American representatives, who, ‘out of fear,’ some times supported the Catholic side, and she commented that ‘The Kennedy regime’s standpoint in population control has vacillated between evasive and foolish.’<sup>55</sup> As a result of the continued Scandinavian initiatives, and the increasing demand for population control aid both from other donors and developing countries, the UN eventually in 1966 adopted a resolution recognising the seriousness of population problems. Lindström’s interest in the population matter was vital to Swedish family planning work, and her personal involvement was a key reason why this area became an important field for Sweden.<sup>56</sup>

In Norway there was no similar early and strong visible political support of family planning. The political parties were mixed, with support found within the Labour and Socialist Left parties, and opposition mainly from the Christian Democratic Party. The coalition government of the Conservative, the Liberal and the Christian Democratic Party did not reach an agreement in the matter. Thus in the case of Norway, the aid administration NU’s interest in population control aid played a crucial part. The aid administration dominated the political debate simply by being ahead of the politicians, and through being ‘experts’ on the matter. In September 1965, ahead of a major parliamentary debate on aid and population, NU appointed a committee, *Norsk Utviklingshjelps familieplanleggingsutvalg*, under the leadership of Evang, to examine whether Norway should provide family planning assistance. The committee unanimously recommended population aid, and NU’s board gave their approval in June 1966. In 1966, NU supported the International Planned Parenthood Federation (IPPF) with a grant, and the following year, the Kenyan family planning project received support.

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<sup>54</sup> S.P. Johnson, *World Population and the United Nations. Challenge and Response* (Cambridge, 1987), p. 19.

<sup>55</sup> Lindström, *Och regeringen sat kvar!*, p. 125.

<sup>56</sup> Interview A. Forsse 26 November 2003.

Karl Evang was not only involved in the population control work carried out through the INP, and head the NU committee on population control, but he also took a similar position as Lindström as a central international propagator of birth control. In 1952, the same year as the INP was established, he proposed the WHO establish a committee on population, which ‘sparked an intense debate’ and the suggestion had to be withdrawn because of the strong opposition.<sup>57</sup> WHO representatives who opposed population control later used the rejection of Evang’s proposal as a precedent, arguing that the matter had been settled.<sup>58</sup> Evang raised the issue again in 1961, when he together with a Sri Lankan representative, proposed that the WHO should promote maternal and child health. The resolution was not adopted.<sup>59</sup>

The comparatively early and strong Scandinavian support of Third World population control can thus be seen as related to the interwar population control policies in terms of similarity of policy, with the state assuming responsibility for the populations’ reproductive choices, and it is also related in terms of actors and decision-makers in both policy areas, such as Myrdal, Ottesen-Jensen, and Evang. Because of these connections, one might argue that the early support for Third World population control may be understood as a continuation of a tradition for involvement in the most intimate spheres of people’s lives. The Scandinavian population policies reveal a willingness of the authorities to actively pursue policies that assumed that ‘the state had the right to decide who could become a parent and remain one. The formation of families, childbirth and sexuality became issues for which the state assumed responsibility.’<sup>60</sup> The experiences with domestic population control policies in the 1930s may have been a reason why the Scandinavian governments just two decades later became concerned with population growth in developing countries, before other donors wanted to involve in this issue. This explanation is further supported by the fact that in a comparative perspective, the Scandinavian sterilisation laws stand out as being both comprehensive and coercive, and other donors who later took up population control aid had not had any similar domestic population control experiences.

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<sup>57</sup> Johnson, *World Population and the United Nations*, p. 10.

<sup>58</sup> Symonds and Carder, *The United Nations and the Population Question*, pp. 64-6.

<sup>59</sup> *Ibid.*, p. 116.

<sup>60</sup> Runcis, *Steriliseringar i folkhemmet*, p. 360.

### ***The population network***

Despite being intrinsically linked to domestic experiences with population control policies, and what seems a widespread belief in social engineering or political planning, the early Scandinavian initiatives in the population control matter would not have been possible without connections to a wider ‘population network.’ Scholars have pointed to the existence of an international network of knowledge, or epistemic community, related to development aid and population, consisting of scientists, philanthropists, politicians and development planners of various kinds. Szreter has argued that during the 1950s, the birth control issue was not politically acceptable in the United States, and USAID did not support Third World family planning programmes until 1967. As a consequence, American demographic communities concentrated on internationalising and professionalizing their discipline, making demographic knowledge applicable to Third World development, and reaching out to development planners in other countries.<sup>61</sup> Swedish and Norwegian development practitioners had close connections with this predominantly American network, and particularly the philanthropic organisations such as the Ford and Rockefeller foundations, and the Population Council,<sup>62</sup> and the interaction with international organisations and experts led to enthusiasm and interest in development matters:

Sweden seemed to swarm with enthusiastic politicians, representatives of professional organisations and debaters, who all had travelled and seen and discussed and thought and promised, and who showed no inhibitions regarding saying what was good for the peoples of the developing countries.<sup>63</sup>

It has been argued that Swedish aid was greatly influenced by the ‘close and extensive’ co-operation with international aid agencies in the early 1960s, and that ‘rapidly increasing budget appropriations easily outran administrative capacity and skills’ and as a result, ‘quite a few’ Swedish aid administrators were more or less

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<sup>61</sup> S. Szreter, ‘The Idea of Demographic Transition and the Study of Fertility Change: A Critical Intellectual History’ in *Population and Development Review* vol.19, no. 4 (1993), pp. 680-1.

<sup>62</sup> Nilsson, *Svenskt bistånd*, p. 16.

<sup>63</sup> A. Forsse, ‘Ämbetsmann i biståndet’ in P. Gumbel, B. Kärre and A. Wieslander (eds.), *...och världen växte* (Uppsala, 1999), p. 53.

trained by international aid agencies.<sup>64</sup> The influence of the ideas of the dominant community of American and British scholars and experts was great, and ‘of all the poverty traps and vicious circles referred to, the most important one was the Malthusian dilemma.’<sup>65</sup> Norwegian reliance on the population network was equally great, with aid administrators describing the international population network as:

...an international, travelling circus...this was a completely new issue, which seemed frightening and difficult and mysterious...there was a large number of people who went to a large number of meetings to discuss what this was all about (...) there was a lot of international co-operation, and we all needed each other because we felt so uncertain about what this [the population issue] was.<sup>66</sup>

International meetings were ‘very useful, and I would not have managed without them (...) they gave me access to an international network, which was very important in an area in which everyone felt very uncertain about what to do.’<sup>67</sup> As the Indo-Scandinavian co-operation over population control shows, Swedish and Norwegian aid administrators maintained close connections with the population network, and relied heavily on advice particularly from American philanthropic organisations.

### ***Population control: a feminist cause?***

The initial reasons for support to the family planning programme were marked by security considerations related to the Cold War, a wish to reach women as a target group for aid became a main reason throughout the period of Indo – Scandinavian co-operation. The latter period of involvement, however, was influenced by general political considerations, public opinion in the domestic environment and the general economic restraints and possibilities, and as a result of this, the aim to reach women somewhat lost ground, at least in connection with the Indian family planning programme.

An important view in domestic debate on population aid was that a reduction of the population growth rate was necessary to ensure continued development. This

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<sup>64</sup> L. Anell, ‘Images of Distant Countries’ in P. Frühling (ed.), *Swedish Development Aid in Perspective. Policies, Problems and Results Since 1952* (Stockholm, 1986), p. 241.

<sup>65</sup> *Ibid.*, p. 238.

<sup>66</sup> Interview K. Stoltenberg 11 April 2000.

<sup>67</sup> Interview K. Stoltenberg 17 April 2004.

argument was coupled with concerns for the effects of population growth on world peace and stability. Population growth could lead to food shortage, and increased differences between the developed and the developing countries could again lead to social unrest, and potentially war. In Norwegian political debate, the ‘population explosion’ was seen as ‘...the greatest problem regarding the provision of sufficient food for the hungry populations of the developing countries (...) it involves, next to a nuclear war, the greatest danger for the future of our world. Family planning is the only way to avoid this grave danger’.<sup>68</sup>

An additional reason behind the Scandinavian interest in family planning efforts in developing countries is closely tied to the rights of women, and women’s influence on policy-making. One view of population aid saw access to family planning means as a basic human right, which could considerably improve women’s status and lives. Swedish aid bureaucrats have argued that ‘Family planning has been an important instrument for the liberation of women, and it has furthered equality between the sexes.’<sup>69</sup> With the concern over population growth and family planning, women were placed at the centre of the development agenda for the first time.

In addition, at a time when Third World population control gained support in the Scandinavian aid administrations and political circles, Swedish and Norwegian policy to an increasing degree became both influenced by and directed towards women. During the 1960s and 1970s, women in Scandinavia gained access to political life in terms of representation in parliament, employment in foreign service and administration to an unprecedented degree, and this may have been an additional force behind the wish to reach women through development efforts.<sup>70</sup> In state departments and bureaucracies, a new group of so-called ‘femocrats,’ senior-level bureaucrats with a connection to the feminist movement, gained influence, and this thoroughly altered the composition of the administration, as well as having impact on political priorities.<sup>71</sup> Women were taking an active part in the political process concerning the population issues, and it is possible to argue that both Alva Myrdal

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<sup>68</sup> Stortingsforhandlinger 1967-68, vol. 7c, 3797.

<sup>69</sup> SIDA FIAB: 344: Memo 12 February 1971, Wahren.

<sup>70</sup> Heppling, *Sverige och u-länderna i FN – en återblick*, p. 137.

and Karin Stoltenberg may be categorised as femocrats. Stoltenberg has argued that the entry of women in aid and foreign policy administration had an influence on the selection of women as target group, and on the family planning agenda: ‘...there were mostly only men in all these [family planning] meetings, and it was evident that I brought a different perspective, simply because these matters were closer to me as a woman.’<sup>72</sup> The emphasis on women-oriented aid should not exclusively be related to the influx of women in politics and bureaucracy, however, and may be seen as a reflection of broader societal changes. As new feminist groups arose, their international framework and perspective had an influence on the fields of research and politics.

Women became important recipient groups for Swedish and Norwegian aid, a Sida paper treating women’s situation in developing countries as early as 1962. In 1975, women were singled out as a target group for Norwegian aid, and plans were made to give development assistance a particular slant towards women, especially within health, education and agriculture. Again, Karin Stoltenberg had a decisive impact on the aid process through an influential report on the position of women in developing countries, and suggestions for policy in the matter.<sup>73</sup> Thus in the period examined in this paper, Scandinavian development policy had a clear gender perspective. The identification of women as a target group gave the family planning matter increased impetus.<sup>74</sup> Population aid fitted well with the emphasis on women, and it has been one of the ways through which it has been realised. Providing development funds to family planning projects may have seemed as a way of reaching women and improving their situation, as well as empowering them.

### ***Indian population control, and Swedish and Norwegian aid: the IPP and the PPP***

In 1952, India became the first country in the world to establish a national family planning programme aiming to reduce the country’s population growth.

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<sup>71</sup> I. Blom, ‘Brudd og kontinuitet’, in I. Blom and S. Sogner (eds.), *Med kjønnsperspektiv på norsk historie. Fra vikingtid til 2000-årsskiftet* (Oslo, 1999), p. 332.

<sup>72</sup> Interview K. Stoltenberg 17 April 2004.

<sup>73</sup> K. Stoltenberg, *Kvinnens stilling i utviklingsland* (Oslo, 1978).

Censuses had been taken since the late 19<sup>th</sup> century, and concern had grown over the country's steadily increasing population.<sup>75</sup> India's population 'problem' became evident in the mid-twentieth century, when the country's population was the subject of various studies, most notably Kingsley Davis' *The Population of India and Pakistan*.<sup>76</sup> Independent India's first census in 1951 was seen as a central tool in the management of the new state, providing data particularly useful for the new population control effort, but also for economic planning. After the 1951 census the size and growth rate of the population were recognised as potential problems, and seen as hindering further development of the country. The debate concentrated on how family limitation should be achieved, and also the appropriateness of contraception.<sup>77</sup>

*Table 1. Population of India since 1901 census (in million)*

<b>Year</b>	<b>Population</b>	<b>Year</b>	<b>Population</b>
1901	238.4	1951	361.1
1911	252.1	1961	439.2
1921	251.3	1971	548.2
1931	278.9	1981	683.3
1941	318.6	1991	846.3
		2001	1.028.0

*Source: Census of India webpages.*

In 1952, the National Family Planning Programme was established, making India the first country in the developing world to have a family planning programme. Despite the early initiative, as late as 1959, Prime Minister Nehru did not see family planning as a top priority.<sup>78</sup> In 1956 a Central Family Planning Board was established, and by 1958, all states had State Family Planning Committees. After the 1961 census

<sup>74</sup> Interview K. Stoltenberg 17 April 2004.

<sup>75</sup> An exception was the decade 1911 – 1921, when India's population dropped somewhat, mainly due to influenza epidemics.

<sup>76</sup> K. Davis, *The Population of India and Pakistan* (Princeton, 1951).

<sup>77</sup> R.H. Cassen, *India: Population, Economy, Society* (London, 1978), p. 145.

<sup>78</sup> B. Stein, *A History of India* (Oxford, 1998), p. 376.

a more comprehensive strategy was elaborated, and a new Department of Family Planning was set up in 1966, with branches extending to India's 593 districts.

The family planning programme was directed primarily at building a large infrastructure for providing family planning services, and a system of clinics and sub-centres which provided family planning services was set up in parallel with the ordinary health service. To encourage popular support a media campaign was conducted, promoting the small family norm through posters, radio, films, and puppet shows.<sup>79</sup> Incentives both in cash and in kind were introduced in the late 1950s, which at one point included the infamous transistor radios. A certain class bias became evident in the programme, as incentives offered for sterilisation attracted the poorer groups of Indian society, whereas a ceiling on individual land-holding encouraged property holders to have large families.<sup>80</sup> In 1966, the family planning programme was made target oriented,<sup>81</sup> and the government indicated that it aimed to limit population growth through the use of 'gentle and civilized pressure, persuasion and compulsion.'<sup>82</sup>

The family planning programme has tried different approaches in order to influence the reproductive behaviour of the population, and in the very first years, the programme focused on the 'rhythm method.' In the late 1950s, there was a shift towards promotion of male sterilisation. In 1966, an IUD (intrauterine device) programme was started, according to recommendations of the United Nations.<sup>83</sup> The response seemed good at first, however numbers soon declined due to the side effects of the IUDs and a lack of information about these,<sup>84</sup> and the programme was seen as a failure.<sup>85</sup> In the early 1970s, the family planning programme's focus shifted towards sterilisation, especially of men, and abortion was legalised in 1971. During the 1975-

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<sup>79</sup> J.M. Brown, *Modern India. The Origins of an Asian Democracy* (Oxford and New York, 1994), p. 390.

<sup>80</sup> Stein, *A History of India*, p. 376.

<sup>81</sup> The target approach implied that the central government provided state health personnel with specific numeric targets to work towards and achieve, supported by various incentives or disincentives.

<sup>82</sup> A.V. Zodgekar, 'Family Welfare Programme and Population Stabilization Strategies in India', in *Asia Pacific Population Journal*, Vol. 11, No. 1 (1996), p. 3.

<sup>83</sup> NORAD: 1452: Report India Consortium November 1969, p. 3.

<sup>84</sup> This was confirmed by the Minister of Health and Family Planning B. Murthy in Lok Sabha, 3 August 1970, when asked by the S. Narain about the IUD programme. NMFA: 37.10/24: 6.

<sup>85</sup> Cassen, *India: Population, Economy, Society*, pp. 149-60.

77 Emergency, the programme achieved a dramatic increase in the number of sterilisations. From the late 1970s onwards, the focus of the family planning programme shifted towards the sterilisation of women, both due to political pressure and due to the availability of new technologies. According to the World Bank, 80 per cent of all sterilisations carried out under the family planning programme were vasectomies in the early 1970s, and ten years later, about 80 per cent were tubal ligations.<sup>86</sup> In the mid-1980s, mother and child health projects were emphasised, and this tendency continued into the 1990s. In 1996, the Government of India abolished the target approach, which for thirty years had required the providers of health and contraceptive services to meet method-specific quotas.

Although the family planning programme for a large part has been funded by the central Indian government, it has also received support from several states and international agencies. USAID, the Ford and Rockefeller foundations, the Population Council and several UN agencies have been involved. The Soviet Union, Switzerland, Belgium, the Philippines and other countries have in the UN voted against giving India support for family planning, alleging that its programme was coercive.<sup>87</sup> The Scandinavian countries have been among the largest bilateral donors to the programme. Despite the continued efforts of the Government of India and various international donors, the Indian population has continued to increase, and is in 2006 estimated to be over one billion.<sup>88</sup>

In 1962 and -67 respectively, Sweden and Norway received requests from the Government of India to supply population control aid. Both countries entered large-scale agreements with India in 1971, supporting sub-programmes under India's centrally run family planning programme. The Scandinavian-funded projects ensured improved family planning facilities at more than 1500 hospitals all over India, and it led to a strengthening of the family planning efforts especially in the States of Karnataka and Uttar Pradesh.

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<sup>86</sup> World Bank, *Improving Women's Health in India* (Washington, 1996), p. 71.

<sup>87</sup> Stein, *A History of India*, p. 377.

<sup>88</sup> From the Census of India webpages: <http://www.censusindia.net/>

From 1971, Norway supported the Post Partum Programme, and the country was the major foreign donor. The Post Partum Programme became one of Norway's main commitments within the field of family planning, and co-operation lasted until 1996. The assistance was provided as programme aid, i.e. funds were provided as grants, and direct involvement from Norway was minimal. In principle, Norway did not have any direct influence on the philosophy or the implementation of the programme. Representatives of the Norwegian aid authorities, however, took part in appraisal and evaluation missions, and did at several times, particularly from the mid-1980s onwards, suggest modifications and changes in the approach of the programme.

The first Post Partum Programme was initiated in 1966 by the Population Council, a New York based organisation established in 1952 by John D. Rockefeller 3<sup>rd</sup>. The Post Partum Programme was implemented in 25 hospitals in 15 different countries around the world. The majority of these countries were South and East Asian, and India participated through Safdarjang Hospital in New Delhi and S.A.T. Hospital in Trivandrum, Kerala.

The Indian government established its own, nation-wide Post Partum Programme in 1969. The programme was maternity-centred and hospital based, aiming to reach women in the time immediately following delivery or abortion. The programme was based on the assumption that the post-delivery (or post partum) period is the point of highest motivation for using a method of birth control, and therefore the best occasion for reaching women with information on these. So-called Post Partum Centres were established at hospitals, which were then equipped to provide family planning services to the patients, as well as to the population of the surrounding areas.<sup>89</sup>

The Post Partum Programme eventually encompassed 1562 institutions. During the first 15 years of operation, the programme was established mainly at the major hospitals in the public health infrastructure of India. All the 106 major hospitals in the health system, the state hospitals and medical colleges, participated in the PPP. On the next level of the health system, the district level, 375 out of approximately 450

district hospitals were involved. In addition to the large hospitals, 73 institutions on the local level took part in the programme. The PPP thus involved a large proportion of the Indian health infrastructure, but with an emphasis at the higher levels and in the urban areas. In the last ten years of co-operation, the Post Partum Programme was extended to 1012 hospitals at the sub-district (*taluka*) level. The total Norwegian contribution to the Post Partum Programme was approximately NOK 550 million, all of which was provided as grants.

The Centres were to provide a free so-called ‘cafeteria’ selection of all contraceptive methods including: female tubal sterilisation (tubectomy), male sterilisation (vasectomy), IUD (intrauterine device) insertions, conventional contraceptives: foams, jellies, diaphragms and condoms, and oral contraceptives. The term ‘cafeteria approach’ was chosen to illustrate that it was supposed to give the clients a broad range of choice, and provide the freedom to choose the method that suited each individual. The voluntary aspect of the cafeteria approach has been questioned, and in reality the emphasis was largely on female sterilisation, with roughly 60 per cent of the patients undergoing tubectomies.

The Indian family planning programme was to a large degree based on the provision of monetary and other incentives for people who accepted contraceptive methods, and there was also a widespread use of disincentives. In addition, all units and personnel within the health system had to work according to targets and quotas. The PPP’s use of such family planning targets and monetary incentives was an area in which Indian and Norwegian views diverged, however Norwegian funding from 1973 onwards nevertheless went to the provision of incentives and cash awards. India in 1996 formally abandoned the use of targets and incentives in the family planning programme.

In the PPP, each Post Partum Centre had to relate to several sets of family planning targets, which placed heavy emphasis on the sterilisation of women. Firstly, each Centre had to produce a number of contraceptive acceptors in proportion to its total number of patients. The PPCs were to produce 20 per cent tubectomies and 10

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<sup>89</sup> B. Stray-Pedersen, E. Valstad and I. Ofstad, Final Programme Review of Norwegian Assistance to

per cent vasectomies.<sup>90</sup> Another guideline stated that the aim was to sterilise 75 per cent of the obstetric cases with three or more living children.<sup>91</sup> In addition, each centre was allocated quotas by the local health authorities, on the basis of demographic goals allocated by the central Indian government to each State. These quotas were converted into figures of family planning acceptors, which were then divided between the individual health workers.<sup>92</sup> In addition, the Indian Ministry of Health and Family Welfare assessed the centres' performance on the basis of number of tubectomies in relation to number of hospital beds. In 1973 a target of 35 tubectomies per bed per year was introduced, and this was raised to 45 in 1980.<sup>93</sup>

Another scheme that encouraged the PPCs to aim for sterilisation of women in particular, was the linking of a 'maintenance grant' to tubectomy production. Grants of Rs. 3 000 per bed per year was provided, subject to the minimum achievement of 300 tubectomies per year per PPC. This arrangement would thus provide each centre with a grant of up to Rs. 18 000 if it could achieve its quota. Despite the name, the 'maintenance grants' were used for staff payments, and functioned as monetary incentives for the staff to achieve the highest possible number of tubectomies.<sup>94</sup> The so-called cafeteria approach of the PPP was seriously compromised through the use of incentives and quotas. Other incentives were offered for the programme's clients, in the form of cash awards for accepting sterilisation. These cash payments were only offered to acceptors of some contraceptive methods, however, and they therefore created a bias in the PPP, compromising the cafeteria approach further. Similar policies, biases and concerns would also make an impact on Swedish aid to Indian population control.

Sweden assisted India's family planning programme from 1968, through the purchase and delivery of contraceptives, and through financial support to a state-run contraceptive factory in Trivandrum.<sup>95</sup> In 1971, Swedish involvement increased as a

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the AIHPPP, Phase I (Oslo, 1985), p. 5.

<sup>90</sup> NORAD: 1452: AIHPPP Report 1969-70, p.35.

<sup>91</sup> Stray-Pedersen, Valstad and Ofstad, Final Programme Review, annex IV.

<sup>92</sup> Miranda, A., Møgedal, S., The All India Hospitals Post Partum Programme, Sub District Level: Report of a Gol/Norad Review Mission Feb.-Mar. 1990 (Oslo, 1990), p. 16.

<sup>93</sup> Stray-Pedersen, Valstad and Ofstad, Final Programme Review, annex IV.

<sup>94</sup> Miranda and Møgedal, The AIHPPP, Sub District Level, 1990, p. 34.

<sup>95</sup> SIDA FIAD: 388: PM of 28.03.72 by Markensten.

development credit and grant agreement was signed by the International Development Association (IDA), and the governments of Sweden and India. The project, which was named the India Population Project (IPP), was based on the national family planning programme, and aimed to identify improvements through the provision and testing of various alternative approaches. The project would complete the health infrastructure to ensure the standard GoI programme could be implemented throughout the project areas, and provide additional inputs in order to test alternative ways in which the programme could be strengthened. Sida's Population Department described the IPP as 'first of all a research project'; however the project's primary concern was to increase the number of acceptors of family planning through improved facilities for sterilisation, the provision of health personnel, and increased population control propaganda through what was called 'education and information' from both mobile and stationary teams. The research activities seem to have been a secondary activity.<sup>96</sup> The costs of the project over a six-year period were estimated at 152.6 million SEK, or USD 31.7 million. The IDA would finance one third of the project, India would cover a third, and Sweden would cover the remainder. The IDA would administrate and supervise the project.<sup>97</sup>

The project consisted of three main elements: 'city programmes' based in Lucknow and Bangalore respectively, a programme called 'the optimal programme' following the approach of the national programme, based in six districts in Uttar Pradesh and five districts in Mysore, and an 'intensive programme,' which aimed to use additional components, based in two districts in each project state.<sup>98</sup>

The 'city programmes' placed special emphasis on reaching mothers before and after birth with family planning information, including women who did not give birth in hospitals. The project would build 14 maternity homes where women could give birth, receive family planning information and counselling, and be sterilised. Special 'motivational programmes' directed at the state populations, would be implemented through the media.<sup>99</sup> The 'optimal' government programme aimed to

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<sup>96</sup> SIDA A1B: 12: Sida memo 1 March 1972, for board meeting 10 March 1972.

<sup>97</sup> Ibid.

<sup>98</sup> SIDA F1AB: 388: Sida memo 15 February 1972, Poluha.

<sup>99</sup> SIDA A1B: 12: Sida memo 1 March 1972, for board meeting 10 March 1972.

run the family planning programme according to the GoI's guidelines. Due to various shortcomings the programme had not been fully implemented anywhere in the country, and the IPP would supply all the missing components, most important of which were personnel and clinical capacity for sterilisation. A Sida memo argued that the demand for female sterilisation had increased and thus district hospitals would be strengthened with sterilisation wards containing 500 new beds. This expansion was hoped to double the number of female sterilisations in Uttar Pradesh, and increase them by as much as a 60 per cent in Mysore, during the IPP's first year.<sup>100</sup>

The 'intensive districts programme' provided several alternative components to two of the districts in each project state. The main element was a rural 'post partum programme,' which aimed to reach mothers with birth control immediately following childbirth or abortion.<sup>101</sup> The clinical capacity for sterilisation and births would be strengthened through a doubling of rural family planning clinics, and an increase of health personnel. The districts would also include a nutrition programme, providing supplementary food to pregnant and lactating mothers, as well as to children up to the age of two. This nutrition programme would 'assess the value of food as a direct incentive for family planning, and second, to evaluate the effects of nutrition of infant mortality and, in turn, the desire for smaller families.'<sup>102</sup> Thus the primary aim was to see if food could be used as an incentive for sterilisation and other birth control methods in the same way as money.<sup>103</sup> Secondly, the programme would check if improved nutrition could have an effect on the use of contraception and family planning, according to the idea that a decreased infant mortality rate could encourage parents to have fewer children. The rural intensive districts also included so-called 'IEC' (Information, Education and Communication) efforts, and mobile teams would spread family planning propaganda among the district populations. Two mobile teams operated in each of the four programme districts, one spreading propaganda and 'motivating' the population, and one providing clinical services such as sterilisation.<sup>104</sup>

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<sup>100</sup> Ibid.

<sup>101</sup> The rural post partum programme followed the general approach of the national Post Partum Programme, financed by Norway.

<sup>102</sup> SIDA F1AD: 1837: G. Zaidan, 'India: Developing a Demonstration Program', 1973.

<sup>103</sup> Wickström, B., *Nutrition and Family Planning in India. Report from the 1976 GOI/IDA/SIDA review mission* (Gothenburg, 1976), pp. 1-2.

The IPP furthermore involved extensive construction works, comprising a total of 1513 buildings. These were, as listed in a Sida document:

14 urban maternity homes, 11 administrative buildings, 19 annexes to hospitals for tubectomies, 41 primary health centres, 47 general purpose family planning annexes, 20 maternity-sterilization wings at existing primary health centres, and 1348 subcentres. The project also includes the construction of 13 auxiliary nurse-midwife training schools.<sup>105</sup>

Thus despite being implemented in two states only, the project entailed a very large expansion of the Indian health infrastructure.

The India Population Project was marked by delays from the very beginning, and a whole year went by between the formal Sida and IDA approval and the start of the project work. The recruitment of Indian personnel proved particularly difficult, and there seems to have been considerable irritation among the donors at not being able to influence the selection of project leaders, as well as a deep distrust of the qualifications of the Indian candidates. After the slow start, things did not improve in the IPP. In December 1973, the IDA's Delhi representative gave cause for further concern: the heads of the IPP in both states had indicated that they knew several reasons why the Indian family planning did not succeed, however that they 'would never dare let their data reveal this as they would probably lose their positions immediately.' Sida's Delhi office asked if this meant that 'the main purpose of the project has been lost.'<sup>106</sup> Thus the main aim of the IPP, identifying flaws and faults in the national family planning programme, was potentially very problematic, as such criticism was not tolerated by the Indian Ministry of Health.

Interestingly, objections towards the IPP's approach, and particularly the project's use of incentives and disincentives in relation to population control, were several times raised by Sida bureaucrats, however this did not affect Sida's policy in the issue – funding continued despite the serious concerns raised by some of the

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<sup>104</sup> Ibid.

<sup>105</sup> SIDA F1AD: 1837: G. Zaidan, 'India: Developing a Demonstration Program', 1973.

<sup>106</sup> SIDA F1AD: 384: Sida memo 11 December 1973, Söderstam.

bureaucrats handling the project.<sup>107</sup> The IPP was also criticised by one of Sweden's largest dailies, *Dagens Nyheter*, but this was brushed aside by Sida representatives in Delhi.<sup>108</sup> The concerns were only to get worse however, and particularly after the period of Emergency in India in 1975 – 77. In 1979, a debate broke out in both the Swedish and Indian press about the role of the Swedish-funded project. Swedish aid authorities were accused of supporting the forceful sterilisation policies of the Emergency period, instances of massacres of civilians were reported to have taken place in some of the project areas, as these protested against forceful sterilisation policies, and this naturally provoked reactions from the Swedish public. The debate also raged within the Swedish aid administration where a campaign was launched to end the aid to the Indian family planning programme. 110 Sida employees signed a petition to end co-operation. The debate also reached the cabinet, which threatened to interfere with the aid administration's decision-making. The result of the debate was that the Swedish aid to the Indian family planning programme was terminated. Despite the debate and disagreement being a reaction to the events in India, the decision to end the IPP support was a practical consideration, made by Sida's Director General Anders Forsse on the basis that the protests were too time-consuming.

In sharp contrast to the development in Sweden, Norwegian population control assistance to India continued with increased vigour after the Emergency, and the Norwegian contribution more than tripled through the early 1980s. The increase of support for the PPP seems remarkable given the Emergency period, and also Sweden's decision to end the support, implying that other concerns prevailed. Despite the fact that the Post Partum Programme was involved in the sterilisation excesses that took place during the Emergency, as the programme provided the main sterilisation infrastructure of India, and the staff was required to adhere to quotas provided by the GoI, Norwegian funding continued and increased. Norwegian aid authorities were also aware of sharp increases in sterilisations performed through the Post Partum Programme during the Emergency, however Norad officially claimed that it was uncertain to what extent the programme had been involved. The increase in

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<sup>107</sup> SIDA F1AC: 326: Travel report 23 November 1972, Forselius, SIDA F1AD: 382: Wahren to Hegardt 26 February 1973, SIDA F1AD: 382: Hegardt to Wahren 7 April 1973, SIDA F1AD: 384: Sida memo 13 June 1975, Hegardt.

<sup>108</sup> SIDA F1AD: 382: Tranaeus to Hegardt 17 January 1975.

Norwegian funding should be understood as a result of overriding concerns, and may be seen in connection with the overall budgetary aims of Norwegian aid, and particularly the aim to reach an aid expenditure of one per cent of the GDP. Sweden had reached this aim in 1976, however Norway was striving to reach it before 1982. The consequences of this concern were extensive: a lot of money went into large-scale projects, and aid administrators looked for ways to spend as much as possible, with little administrative work, overlooking the consequences of assistance. In addition, Norway could afford to chase the one per cent goal at a time when the new-found North Sea oil riches boosted the economy. The Indo-Norwegian population control co-operation continued until 1995, yet from the mid-1980s onwards, Norad displayed an increasing willingness to criticise the PPP, and the general approach of the Indian family planning programme.

The Swedish decision to end support for the IPP, and also the increased Norwegian willingness to criticise the PPP may be related to what has been called a period of crisis in international population work, beginning in the early 1980s.<sup>109</sup> The 'population explosion' had not materialised, birth rates were levelling off, and the family planning question lost urgency. At the same time, strong reactions emerged in relation to the use of pressure and force in population control programmes, particularly visible through the Emergency in India, and as a result support for the policy area decreased. Norwegian criticism and attempts at influencing the PPP may be interpreted as reflecting the decrease in political acceptability of population control, and as a result Norad focused more on the health aspects of the programme, emphasising efforts to secure maternal and child health, as well as education and training. Research has found that due to the crisis in population circles, demographers applied their research to new areas, hoping to identify new rationales to support population control efforts, and sought these within maternal and child health, the status of women, and environmental degradation.<sup>110</sup> The reframing of family planning to MCH and eventually reproductive health has been seen as providing an ideological benefit, as it offers a politically correct justification for continued population control.<sup>111</sup> At the same time, however, this move to a focus on maternity care has been

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<sup>109</sup> Greenhalgh, 'The Social Construction of Population Science', pp. 52-60.

<sup>110</sup> *Ibid.*, p. 53.

<sup>111</sup> Hodgson and Watkins, 'Feminists and Neo-Malthusians', pp. 108-9.

found to have simply provided a new justification for population control, resulting in even stronger pressure for family planning results through MCH in the post-Emergency period.<sup>112</sup>

As the PPP co-operation lasted for 25 years, the programme documents provide an exceptional overview of how Third World population control has been justified from the early 1970s, to the mid-1990s. The vocabulary has ranged from 'population control' to 'family planning,' to 'family welfare,' to 'mother and child health' via 'nutrition,' 'safe motherhood and child survival' to 'environmentalism,' before ending up with 'sexual and reproductive health.' Barrett and Tsui have found that the symbolic meaning inherent in a government's establishment of a population control policy greatly increases its likelihood for receiving funding, as well as the amounts received, and this indicates that the application of approaches that the international donor community finds relevant may have a similar symbolic effect, producing continued or increased funding.<sup>113</sup> Indeed, this tendency can be identified in the Indian family planning programme, as changes in international population discourse has led to the administrators having to adapt to 'new concepts coming in fast.'<sup>114</sup>

Despite Norwegian efforts to improve the PPP, aid was rapidly scaled down and ended due to political considerations, related to an increasing realisation on the Norwegian side that India's development aims were substantially different to Norway's. India's development of nuclear weapons, the country's arms industry, and the lack of efforts to reduce poverty in particular were decisive for the decrease in aid, which again led to the termination of the PPP. The termination of Norwegian aid to Indian family planning was thus not related to the needs of the Indian family planning programme, or any objections to the contents or approach of the PPP as such. The decision was rather based on changing Norwegian priorities and a rapid reduction of total aid to India. A parallel development took place in Swedish aid to India in the same period.

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<sup>112</sup> I. Qadeer, 'Our Historical Legacy in MCH Programmes' in M. Krishnaraj, R.M. Sudarshan and A. Shariff (eds.), *Gender, Population and Development* (Oxford, 1998), p. 278.

<sup>113</sup> Barrett and Tsui, 'Policy as Symbolic Statement', p. 229.

<sup>114</sup> Interview T. Bhasin 1 November 2000.

Regarding the results of Scandinavian population aid for India, this is difficult to estimate on the basis of Swedish and Norwegian archives, in which Indian material has been selected according to what use it has had for Scandinavian aid administrators. It is certain, however, that the IPP and PPP funding led to increased population control efforts over a long time period, and to a strengthening of hospital facilities. When the support ended, the programmes were either modified drastically or ended due to lack of funds, which points to the crucial roles played by Swedish and Norwegian support. In terms of influence on the development of the policy of the Indian family planning programme, the Swedish and Norwegian involvement may be expected to have had little impact, as is revealed through frequently voiced frustration in the Sida and Norad material. Despite repeated Norwegian attempts at influencing the programme, it rather adapted to general changes in thinking on population and development, as for example expressed through the international conferences on population and on women.<sup>115</sup> As recent scholarship has pointed out, if recipient country planners accept and apply the donor-approved changes in development aid vocabulary, this may increase their chances of receiving funding.<sup>116</sup> There is reason to suspect that the Indian change of labels from ‘family planning’ to ‘family welfare,’ and the later focus on ‘mother and child health’ as well as the ‘safe motherhood and child survival,’ reflect such willingness, and has had little actual impact on the implementation of family planning.

The examples of the IPP and the PPP, and the eventual termination of Swedish and Norwegian aid to India, are striking in highlighting the fact that most decisions on the aid co-operation process were made according to aims and considerations on the donors’ side. Indian wishes and priorities had very limited influence on the bilateral co-operation, and the overall Swedish and Norwegian budgetary priorities were paramount throughout the process. Whereas India allowed Sweden and Norway little influence on the contents of the aid programmes, the donor governments had decisive impact on the scale of co-operation.

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<sup>115</sup> Interview T. Bhasin 1 November 2000.

<sup>116</sup> Hodgson and Watkins, ‘Feminists and Neo-Malthusians’, p. 511.

### ***Conclusions: population control, Scandinavian aid, and Indian family planning***

Scandinavian efforts in the population field predated American initiatives, which have hitherto been regarded as decisive, by nearly a decade. Although the impact of American politicians, decision-makers, bureaucrats, scientists, and philanthropic organisations in the population matter should not be questioned, it is important to note the part that Scandinavian initiatives have played in preparing the ground for more comprehensive efforts, breaking the silence on a topic that all other development aid donors found too controversial to handle. Previous works on the history of international population control being based mainly on American sources, the example of the Scandinavian efforts points to a need to use a wider range of material for the writing of this history, and for examining the participation of small states, as opposed to the earlier focus on greater powers.

Causes for the comparatively early Scandinavian involvement in Third World population control can be identified as the countries' domestic experiences with population control policies, a strong belief in political planning combined with the influence of medical professionals, as well as connections to an international network of bureaucrats, decision-makers, politicians and experts.

Scandinavian aid to the Indian family planning programme can be seen as related to Swedish and Norwegian security concerns. Population aid gained importance in a period when aid budgets expanded rapidly, and efforts were increasingly directed at women. The latter period of involvement, however, was influenced by general political considerations, domestic public opinion, and general economic restraints and possibilities. The involvement was reduced and finally terminated due to changing political and economic considerations in the donor countries. In the mid-1990s, the Swedish and Norwegian governments drastically reduced their aid commitments to India, and the country lost its status as a priority country. The official explanation has been that India had reached a fairly high level of economic development, however the termination of aid can also be seen as related to India's testing of nuclear weapons. If this is the case, Scandinavian aid to India should

again be viewed within a perspective of security and a wish to promote international stability.

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