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THE POLITICS OF FERTILITY: POPULATION AND PRONATALISM IN LADAKH

In India's northwestern region of Ladakh, the linkage between reproduction, politics, and fertility is both complicated and contested, evident in increasing population discourses and the re-emergence of a Buddhist pronatalist movement. This paper examines the impacts of population discourses and pronatalism on women's reproductive decision-making, as well as on the delivery of healthcare throughout Ladakh. Population discourses currently circulating produce two reproductive subjects—the “hyper-fertile Muslim woman” and the “vulnerable Buddhist”—both of which have been central in revitalizing Buddhist pronatalism. Data collected through a hospital-based survey and interviews shows that fertility behavior is shaped by religious interpretations, political mobilization, and pressure to be culturally loyal. Fertility decisions are not simply about one's reproductive choices and desires—but are instead situated in a contested context where Ladakhis are worried about culture loss. While these cultural pressures differently impact Muslim and Buddhist women, the growing politicization of reproduction results in continued ethnic/religious conflict that has far-ranging impacts throughout the region.

A Buddhist woman walks into the maternal child health (MCH) ward at Leh's Sonam Norboo Memorial (SNM) hospital with a baby strapped to her back, tied in the traditional way: with the baby lying flat against the mother's back and a tight knot tied in the front of the mother's chest. She enters the crowded MCH ward hesitantly. A young nurse barks at her, “*Achay-le* [sister], sit here,” pointing to the crowded bench in the hall. When it is the woman's turn to give her reproductive health history, she shyly bows her head and whispers, “I'm here for the copper T.”¹ When asked how many children she has, she says that though she has two children, she has been pregnant four times. “Family planning is a sin but I like family planning too,” she explains. The next patient, a 23-year-old Muslim mother of two, echoes this view: “I am using a copper T but people tell me that I should remove it...but I have a small baby and I want the gap,” she asserts. Family planning is controversial in Ladakh. Though Buddhist and Muslim women both describe family planning as a sin, they also express how grateful they are to space their pregnancies. Doctors also have conflicted

feelings about family planning: “family planning is good; you shouldn't bring (up) an unwanted child,” a female surgeon said, “though I'm worried because the population growth rate is declining so one day the Ladakhi population will be extinct, especially the Buddhist population; I'm worried on the whole.”

Family planning—which was unproblematic just over a decade ago—is becoming politicized and increasingly linked to ethnic and religious conflict. Public support for family planning has waned while religious opposition to particular contraceptive methods and practices has escalated (Smith, 2009a, 2009b). Furthermore, population concerns have led to the emergence of a Leh-based pronatalist movement that targets Buddhist women, encouraging them to “out breed” the Muslims. Yet these fertility politics impact Buddhist and Muslim women differently; high fertility is encouraged for Buddhists but is thought by many Ladakhis to indicate the “backwardness” of Muslims. Taken together, this indicates the multiple ways that reproduction in Ladakh is “stratified,” where power relations—especially those in the religious and political spheres—are shaping reproductive practices and ideologies (Ginsberg and Rapp, 1995). In this article, I show how the population discourses

1. Copper T is a type of intrauterine device (IUD) that is common in India.

circulating throughout Ladakh produce two reproductive subjects—the “hyper-fertile Muslim woman” and the “vulnerable Buddhist.” These discourses are generating a pronatalist movement and are escalating hospital politics, both of which impact women’s reproductive decision-making and the delivery of healthcare throughout Ladakh. In this way, reproduction has become a space not only for identity politics between groups but also for real politics that impact the lives of Ladakhi women. As a result of growing reproductive politics, there is a disjuncture between idealized subjectivity (cultural pressures regarding fertility behavior) and practice (women’s actual fertility practices). This split subjectivity—where women and gynecologists both monitor their statements and practices regarding fertility and family planning—indicates what kind of strategies are needed when reproduction becomes so highly politicized.

Based on data compiled during 16 months of research in Ladakh between 2006-2011, I show that fertility practices of Buddhist and Muslim women do not align with the religious and political discourses from their respective communities. Research was conducted among women, men, medical staff, religious authorities, and political leaders in both urban (Leh, Kargil) and rural (Diskit) sites, using four methods: interviews, participant observation, a survey, and archival research. I conducted semi-structured interviews with a diverse pool of women—Buddhist, Muslim, rural, urban, married, and unmarried—as well as with men, adolescents, medical staff; NGO workers; and religious and political leaders. I conducted a hospital-based survey with 237 women in Ladakh’s largest hospitals (Leh, Kargil, Diskit) that generated data on contraceptive use and knowledge; fertility rates and preference; delivery history and preference; and attitudes towards family planning. Women’s opinions on family planning—where most supported it, yet also called it a sin—were expressed in semi-structured interviews as well as through my hospital survey. Participant observation in hospitals allowed me to witness interactions between patients and medical staff, as well as deliveries, surgeries, gynecological exams, and prenatal check ups. Archival research was conducted in order to understand the history of ethnic/religious conflict and population trends.

POPULATION GROWTH AND POPULATION DISCOURSES

Ladakh is a high-altitude region cut off from the rest of India during winter, which exacerbates already-existing sentiments of political marginalization.² Ladakhi Muslims complain that Buddhists dominate regional politics, while

2. Frustrated with the lack of regional representation and cognizant of Jammu and Kashmir’s status as the only Muslim majority state, many Ladakhis feel doubly marginalized—by both the state and the Indian nation (Bhan, 2006). J&K state has special status under the Indian Constitution, where Article 370 stipulates that while the Indian Parliament can determine issues of defense, communications and Foreign Affairs, all other laws require acceptance from the J&K state government.

Buddhists perceive themselves as a minority within a Muslim-controlled state government (van Beek, 2004). With Ladakhis making up less than 2.3 percent of Jammu and Kashmir state’s population, competition among Buddhists and Muslims for the few government seats is fierce.³ This is reflected regionally, as Leh district has a Buddhist majority (77 percent) while Kargil district has a Muslim majority (80 percent).⁴ Though this sense of political marginalization is both widely shared by Ladakhis and has persisted over time, it underlies the current perception of a population crisis.

Those who worry about Ladakh’s future often advocate positions that appear contradictory, such as simultaneously supporting family planning and pronatalism. Dundup,⁵ a young married man in Leh who works for a local non-governmental organization (NGO), explained the importance of children to the Buddhist community: “We should have at least four or five children. . .having two is not enough. Ladakh is a very big place and we don’t have the problem of poverty like the rest of India. . . for our generation we did a very wrong thing [referring to the Indian government’s National Family Planning program], we are killing our generation.” Like many Ladakhis, Dundup has a strong pronatalist position, based on his perception that the Ladakhi population—specifically Ladakh’s Buddhist population—is in decline. This perception is fueled by broader Buddhist concerns that Buddhism is weakening and under threat, though this relies upon earlier histories of Buddhist/Muslim conflict (van Beek, 2001). Yet Dundup also advocates family planning, adolescent sexual health education, and access to contraception. For Dundup, the message of pronatalism (“reproduce more”) and family planning (“a small family is a happy family”) do not conflict.

Neither pronatalism nor family planning are new to Ladakh, but what is new is the heightened sense of controversy that surrounds them both. While population numbers are currently politically charged, fears of a growing Muslim population have long existed among Ladakh’s Buddhists (Bray, 1991; van Beek, 2004).⁶ Pronatalist activism does more than just encourage women to continue reproducing; it also takes a clear position against contraception, specifically permanent methods such as ligation (permanent female sterilization). Family planning—which was first introduced in Ladakh during the early 1980s—has been instrumental in changing contraceptive behavior, even as it also evokes controversy. Together, pronatalism and family planning generate a complicated population discourse that affects the delivery of reproductive healthcare.

This discourse links population strength with cultural

3. There is one Member of Parliament (MP) seat for Ladakhis in the central government. In the J&K state government, there are four Member of Legislative Assembly (MLA) seats—two for Kargil and two for Leh.

4. See Leh district and Kargil district websites (and <http://kargil.nic.in/>).

5. Dundup is a pseudonym, as are all other names in this piece.

6. Pronatalist activism emerged in the 1930s among the Buddhist pandit community in Srinagar. See van Beek (2004) for more details on the Kashmir Raj Bodhi Maha Sabha.

strength, such as the Buddhist doctor who explained, “to preserve our Ladakhi culture, our population should be higher. We should have more population.” While some worry about population growth, others worry about population composition, specifically that of Muslims and Buddhists. Although they have similar population numbers and growth rates (see Tables 1 and 2), it is common for each group to state that they are in the minority (Bray, 1991; Gutschow, 2006).⁷ These kinds of claims made by Ladakhis reflect India’s national reservation policy, a form of affirmative action intended for historically disadvantaged groups, which follows caste groupings and tribal affiliations (i.e. Scheduled Caste and Scheduled Tribe status). Since population worries and declarations of minority status rely upon numbers, practices of counting have become more politicized.

There is little consensus on Ladakh’s population numbers, trends, and composition. Population data is limited and unreliable, as there are inconsistencies between data from the Jammu and Kashmir (J&K) state, the national census, Ladakh’s health department, NGOs, and independent research groups. As shown in Tables 1 and 2, Ladakh’s population is small (290,492) compared to other regions of India, though it has been steadily growing since the 1970s, even as the growth rate has been declining since

2001 (Guilmoto & Rajan, 2002; Jina, 1996, Government of India, 2001, 2011).⁸

What is striking in the following tables is the shift in population composition that occurred between 2001 and 2011, which is calculated at the district level rather than by specific religious group. While it might appear that in ten years (2001-2011) the region moved from a Muslim majority to a Buddhist majority, Muslims still remain the majority by a small margin, even though the Buddhist population is currently growing faster. In 2001, the census showed that the population of Buddhist-majority Leh district had fallen behind that of Kargil district. Yet, by 2011, Leh district had surpassed Kargil, likely due to efforts to encourage Buddhist reproduction.

Interpreting these population composition shifts is not an easy task, especially when both groups make minority claims. Furthermore, while migration levels into the region (i.e., Kashmiris, Nepalis) have steadily increased over recent decades, migration is also susceptible to mistakes, such as double counting, as well as the “politics of counting.”⁹ The recent population growth rate in Leh district suggests that Buddhist pronatalism and anti-family planning activism are succeeding in changing fertility practices.

Table 1: Population by district

Total Population	Kargil district (Muslim-majority)	Leh district (Buddhist-majority)
1981 census	65,992	68,380
1991 census ¹⁰	N/A	89,474
2001 census	119,307	117,232
2011 census	143,388	147,104

(Government of India, 2001 Leh and Kargil government websites (<http://leh.nic.in/> and <http://kargil.nic.in/>))

Table 2: Population growth rate by district

Population Growth Rate	Kargil district (Muslim-majority)	Leh district (Buddhist-majority)
1991-2001	33.55	30.15
2001-2011	20.18	25.48

(Government of India, 2001, 2011)

7. The remaining minority of Ladakh’s population is comprised of Christians, Sikhs, and Hindu families (Government of India, 2001, 2011).

8. Also see <http://www.nfhsindia.org/> and <http://www.measuredhs.com/>.

9. The 2011 census initially reported Ladakh as having the highest child sex ratio in India, which was due to counting the military.

10. Due to civil unrest, there is no census data for Kargil district for the 1991 census.

“Demographic depiction” is the term Geoff Childs uses to describe the deployment of population statistics and representations in such a way that it will “justify a current power structure or rationalize a state’s intervention in the intimate realm of reproduction” (Childs, 2008: 211). This occurs not only through the use of statistics to convey scientific “truths” but also through the use of particular language that adds subjective meanings onto numbers (such as adjectives like “extreme” and “excessive” to describe population trends). Demographic depiction illustrates how power and knowledge work together, where institutions of power, such as the state, can easily produce subjective portrayals of the population, which are taken to be objective (Childs, 2008; Foucault, 1997). Demographic depictions are powerful because numbers can cause strong reverberations throughout communities, as “demographic perceptions about communities can lead to exactly the kind of political and social instability that demographic events themselves can” (Basu, 1996: 154). There are multiple explanations for the changes in Ladakh’s population over the past few decades, yet a general sense of worry about Ladakh’s population future persists.¹¹ Group struggles—specifically, the relationship between the majority and minority—are articulated in cultural terms, where struggles result in demographic tensions and occasionally violence.

Population discourses in Ladakh—both that of Buddhists and Muslims—fluctuate between expressions of competitive demography and a sense of Ladakhi exceptionalism. Competitive demography emerges from the pervasive feeling of marginalization among Buddhists, who worry about their population decline and are convinced that Muslims are “out-breeding” them. From their perspective, the diminishing number of Buddhists indicates both the weakened state of Buddhism and the likelihood of Muslim dominance in the region. These population worries reinforce pervasive feelings of political marginalization that are felt acutely in villages, where rural to urban migration and the preference for secular education are causing notable changes. For example, a *lama* from Zangskar explained the rationale for more children, as he linked population numbers with power in the community.

We need more births...we need to be more influential...I told the villagers that we should have more children: 6 per family at least. No problem, we have a school, we have a gonpa, we have a nunnery. We can take more people, there’s no problem, I told them. More people is more power. 500 people, 500 power. 1,000 people, 1,000 power. Then only we will be heard.

11. These include the following: changing fertility practices (decreasing polyandry, family planning and contraceptive use); changing household structure (rural to urban migration); improvements in medical care (increased life expectancy and decreased infant and maternal mortality), and the decreasing strength of the monastic system.

In addition to fears of a weakened Buddhism and weak Buddhist political base, the competitive demography discourse also characterizes growing Muslim fertility as a threat. A growing number of Buddhists have blamed family planning use for the decline of the Buddhist population. They also explain the growth of the Muslim population as due to Muslim women’s reluctance to use birth control. For example, as a member of the Buddhist women’s group *Ama Tsogspa* explained, “Muslim women didn’t do ligation or spacing so their population is increasing and we (Buddhist women) did ligation and spacing and so now our population is decreasing.” Religion gets taken up in the competitive demography discourse, where the presumed high fertility of Muslims is associated with Islam, whereas Buddhists point to their religious practices (the lama system and historical polyandry) to explain their low fertility. Yet, these characterizations of distinct Muslim and Buddhist positions on fertility control overlook women’s actual support for family planning, as well as the complexities of reproductive decision-making in such a politicized context.

Though they have different explanations for population change, Muslims and Buddhists express their distinct experiences of regional marginality, which is articulated as “Ladakhi exceptionalism.” This view argues that Ladakh’s low population and low fertility distinguishes it from the rest of India (Guilmoto & Rajan, 2002; Gutschow, 2006). Because Ladakh’s culture is characterized as under threat—from a range of “outside” influences including modernity and the impact of foreigners—some community members argue that Ladakh’s low population warrants its exclusion from the national population policy. In November 2007, the Ladakh Buddhist Association (LBA) requested the Jammu and Kashmir state government to stop promoting family planning in Ladakh, with the ex-president of LBA writing, “The Ladakhi race has limited population in the country and there is apprehension of its extinction. Hence, you are requested not to apply small family norms in the district as a special case” (Ul-Hassan, 2007). Similarly, the LBA has also sent letters to SNM hospital that demand the stop of tubal ligations and abortions (Smith, 2009a, 2009b). While Ladakhi exceptionalism is most evident among Buddhists, the sentiment that Ladakh is different from the rest of India and has unique needs is also shared by Muslims. Whatever shape the population discourse takes in Ladakh—competitive demography or Ladakhi exceptionalism—the population continues to be perceived as a problem that has both political and reproductive ramifications.

“HYPER-FERTILE” MUSLIMS AND “VULNERABLE” BUDDHISTS

Population discourses produce two kinds of reproductive subjects: the “hyper-fertile Muslim woman” and the “vulnerable Buddhist.” The construction of the “hyper-fertile Muslim woman” relies on the idea that Muslim women are linked closely with tradition, and that tradition means high

fertility. This perception of high Muslim fertility is deeply entrenched and pervasive in India, particularly evident in reports contrasting Muslim and Hindu fertility in demography and development (Basu, 1996). The “vulnerable Buddhist” subject is created through discourse that characterizes Buddhism as weakening, often due to “outside” forces such as modernity, tourism, and development (Crossette, 1996). Like the “hyper-fertile Muslim,” the “vulnerable Buddhist” subject relies upon broader regional debates within Asia, where Buddhism is perceived as being “under threat.” These two reproductive subjects are a powerful reminder of how population is becoming a matter of social concern in Ladakh, while also reflecting broader debates going on in South Asia about modernity, development, and communalism.

Reproductive subjects have been at the receiving end of a wide range of policies aimed at controlling fertility and managing reproduction. The social body is controlled through “technologies of sex,” where individual bodies are disciplined and the population is managed simultaneously

leads to further assumptions that they would be opposed to family planning. Yet, this is not reflected in my data, which shows that Muslim women not only support family planning (as an idea), but also are having far fewer children than is typically assumed (see Table 3, 4, 5).¹² Though Buddhist women still had a lower average number of children, the difference is not nearly as significant as the discourse would suggest.

The average number of children is lowest in urban Leh and Kargil and highest in rural Diskit, where contraceptive methods are rarely available. This reflects not only the importance of having children in rural areas but may also reflect the increasing influence of pronatalism on Buddhist women’s fertility. Yet, similar to what Geoff Childs found in his research with Tibetan women in exile, fertility can remain low even in the presence of a strong pronatalist ideology (Childs, 2008). While Ladakhi Buddhists may publically support pronatalist ideology, they still have low fertility (1.98), which is lower than the total fertility rate (TFR)

Table 3: Average number of children ever born (CEB) by region and religion

Location	Average # of children: Muslim women	Average # of children: Buddhist women	Both Buddhist & Muslim women
Leh	1.83	1.66	1.69
Kargil	2.27	2.0	2.23
Diskit	2.85	2.27	2.47
Average of three regions	2.34	1.98	2.11

(Foucault, 1978). These technologies rely upon knowledge of sexuality, population, and health, as well as the convergence of political and economic interests on sexuality (morality campaigns, ideologies of sexual responsibility, control of reproductive choices). Women who willingly control their fertility in compliance with state-sponsored population control programs become sexually responsible subjects, in that they enact the self-regulation of their sex life. India has numerous incentive programs that encourage women to discipline themselves. In Ladakh, women are paid by the state if they deliver their child in a hospital, get an IUD/IUCD inserted, or become sterilized. Practices that make one legible to the state—i.e., adopting family planning or having an institutional delivery—not only render one legitimate in the eyes of the state but also have social and gendered meanings, such as when particular practices are characterized as “modern” or “backwards” (Kanaaneh, 2002). Certain sexual practices—such as polyandry and arranged marriages—are associated with tradition and viewed as “backwards,” whereas “modern” sexual subjects are educated on sexual risk and family planning (Abu Lughod, 2005).

Muslim women in Ladakh are presumed to be more strongly linked to “tradition” than Buddhist women, which

of Jammu and Kashmir state (3.0) and the nation (3.2).¹³

Though contraception is available, it is primarily accessible to those in urban areas, since rural health posts do not reliably stock contraceptives. Of the five methods available,¹⁴ IUDs are the most common method across

12. My fertility data is based on conducting 237 hospital-based interviews with Buddhist and Muslim women in three locations (Leh, Kargil, and Diskit). My data reports on the average number of children women are having (CEB, children ever born), not the total fertility rate (TFR), which is calculated differently. The TFR reflects the average number of children that would be born to a woman during her reproductive lifetime, calculated by averaging the average number of children for women of each year of reproductive age. The low number of children ever born (CEB) in Ladakh is due to fertility choices, rather than infant mortality, which is fairly low for the region.

13. See Guilmoto and Rajan, 2002. The 2005-2006 National Family Health Survey, conducted by the Jammu and Kashmir state, reports a different TFR for the Jammu and Kashmir state (2.4) and the Indian state (2.7). Though calculating TFR differs from calculating the average number of children, it is evident that Ladakhi fertility is low in comparison to the state and region. Working from a small sample size, Sara Smith reports a higher number of children for women in Leh district, with a mean number of children for Buddhists (3.18); Sunnis (2.44); and Shi’as (3.25).

14. IUD/IUCD (intrauterine device); male and female sterilization (tubectomies, laparoscopic ligation, and male vasectomy); condoms, birth control pills, and injectable hormones (Depo-Provera).

Ladakh, as they do not require additional resupply or regular check-ups, appealing to rural women who have travel far distances to health centers. Along with IUDs, sterilization (ligation) is another popular method of contraception. That permanent and long-acting contraceptive methods are most used in Ladakh is not surprising, given the government incentive schemes that encourage their use.¹⁵ My research shows contraceptive use to be high among Ladakhi women, evidenced by the number of women who reported using (or having used) contraceptives, along with statements from interviews about desires to space their family (see Table 4). Among women interviewed at the three hospitals (Leh, Kargil, Diskit), the average percentage of contraceptive use is 75 percent. Regionally, contraceptive use was highest in Leh (80 percent), followed by Diskit (75 percent) and then Kargil (62 percent). While the average contraceptive use of Buddhist women is higher (80 percent) than that of Muslim women (65 percent), the rate of Muslim women's contraceptive use is still higher than India's national average (56 percent) or that of the Jammu and Kashmir state (53 percent). What is also notable is that Leh is the only location where Muslim contraceptive use (89 percent) is higher than that of Buddhists (78 percent), which suggests the influence of the pronatalist movement on Buddhist women's fertility.¹⁶

What emerges from my hospital survey is the following: Muslim fertility is not as high as perceived; contraceptive use is extensive throughout Ladakh; and disparities between Buddhist and Muslim reproductive behaviors are not as

political context, religious and “cultural” groups such as the LBA can mobilize and unify Buddhists, even as it conceals divisions that erupt within their own community. The pronatalist movement reflects this sense of Buddhist vulnerability and re-emerged in recent years in response to the politicized debates about Ladakh's population. Members of Buddhist community groups and religious leaders have actively promoted pronatalism and advocated against family planning through conducting village visits. During these visits, Buddhist women are told about the population threat, that family planning is a sin, and encouraged to produce more Buddhist children. According to a 31-year-old Buddhist mother in Nubra, the LBA began organizing village visits there in 2005, and there have been annual meetings there ever since:

First, LBA comes to Diskit, then they say don't do ligation because all our population is going down and the Muslim population is going up. Then one day the Muslim population will be higher than us. Then all the women are scared, thinking what will happen with our children?

Women in Nubra acknowledged a heightened sense of worry about the population, although their worries were highest immediately after village visits, with their worries dissipating over time. Village visits cause women to have conflicted feelings about using contraception. For example,

Table 4: Contraceptive use by region and religion

Location	Contraceptive use: Muslim women	Contraceptive use: Buddhist women	Both Buddhist and Muslim women
Leh	89%	78%	80%
Kargil	59%	83%	62%
Diskit	59%	83%	75%
Average of three regions	65%	80%	75%

dramatic as perceived.

The perception of high Muslim fertility and Buddhist vulnerability is not simply due to feeling marginal in relation to the Indian state. This perception also reflects internal political tensions within Ladakh, where religious unity and population strength are considered necessary for securing political power (van Beek, 2004). Given this complicated

a 39-year-old Buddhist woman with two children noted that she had never regretted having ligation surgery, yet began to feel regretful during pronatalist village visits. A 50-year-old Buddhist mother of three from Panamik village told me that she doesn't regret her ligation, but now tells her daughter to give birth to more children than she had. Some women questioned the pronatalist discourse, noting that it was difficult for poor women to take care of many children and that having many children was difficult for women's health, two issues often overlooked in village visits. On April 17, 2008, an anonymous letter was posted throughout Leh's Main Bazaar, which described apocalyptic warnings about what would happen to Ladakh's Buddhist population. Titled “Where has Ladakh been taken?”, the text includes the

15. Government incentive schemes encourage use of particular contraceptive methods—paying women 10 rupees to get an IUD inserted and 600 rupees to get ligation surgery performed.

16. It is important to note that my data is taken from interviews conducted with women at the hospital, which likely reflects a higher contraceptive use than those women from far villages who are less likely to travel to the hospital.

following:

Evil eye has struck. Leaders are paralyzed. Temples are locked. Buddhists are at a loss. Unity has been destroyed...Friends have become enemies and our country has filled with shit. Leh city is filling up with bad smells. Ladakh has become a place of fighting. Our leaders' unity has been broken. Buddhists' backbone has broken. The legs of development have been broken...The Buddhists are divided...All the Buddhists have lost their shame. There are bars opening everywhere. The Lineage has become useless. All girls have become nuns. Brothers have married the same wife. *Countless birth doors have been closed. Buddhists are going to be finished* [emphasis mine]. We're at the end of time. Glaciers have melted away. Untimely floods have come. Grasshoppers have eaten half the country. Lamas and monks are mixed in all kinds of things. The knife is at our throat and we are blaming each other for murder. Religion has been harmed. Hey Buddhists, think about it. Still you have time to think. One day you'll have to leave this place. One day you will have to convert to another religion.

This letter exemplifies the worry of a weakened Buddhism—by internal conflict, lack of unity, and weak morals. This is linked to concerns that the Buddhist population is dying out, indeed, “countless birth doors have been closed” and “Buddhists are going to be finished.” Though Muslims are not explicitly addressed in this letter, it is evident that conversion fears and fertility are linked to cultural survival. Muslim reaction to Buddhist pronatalism is a general reluctance to speak about the issue or feigned ignorance. While some Muslims are sympathetic to Buddhist population worries, they are not in agreement with the communal undertone of the pronatalist movement. As a Muslim leader in Leh explained, “I have sympathy for the LBA position because Ladakh was a Buddhist country. They are just worried about demographics changing, so Buddhists are naturally very worried. But they should not communalize the issue.” The reluctance of Muslims to react directly and strongly to Buddhist pronatalism is likely due to worries that the population issue could escalate already existing tensions between the two groups.

FAMILY PLANNING: SINFUL YET SUPPORTED

Opposition to family planning in Ladakh is expressed in both religious and political terms. Political opposition is articulated as an issue of representation, where having a lower population means less power and visibility within the state. While religious opposition from Buddhist and Muslim leaders portrays family planning as sinful, there are distinct differences between the two religious communities. Buddhists

point to the authority of His Holiness the Dalai Lama, who himself has made statements about population, where he both supports family planning and advocates increasing the Tibetan Buddhist population (Childs, 2008; French, 2003). The difficulty of reconciling Buddhist principles of non-violence with the global issue of overpopulation is evident in the following statement from His Holiness:

From a Buddhist viewpoint, every human being is precious and one should avoid family planning and birth control. But then if we look from the global level, that precious human life is now overcrowding the world. As a result not only is it a question of survival of a single human being but that of the entire humanity. Therefore the conclusion is that family planning is necessary provided it is based on non-violent principles (Childs, 2008: 169).

Although His Holiness the Dalai Lama is revered and admired by both Ladakhi Buddhists and Muslims, many of his comments (“every life is precious”) have at times been utilized to justify Ladakhi pronatalism. Furthermore, many Ladakhis have noted that there is a discrepancy between what the Dalai Lama says in English and his speeches in Tibetan, where he refers more explicitly to the vulnerability of the Tibetan population and encourages pronatalism. Prominent Ladakhi Rinpoches have spoken publicly on pronatalism and contraception, and have made statements that link contraception to murder (Smith, 2009a, 2009b).

Because many Buddhists equate contraception and abortion, preventing conception is viewed as a sin (Childs, 2008). The Ladakhi terms for contraception—*skye gog/skyes go thabs* (birth control methods); *thugu mi skecesi thaps* (methods to not have children); and *skezgo kak* (to block the birth canal)—are understood locally as both “birth control” and “closing the birth canal/birth door” (Norman, 2010). Thus, the use of contraception blocks the birth door and prevents the rebirth of another Buddhist. Ladakhi Buddhist opposition to family planning is more than just recognizing that life is precious—the use of family planning is specifically singled out as a sin. While the LBA has been most active in opposing permanent methods of contraception, many members are also against temporary methods as well. An ex-president of the LBA explained:

When the small family norm was introduced in India, the medical people actively enforced it...but now the attitudes are changing. Now health facilities have improved so we shouldn't bother with family planning at all. Monks talk of both permanent and temporary methods of family planning as being wrong from a religious point of view. When you are reborn, the soul is roaming around somewhere when you stop

and disrupt the soul with something like family planning.

From a Buddhist perspective, family planning interrupts *Bardo*—the liminal time between death and rebirth—when souls are reborn (Nyima Rinpoche, 1991). Ligation is perceived as especially sinful because it permanently “closes the door” (*rgo cukces/rdumces/ban cukces*) to a new life. Temporary methods are more accepted, since women can have more children later. Most opposition to family planning is directed at permanent procedures—such as ligation and abortion—which are stigmatized, even though both remain legal and available.¹⁷ Beginning in 2005-06, stickers detailing proper moral and reproductive behavior began appearing throughout Leh, primarily pasted onto buses, store windows, and even within Leh’s SNM hospital. Produced by the LBA, the text of the stickers stated:

The four facts:

1. Abortion is a cause to sever oneself from human rebirth in the next lives.
2. Marriage between close kins is non-virtuous sexual misconduct.
3. It is an act of partiality if the inheritance is not equally distributed among brothers and sisters.
4. Disloyal it is, not to have affinity to one’s own ethnic cultural values.

In naming these four premises as “facts,” these stickers link proper moral behavior with cultural and ethnic obligations. The “fact” about abortion is that it will continue to negatively affect women—not just in this lifetime, but also in their subsequent lives. Thus, abortion and ligation are not only sins in this lifetime, but will have clear karmic effects into one’s next life. Some felt that the use of temporary methods—such as an IUD—could affect the level into which one was reborn. As a mother from Diskit explained:

I wouldn’t get ligation because it’s a very big sin. Suppose I die with ligation and then I [am] never born again as a person. Some people say this. If menopause comes, I should remove the IUCD because it is so *dikpa* [sinful]. If you die with the IUCD it is so *dikpa*. Elder people say this. You should throw it away. [If you die with the IUD still inserted] also you will not be born as a human being in the next life.

Every birth that is prevented through contraception deprives someone else of a human rebirth. Furthermore, one’s sins

17. Though abortion is a sin, there are circumstances where it may be permitted. “Buddhists are more willing to condemn abortion on moral grounds than to oppose legislation of it, often being more permissive in practice than in outlook” (Harvey, 2000: 350). See Harvey, 2000 for a further discussion on Buddhist ethics.

come with you during the process of rebirth. This means that when a woman uses family planning in this life, it will affect her subsequent level of rebirth, as she will likely be reborn in a lower kingdom (*rung*).¹⁸

Though there are no karmic consequences in Islam, there are religious explanations for why family planning is opposed. Having a child is viewed as a gift of God, and to prevent that gift (through contraception) is sinful. Permanent methods, such as abortion and sterilization, are *haram* and considered sinful because they cannot be reversed (Mahdavi, 2008; Tober et al, 2006). Engaging in practices considered *haram*—such as sterilization—has real life effects on both women and men. For example, in her writing about family planning in Kashmir, Sangeeta Chattoo describes the social ostracization of Kashmiri men who have had vasectomies, where they are not allowed to enter mosques, which in effect changes their relationship to God (Chattoo, 1990). Yet, there is nothing specifically in the Qur’an that argues against contraception, and religious perspectives on contraceptives differ greatly across the Muslim world (Hoodfar, 1995; Mahdavi, 2008). According to Islamic law, the fetus is not considered to have a soul until 120 days (17 weeks), which is why it is often permissible to have an abortion in the first trimester (Mahdavi, 2008; Tober et al, 2006). That abortion is both permitted and considered a sin indicates the space within local interpretations of Islam that tolerates birth control.

In contrast to Buddhist leadership in Ladakh, Muslim religious leaders and community organizations have not taken a specific stance against family planning, though some religious leaders are strongly opposed to it. One Muslim leader in Leh explained, “If a Muslim woman is sick, then family planning is allowed. You have not violated Islamic Shari’a. Abortion is a sin because of killing. Ligation is allowed. The Muslim community has never made a position covertly or overtly about family planning.” Though Muslim leaders may be personally opposed to family planning, they have not engaged in political activism against it. As the Indian demographer Alaka Basu has noted, Islamic opposition to family planning is often more about politics than religion (Basu, 1996).

Islamic opposition to family planning is contextual, with exceptions often made for women’s health and other social conditions. Sameena, an unmarried Muslim girl in Hundar village, described the complexities surrounding family planning in Islam, as it is commonly viewed as a sin in Ladakh but there are also allowances made for it. “Ligation is a sin. A child is God’s wish. How much children we have is God’s wish. We cannot go against God’s wishes,” she stated,

18. While one’s level of rebirth may be affected by family planning, Smith noted that family planning cannot produce certain birth outcomes. “According to Buddhist women I interviewed, Rinpoches argue that each child comes with its own *sode*, or luck, (in this context, it could also be interpreted as karmic burdens) and thus attempts to produce certain outcomes through family planning are futile” (Smith, 2009a: 147).

“but family planning is allowed in certain circumstances—for the very poor, like if they cannot look after the child, or a situation where the women’s health is in danger or if there is a rape.” Even with these accommodations, Muslim women’s reproductive decision making is still constrained by religious opposition, which is much more notable among Shi’a women (Grist, 2008; Smith, 2009a, 2009b). Yet, like Buddhist women, Muslim women stated that family planning was a sin, yet used contraception and were grateful to be able to space their families.

Like Muslim and Buddhist women, religious and political leaders appeared to contradict their public opposition to family planning. Gynecologists frequently pointed out to me that the men most vocal in their opposition to family planning all had fewer than two children. Speaking about religious leaders, one gynecologist in Kargil noted, “They always say that family planning is a sin (*gunaah*; *gunha*). But they are sending their wives to the doctors, saying ‘please do this’ [referring to ligation] but then are lecturing to others [in the community] not to [get sterilized]. Some say both [ligation and IUDs] are a sin, some say only ligation...as for my opinion, it is not a sin in Islam. Islam doesn’t say you don’t go for family planning. It’s an interpretation of religion.” Interviews with hundreds of Ladakhis show that support for family planning is widespread despite the prevalent discourse that constitutes it as a sin.¹⁹

Both Muslim and Buddhist women support family planning, even as they describe it as a sin and make

Some people say it’s not good, but for my opinion I feel it’s good...Otherwise we have so many children who we cannot clothe and feed, and I think that it also a sin! Other ladies who already had ligation nobody said anything to them...in those days, it was easily acceptable, nowadays, more people are saying negative things about it.

According to my data from hospital survey, when specifically asked about “family planning,” 52 percent of women *unequivocally* support family planning, 17 percent support family planning *conditionally*—after having “enough” children or through distinguishing temporary and permanent methods (“ligation is a sin but spacing is good”). While 13 percent were *unsure*, only 9 percent were directly *opposed* to family planning. Those opposed typically mentioned the influence of community groups that were active in pronatalism. Seven percent stated that their support *depended on external factors*—such as the health of the mother, the importance of education, and family/household security.

This data suggests that total opposition to family planning in Ladakh is low; that Buddhist women are more conflicted about family planning than Muslim women; and that Muslim women are more supportive of family planning than is often assumed. This runs counter to the strongly held perception that Muslim women are reluctant to use family

Table 5: Family planning support by religion

Opinion on family planning?	All women	Buddhist women	Muslim women
Unequivocal support	52%	49%	58%
Conditional support	17%	15%	21%
Unsure	13%	17%	6%
Opposed	9%	9%	9%
Support depended on external factors	7%	8%	4%

distinctions between permanent and temporary methods (see Table 5). Sterilized women characterized ligation as a sin, yet would add that they had no regrets about choosing a permanent method of contraception. Some women were scolded by family members or were made to feel guilty about their ligation by religious and community members. A 47-year-old Buddhist woman from Chilling with three children who had a ligation ten years ago explained:

19. This is based on interviews conducted in Leh, Kargil, Sankoo, Diskit, Chushot, Chamshen, Panamik, and Hundar. Interviews were with Buddhists, Muslims (Sunnis, Shi’as, NurbakShi’as) and among a wide variety of groupings (married and unmarried; women and men; doctors and medical staff; and religious and political leaders)

planning. While most women support family planning, women tend to join the public discourse about population worries, rather than take a stance on access to contraception and family planning.

Children’s education and the increasing costs of raising children were the most commonly stated reasons women gave for family planning use. Fertility decisions were linked to education. As others have noted, changing fertility practices are often due to a shift in attitude among parents, who begin to prefer “quality” children to quantity (Greenhalgh, 2005; Smith, 2009a, 2009b). In Ladakh, pursuing an education invariably means that children will leave their village and move to urban sites—such as Leh, Kargil, or outside Ladakh—to pursue additional education. While their pursuit

of education may open up new employment opportunities, it also disproportionately places a higher agricultural burden on parents and grandparents, who remain in the village (Hay, 1997). Given urban migration and employment transfers, the decision to limit one's fertility has become entangled in wider worries about the strength of Ladakhi culture.

Fertility decision-making presents a paradox, where having fewer children means less familial security. In a context where children are expected to take care of aging parents, the fear of being alone as one ages is salient. Thus, some parents decide to have *more* children because they feel insecure about the survival of their children. A Sunni father in Kargil district described how child survival and religious norms took precedence over his desire to have a small family.

The Muslim population is increasing because people don't plan families, now we have more money so (it is) easier to have more children... my wife had 7 children, 4 died, 3 survived. I only wanted one boy and one girl...so we Islamically plan our family but the Indian government forces us to plan our family. If an epidemic comes, then what to do?

By "Islamically planning their family," the Sunni father saw his wife's fertility as within God's hands. This couple did not use "modern" methods of contraception because it went against their religious beliefs, instead viewing each pregnancy as according to God's wishes. Though it would appear that concerns about child survival would dissipate with improvements in reproductive healthcare, many still worried that a ligated woman could lose her existing children due to diseases or accidents, which would leave her childless. Together, the concerns about family security, changing household composition, and migration underscore the larger anxieties about population.

THE POLITICIZATION OF REPRODUCTION

"Where else in the world is there an abortion day or a sterilization day declared at the hospital?" a Buddhist doctor asked me during an interview. He was referring to the earlier era of family planning in Ladakh (1980s-90s), when certain days of the week were set aside at the hospital for sterilization surgeries, which came to be known as "ligation day." The recent elimination of "ligation day" at the hospital indicates how the politicization of reproduction is impacting the medical sphere.

Together pronatalism and activism against family planning have affected the delivery of reproductive healthcare. Buddhists worried about the population, many of whom are from the LBA, are associated with a number of politicized incidents, such as interference with ligation clinics and anonymous threats against those who work in reproductive health (Gutschow, 2011). Doctors at Leh's SNM hospital describe a staff that is often uncooperative, particularly when

it comes to abortion or ligation surgeries, which go against their religious beliefs. Stories abound of hospital staff that refuse to assist gynecologists with controversial surgeries, such as ligation and abortion. It has also been rumored that medical equipment, such as the laparoscope, has been deliberately vandalized. One gynecologist explained the constraints she was under:

There are major problems with the staff, particularly with abortion, the nurses are uncooperative...they say that when surgeries are listed on OT [operating theater] list, it's too public. Thus, staff say to me to perform abortions and ligations in the delivery room, which is more discrete but then the labor room staff complain, saying 'why should it happen here?'

Activism against family planning has targeted Ladakh's few gynecologists. One described how a male from the Youth Wing (an ancillary group within Ladakh's largest cultural association, the Ladakh Buddhist Association) told her that she would have to personally explain to His Holiness the Dalai Lama why the Buddhist population is decreasing. These types of statements not only overlook Ladakhi women's own agency in choosing to plan their families but also presume that the Buddhist population is in decline, even though there is little numerical data to support this. "If you don't want family planning, then don't use it," one gynecologist said, a bit exasperated, "but don't interrupt my work." After describing the politicized and tense hospital environment, one doctor said, "I just want cooperation in the hospital."

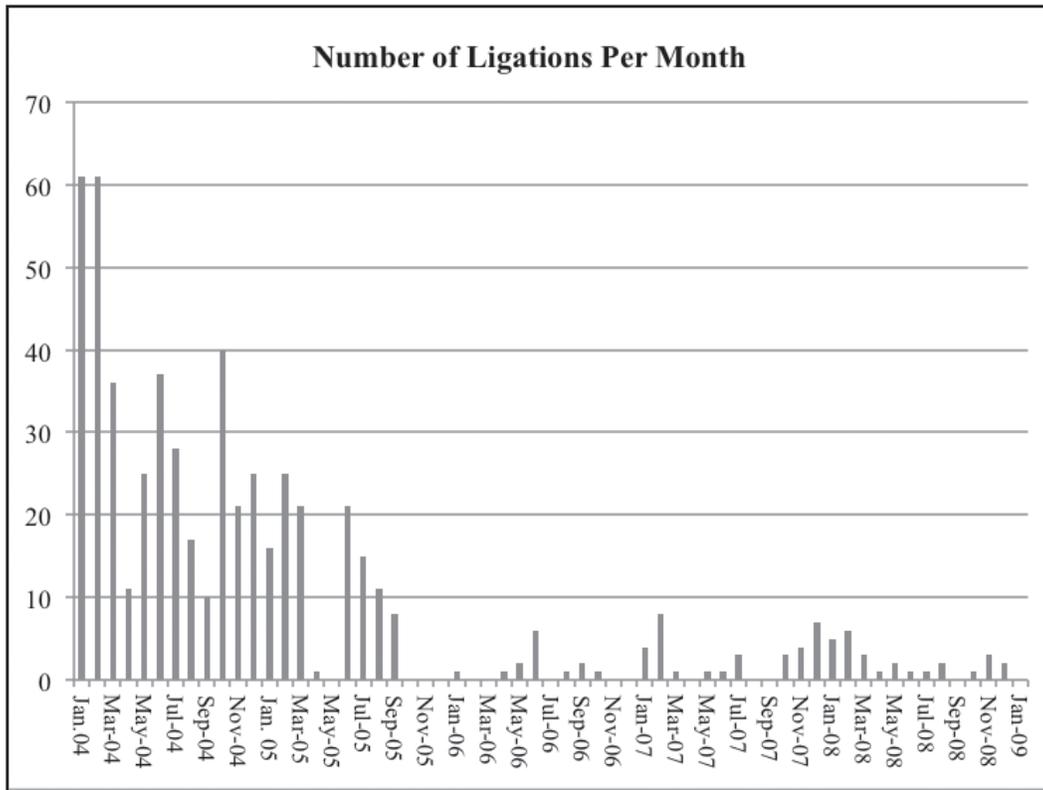
While gynecologists overwhelmingly support family planning and contraceptive access, most doctors stated their preference for temporary spacing methods and a desire to avoid ligation. A male doctor with three children explained, "I prefer other methods of birth control besides ligation. (Ligation is) only for those with four or five children, but not for those with two or three children." Opposition to ligation was evident among male doctors, such as the Buddhist doctor who said, "Ligation should be stopped for at least 10-15 years. Spacing should be there but ligation is not necessary. Ligation and NSV (nonsurgical vasectomy) should be stopped entirely."

In addition to impacting the work of gynecologists, hospital politics surrounding contraception impacts women's access to reproductive healthcare. Most notable is the significant decline in ligations, which decreased 97 percent between January 2004 and January 2009 (see Table 6). While the average monthly ligation rate at SNM hospital during 2004-2005 was 41, it had declined to an average of two surgeries a month by 2008-2009. The rapid decline in ligation shows the influence of the activism against family planning. Furthermore, it has also influenced attitudes towards temporary methods, with a number of village

women telling me in interviews that ligation and IUDs had become illegal, even though they remain legal and available. As reproduction has become more politicized in the hospital setting, it not only impacts the reproductive choices of Ladakhi women but also creates a culture of surveillance among the medical staff within the hospital.

and the nation. The idea that Ladakh's cultural strength must be preserved is something upon which all Ladakhis from all regions and religions agree. On the other hand, these discourses have polarized relations between Muslims and Buddhists. Characterizations of Buddhist and Muslim fertility—Buddhists as more vulnerable and Muslim women

Table 6: Ligation decrease at SNM hospital, Leh



CONCLUSION

Population discourses and fertility behavior appear contradictory in Ladakh. How to explain pronatalist activists who themselves plan their families? Or the different perceptions Muslims and Buddhists have about each other's population while also sharing similar population anxieties? Two population discourses—competitive demography and Ladakhi exceptionalism—unproblematically coexist in Ladakh, which creates particular kinds of reproductive subjects (the “hyper-fertile Muslim” and the “vulnerable Buddhist”). These discourses also have material effects—generating pronatalism and intensifying hospital politics—which impact gynecologists, shape women's reproductive decision-making, and limit access to care.

Furthermore, these discourses are shaping relations between and among Buddhists and Muslims, at times unifying them in a shared Ladakhi identity (via the “Ladakhi exceptionalism” discourse), at times polarizing them along religious and regional grounds. On one hand, the population issue unifies Ladakhis in moments when they feel threatened and marginalized within the Jammu and Kashmir state

as hyper-fertile and unwilling to use family planning—are not only deeply entrenched, but also are called upon when communal tensions erupt.

The politicization of reproduction has put both women and gynecologists in difficult positions. While gynecologists are committed to reproductive education and access to contraception, many are also worried about Ladakh's population. Similarly, though women were happy to space their family, they also felt it was a sin. “We should not do family planning on the religious side, according to Buddhism, I did a sin,” a 39-year-old Buddhist woman with two children explained, though she then smiled and added, “but for myself it is good.” This comment illustrates the division between idealized subjectivity (ideals of proper behavior according to religious affiliations, political pressure, and family obligations) and practice (where women use birth control). Ladakhi women are thus left in a difficult position—where their reproductive decisions are constrained by religion and politics, yet they express a desire to be able control the number of children they have.

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