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On Not Being Born: Contraceptive Experiments in the Era of Demopower

In December 1971, as Bangladesh's war for independence from Pakistan drew to a close, the new republic's government faced a host of problems: there were between one hundred thousand and five hundred thousand war dead, a crisis of millions of refugees who had fled west across the border to India, expected food shortages, and the aftermath of what newspapers across the world described as "the rape of Bangladesh."[1] Depending on (highly contested) sources, it is estimated that between two hundred thousand and four hundred thousand women were raped—some by Pakistani soldiers, others by Bengali collaborators (*Razakars*), and also by Bengalis who did not support the Pakistani cause.[2] Recognizing the exigent need for medical care—gynecological and otherwise—the Bangladeshi government was quick to accept an offer from the International Planned Parenthood Federation (IPPF) to send a delegation of doctors to Dhaka. Working with local health-care providers, the IPPF set up a makeshift clinic to attend to what Dr. Malcolm Potts, who was a member of the delegation, describes as a ravaging range of venereal disease; infection; and, of highest medical and political priority, unwanted pregnancy.[3]

Assisting them was Harvey Karman, an American man who had recently left his PhD program in psychology at UCLA to devote himself full time to his passion for abortion rights. Karman's time in Bangladesh would come to

[1] This term was a ubiquitous lede in international news reports and accounts of the war. For a longer account of this coverage and discourse, see Saha (2019).

[2] The latter category is the most vexed, subject to the most strenuous contestation both of narrative and number. It ruptures the compellingly contained narrative in which the nation, long metonymized as a woman, was violated militarily as her representative women were violated. Rape of Bengali women—a substantive proportion of whom were Hindu—and ethnic Bihari (Urdu-speaking Muslims who migrated to East Bengal during and following the 1947 Partition of British India) women by Bengali men who were neighbors, intimates, and, at times, Mukti Bahini (Bengali guerrilla freedom fighters), mars the seamlessness of the nationalist narrative. For analysis of rape during the war and the contestation over statistical and descriptive accounts, see D'Costa (2011), Saikia (2011), and Mookherjee (2015). For other accounts of rape during the war, see Mascarenhas (1971), Brownmiller (1975), and Chowdhury (2015).

[3] Personal interview with Malcolm Potts in Berkeley, California, May 25, 2016. On how women were moved between the rehabilitation centers to the clinic and the forms of data collection and archivization engaged therein, see Saha (2019).

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be a central node in his development of two abortion technologies. One is celebrated as a technique of the contemporary global development apparatus, and the other is reviled as a debunked medical atrocity. The first, known as menstrual regulation, is now the fourth most common form of contraception in the developing world, particularly prevalent in Bangladesh, Cuba, and across sub-Saharan Africa, where abortion is illegal (Sedgh et al. 2007; Miller and Valente 2016). Menstrual regulation, a manual vacuum aspiration technique that allows lay providers to perform nonsurgical extractions of menses before a pregnancy has been confirmed, has been strategically figured as abortion that will not be so named.[4] This practice was once designed to sidestep the force of the law in a pre-*Roe* America and to offer women autonomy over reproductive decisions outside the clinic. Moreover, the practice of menstrual extraction transformed into the technique of menstrual regulation as it was instituted into a global apparatus of reproductive management. In addition to performing and promoting menstrual regulation while in Bangladesh in 1971, Karman also began to develop what he would call the "super coil" method for second-trimester abortions. Super coil, also intended to be performed by lay providers, involved the insertion of plastic tubing into the uterus to induce the expulsion of fetal tissue. Unlike menstrual regulation, which has had an object life far outliving Karman's work, the super coil method became notorious for a 1972 incident in which fifteen Black women in Philadelphia had the procedure performed on them, and nine of those women suffered grievous injuries.

This essay begins with an account of Karman's work on these reproductive technologies, part of what he believed to be a domestic and international humanitarian project, to demonstrate the ways in which those techniques and their circulation are essential to a demopolitical regime committed to the management of nonbirth. The purported development success of Bangladesh, which in the near half century since its independence has received more than $50 billion in foreign aid—the vast majority of which has been in the form of international loans—has been pinned to reproductive control. Not being born in Bangladesh is the goal of a global futurism that invests itself not in reproduction and the management of life but in contraception and the prevention of birth. "Not being born" is a term I take from Michelle Murphy's excellent, incisive account of the management of life and death in *The Economization of Life*, where Murphy identifies it as one of three

[4] While there has been an increase in the number of pharmaceutical menstrual regulations through the use of misoprostol in the past decade, manual vacuum aspiration remains the most common and safest form. See Marlow et al. (2015).

necropolitical modes in Bangladesh (2017, 84). For this essay, not being born is not a necropolitical condition but rather what I term a "demopolitical" one.[5] Demopolitics is the form of biopolitics historicized and contextualized to the contemporary global development apparatus. Herein, the management of life by demographic surveillance, monitoring, and abstraction is pinned to the economization of gendered labor. Demopower invests in a curious double futurity. The first is aspirational, metonymized by the figure of the individual woman who is the subject of this regime and moves, has moved, or is moving toward globally agreed upon markers of empowerment. The second form of futurity is grammatically and ideologically prophylactic, in the form of the population to be controlled, the birth to be prevented, and the family to be planned as limited and nuclear. Demopolitics, at its essence, is a project of managed futurity, oriented toward tracking and regulating the reproduction of its subjects.

What in the developed world goes by the name "reproductive justice" is, in the developing world, "population control." Menstrual regulation, as an abortion technology that fills the critical gap between prophylactic failure and contraceptive access, works in service of the figure of political futurity in postcolonial Bangladesh: the working woman. Unlike state romanticizations of the girl child in neighboring India and China, Bangladesh pins its ideological and economic hopes on the adult woman who can labor safely (and palatably for a global Northern consumer public) in the garment industry, which now drives the nation's development. Thus, reproductive health and choice is the crucible of political possibility in Bangladesh—by way of the singular, sovereign individual interpellated by demopower, and also by the very population that neo-Malthusian investment at the core of development policy seeks to curtail and control. This is the fundamental paradox: reproductive rights, which have been conditioned through the figure of the individual, are the proving grounds for the development of a population in need of external management for some unmarked and potentially unending time to come.

Though abortion is illegal under Islamic law, the taboo of its name owes to the liberalization of the global gag rule or the Mexico City policy, which first in 1984 and most recently again in 2017 prevented nongovernmental

[5] This term borrows from the work of Ranjani Bhatia et al. (2020, 337) on "demopopulationism," which describes the institutional structures of knowledge production designed to intervene in population growth by way of managing reproductive norms. Crucially, they argue, at the same time, "demopopulationist policies and projects aim to produce female subjects who empower themselves, promote economic development, and reduce environmental degradation by controlling their fertility. These policies and projects emphasize strategies of individual optimization—predicated on correct management of bodies, fertilities, and reproduction" (338).

and international agencies from receiving funding from the United States government if they performed, funded, or promoted abortion services. Since its independence, Bangladesh has been tied to a global aid/debt apparatus as a condition of postcolonial statehood. Yet its closely monitored development indicators depend on a contraceptive practice that necessarily calls itself something other than the word that evokes one of the most virulent cultural and political debates of contemporary America. In so doing, it also renders exceptional women's sexual and reproductive health practices in the parts of the world in which American state intervention thrives.

Menstrual regulation, as popular and necessary contraception, sits at the juncture of development policy's discourse of gendered empowerment and liberalism's duality of choice and life. Through access to contraceptives like menstrual regulation, funded and distributed by a global aid apparatus of which American money is key, Bangladeshi women are "free" to have fewer children and attain markers of social and somatic well-being that correlate to modernity. They are in this fantasy liberated into development—an ongoing, asymptotic project of progress toward autonomous, coherent, liberal subjecthood. In Bangladesh, it is the prevention of birth that makes for better lives, for lives worth living, for lives that might someday come to occupy the privilege of individual reproductive choice. Until then, in the ongoingness of time in the developing world, those choices and possibilities are collectivized.

This essay will argue that reproductive technologies primed a population of Bangladeshi women to be subjects of the international development apparatus whose measures of success and failure would be quantifications of their bodies. Abortion technology experiments, their human costs, and the legal victories are tied up in a global project in which Brown women are raised up into empowerment by the neoliberal development capital of the global North. Not just symbols of development possibility in the abstract, Bangladeshi women are the material, quantifiable basis of state progress as their bodies are vivisected into statistical markers of the Human Development Index: life expectancy, maternal mortality, infant mortality, access to contraception, education. At the same time, this demopolitical regime implicates an international feminist debate over the terms and form of reproductive and indeed economic justice.

To be clear, I am not arguing against access to contraception, against access to the broadest complement of reproductive and sexual health choices being available to women in Bangladesh or anywhere else in the world. Human development indices that have tracked women's increased access to health services, education, and independent income bear out that women live longer, healthier, more productive lives than prior to the intervention of development

capital. But this essay asks a different question of the developing and postcolonial world: where population control and family planning are the avowed mandates of both state and international policy, what does a politics of reproductive choice look like?

Humanitarian experiments

When Harvey Karman arrived in Dhaka in late 1971 with the IPPF delegation, he had already become something of a celebrity in the world of abortion rights activists. It should be said from the outset that Karman is among the more controversial figures in the history of American abortion debates. Celebrated in some pro-choice circles for his decades-long commitment to abortion rights, Karman developed critical technology that shaped how doctors and lay providers performed abortions across the world. But Karman's critics are not just those who oppose the legalization of abortion or its access. Karman's experiments in abortion procedure came at the cost of an untold number of lives. Because of the aura of silence around abortion at the time and the particular constitution of women on whom Karman practiced, we have neither comprehensive anecdotal accounts nor figures for his successes and for his failures, which resulted in infection, catastrophic injury, and death. This essay gathers an archive of material from interviews with those who knew and worked with Karman, like Malcolm Potts; Karman's own narrative in the press; historical accounts; and feminist historiography. It is critical that we attend to the full feature of what Karman made possible as part of this critical inquiry into the demopolitical management of futurity through nonbirth: increased access to reproductive choice; safer abortions for some, increased risk of death and injury for others; the whitewashing of the history of reproductive technology.

Karman had no medical degree or formal training but had since the 1950s acted as an abortion mule, driving women in Southern California across the border to Tijuana for abortions. Over the course of his work in the abortion network in the Los Angeles area, Karman began to notice that while hospitals in the city could not perform abortions, they would regularly, as an emergency room procedure, perform dilation and curettages (D&Cs) if a pregnant woman arrived with vaginal bleeding. The overworked and understaffed emergency rooms often did not perform ultrasounds early in the pregnancy, proceeding instead directly from observed diagnosis to treatment. Karman recognized that if a woman could mimic the symptoms of a partial miscarriage, she could undergo a safe, immediate, medically induced abortion without the risk of travel to Mexico. So, he began to test his theory by injecting women who sought abortions with pipettes of their own blood and bringing them to notably busy emergency rooms in the city. This was an ad hoc and unpredictable

maneuver that in the end drove home for Karman the need for a more local solution.[6]

Initially Karman took to practicing lay abortions himself, employing the common curettage method of scraping clean embryonic tissue. In 1955, he performed an abortion using this method on a woman in a Los Angeles motel room; she died from complications from the procedure. As a result, Karman was convicted of performing an illegal abortion and sentenced to two years in prison (Goldberg 2009, 38). Accounts of Karman's contribution to the reproductive rights movement—especially from those like Malcolm Potts, with whom Karman worked in Bangladesh and who went on to publish and from whom I myself first learned of Karman—gloss over this early period of gynecological experimentation. It is represented as the collateral damage in the battle for reproductive rights in America, the cost born of the criminalization of abortion. Culpability for the death of this woman, whose name has been erased from the record, falls, in most tellings, squarely on the shoulders of the American state that had kept her from a safe, legal abortion in the first place. This is true. Karman's work was only possible because of decades during which American women took on enormous risk to obtain abortions. But Karman's zeal for abortion access nonetheless seemed unconstrained by concern for the actual health and well-being of the women on whom he performed his lay procedure.

After Karman's brief incarceration, he began work on an alternative, non-curettage procedure. Curettage, in which the uterine wall is scraped clean of embryonic matter during a traditional abortion, carries a significant risk of uterine perforation, not to mention infection, lesion production, and scar tissue formation (Tunc 2008a, 356). However, in Eastern Europe, where abortion has never been banned, medical science had moved past a reliance on curettage procedures and toward vacuum aspiration. There, instead of uterine scraping, a suction is created by a cannula that then removes uterine contents, with no need for any sharp instruments at all. Karman drew on the research of Chinese gynecologists to develop a plastic cannula that, with the use of a syringe to create a manual suction, could be inserted along the wall of the uterus to extract menses and embryonic matter (Tunc 2008a, 356). Michelle Murphy notes that American radical feminist groups like the Redstockings had been circulating an untranslated guide to a similar form of manual vacuum aspiration written by Chinese gynecologists (2012, 155). But Karman's method, then called "menstrual extraction," and his unpatented but popularly eponymous Karman

[6] This account of Karman's life and work comes from interviews with Malcolm Potts, in addition to work by Leonard Laufe (1977) and Emin Tanfer Tunc (2008a, 2008b), an interview with Karman by Robert Lynne in *Cosmopolitan* (1973), and the extensive reportage by *off our backs*. See also Karman (1972), Karman and Potts (1972), Mattingly (1973), and Scotti and Karman (1976).

cannula were quickly and enthusiastically adopted by lay abortionists and medical professionals alike. The plastic cannula itself was cheap and easily available; nonsurgical, the procedure was safe and simple enough to be performed by trained laypersons. This democratic nexus of object and procedure made Karman's cannula aspiration procedure the darling of reproductive self-help activists like Carol Downer and Lorraine Rothman, who saw it as a transitional technology away from the medicalization of abortion rights and toward greater autonomy for women (Murphy 2012, 155). Indeed, Downer had also developed a menstrual extraction method in this period, though Karman's use of the readily available and affordable plastic cannula proved remarkably exportable. Murphy writes, "As a practice meant to occur only outside law, profession, and commodification, Menstrual Extraction, if not widespread, was iconic of the most radical goals of the movement, the self-governing of reproduction, or, as Rothman expressed it, 'controlling our own biologies'" (160). Extracting menses, whether by use of manual vacuum aspiration or pharmaceutically, has long been a critical technique of gynecological self-care by women. Both technique and instrument, menstrual regulation was a testament to individual, noninstitutionalized reproductive choice.

While menstrual extraction became popular among DIY feminists in the Los Angeles area, it was also traveling to the other side of the world with Karman as he joined the IPPF in Dhaka at the end of 1971. Doctors Geoffrey Davis (Australia), Leonard Laufe (United States), and Malcolm Potts (United Kingdom) worked with local providers to provide exigent gynecological care, including abortions, at the state-sponsored clinic in Dhanmondi. Before and during their stay in Bangladesh, Potts and Davis both note that they likely treated only a fraction of the women who might have become pregnant as a result of war rape. Other than those who, by virtue of staying at the Women's Rehabilitation Centre in Dhaka or actively seeking out formal avenues of care, received treatment by the IPPF delegation, women underwent either lay curette procedures or availed themselves of such local remedies as using milkweed as an abortifacient (Burhanuddin 1975, 1; Abernethy 2018, 51).[7] These

[7] Virginia Abernethy notes that A. F. M. Burhanuddin carried out trials on 108 women during and following the war using milkweed as an abortifacient. He inserted the creeper vine into the cervical canal to induce abortion within three days (2018, 51). In 1974, Burhanuddin himself published an article in the *Journal of the Asian Federation of Obstetrics and Gynaecology* on the use of *Asclepeadaeae* (milkweed) for women between twelve and twenty-four weeks pregnant. At no time in the reported study does Burhanuddin note the etiology of the pregnancies, the context of the war, or the rationale for the use of the abortifacient at the very end of the second trimester. He notes, however, that despite some complications, the method appears effective and "compares favorably with other experimental methods (urea, alcohol, laminaria tents, or Karman coil methods)" (1).

informal abortions, which took place around the country, met the need of scale that the IPPF delegation simply could not.

During the IPPF stint in Bangladesh, abortions were legalized in order to effect a particularly nation-building form of ethnic cleansing: because the official state narrative held that Bangladeshi women had been raped by Pakistani soldiers during nine months of war only, the state mandate was constrained to those women whose pregnancies fell within that gestational period and symbolically toward all women who potentially carried children of Pakistani blood.[8] The major task of this imported contingent of doctors and volunteers was to purify the reproductive vessels of this new nation—to end viable pregnancies that had Pakistani paternity and to ensure the continued fertility of Bangladeshi women who might go on to bear new national subjects. Thus, at the end of four months (the limit of time at which a pregnant woman brought to an IPPF-staffed facility would have conceived during the war and yet still safely be subject to an abortion) the IPPF doctors departed from Dhaka, having completed the terms of their agreement with the government.

Though the official IPPF delegation and their legal status in Bangladesh expired quickly, Karman's personal mandate seems to have stretched beyond that. Potts recounts that toward the end of the mission, Karman took off in a UN helicopter out of the capital for several weeks. During that time, Karman claimed to have performed abortions and trained local laypersons and paramedical professionals in the vacuum aspiration procedure he had been developing.[9] In line with his self-styled persona as renegade humanitarian, Karman's time in rural Bangladesh has no official account but served both for the Bangladeshi government, which would take up his aspiration technology wholesale (especially when marketed by USAID as contraception), and for Karman himself, as proof of the potential for abortion as a critical technology of empowerment.

When Karman disappeared into the Bangladeshi countryside, he was not simply distributing plastic cannulas and demonstrating vacuum aspiration. He had, in the months before his trip to Dhaka, been working on a procedure that he hoped would be as effective at second-trimester abortions as his manual aspiration seemed to be for first trimester.[10] Karman returned with

[8] Sheikh Mujibur Rahman, symbolically essential to the rehabilitation program, is quoted as saying to a social worker tasked with gynecological care and arranging overseas adoptions, "Send away the children who do not have their fathers' identity. They should be raised as human beings with honor. Besides, I do not want that polluted blood in our country" (in Ibrahim 1998, 18; translation my own).

[9] Personal interview with Malcolm Potts in Berkeley, California, May 25, 2016.

[10] Reports that Karman performed procedures on women up to and past twenty-four weeks of gestation engage a phrase often deployed in abortion debates, that of so-called

uncorroborated stories of having performed dozens, potentially hundreds, of abortion procedures on women using his new method, which he called the "super coil." It consisted first of the insertion of flat plastic strips that were wound up into coils and attached to strings; these would be inserted into the uterus for between twelve and twenty-four hours, during which time they would unfurl to shred the embryo and surrounding matter. Thereafter, the coils would be pulled out, causing the uterus to expel the contents (Tunc 2008b, 6). Fundamentally, the procedure irritates and injures the uterus while at the same time destroying the fetus. Karman was convinced that the super coil, like the plastic cannula, could and should be performed by lay providers and even claimed that it required no anesthetic or dilation.

We have only the barest record, anecdotal or otherwise, of Karman's super coil experiments in Bangladesh. Even his own self-aggrandizing account of performing the procedure throughout villages comes only by way of those to whom he relayed it. Certainly, we do not have any from the women on whom Karman performed the super coil procedure, neither qualitative narrative nor quantitative data on its risks, its side effects, and its potential fatality. The Bangladesh government's adoption of menstrual regulation as a state technology, a contingent effect often figured as causal in Karman and Pott's accounts, does not tell us anything about this other technology's use in this period. However, after leaving Dhaka, Karman continued to develop his coil technique, apparently convinced by his time in Bangladesh that it could be used safely far later in pregnancy and supported by the American abortion activist and head of National Women's Health Coalition Merle Goldberg, who had originally invited Karman to Dhaka as part of the IPPF contingent. The "mercy mission" that took a group of doctors to attend to the reproductive future of Bangladesh in the waning days of the war seemed to have, for Karman and Goldberg, a natural addendum in an underground clinic in West Philadelphia. In May 1972, a year before *Roe v. Wade* would

late-term abortions. This moniker, while evocative, is not a medically agreed upon category. The American College of Obstetricians and Gynecologists describes a "late-term" pregnancy as one between 41 0/7 weeks and 41 6/7 weeks of gestation, the stage of pregnancy following "full-term" and preceding "post-term" (Spong 2013). The phrase "late-term abortion" came into popularity in the 1980s and 1990s, culminating in policy debates over intact dilation and extraction (intact D&E) or "partial-birth abortions" in 1995. In 1998, a pair of competing articles was published in the *Journal of the American Medical Association* about what the tipping point of such a procedure should be (Grimes 1998; Sprang and Neerhof 1998). The 1995 Partial-Birth Abortion Act, which was vetoed by then-President Bill Clinton twice over, banned "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery" (Partial-Birth Abortion Ban Act of 1995. H.R. 1833, 104th Congress). Lack of medical clarity about the viability of a fetus has opened up a vast debate about the legal status of fetal life.

make abortion legal in the United States, Karman invited a news crew from WNET-TV to record a trial of the coil, performed in Philadelphia by a local Black doctor—Kermit Gosnell—on fifteen low-income Black women in their second trimesters who were bussed in from Chicago, where they had been barred from access to safe abortions.

What is the thread that binds the bodies of Bangladeshi women, subject to sexual violence during war and availed of state-sponsored reproductive intervention, and poor Black women, denied access to safe legal abortions by virtue of federal law and vast structural inequality in medical care and political access? Counterintuitively, Karman and Goldberg's attenuated "mercy mission" suggests a common traffic in bodies, a shared condition of dispensability of these poor, dark women in service of a project of individual liberal rights that are oriented toward white American women. I am not here arguing that there is some perfect similitude between Black American women and Bangladeshi women, some melanated sisterhood of global precarity. Rather, I want to push us to think about what connects these women alongside the critical disjunctures between them and their reproductive possibility. Whereas Karman's confidence in the success of his super coil procedure depended on the unverifiability of his experiments on Bangladeshi women, he and Goldberg pivoted toward an archiving impulse in Philadelphia. Without the consent of the women who had been brought in, Goldberg and the WNET crew kept the cameras rolling as Karman, insistent that the trials evince not just the efficacy of the super coil technique but also of the "paramedical" practitioner, turned to curettage D&Cs and used drugs to induce labor in women for whom the super coils were failing. They kept the cameras rolling, too, as several women began to hemorrhage and had to be taken to the hospital. Three women would suffer catastrophic injuries, including the need for a hysterectomy. Nine of the women in Gosnell's Philadelphia clinic on that day reported serious complications. In 1974, Karman would be found guilty of two counts of practicing medicine without a license in relation to his super coil experiment and fined five hundred dollars.[11]

It would be easy to subsume the events of Mother's Day 1972 into a narrative of Harvey Karman's grotesque hubris. But to make this a story about Karman would, in fact, reproduce the terms by which some bodies in the world have their births controlled, their populations managed, and their families planned, while others battle for reproductive rights. As Dorothy

[11] The events and the subsequent trial are documented by a series of articles in *off our backs* between 1972 and 1974. See Chapman (1973), Dejanikus (1973), Philadelphia Women's Health Collective (1973), *off our backs* (1974), and Forefreedom, Chapman, and Hubley (1975).

Roberts argues in *Killing the Black Body*, on the one hand, "regulating Black women's reproductive decisions has been a central aspect of racial oppression in America" and, on the other hand, "the control of Black women's reproduction has shaped the meaning of reproductive liberty in America" (1997, 6). It is no accident that the women Karman experimented on in Philadelphia were poor and Black. Liberalism does not distribute choice equally. Nor is the value of life as equitably measured. Karman's super coil experiment, in the apparent service of a feminist project of individual rights, took on test subjects for whom access to safe, adequate gynecological care was structurally curtailed.

Contemporary debates around abortion rights have rigidly constellated themselves around the conflict between the "right to life" and "freedom of choice." What Karman's super coil experiments reveal are the people who are the necessary precursors to that subject, the unnamed, unenumerated, undifferentiated objects of intervention, experimentation, and study. Or, more precisely, the broad reaches of a demopolitical regime in which futurity is necessarily curtailed. In the case of the Bangladeshi women whom Karman believed himself to be saving, abortion technology as a part of a broad contraceptive regime has become instrumental to a new narrative of salvation, a developmentalist one in which they are being primed to become individual, laboring subjects—a new liberalizing project of life.

Regulating birth, managing life

During the time that the Planned Parenthood delegation was in Dhaka offering exigent gynecological care, a broader family-planning regimen was being implemented. When the Bangladeshi government, through Justice K. M. Sobhan, accepted the IPPF's offer of assistance and temporarily suspended the extant legal ban on abortion, it instituted a demopolitical state of reproductive management that has abided long after the medical crisis of wartime rape and Planned Parenthood's presence in Bangladesh. The Penal Code of Bangladesh, inherited from the 1860 Penal Code of British India, held that, "Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine."[12]

[12] Penal Code of Bangladesh, 1860, "Of the Causing of Miscarriage, of Injuries to Unborn Children, of the Exposure of Infants, and of the Concealment of Births," § 312.

For the critical period following the war during which abortions might be reasonably performed, the government of the new republic instituted a de jure abeyance on this law, borne out by the official nature of Planned Parenthood's presence. After that exigent moment had passed, however, the Bangladeshi government, now subject to the demands of a global aid apparatus that pinned necessary food and infrastructural support to a variety of demographic markers, would transmute de jure consent into de facto procedure.

In 1977, the Cholera Research Laboratory (now known as International Centre for Diarrhoeal Disease Research, Bangladesh—ICDDR, B) introduced menstrual regulation as part of a broad contraceptive complement to its village-based family planning initiative in its largest surveillance site, Matlab, just outside the capital of Dhaka. Once a project of the South-East Asia Treaty Organization, after the war and the inundation of foreign aid funding from USAID, the Matlab field site moved its focus away from disease research and toward family planning. This shift, Murphy notes, reflected "the priorities of the new state, and also of US foreign policy. Hence, a new set of sexed futures, toward economic development understood to be tied to population control and preventing future births, recomposed Matlab research" (Murphy 2017, 101). The humble plastic cannula and manual aspiration method that now bears Karman's name was integrated into the Contraceptive Distribution Project at Matlab, designed to blanket the area with both access to and education about contraception, carried out by local, trained laypersons, many of whom were women (Marlow et al. 2015). Indeed, in becoming an essential technology of this development project, Karman's invention takes on a new name: menstrual extraction by Karman cannula becomes menstrual *regulation*. That is, it now announces its intent to regulate a broad concert of reproductive processes rather than intervene in a single gynecological moment. Matlab's project intuited, correctly, that one major barrier to contraception was that of the gendered division of life and labor in Bangladesh, in which, until the rise of industrial garments work in the 1990s, women largely did not work in formal sectors outside the home.

By having young, educated women local to the area distribute and oversee contraceptive management and family planning services, the contraceptive project at Matlab engaged village women on the terms of their existing social lives and intimacies. Menstrual regulation, as practiced in this model, was a form of reproductive management that could be performed outside of a clinical setting, by local female lay practitioners. Women who have had menstrual regulation procedures—quantitatively and ethnographically subjects of a variety of demographic studies—often describe the scene of shared decision making around the procedure as twofold: first, in terms of why they

seek menstrual regulation; and second, whether and how they (and almost always their husbands) chose or not to use regular contraception. Negotiations about birth rate, household finances, and social approval shape these choices as much as literacy, health education, and access to care (Gipson and Hindin 2007).

When contraception is absent or fails, Bangladeshi law ostensibly holds that a woman must seek out the consent of her husband before obtaining a menstrual regulation. In practice however, this is often the scene of another intimate negotiation between the woman and the local community health provider in which the woman's presence vouchsafes consent in the absence of her husband. Choices about reproduction and its limitation are worked through among Bangladeshi women, not limited to the individual or even to the heterosexual couple. On the one hand, we might see the demopolitical emphasis on population management replayed here on a profoundly intersubjective scale. On the other hand, we see the ways in which questions of desire and intent, which structures of governance cannot quantify and which do not evoke a liberal idiom, might be played out in the encounter between female lay health provider and the patient. One woman, Fatema, surveyed by one of ICCDDR, B's demographic surveillance systems, notes when asked whether she consulted her husband, "No. What will I tell him? He is illiterate. He does not know about whether we should do MR or not" (in Gipson and Hindin 2007, 194). The frankness of her response is telling of the ways in which the pervasive monitoring of women's reproductive health and choice in Bangladesh has made it so that women can express desires and choice to the professional stranger with a kind of startling intimacy. The demographer, like the lay provider, is a common feature of life, as likely to be consulted and narrativized to as one's own partner or kin.

The informality of menstrual regulation, like its ubiquity and cost-effectiveness in its deployment by American DIY feminists, makes it an accessible and practical solution for women who either by choice or circumstance do not engage other modes of contraception or face contraceptive failure. It makes the termination of a pregnancy cheap, local, and safe—indeed, doing so explicitly without even confirming the pregnancy so as not to codify the practice as abortion. Menstrual regulation is today the fourth most common form of contraception in the world—the vast majority of its use in developing countries, like Bangladesh, where abortion is banned.

From Bangladesh to Cuba to Nigeria to Indonesia to Peru, women employ menstrual regulation as a form of contraception in the face of legal, economic, and cultural restrictions on abortion and more traditional methods of birth control. In its sanctioned form, it allows women who have noticed missed periods to induce very early pregnancy abortion. Within

conditions of constrained consent or limited resources, women can make choices about their reproduction locally, intimately. But the narrative whitewashing of menstrual regulation bears the mark of the history of exploiting vulnerable women as guinea pigs for a technology that is celebrated as empowering and progressive. Indeed, Bangladesh's lauded development success is a deeply gendered one, carried on the wing of improvements to women's health funded by international aid. The nearly five hundred thousand menstrual regulations performed in Bangladesh every year are hailed as a critical contraceptive technology that in turn makes possible continual declines in maternal mortality rates and Bangladesh's steady rise through the development indices used by aid agencies.

Though population control has been a central tenet of international development policy since the 1950s, American foreign policy honed its investment—quite literally—in foreign aid through the management of reproduction from 1970. Establishing the Commission on Population Growth and the American Future, headed by John D. Rockefeller, President Richard Nixon declared, "One of the most serious challenges to human destiny in the last third of this century will be the growth of the population. Whether man's response to that challenge will be a cause for pride or for despair in the year 2000 will depend very much on what we do today. If we now begin our work in an appropriate manner, and if we continue to devote a considerable amount of attention and energy to this problem, then mankind will be able to surmount this challenge as it has surmounted so many during the long march of civilization" (US Commission on Population Growth and the American Future 1972). Global family planning measures were a security priority for the American government, as much as they were an ethical one.[13]

This sentiment materially and ideologically sharpened in Bangladesh where the government continued to target women's reproductive health as a central project: "Women's emancipation, besides contributing directly to social and economic uplift in Bangladesh, will also give a new and positive direction to our country's family planning efforts. It is a well-known fact that birth rates go down as women's emancipation goes up."[14] The state prophesied the intimate link between the reproductive health of Bangladeshi women and the discourse of empowerment that has structured international

[13] Denise Horn argues that "family planning policies were originally designed by US policymakers and bureaucrats as a means of controlling and maintaining access to resources or protecting US interests abroad; on this view, family planning is not simply a matter of women's rights; it is an issue of state security" (2013, 196).

[14] "Bangladesh Women's Emancipation Programme," unpublished document, Jill Sabella Private Collection, Dhaka, Bangladesh, February 1972.

aid policies since 1971. International NGOs and development agencies pressed the point of population control while local organizations recognized that contraceptive access offered women new possibilities in both their intimate and economic lives. The production of Bangladesh as a site of intervention and surveillance by donor countries depends on the gynecological life of women, originating with women who were subject to sexual violence during its war for independence.

Contraceptive intervention into the bodies of women who had been raped during the war both laid the groundwork for a revived ethnic nationalism—a nation without Pakistani blood—and, on the other, primed the site for development aid. But born as it is into the ambit of an American empire of debt, pinned to loan-based international aid structures, Bangladesh's case is neither singular nor isolated. Normative markers of health, well-being, and progress produced by the developed world rely not just on the historical experimentation on women but on the continued visibility of women's reproductive bodies. As in the case of the contraceptive trials conducted on Puerto Rican women in the 1950s (see Briggs 1998; López 2008; Córdova 2018), the relationship between access to reproductive health care and access to a language of rights and agency for poor women in the developing world is mediated by a global system that produces those nations as inchoate stewards of their own populations.

One of the most familiar taglines by which Bangladesh is known, "International Basket Case," comes from the pronouncement by U. Alexis Johnson (and incorrectly attributed to Henry Kissinger) as it became clear that East Pakistan would win its independence (*New York Times* 1972). Bangladesh was diagnosed as pathological at its inception, an incoherent and insolvent blight on the modern world. Today, as a result of the pacts of international support, indebtedness, and intervention it entered into in the early years of its nationhood, Bangladesh hosts an almost unthinkable density of international NGOs focused primarily on public health. Every development success, every incremental accession in indices, every averted disaster faced by the country in the past half century has been lauded as evidence of its triumph over its ontological condition. Bangladesh's entrance into postcolonial statehood was also its emergence into the ambit of an empire of debt and international governance.

Within this dense network of demopower, the body of the Bangladeshi woman and her reproductive potential is central. She is the litmus test of the developing state and engine of its productive labor potential; Bangladesh's incremental move toward middle-income country status depends in no small part on both the quantification of her development potential and the material objects of her labor. Indeed, the relationship between women's health (and

particularly reproductive health) and quantifications of state development is significant enough that "gender" qualifies as its own category within the normative measure of the Human Development Indices. Originally intended to demonstrate the gap between access and achievement between men and women, the Gender Development Index measure for Bangladesh, among other "developing" countries, now testifies to the ways in which women's health and labor is the engine, rather than the brake, of state progress. But for all of the acclaim of its development success, Bangladesh does not actually rank highly in the Human Development Indices. Even in the Gender Development Index, it ranks below 135 other countries for measures like prenatal care, maternal mortality, adolescent birth rates, and child marriage. Where it outstrips other states, however, is in two significant measures: high contraceptive prevalence and low unmet need for family planning. Here, in the question of access to contraception—to choices for conception, to education about contraception, and to contraceptive implementation—Bangladesh is a development success. And that success is both the product of and rationale for increased aid by international agencies like USAID, the Danish International Development Agency, and the UN Population Fund. Contraception, in the case of Bangladesh, is a technosocial apparatus of life making that depends on the prevention of life.

When the Bangladeshi government suspended its abortion ban and then actively began promoting menstrual regulation in 1971, it inaugurated a now decades-long collaboration with a global aid apparatus to produce a demopolitical regime in which the issue of sovereignty is displaced from the state onto a structure of quantifiable debt and development. Here, the conflict is neither the Foucauldian disciplinary "make live or let die," nor the prior, "let live and make die" (Foucault 1997, 241, 246–47). Rather, it is "control birth and make count." The popularity of menstrual regulation is central to developmentalist narratives of Bangladesh because in 1973 the Helms Amendment to the 1961 Foreign Assistance Act (which restructured foreign aid organizations and created USAID) decreed that "no foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions."[15] The 1984 Mexico City Policy—or the Global Gag Rule, as it is commonly known—formalized this amendment into practice, making it illegal for foreign aid to be given to organizations that either perform or educate on abortions. Bangladesh's continual support from USAID depends on adherence to this policy. Menstrual regulation circumvents the gag rule while supplementing the yet-incomplete

[15] "Helms Amendment to the Foreign Assistance Bill," 1973, US Government Printing Office (enacted).

access to contraception. Indeed, though it is called contraception, menstrual regulation is best understood as a technological hinge between contraception and reproduction. It offers choice in the face of limited or failed access.

Here, I want to pause to note the transformation of Karman's cannula aspiration method into a systemized technology of population control within a global demopolitical regime. It bears mention that while, in the hands of a small group of American women seeking greater access to reproductive choice in the context of communitarian care practices, the technique would fall out of prominence quickly—aided by the epistemic shift of the passage of *Roe v. Wade* in 1973—in Bangladesh, menstrual regulation would come to be institutionalized within a set of practices targeted at the prime demographic of development policy. Describing the suspension of abortion prohibition following the war as an Agambenian state of exception, Nayanika Mookherjee argues that "the exceptional practice of abortion also made way for the institutionalization of the norms of family planning, the rapid increase in the role of NGOs in addressing women's health services, and the concomitant transnationally funded population control programmes centred on [menstrual regulation]" (2007, 350). Menstrual regulation as a technique of governance, that is, as a demopolitical technology, does track the transition from the Bangladeshi state's investment in the production of an ethnically regulated national body to the primacy of a global regime of development oriented toward a reproductively regulated body. However, we would be wrong to describe this institutionalization in terms of sovereign power and the law as such. It has become something of a scholarly commonplace to describe Bangladesh as an NGO state, implying that the state, which has failed to provide for the needs of its population, has been supplanted rather than supplemented by the network of national and international nongovernmental organizations that have flourished in Bangladesh in the decades since its independence. But sovereignty, in the case of Bangladesh, is in fact a shared enterprise, a symbiosis between state, local, international, and transnational actors maneuvered within a complex web of surveillance, quantification, financialization, debt, and management.

State sovereignty in the postcolonial case both reifies and defies the normative principles of liberal political democracy, which would imagine the state as a synecdoche of the self-sovereign individual. At the same time, the terms by which Bangladeshi women are able to conceive and implement choices of reproductive management echo and distort those of women in the global North. Indeed, "rights" and "empowerment" represent two poles through which, in both the liberal paradigm of the American state and the global geopolitical one, a life worth living is created by way of the management of the female body, the regulation of her reproduction, and the quantification of her labor. The battle for abortion rights in America continues, but while

menstrual regulation abides in Bangladesh today as a necessary technique of development, the terms of choice and desire are decoupled entirely from pleasure or even sex as something other than social and biological necessity. For the Bangladeshi woman in the context of the development state, we can talk about empowerment and freedom, but the idiom of pleasure has not yet been inaugurated.

Nonreproductive futures

In a landscape far removed from Bangladesh, queer theorist Lee Edelman writes of encountering an antiabortion poster outside of a coffee shop in Cambridge, Massachusetts. Ventriloquizing the poster, Edelman asks, "Who would, after all, come out for abortion or stand against reproduction, against futurity, and so against life?" (2007, 13). His answer, in the context of an argument against a politics of reproductivity, is that it ought to be queers (implicitly white, bourgeois American queers like himself) who dismantle the contract between citizen and life mediated through the figure of the child. But an answer to his question need not be polemic. Materially, in the technologies and ideology of development policy, is vividly an answer to Edelman. A vast global demopolitical apparatus, distributed by international and national organizations from Europe and America, financializes an investment *against* reproduction. It monetizes, through loans, grants, and in-kind services, a commitment to nonreproductivity, to a future without futurity for some. A comprehensive and powerful ideology governs the American empire of debt, producing a homology between development and nonreproduction. For one, the state must remain underdeveloped (aspirationally developing) in order to warrant the infusion of money into its coffers and the continued oversight by the system of debt governance. Presently continuous, "developing" countries sprint, jog, and stumble on the treadmill of national economic possibility in which mounting debt sets the incline precipitously.

In this final section I want to suggest that the history and afterlives of Karman's two abortion technologies offer us a way to understand the material life of queer futurity. Demopolitics ensures managed, *limited* futurity for the postcolonial world. Edelman describes reproductive futurism as that by which politics is oriented, singularly, toward the Child: "That Child remains the perpetual horizon of every acknowledged politics, the fantasmatic beneficiary of every political intervention. Even proponents of abortion rights, while promoting the freedom of women to control their own bodies through reproductive choice, recurrently frame their political struggle, mirroring their anti-abortion foes, as a 'fight for our children—for our daughters and our sons,' and thus as a

fight for the future" (2007, 3). Curiously however, for Edelman as for his ideological foes, this political fixation on the figure of the Child comes with the necessary elision of women whose bodies are staked in the abortion debate. Feminist critiques of Edelman exigently draw attention to the disappearance of women in the reproductive futurism Edelman bemoans.[16] Penelope Deutscher offers a fantasmatic supplement to Edelman's Child in the figure of the Mother. She writes, "This imaginary Mother is an unselfish, responsibilized moral agent, conduit of individual and social hopes. . . . She is a social factor maximizing health and well-being (of children and communities—thus she is also a biopolitical figure, both individualized and understood as a factor in the health and future of populations)" (2017, 51). Abstracted mothers, in this reproductive futurism, are the templates for the gendered future to come, models of individual rational subjecthood into which the Child of this deeply American vision will develop.

But as we have seen, in the case of Bangladesh, the putative figure of politics and futurity is not the Child. Indeed, it is not even the Mother. For the developing world, overly fecund, the adult reproductive but not reproducing woman is the subject of intervention and the object of investment. At the same time, reproduction and reproductive futurism as state projects in the third world (i.e., the demopolitical investment in not just maintaining life but propagating it—or some form of it) are figured as threats to a global economic order. The population time bomb threatens to eradicate the world. But this world is not the world in which populations are booming out of control; rather, there is a divide between world and population.

Sites of population are the ones that are to be managed, to be regulated, to be planned. "The world," as many postcolonial scholars have argued, is the imaginative site of modernity. It is where choice—purchasing and reproductive—is individual and rights based. For populated places not yet in the world, futurity is not about reproduction but rather about its limitations, not about life but about not being born. This is the condition of the global South: not being born is the ongoing necessary precondition for life elsewhere. In this light, we can see the development of menstrual regulation as part of a practice of managing not-life, of managing parts of the world on whose nonreproduction our futurity depends. Development, then, commits itself to regulating nonbirth under the guise of future progress toward better life. The more that birth can be prevented, controlled, managed, the greater the sign of development.

[16] See Johnson (1986), Doyle (2009), Deutscher (2017), and Wiegman (2017), among many others.

For postcolonial women, those whose lives and health are materially charged through the ambit of an imperial demopolitical project, a queer kind of futurity is being implemented, one that does not aspire or accede to the curtailed ones of reproductive choice as hallmark of liberal subjecthood.[17] Outside the discourse and the technologies of reproductive health care of a *Roe* America and as highly surveilled barometers of state progress, the anonymized and collectivized body of postcolonial women offers alternate forms of political imagination around their bodies and labor. The individuated, agential body of the North American woman whose political cry might be "My body, my choice" is not-yet, and perhaps not-ever, reproduced in the belated body of the postcolonial woman for whom body and choice are constituted socially and demopolitically. When Harvey Karman arrived in Bangladesh in 1971, he believed himself to be participating in a humanitarian mission that would offer the women of that postcolonial state access to gynecological care and reproductive choice as of then impossible in the United States. And indeed, the technology he imported would come to be incorporated into a demopolitical system funded by the United States as an instrumental bridge over the same ideological debates around abortion, its legality, and morality. What menstrual regulation technology and the systems of demographic surveillance by which it is administered have also done in Bangladesh, however, is introduce forms of reproductive decision making and visions of futurity for which there are no models and mandates in the global North.

Edelman's critique exhorts a form of politics that is not hopeful, that "insist[s] that that future stop here" (2007, 30). Given the catastrophic climate crisis that so exigently threatens the Bangladeshi woman, whose laboring possibility will almost certainly give way to the inexorable demands of the rapid rise of water levels in the Bay of Bengal, futurity is a curious form of politics. Thus, the adult Bangladeshi woman whose reproduction is the fulcrum

[17] On the one hand, we have the politically strident call of queer theory to reclaim the death drive and celebrate the ecstatic shatter of *jouissance* in sexual pleasure and, on the other hand, the purportedly humanitarian regulation of development policy to promote a debt drive and exhort the catastrophic explosion of population through reproduction. The debt drive is the force, figured by global aid apparatuses, of inescapable obligation as a structure of life management.

In the middle of these discourses, rarely (if ever) placed in relation to them, is the shared ground of political futurity that diverges from the normative. I am not arguing for some blanket or aspecific deployment of queer but rather pointing to the site at which Edelman's argument has faced significant critique—its Eurocentric, white, male, homosexual self-investment—to suggest that something is at work here that usefully reveals what gets exported into the world to uphold a vision of American futurism, an economic and political project that is exceptionalist and interventionist.

of state—and in the neo-Malthusian imagination, global—progress and possibility stands as a figure of hope when she refuses. When she does not give birth, when her reproduction is curtailed, her productivity simultaneously makes for the productivity of a global order. In contemporary demopower, her collectivization and abstraction are structurally necessary. Perhaps this populated form of possibility, as much as it is figured as a threat to futures in the global North, might offer the terms of a new reproductive politics, of a new model of reproduction or its refusal beyond that of choice.

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