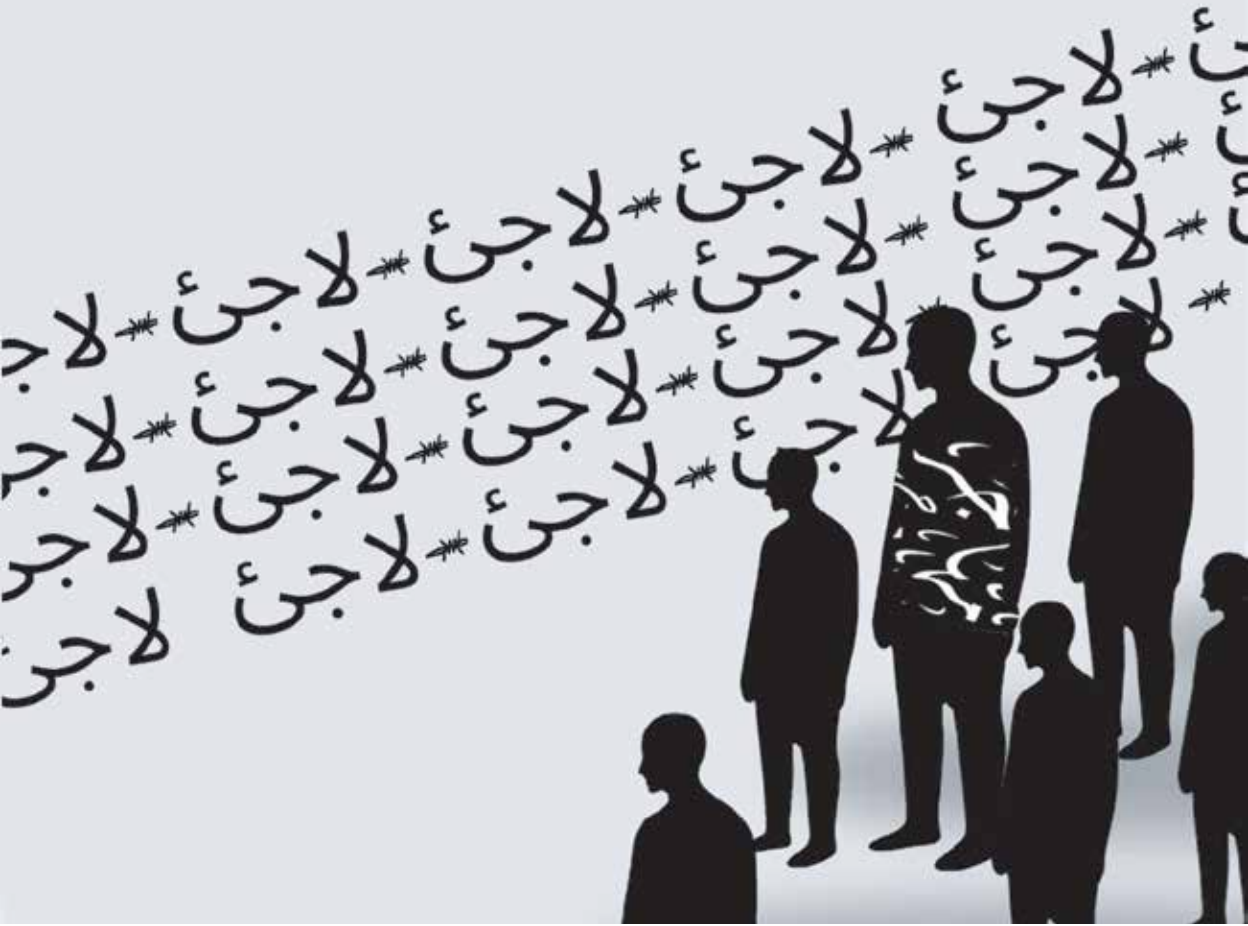


The Yale Review of International Studies

Acheson Issue
Volume XV, Issue IV

**Language, Categorization, and Control:
Examining Exclusion in Refugee Regimes
Through the Shift From Muhājir to Lāji'**
Cover Story by Cormac Mackay Thorpe



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Dear Reader,

In a world of fast-moving politics and a shifting world order, the pieces we've selected for this iteration of the Acheson call us to think about international relations in a different light. Ranging from medical diplomacy to language in migration and narratives of abortion in the rise of a nation, our authors grapple with societal dynamics beyond the conventionally explored framework. From these selections, readers will be able to glean lessons from history and discover new ways of thinking about the world.

The following works have been thoroughly researched, written, and edited by an outstanding group of student writers. Student scholarship occupies a special place in the study of international affairs by fostering global awareness on campus. We believe these pieces encapsulate that aim with nuance and grace. With the publication of the 15th edition of the Acheson Issue, we are proud that the Yale Review of International Studies continues its role as the premier student publication at Yale for students interested in learning about the world.

In addition, we would like to thank our Head Design Editors Camille Roussel and Yasmine Samolada, and the YRIS staff and board who helped make this issue happen. We are incredibly grateful to have such a dedicated, passionate, and efficient team working with us. This year has been filled with a range of obstacles and successes, but your support has made it all possible.

This issue marks the first under our tenure at the helm of YRIS. We're excited to see what the year has in store.

Sincerely,
Isabel Mestey-Colon and Vittal Sivakumar
Editors-in-Chief,

CORMAC MACKAY THORPE

MAYA S. WEITZEN

PAULINA TEIN

Essays

Language, Categorization, and Control: Examining Exclusion in Refugee Regimes Through the Shift from Muhājir to Lāji

Introduction

Today, roughly half of the world's refugee population is Muslim, and roughly half of all refugees are hosted in Muslim-majority states.¹ This surge in refugees has set off broad panic — especially throughout the Western world — that has led to the tightening of borders and abandonment of human rights protections for refugees.² A wave of modern scholarship responds to mass migration flows with a core claim: international secular law, now ubiquitous in Muslim-majority states, is inadequate, and these states should revive the inherently more protective concepts in Islamic law and history. This is also true of today's "online imams" — those who have mass followings on social media platforms. The interpretation of Islamic law on this issue often invokes a handful of Qur'ānic verses alongside the 622 *Hijra* of Muḥammad and his followers from Mecca to Medina. Though some scholars like Muḥammad Khalid Masud make an effort to discuss the historical ties between the 7th-century emergence of this terminology and its political application today, most only allude to the existence of a legal tradition expressed through *fiqh*³ (literature on substantive law).⁴

1 Islamic Relief, "The Rights of Forced Migrants in Islam," Islamic Relief Worldwide, 2014.

2 Lydia Polgreen, "Something Extraordinary Is Happening All Over the World," *The New York Times*, January 31, 2025.

3 Throughout this paper, I use the *International Journal of Middle East Studies* conventions for Arabic, Ottoman Turkish, and Turkish transliterations. Dates refer to the Common Era unless otherwise noted. I follow the guidelines of the *Chicago Manual of Style*, 17th edition. Translations are my own unless otherwise noted. All errors are my own.

4 Muḥammad Khalid Masud, "The Obligation to Migrate: The Doctrine of *Hijra* in Islamic Law," in *Muslim Travellers: Pilgrimage, Migration, and the Religious Imagination*, edited by Dale F. Eickelman

This paper assesses the claims of modern scholarship about Islamic law, primarily through political history in Anatolia and the Levant between the 1860 Ottoman Migrants Commission and the 1948 Arab-Israeli War.⁵ Though I briefly reference legal and historical examples in Islamic history from the Qur'an through the late Ottoman state, my central focus is on the aforementioned period, even more specifically on the interwar Levant. The end of the nineteenth century through middle of the twentieth represents a transitional moment in the influence of Islamic law on the concepts of refugees and asylum, which I argue can be shown by the previously unexplored transition in the Arabic word for "refugee" from *muhājir* to *lāji*'. This change in terminology implies a new cooperation with the international system, specifically the United Nations.



II

THE FADING USAGE OF ISLAMIC MUHĀJIR IN FAVOR OF THE NON-ISLAMIC LĀJI' DEMONSTRATES THE DIMINUTION OF THE RELEVANCE OF ISLAMIC CLASSIFICATIONS AND RISE OF INTERNATIONAL ONES."

Rather than retelling a comprehensive history of refugee crises and their interplay with Islamic law, I will focus on how the language for persecution and displacement during this period — used by religious scholars, policymakers, and refugees themselves — described experiences and created legal categories. For my analysis, I draw on Carol Gluck and Anna Lowenhaupt Tsing's anthology, *Words in Motion: Toward a Global Lexicon*, and Raymond Williams's reference book, *Keywords: A Vocabulary of Culture and Society*.⁶ I track "refugee" and its surrounding "affinity words" (terms that are often used in the same context) in both Islamic and international law, using them as a methodological entry-point into social and political

practices.⁷ As Williams writes, the problems of the meanings of the word "refugee" are inextricable elements in the problems it attempts to discuss.⁸ My purpose is not to determine "correct" linguistic usage, but rather to analyze the usage of language as a conscious choice for political ends.⁹ Tracking language involves tracking the political and legal categories it entails. The fading usage of the Islamic *muhājir* in favor of the non-Islamic *lāji*' demonstrates the diminution of the relevance of Islamic classifications and rise

and James Piscatori, 29–49. London: Routledge, 1990; David R. Vishanoff, *The formation of Islamic hermeneutics: how Sunni legal theorists imagined a revealed law*. American oriental series. New Haven, Conn.: American Oriental Society, 2011. Chapter 7.

⁵ I draw especially on the work of scholars Vladimir Hamed-Troyansky and Laura Robson, who situate origins of the modern international refugee regime in this time and region.

⁶ Carol Gluck and Anna Lowenhaupt Tsing, *Words in Motion: Toward a Global Lexicon*. Durham: Duke University Press, 2009.

⁷ *Idem*, 3, 8.

⁸ Raymond Williams, *Keywords: A Vocabulary of Culture and Society*. Rev. ed. New York: Oxford University Press, 1985. 15.

⁹ *Idem*, 11.

in international ones. More broadly, it illuminates a shift from a religion-based framework under empires to a nationality-based framework under nation-states in the Middle East.¹⁰

As I show this shift through the lens of language use in refugee histories, I also argue that international law did not replace an inherently more generous refugee protection framework. A distinct political category for Muslim refugees created by the term *muhājir* disappears after the dissolution of the Ottoman Empire, the term *lāji*¹¹ creates a non-Islamic category. However, all of the architects of refugee policies under Islamic and international law demarcated the category of “refugee” to exclude or instrumentalize people fleeing persecution. Shaped by political interests in the face of refugee crises, leaders and policymakers — within the Ottoman Migrants Commission, national governments, League of Nations, and United Nations — often prioritized their own interests, leaving refugees without substantive protections, paths to citizenship, or access to rights afforded to locals. Even regimes that were generous towards individuals were not so out of benevolence, but utility to those in power. Though this may be unsurprising, it rejects modern scholars’ ideas that a return to Islamic law as a basis for refugee protection would bring benefits to refugees.

To begin, I will first clarify what I mean by “refugee.” The term is most commonly defined today along the lines of the 1951 Convention Relating to the Status of Refugees (and its 1967 Protocol): someone who is “outside the country of his nationality [or outside of the country of former habitual residence] and is unable or unwilling to avail himself of the protection of that country” due to a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.”¹¹ While this definition clearly excludes certain categories (disability, gender, and sexual orientation, for example), the basic requirements of expulsion, flight, or forced migration, combined with an inability to return based on fear of persecution or oppression remain consistent across most other definitions. In the modern era, “refugee” is distinguished from “internally displaced person” by crossing an international border, and “forced migrant” is often defined as a broader category. “Asylum seeker” is someone in the process of being approved for official protections. Because these distinctions are all based on modern nation-states and legal structures — and the term *muhājir* does not make these distinctions — for the purposes of this historical paper, I will hold a refugee to be someone who (at least in part) involuntarily leaves their home and is unable or unwilling to return. I will be considering how use of the term “refugee” determines who qualifies, what protections they are entitled to, and who provides them.

This paper has four sections to demonstrate my two

¹⁰ I define “framework” in this case as a set of laws, principles, and language governing the safeguarding and provisions (“protections”) for refugees. Though in certain instances I explore Islamic tradition more widely, this paper focuses mainly on the Levant, Anatolia, and the Arabian Peninsula. I do not examine the rich literature on the Partition of India and ensuing refugee crises, nor that of *muhaxhir* in the Albanian context. For a look at orphan and refugee narratives in Palestine as illustrative of a shift from empires to nations during the interwar period, see Lauren Banko, “Migrants, Residents, and the Cost of Illegal Home-Making in Mandate Palestine.” *Jerusalem Quarterly*, no. 84 (Winter 2020), 58.

¹¹ 1951 Convention Relating to the Status of Refugees, 189 UNTS 137. Article 1. A. (2).

main arguments — namely, that tracking the shift in terminology for refugees from *muhājir* to *lāji*’ demonstrates accession to an international refugee regime and that both Islamic and international law created refugee regimes built on categories of exclusion for political gain.

In the first section, I will synthesize current viewpoints from academics, international organizations, and popular religious discourse, in order to understand how concepts from early Islamic history are mapped onto today’s political problems. By integrating these perspectives, the first section reconstructs what I term an “Islamic refugee protection framework.” Though it does not directly contribute to the two main arguments, it is necessary to ground the ensuing arguments in the paper.

The second section, which occupies the main portion of the paper, examines the period between 1860 and 1948, when the usage of the term *muhājir* to refer to refugees was replaced by the term *lāji*’. I begin by briefly referencing the categories of *dhimmī* and *muhājir* in Islamic legal history. Then, I chronicle the categories that states used to define refugees in the cases of the Ottoman Migrants Commission, early Jewish settlement in Palestine, the Armenian Genocide and refugee crisis, the establishment of an international refugee regime by the League of Nations, the 1923 Population Exchange, Turkish linguistic reforms, the emergence of the term *lāji*’, and the Palestinian refugee crisis — demonstrating how both Ottoman and international law systems, especially at their confluence, served the interests of political elites.

In the third section, I will review the period following this transition, demonstrating how multilateral political engagements between Arab and Muslim-majority states, as well as constitutional principles, have largely been unfulfilled.

My conclusion builds on the two central arguments of this paper, ending with a call for a pragmatic approach to pursuing refugee protections that might be separable from state abuse.

Reconstructing a Modern “Islamic Refugee Protection Framework”

In this section, I will review recent scholarship and popular religious viewpoints on refugees in Islam, parsing the bases of its claims to reconstruct what I will refer to as an “Islamic refugee protection framework.”¹² Its main components, as I will show, are first the invocation of the first and second *Hijra*, second, a combination of protections for Muslims and non-Muslims, and third, a larger Islamic humanitarian system. I will proceed to demonstrate how these perspectives construct an Islamic history and legal tradition that claims to contain generosity and more substantive protections than secular or international law. Finally, I conclude this section by calling for the evaluation of this

¹² Arafat Madi Shoukri’s 2007 doctoral thesis titled “Refugee Status in the Arab and Islamic Tradition” offers the most comprehensive account. Kirsten Zaat, in a 2007 paper published through the United Nations High Commissioner for Refugees (UNHCR) is often cited in similar papers.

”

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OF MUSLIMS...”

framework through actual historical application, which motivates the following section of the paper. Modern texts claim an “Islamic refugee protection framework” based on textual exegesis rather than historical examples that are truly evaluative.

The first component of an “Islamic refugee protection framework,” as it is conceived of by today’s scholars of refugees in Islam and by Muslim leaders, is early Islamic history — specifically the first and second *Hijra* — as the demonstration of a foundation of ethics centering refugees. Muḥammad Khalid Masud, former Chairman of Pakistan’s Council of Islamic Ideology, argues that the original meaning of *hijra* is “to abandon” or “to break ties [especially of kinship] with someone” and then to create new ties, primarily referring to the migration of Muḥammad and his followers.¹³ Papers published by UNHCR and the Organization of Islamic Cooperation (OIC) both cite the first *Hijra* as the forced migration of early Muslim *ṣaḥāba* (companions) of Muḥammad to Abyssinia circa 613–615 as a result of persecution by the ruling Quraysh in Mecca.¹⁴ The Christian king in Abyssinia offered protection to the companions and rejected requests by Meccan envoys to turn them over.¹⁵ Omar Suleiman, an American Islamic scholar named one of the 500 Most Influential Muslims in the world, cites *ḥadīth* to explain that this could have been Muḥammad’s praise for the quality of hospitality found in all people, regardless of religion.¹⁶ Ahmed Abou-El-Wafa, a professor at Cairo University, argues that this flight represents Islam’s ultimate goals of asylum, safety, and non-refoulement — a principle of international law that forbids one country from deporting a person to another country where they would face threats to their life or freedom.¹⁷

The *Hijra* of Muḥammad and his companions from Mecca to Medina in 622 is used to prove further the centrality of refugee protections in Islam. Their new hosts again promised and provided protection.¹⁸ As professors Ray Jureidini and Said Fares Hassan write, the *hijra* created a strong bond between those who had fled Mecca — known as *muhājirūn* — and the hosting community in Medina — known as *anṣār*.¹⁹ Ismail Ibn Musa Menk, the Grand Mufti of Zimbabwe, notes that the *anṣār* shared their wealth, houses, food, and farms, helping create a bond of brotherhood

13 Masud, “The Obligation to Migrate”; W. Montgomery Watt, “*Hijra*.” *Encyclopaedia of Islam New Edition Online (EI-2 English)*. Brill.

14 Kirsten Zaat, United Nations High Commissioner for Refugees, “New Issues in Refugee Research: Research Paper No. 146: The protection of forced migrants in Islamic law,” December 2007; OIC Ministerial Conference on the Problems of Refugees in the Muslim World, 27–29, November 2006.

15 Ahmed Al-Dawoody and Tilman Rodenhäuser, “The principle of non-refoulement under Islamic law and international law: complementing international legal protection in Muslim contexts.” *Humanitarian Law and Policy*. ICRC. June 20, 2021; Khadija Elmadmad (2023). “Refugee Rights in Islam and in Modern Refugee Law With Special Reference to The Non-Refoulement Principle.” *Middle East Journal of Refugee Studies*, 8(2), 51–68.

16 Yaḳeen Institute. 2018. “*ḥadīth* #31: Islamic Ethics Regarding Asylum, Refugees, and Migration | 40 *ḥadīths* on Social Justice.” YouTube. March 22, 2018.

17 Ahmed Abou-El-Wafa. “The Right to Asylum between Islamic Shari’ah and International Refugee Law: Consequences for the Present Refugee Crisis,” *Max Planck Yearbook of United Nations Law Online* 19, 1 (2016): 305–336.

18 Al-Dawoody and Rodenhäuser, “The principle of non-refoulement under Islamic law and international law.”

19 Ray Jureidini and Said Fares Hassan. *Migration and Islamic ethics: issues of residence, naturalisation and citizenship*. Studies in Islamic ethics. 2–3. Leiden: Brill, 2020.

(*mu'ākhāh*) between them.²⁰

Ahmed Al-Dawoody, Legal Advisor for Islamic Law and Jurisprudence at the International Committee of the Red Cross (ICRC), as well as Shoukri and Abou-El-Wafa, acknowledge that the practice of granting protection to people in refugee-like situations (often expulsion from their tribe) was an established tradition in pre-Islamic Arabia.²¹ Shoukri claims that this contract between seeking and providing protection (*istijāra* and *ijāra* respectively), collectively referred to as *jīwār*, came to represent a divine path to God's grace.²² While the seeker of refuge, known as



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the *musta'jir*, received material help and protection, the provider of refuge, known as the *mu'jir*, received praise, fame, and high status.²³ Menk and Suleiman agree that God rewards those who provide refuge.²⁴

After citing history, a second major claim among Muslims and scholars of Islam is that the religion combines protections for both Muslims and non-Muslims. Four verses of Surah al-Nisa (4:97–100) are often employed:

مَتَنُكَ مَيِّفِ اَوْلَاقِ مُهِسُفِنَا يَمِلَاطُ ؕ ؤَلَيْلِمَلَا مُهَيَّفَوْتَنِي دَلَّ اَنْ اِ
عَسُو لَلْ اَضْرَا نَكْتَمَلَا اَوْلَاقِ ضِرَّالْ اَيِّفِ نِيْفِ غَضَّتْسُمْ اَنْكُ اَوْلَاقِ
اَرِيصِمُ تَبْءَاسُو مِّنْ هَجْ مُهَيِّوْا مَ كَيْتَلْ وَاَفِ اَهِيْفِ اَوْرَجِ اَمْتَفِ

Indeed, those whom the angels seize in death while they are wronging themselves — they will say, “In what [condition]

20 Mufti Menk. 2020. “Welcome the Refugees - Mufti Menk.” YouTube. September 28, 2020; see also ThereIsNoClash. 2020. “The Refugee Issue | Episode 13.” YouTube. May 8, 2020.

21 Al-Dawoody and Rodenhäuser, “The principle of non-refoulement under Islamic law and international law.”

22 Arafat Madi Shoukri, 2008. “Refugee status in the Arab and Islamic tradition: A comparative study of Jihar, Aman and the 1951 Geneva Convention relating to the status of refugees.” Ph.D. Dissertation, University of London, School of Oriental and African Studies (United Kingdom), 4, 43; Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 317.

23 Shoukri, “Refugee status in the Arab and Islamic tradition,” 10.

24 Yaqeen Institute, “ḥadīth #31”; Mufti Menk, “Welcome the Refugees.”

were you?” They will say, “We were oppressed on the earth.” They will say, “Was not the earth of God spacious so that you could emigrate therein?” For those, their refuge is Hell, and evil it is as a destination.

نُوعِي طُتْسَيِ الْبِنْدِلُولِ أَوْ أَسْنَلِ أَوْ لَأَجْرَلِ أَنْ مَنِي فَعَضَتْ سُنْمَلْ أَلِ
 أَلِي بَسْ نَوْدَتْ هِي أَلِ وَكَلِي ح

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 OFTEN PROMISED"**

Except for the oppressed among men, women, and children who cannot [devise] a plan, nor are they guided in a way.

هَلْ لَأِ يَسَعُ كَيْلِ وَأُفِ
 أَوْ فَعُ هَلْ لَأِ نَ الْكُفْرِ مَنَعُ وَفَعِي نَأِ
 أَوْ فَعُ

It is they whom God may pardon. And God is ever-pardoning, ever-forgiving.

لِي بَسْ يَفِ رُجَاهِي نَجْمِ
 أَمْ غَرِمِ ضِرَالِ يَفِ دَجِي هَلْ لَأِ
 نَمِ جِرْخِي نَجْمِ عَسْ وَ أَرِي بَتِكَ
 هَلْ لَأِ يَلِ أَرِجَاهِمِ بَتِي بِ
 هُرْجِ أَعْقِ وَ دَقْفِ تَوْلِ الْكِرْدِي مَتِ
 أَوْ فَعُ هَلْ لَأِ نَ الْكُفْرِ هَلْ لَأِ يَلِ عِ
 أَمْ يَحِرِ

And whoever emigrates in the cause of God will find many safe

havens and abundances on the earth. Whoever leaves their home as an emigrant to God and his messenger and dies — his reward has become incumbent upon God. And God is ever-forgiving and ever-merciful.

These verses are interpreted to establish an obligation to migrate from a land of religious oppression to a land of free practice (termed by early jurists *dār al-ḥarb*, literally “abode of war” and *dār al-Islām*, literally “abode of Islam,” respectively).²⁵ This applies unless, as 4:98 suggests, one is unable to escape.²⁶ There are still debates as to what qualifies as religious persecution. Like their ancient predecessors, Muslims who migrate according to this framing are called *muhājirūn*.

Surah at-Tawbah (9:6) is what Professors Khadija Elmadmad and Muddathir ‘Abd al-Rahim see as the “cornerstone”

25 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 324; Khadija Elmadmad, Asylum in Islam and in Modern Refugee Law, *Refugee Survey Quarterly*, Volume 27, Issue 2, 2008, 54.

26 Zaat, “The protection of forced migrants in Islamic law,” 18.



and “linchpin” of all Qur’ānic refugee protections for non-Muslims.²⁷

لَلَّذِينَ آمَنُوا مِنكُمْ إِذَا سَأَلْتُمُوهُم فَيُؤْتُونَكُمْ مِمَّا رَزَقْنَاهُمْ يُوقُونَ لَهُمْ أُوْلَئِكَ هُمُ الْمُؤْمِنُونَ الَّذِينَ آمَنُوا بِكُلِّ رَسُولٍ مِّن رَّبِّهِمْ وَإِن يَكْفُرُوا بِهِ لَنَحْنُ زَاهِدُونَ أُوْلَئِكَ هُمُ الْمُؤْمِنُونَ الَّذِينَ آمَنُوا بِكُلِّ رَسُولٍ مِّن رَّبِّهِمْ وَإِن يَكْفُرُوا بِهِ لَنَحْنُ زَاهِدُونَ أُوْلَئِكَ هُمُ الْمُؤْمِنُونَ الَّذِينَ آمَنُوا بِكُلِّ رَسُولٍ مِّن رَّبِّهِمْ وَإِن يَكْفُرُوا بِهِ لَنَحْنُ زَاهِدُونَ

And if any one of the polytheists seeks your protection, then grant him protection so that he may hear the word of God. Then escort him to his place of safety. For they are a people who do not know.

This verse entails the idea of *amān* (security given by a Muslim to a non-Muslim), which is granted to a non-Muslim who by definition becomes a *musta’min*. Originally a way to offer clemency to adversaries in battle, it is a temporary grant that lasts a year — according to Abou-El-Wafa — before the *musta’min* must either convert to Islam or become a *dhimmī* (an inferior non-Muslim subject who is protected and given religious freedom in exchange for paying a tax called *jizya*).²⁸ Though *dhimmī* status can only be given to Christians and Jews, in his remarks at a conference to combat Islamophobia, UN Secretary-General António Guterres interpreted 9:6 to apply to all non-Muslims.²⁹ Islamic Relief calls all categories of forced migrants granted protection by an Islamic state *musta’min*.³⁰ *Amān* can be official or private; given by the poor, sick, blind, and sometimes even by slaves; and given to anyone irrespective of status or persecution.³¹ It entails a duty among hosts to protect the *musta’min*’s life, kin, and property from assault or insult; to treat the *musta’min* with dignity and respect; and to return them to a place of safety.³² ‘Abd al-Rahim alleges that *musta’minūn* have the right to work and freedom of religion.³³ Some interpretations claim it includes access to the local judicial system, while others argue that *dhimmī* status also entails *amān*.³⁴ Though the grant is individually-given, it must be respected by all Muslims in Muslim lands, including the political authority.³⁵

Comparing protections available to Muslims and non-Muslims, ‘Abd al-Rahim strongly endorses the idea of *jiwār* (seeking and providing protection).³⁶ *Musta’minūn* are the non-Muslim analog to *muhājirūn*, though in order to be permanently

27 Shoukri, “Refugee status in the Arab and Islamic tradition,” 2; Khadija Elmadmad, Asylum in Islam and in Modern Refugee Law; Muddathir ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam,” Refugee Survey Quarterly, Volume 27, Issue 2, 2008, 19.

28 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 327. Muslims paid *zakāt* and had a communal obligation to fight, while *dhimmī* did not.

29 “Secretary-General’s Remarks at High-Level Event to Commemorate the International Day to Combat Islamophobia [Bilingual, as Delivered; Scroll down for All-English and Arabic] | United Nations Secretary-General.” It is worth noting the leader of the international system’s endorsement, at least to some extent, of international law’s compatibility with the Islamic law it replaced.

30 Islamic Relief, “The Rights of Forced Migrants in Islam.”

31 Zaat, “The protection of forced migrants in Islamic law,” 20.

32 OIC Ministerial Conference, Point 3.

33 ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam,” 21.

34 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 327.

35 Ibid. See also “A Contextual Approach towards Improving Asylum Law and Practices in the Middle East.” 2025. Juragentium.

36 ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam.”

protected, a *musta'min* must become a *dhimmī*.

The third part of the “Islamic refugee protection framework” created by modern scholars and prominent religious leaders is the positioning of Islamic modes of refugee protection in a broader set of humanitarian aims they assert are inherent to Islam. Zaat finds 396 references in the Qur’ān to protection and assistance — including 20 covering *hijra* and *amān*, 12 on sanctuary, 68 on charity — plus more than 850 *aḥādīth* dealing with protection and assistance.³⁷ UNHCR and Islamic Relief (a prominent humanitarian non-governmental organization) cite verses that praise those who assist the needy or helpless, entitle everyone to certain rights, and uphold standards of justice.³⁸ Both obligatory and encouraged charity, *zakāt* and *ṣadaqa* respectively, may be seen as part of a broader system of support for the needy. Abou-El-Wafa generously interprets *ibn al-sabīl*, a category of people eligible for *zakāt* that is normally translated as “traveler” or “wayfarer,” as refugees to whom welcome and care should be prioritized.³⁹ Zaat writes that provisions aim for eventual self-sufficiency.⁴⁰

In all modern literature on the subject, Islamic customs of refugee protection are guaranteed by individuals, locally- and religiously-based, obligatory on the provider, and imply non-refoulement. *Amān* can be granted by ordinary people and does not usually require formal documentation, though some Mālikī jurists require *amān* to be approved by the state.⁴¹ In contrast to modern international law, which gives refugees a right to apply for asylum, Zaat argues that “asylum” in Islam must be granted — it is “both a right to be enjoyed and an obligation to be provided by virtue of our humanity alone.”⁴² This obligation, Professor Dallal Stevens argues, applies to all.⁴³ Stevens writes that “the Qur’ān requires that refugees and migrants be welcomed and treated well, and should not be refused admission, rejected at the borders, or sent back to the country of origin.”⁴⁴ Abou-El-Wafa and ‘Abd al-Rahim agree with this principle of non-refoulement, the only alternatives being voluntary repatriation and local integration (as a *dhimmī* or a convert).⁴⁵

Shoukri, Stevens, Al-Dawoody, Abou-El-Wafa, Elmadmad, ‘Abd al-Rahim, and Zaat use the three components I have described — Islamic history, protections for Muslims and non-Muslims, and

37 Zaat, “The protection of forced migrants in Islamic law,” 6, f.n. 30.

38 United Nations High Commissioner for Refugees (UNHCR), *Islam and Refugees — High Commissioner’s Dialogue on Protection Challenges*; Theme: Faith and Protection (12-13 December 2012), December 2012.

39 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 313. Cites Qur’ān 9:60, 59:8, and 59:9.

40 Zaat, “The protection of forced migrants in Islamic law,” 27.

41 ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam.” On page 21 n.18, he writes “These points are discussed in considerable detail in such classic works as Al-Sarakhsi’s *Al-Mabsut*; Al-Shaybani’s *Kitab al-Siyar al-Kabir* and Al-Kasani’s *Badai al-Sanai*. These are all used and discussed, along with many others, by M. Hamidullah”; see also Ahmed Al-Dawoody, *The Islamic Law of War: Justifications and Regulations* (New York: Palgrave Macmillan, 2011), 131.

42 Zaat, “The protection of forced migrants in Islamic law,” 8.

43 Dallal E. Stevens, “Shifting Conceptions of Refugee Identity and Protection: European and Middle Eastern Approaches” (August 1, 2014). Published version in Susan Kneebone, Dallal Stevens and Loretta Baldassar, “Refugee Protection and the Role of Law: Conflicting Identities” (Routledge, 2014), ch 5., Warwick School of Law Research Paper No. 2014/10, 86.

44 Stevens, “Shifting Conceptions of Refugee Identity and Protection,” 86.

45 ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam,” 21.

a larger humanitarian system — to claim that an “Islamic refugee protection framework” is more generous and expansive than those offered by international law.⁴⁶ These claims are primarily based on the non-distinction between people in need as “refugees” and a mandate to grant protection, not just to consider it.⁴⁷ Furthermore, as Zaat argues, these protections are “indigenous” and “culturally viable” rather than reliant on Western constructions.⁴⁸ Though they argue that Muslim-majority states have today abandoned Islamic law, these authors recognize that religious influence can help establish legitimacy. They therefore propose the adoption of agendas for protection that strengthen international efforts to protect refugees in “Muslim contexts.”⁴⁹ Zaat even suggests court systems and local mechanisms for enforcement.⁵⁰

To understand if this modern “Islamic refugee protection framework” is as generous as claimed, it should be evaluated by historical application of the same concepts modern scholars invoke. Despite its compelling construction from scripture, this framework is primarily theoretical.⁵¹ Even if Islamic legal principles allow for the extrapolation of Qur’ānic teachings to anachronistic refugee crises, this paper focuses on how a broader “Islamic refugee protection framework” came to be in its application.

To do so, I will spend the next section of this paper briefly characterizing the historical progression of *fiqh* and other forms of Islamic law, and then examining in more depth the Ottoman state’s refugee regime, which explicitly centers Islam. Most scholars allude to *fiqh* as a way to understand the development of Islamic ideas related to refugees, though Zaat says that there is no “readily available particularised *fiqh*” on the matter.⁵² Instead, she suggests, we should use principles like *maṣlaḥa* (a juridical category literally meaning cause or source of good) to interpret scripture to support refugees.⁵³ However, this would define a protection framework prescriptively rather than descriptively, ignoring complicated realities.

I argue that chronicling the practical implementation of ideas related to refugees in Islamic history is far more illustrative than a modern reconstruction of Islam’s protections. Especially during a critical period between 1860 and 1948 in Anatolia and the Levant, the influence of these theorized Islamic principles on refugee protection waned in favor of Western conceptions.

46 Stevens, “Shifting Conceptions of Refugee Identity and Protection,” 86; Shoukri, “Refugee status in the Arab and Islamic tradition,” 183; Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law”; Al-Dawoody and Rodenhäuser, “The principle of non-refoulement under Islamic law and international law”; Zaat, “The protection of forced migrants in Islamic law,” 1; Khadija Elmadmad, Asylum in Islam and in Modern Refugee Law, 52, 53; ‘Abd al-Rahim, “Asylum: A Moral and Legal Right in Islam.”

47 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 313.

48 Zaat, “The protection of forced migrants in Islamic law,” 35.

49 Idem, 34; OIC Ministerial Conference; Al-Dawoody and Rodenhäuser, “The principle of non-refoulement under Islamic law and international law.”

50 Zaat, “The protection of forced migrants in Islamic law,” 34.

51 Idem, 20.

52 Idem, 1.

53 Idem, 28. For an extensive engagement with the topic, see Opwis, Felicitas Meta Maria, *Maṣlaḥa and the purpose of the law: Islamic discourse on legal change from the 4th/10th to 8th/14th century*, Studies in Islamic law and society, Leiden: Brill, 2010.

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”THE OTTOMAN
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Terminology is a critical and previously unexplored method of understanding this socio-political shift. Scholar Yousif Qasmiyeh notes that Shoukri should have addressed the “evolution of Arabic terminology pertaining to protection,” as the modern Arabic term *lāji*’ and its derivatives “directly equate” to *muhājir*, *musta’min*, and *musta’jir*.⁵⁴ This paper addresses this critique with an in-depth examination. As I will show primarily through the late Ottoman case, even before its replacement with international law, Islamic principles were not as purely applied as modern scholars suggest, often bowing to political objectives.

1860–1948: From *Muhājir* to *Lāji*’

Having reconstructed what modern authors assert is an “Islamic refugee protection framework” in existence since the seventh century, I now examine the implementation of Islamic principles during the period in which a system based in international, secular law was adopted in the region. I again track the word “refugee” and its surrounding vocabulary, freshly arguing how this history of legal change can be told through linguistic change. Through consideration of a series of crucial historical events between the late-nineteenth and mid-twentieth centuries, I demonstrate that the shift in terminology for the protection of refugees from *muhājir* to *lāji*’ reveals the decline in Islamic law influence and its categorization of migrants. As Stevens notes, “the move away from what might be termed ‘holistic protection’ of Islam and traditional Arab hospitality owes much to the twentieth century history of the region, the influence of the UK, France and the US, and the dependence on international humanitarian assistance.”⁵⁵ The word “refugee” followed the formation of nation-states in the Middle East as they became part of an international order.

However, I will also show that this imposed system, when implemented, was not wholly unfamiliar or fundamentally different from pre-existing forms of refugee protection — even if it forcibly made the Levant the site of nascent internationalism. Though Stevens characterizes this shift correctly, she wrongly assumes “holistic protection” existed under an Islamic legal system. As I will note, Islamic law on refugees was neither uniform nor decisive, and in the case of the Ottoman Migrants Commission, it was not benevolent and holistically protective. Through examination of the terms *muhājir* and *lāji*’ — along with *mülteci*, *mübādil*, *göçmen*, *nāziḥ*, and others — I show that like international law, Islamic influences as implemented in the Ottoman case are driven by their primary purposes: to classify, exclude, and control, rather than to include and protect.

This section takes a primarily chronological but thematically clustered approach. I begin with a short description of refugee classifications in Islamic legal history, directly responding to the claims of modern scholars. However, I focus primarily on the

54 Yousif M. Qasmiyeh, *Refugee Status in Islam: Concepts of Protection in Islamic Tradition and International Law*, by Arafāt Madi Shoukri, *Journal of Refugee Studies*, Volume 24, Issue 3, September 2011, 631. Though these terms address different religious populations, based on the history of its usage, I consider *muhājir* to be the central word for “refugee,” while the others are “affinity words” in my analysis.

55 Stevens, “Shifting Conceptions of Refugee Identity and Protection,” 87.



"THE OTTOMAN REFUGEE RESETTLEMENT REGIME PROHIBITED JEWS FROM SETTLING EN MASSE IN PALESTINE."

Ottoman refugee regime as a practical counterpoint to the modern framework's theory. With the Ottoman Migrants Commission example, I show how leaders utilized *muhājirīn* to expand territorial control and religious orthodoxy. This directly links to the prevention of mass Jewish settlement in Palestine and to the Armenian Genocide. I argue that Christian refugees, though they were received warmly by many Muslims, fell under the control of British and French authorities more concerned with imperial ambitions than rights protections. The emerging international system moved to narrowly define refugees by nationality, excluding most people fleeing persecution. In Iraq and Syria, refugees were employed as tools of colonial enforcement. Yet another example of the exclusion of early international regimes occurs during the 1923 Greek-Turkish population exchange. These exclusions fit into a period of terminological shifts in Turkish. I then assert the linchpin of my analysis, showing how the word *lāji* emerged mainly through newspapers as an alternative or

additional classification to the word *muhājir*. The words themselves were used to delineate; Arabs took up *lāji* to make strategic claims on behalf of Palestinians in the international system, and UNRWA created a legal category to exclude Palestinians from refugee protections. Though Arabic vocabulary and refugee protection frameworks shifted, a common through-line of exploitation for political gain remained.

What modern authors assert as an "Islamic refugee protection framework" in existence since the seventh century eschews a far more complex history. The "Islamic tradition" on refugees is not unified or generalizable across more than a millenium of history and legal thought in a wide expanse of territory. Juristic positions, demonstrated by both *fiqh* and *fatāwā* (legal opinions), applied doctrine to political realities — mainly encounters with non-Muslim subjects and foreign militaries.⁵⁶ Furthermore, jurists used the concepts of *hijra* and *dhimmī* status — which would be apply to Muslim and non-Muslim refugees in the wake of the Reconquista and Mongol invasions, and in the Ottoman Empire — to justify their own political or legal views.⁵⁷ *Hijra* during the emigrations to garrison cities was a *jihād*-related

56 Khaled Abou El Fadl argues that firm and cohesive juristic positions on Muslims outside of *dār al-Islām* developed (and became stricter) only after the twelfth century as a direct result of the loss of Muslim control over Sicily and parts of al-Andalus to Christians. See Khaled Abou El Fadl, "Islamic Law and Muslim Minorities: The Juristic Discourse on Muslim Minorities from the Second/Eighth to the Eleventh/Seventeenth Centuries." *Islamic Law and Society* 1, no. 2 (1994), 141. Jurists and rulers exhibit large varieties and extensive disagreements, and though many of the treatises of jurists are available to us, the archives of rulers who would have implemented policies have mostly been destroyed.

57 For one example, see Jocelyn Hendrickson, *Leaving Iberia: Islamic law and Christian conquest in North West Africa. Harvard series in Islamic law.* [Cambridge, MA]: [Harvard University Press], 2021, especially her characterization of Ahmad b. Yahyā al-Wansharīsi (d. 1508).

obligation, not “migration” in the modern sense.⁵⁸ It gained its meaning for Muslim refugees as a subject of debate among *ahādīth* and jurists about the obligation of Muslims in *dār al-ḥarb* to make *hijra*.⁵⁹ Legal positions on the topic expressed desires to maintain the moral purity, defense, and advancement of Muslims and Islam, which only occasionally related to “persecution” (and thus a sort of refugee status) when Muslims were seen as unable to practice their religion freely.⁶⁰ As for *dhimmī* as a political concept, one example comes after Jewish expulsion from Iberia in 1492, though it cannot be claimed to be representative of a complete tradition. Bayezid II granted *dhimmī* status to Jews arriving in the Ottoman Empire, though he also differentiated them as *yahūdī* (Jewish), which consigned them to inferior jobs, inability to access European capitulations, and often monetary support of his reign.⁶¹

Facing multiple migration crises between the 1850s and World War I, the Ottoman Empire established a refugee resettlement regime that represents an initial phase in the linguistic and socio-political shift in the consideration of refugees. This regime was embodied by the Ottoman Refugee Commission, which was created in 1860 to respond to the arrival of hundreds of thousands of North Caucasian Muslims fleeing Russian expansion and ethnic cleansing. Rather than an international order established in the interwar period, this was the origin of refugee resettlement in the modern Middle East, and it emerged as the response of an Islamic empire to European colonialism.⁶² The language used by the state and refugees themselves was centered around the term *muhājir*, which could encompass the experience of flight, statelessness, and immigration to an Islamic land and had deep ties to Islam. None of the present-day translations of “refugee” in Turkish, Arabic, or Russian were used to refer to North Caucasian *muhājirūn*.⁶³ While individuals pursued their own security and stability through any means they could, the Ottoman Empire — like every other international power — sought to use the refugee crises to consolidate imperial authority through economic growth, increased control in nomadic areas, and religion-based demographic engineering.⁶⁴ Refugees were supported because they bolstered the Muslim population and identity, buoyed the failing economy, and maintained a presence in far-flung regions.⁶⁵ In the aftermath of the 1853-56 Crimean War and 1817-64 Caucasus War, 1877-78

58 Masud, “The Obligation to Migrate,” 35; Patricia Crone, “The First-Century Concept of ‘Hijra.’” *Arabica Journal of Arabic and Islamic Studies*, 41, 364, 1994.

59 Khaled Abou El Fadl, “Islamic Law and Muslim Minorities: The Juristic Discourse on Muslim Minorities from the Second/Eighth to the Eleventh/Seventeenth Centuries.” *Islamic Law and Society* 1, no. 2 (1994): 144–150; For a seminal treatise on Islamic “international law,” see Muḥammad ibn al-Ḥasan Shaybānī and Muḥammad ibn Aḥmad Sarakhsī. *Kitāb al-siyar al-kabīr: al-mujallad al-thālith*; See also Hendrickson, *Leaving Iberia*, 12, 25–26, 182, for her discussion of al-Wansharīṣī’s fatāwā and Algerian mufti Aḥmad ibn Abī Jum’ah al-Wahrānī’s opinion, often called the “Oran Fatwā.”

60 Masud, “The Obligation to Migrate,” 32.

61 Abdelwahab Meddeb, Jane Marie Todd, Michael B. Smith, and Benjamin Stora, *A History of Jewish-Muslim Relations: From the Origins to the Present Day*, (Princeton, NJ: Princeton University Press, 2013), 177–178, 185–187.

62 Vladimir Hamed-Troyansky, *Empire of Refugees: North Caucasian Muslims and the Late Ottoman State*. Stanford, California: Stanford University Press, 2024, 57.

63 Idem, 8.

64 Idem, 6, 77–79.

65 Idem, 6.

Russo-Ottoman War, 1912-1913 Balkan Wars, and World War I, it had settled three to five million Muslim refugees throughout the Balkans, Anatolia, and the Levant.⁶⁶

The Ottoman regime, as well as the refugees who helped define its response, used the term *muhājir* to denote a refugee, and styled itself as a refuge for Muslims. Though the term was sometimes used for non-Muslim refugees, it was far more linked to Islam throughout history and entails a combination of emigrant, refugee, and immigrant, accurately encompassing Russian expulsions of Muslims but also emigration to escape poverty and resettle in *dār al-Islām*.⁶⁷ “*Hijra*” could describe both the religious persecution of the refugees and the Ottoman state’s requirement to protect them, both of which were at the core of the regime.⁶⁸ Essentially all Muslim refugees were welcomed into the Ottoman state, and *muhājir* became a new administrative category for refugees registered with the Commission, which could then provide extensive assistance in the resettlement process.⁶⁹ Common Muslim identity, especially when no common language existed, helped these refugees integrate with their host communities.

Refugees were given tax and conscription exemptions and aid packages to get through the first harvests and winters, often conditioned on their pledged allegiance to the Sultan, settlement in the hinterlands of the Empire, and agreement to cultivate the land. Professed out of religious obligation to help Muslims settle in *dār al-Islām*, the government set up the Charity Commission to provide aid, healthcare, and employment for Muslims and Christians reaching Istanbul.⁷⁰ Yet an underlying reason for welcoming refugees — especially from the North Caucasus — was the fear that they might be conscripted in a foreign army to fight against the Ottomans.⁷¹ They were seen as “warlike” peoples who might rebel against the government as they had in their homeland, so they were scattered across the empire to prevent their concentration and organization. Circassian families would be settled in a one-to-four ratio with Turkish families. These new Ottoman subjects could also temper the unwieldy attitudes of tribesmen and nascent national movements on the periphery in the Balkans. After the Congress of Berlin stripped the Empire of much of its European land in 1878, displaced peoples were once again settled as bulwarks to secure stolen agricultural land from tribal aggression, this time from Bedouins in the Levant.⁷² In the process of resettling refugees who were mostly Muslims, the state dispossessed people on its frontiers of their land and livelihoods.

For North Caucasian Muslim communities, the dominant literary language was Arabic, and faith — tied up in usage of

66 Idem, 3.

67 P. J. Adamiak (2018). *To the Edge of the Desert: Caucasian Refugees, Civilization, and Settlement on the Ottoman Frontier, 1866-1918*. UC San Diego; Hamed-Troyansky, Vladimir. *Empire of Refugees*, 8–9.

68 Hamed-Troyansky, *Empire of Refugees*, 63–64.

69 Idem, 70.

70 Kemal H. Karpat, “The *Hijra* from Russia and the Balkans: The Process of Self-Definition in the Late Ottoman State,” 689–711. In: *Studies on Ottoman Social and Political History*; Stevens, “Shifting Conceptions of Refugee Identity and Protection,” 80.

71 Stevens, “Shifting Conceptions of Refugee Identity and Protection,” 81.

72 Montgomery Watt, “*Hijra*.”

terms like *hijra* — played an important role in articulating their displacement and loss. ‘Abd al-Raḥmān al-Thughūrī (Sogratlinskii), a Naqshbandī *shaykh* in the late 1870s, wrote an Arabic-language treatise on *hijra* in which he urged all North Caucasian Muslims to emigrate out of duty to leave *dār al-ḥarb* when no hope remained through *ghazā* (fighting non-believers).⁷³ *Jihād*, according to al-Thughūrī, was not abandoned; it could still be waged from within the Ottoman Empire.⁷⁴ In 1860, Ḥājj Biy-Sultān, who had emigrated from Kabarda to the Ottoman Empire, wrote and disseminated an Arabic appeal asking, “May Almighty Allāh save you from what you would otherwise regret,” and proclaiming that “all Circassians are heading to the Ottoman state, whereas you are staying with the infidels.”⁷⁵ He continued, “if you live by *sharī‘a* law and follow all that is prescribed by the Prophet, you must immediately leave for the Ottoman state.”⁷⁶ These perspectives emerged from a centuries-long dialogue among North Caucasian Muslims about whether or not the tsardom (since the Russian conquest) could be *dār al-Islām*.⁷⁷ Those supporting *hijra* also used printing technology to sway public opinion in favor of emigration. The Russian government suspected that some *muhājirūn* planned to send Qur’ānic verses and pro-*hijra fatāwā*, printed in Cairo, to North Caucasian Muslims.⁷⁸ It was clear that individuals during this time period used Qur’ānic language to describe their plight.

By the 1900s, the Ottoman regime had intertwined the categories of Muslim, Turkish, and Ottoman, using Muslim refugees as integral pieces in national homogenization through Islamization. After the 1860s, the vast majority of *muhājirūn* to the Ottoman Empire were Muslim. After 1878, most were Turkish-speaking Muslims from the Balkans. The office overseeing immigration matters changed its name to *Muhācirīn-i Islāmīye Komisyonu ‘Alīsi* (High Islamic Immigration Commission) in 1887.⁷⁹ Responding to various migrations, growing unemployment and destitution, and British and French encroachment, Ottoman subjects increasingly supported Pan-Islamism.⁸⁰ The administration was seen as incompetent and religiously corrupted by European-style reforms. (Commissions themselves, which were widespread in the late Ottoman state, were originally associated with the centralized bureaucratic administration of European nation-states in the nineteenth century.⁸¹) In response, the new sultan, Abdulhamid II, harnessed these grassroots Islamic fundamentalist sentiments

73 Princeton University, Firestone Library Special Collections (Princeton, New Jersey), Garrett 2867Y (Mach 2034), ff. 91b–94a. Courtesy of Vladimir Hamed-Troyansky.

74 Zainab Ahmeddibirovna Magomedova, “Abd al-Rahman-Hajji al-Sughuri: Ideologist of Sufism and Sheikh of the Naqshbandi Tariqa,” n.d.

75 RGVIA f. 13453, op. 15, d. 343, ll. 112–13 (March 1860). In 262 f.n. 149, Hamed-Troyansky, Vladimir. *Empire of Refugees*.

76 Ibid.

77 Masud, “The Obligation to Migrate”; Robert D. Crews, *For Prophet and Tsar: Islam and Empire in Russia and Central Asia*. Harvard University Press, 2006. 3, 86–89.

78 GARF f. 102, op. 96, d. 1285, ll. 2-3 (5 October 1898). In 263 f.n. 155, Hamed-Troyansky, Vladimir. *Empire of Refugees*.

79 Karpat, “The Hijra from Russia and the Balkans.”

80 Idem, 142.

81 Huri Islamoglu, “Komisyon/Commission and Kurul/Board: Words That Rule.” In *Words in Motion: Toward a Global Lexicon*, edited by Carol Gluck and Anna Lowenhaupt Tsing, 265–85. Duke University Press, 2009. 281–282.



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into state-supported orthodoxy.⁸² Whereas the Tanzimat-era Immigration Law of 1857 welcomed all immigrants, the Hamidian government adopted a sectarian logic wherein loyalty lay only with co-religionists, so it explicitly courted Muslims and blocked others.⁸³ By the turn of the 20th century, the Ottoman state all but refused to accept non-Muslim refugees and forbade Muslim emigration.⁸⁴ This carried through to resettlement administration — in the North Caucasian refugee villages, the government preferred to appoint non-*muhājir* imams to ensure proper Islamization.⁸⁵

Ottoman leadership created administrative categories for different types of migrants, embracing evolving international norms which dictated that migrant status would be determined based on nationality rather than rationale for migration or belonging to a religious community. *Mülteci* applied to political exiles, especially Poles and Hungarians fleeing suppression of widespread uprisings in 1848.⁸⁶ In 1913, the government clarified that whereas *muhācirūn* had arrived in the Ottoman Empire having been stripped of their previous nationality (as was the case for those coming from the Russian Empire), *mülteciyyūn* still had their foreign nationality.⁸⁷

In contradiction with the Islamic law principles it had previously upheld after the Reconquista and Alhambra Decree, the Ottoman refugee resettlement regime prohibited Jews from settling *en masse* in Palestine.⁸⁸ Skepticism about imperialism and desire to maintain state control through religious homogenization superseded concerns about Islamic duty. In 1890, Abdulhamid II asked: “Why should we accept Jews whom the civilized European nations do not want in their countries and whom they have expelled?... It is not expedient to do so, especially at a time when there is Armenian subversion.”⁸⁹ The Sultan clearly understood that rising anti-Semitism and subsequent Jewish flight constituted a refugee crisis, yet his response was not the welcoming one it continued to be for Muslim refugees; rather, the decision not to take them in was pragmatic. Ottoman decrees in 1884, 1887, and 1888 were issued against Jewish migration to Palestine; it was formally restricted in 1899.⁹⁰ In 1909, the Ottoman parliamentarian Ahmed Rıza Bey remarked, “If the Jews are moderate, the government will not oppose bringing them into the empire,” yet he warned that “if the Jews make out of Zionism

82 Karpas, “The *Hijra* from Russia and the Balkans,” 145.

83 Hamed-Troyansky, *Empire of Refugees*, 81.

84 Laura Robson, *States of Separation: Transfer, Partition, and the Making of the Modern Middle East*, University of California Press, 2017, 22.

85 Hamed-Troyansky, *Empire of Refugees*, 194.

86 Abdullah Saydam, “Osmanlıların Siyasî İlticalara Bakışı Ya Da 1849 Macar-Leh Mültecileri Meselesi”. *Bellekten* 61, sy. 231 (Ağustos 1997): 339-86.

87 Hamed-Troyansky, *Empire of Refugees*, 269 f.n. 128: “In 1909, the Ottoman government reaffirmed that North Caucasian muhājirīn should have their Russian subjecthood revoked before arriving in the Ottoman Empire”; Hamed-Troyansky, Vladimir. “Imperial Refuge: Resettlement of Muslims from Russia in the Ottoman Empire, 1860–1914.” Ph.D. Dissertation, Stanford University, 2018.

88 Karpas, “The *Hijra* from Russia and the Balkans,” 138.

89 Robson, *States of Separation*, 16.

90 Hamed-Troyansky, *Empire of Refugees*, 268–269.

a political question... then a Jewish question will be created in Turkey and its outcome will be very bitter.”⁹¹ This clarifies that the Ottoman response was not just pragmatic for previously-stated governmental interests, but also tied up in the politics of Jewish settlement in Palestine and resisting further capitulations to European powers.

The Committee of Union and Progress (CUP), a revolutionary organization that initiated the 1908 Young Turk Revolution, aimed to preserve the Ottoman state through Turkish nationalist propaganda tied to Islam.⁹² Efforts by *muhājir* elites to reclaim their identity and former homeland—through organizations like the Circassian Society of Unity and Mutual Assistance and its renaming as the Committee of North Caucasian Political Emigrés in Turkey—were supported by the CUP, which tried to manipulate the independence movement to expand Ottoman control.⁹³ Defeats in the Balkan Wars of 1912–1913 further fueled anti-Christian sentiments and support for the CUP. In January 1913, the CUP led a coup, and under the leadership of the “Three Pashas” from 1913 to 1918 engaged in explicit demographic engineering. In 1913, the CUP reinvigorated resettlement of Muslims to sedentarize nomads and gather data on religious and ethnic minorities, and with the help of North Caucasian *muhājirūn*, secretly prepared the logistics to deport Ottoman Armenians.⁹⁴ The 1915 Relocation and Resettlement Law provided a legal framework for deporting Christians. Muslims were resettled in properties and farmlands from which Christians were forcibly removed.⁹⁵

In the ugliest manifestation of its demographic engineering, the Ottoman state killed between 600,000 and 1.5 million Armenians, along with 200,000–275,000 Assyrians and at least 84,000 Greeks during World War I. These genocides, perpetrated by military and civilians (including North Caucasian *muhājirūn*), left behind hundreds of thousands of refugees who would become wards of the international system under the League of Nations. British and American officials witnessed the deportations to places like the Ras al-‘Ayn camps, which would motivate their humanitarian interventions.⁹⁶

Responses from Muslim individuals and religious leaders to the Armenian Genocide echoed vocabulary and acts often, but not always, rooted in Islamic tradition. Collections of stories recount the Muslims who helped hide Armenians in their homes to avoid deportations and welcome refugees fleeing massacres into their families. Arab Muslims in particular are said to have condemned

91 Robson, *States of Separation*, 15.

92 Hamed-Troyansky, *Empire of Refugees*, 83.

93 Georgy Chochiev, “Reclaiming Homeland: The Caucasus-oriented Activities of Ottoman Circassians during and after World War I.” Chapter 23, 596–620. In *War and Collapse: World War I and the Ottoman State*. Utah Series in Middle East Studies (University of Utah Press). 2016.

94 Hamed-Troyansky, *Empire of Refugees*, 164.

95 Uğur Ümit Üngör and Mehmet Polatel, *Confiscation and Destruction: The Young Turk Seizure of Armenian Property*. Bloomsbury Academic, 2011.

96 Report by a resident of Syria on the condition of Armenian deportees, November 27, 1916. FO 371/2783/24258; Report on the deportation of Armenians from Zeitun, July 21, 1915. RG59, 867.4016/104; Report on the forced exile of the remaining Armenians from Aintab and Marsh, November 15, 1922. FO 371/7875/18/E 13426.

the mechanisms of the genocide.⁹⁷ Armenians were sheltered by Kurdish chieftains in Diyarbekir and Siirt, as they had built up mutual relations based on quasi-feudal patterns of life.⁹⁸ Indeed, many had lived alongside Armenians who had been expelled in earlier imperial schemes like Shah Abbas's forced deportations known as the "Great Exile." In the April 1, 1914 issue of *Lughat al-'Arab* (a philological and historical journal launched by Carmelite father Anastase-Marie al-Karmali in Baghdad), Armenians are mentioned as people who were displaced (*nāziḥūn*) by a "forced expulsion."⁹⁹ Though describing historical events, we see here that the language does not yet incorporate terms like *lāji* to describe events that would today be described in that way. Kamil al-Ghazzi, a historian and journalist who wrote about events in Aleppo during this period, used the words "evacuation" (*ijlā*), "relocation" (*naql*), "expulsion" (*naft*), "flight" (*farār*), and "foreign/diaspora community" (*jāliya*) to describe Armenian refugees arriving in the city.¹⁰⁰ He writes about their arrival and staying in houses, but not with vocabulary associated with either modern refugee regimes or Islam. Translated into Arabic, the chilling memoirs of Mehmed Talat, considered the architect of the genocide, use the word *naft*.¹⁰¹

The most prominent response in the Arab world, constructed with the language of Islamic tradition, was from al-Ḥusayn ibn 'Alī, the Sharif of Mecca. On April 29, 1918, he issued the following decree:¹⁰²

فلخت نم لك ىلع ؤظفاحملا مريرحتب ببوغرملا ناو ...
 ؤي نمرالا ؤي بوق عيلا ؤفئاطلا نم مكريئاشع نيبيو مك تادجو مكفارطأ
 ىلع نوظفاحت امك مهيلع نوظفاحتو مهرومأ لك ىلع مهنودعاست
 مهنعظ يف هيل! نوج اتحي ام لك نولستو مكئانباو مكلا اومأو مكسفنأ
 ... نيملسملا ؤمذ لهأ مهناف مهنماق او ...

What is desired for its liberation is to preserve all those who are left behind — among your parties and authorities — of the Armenian Jacobite sect. Help them in all of their affairs and protect them as you protect yourselves, your money, and your children, and facilitate everything they need in their journeys and residences, for they are *ahl al-dhimma* of the Muslims.

As refugees crossed into Iraq and Syria, over which the British and French were actively establishing control, the two nations initiated resettlement schemes. Ostensibly to act upon humanitarian sympathies for the minority groups, these plans had clear links to territorial ambitions and desires to protect who they

97 Shirinian, George N. "Turks Who Saved Armenians: Righteous Muslims during the Armenian Genocide." *Genocide Studies International* 9, no. 2 (2015): 221.

98 Vahé Tachjian, "Expulsion of the Armenian Survivors of Urfa and Diarbekir, 1923-1930," from *Armenian Tigranakert/Diarbekir and Edessa/Urfa*, Volume 6 in the series *Historic Armenian Cities and Provinces*, edited by Richard G. Hovannisian (Costa Mesa, 2006), Chapter 17, 527.

99 "Ba'ḍ al-āsmā' wa-l-ālfāz al-ārmaniyya," *Lughat al-'arab*, 540-542, April 1, 1914.

100 Kāmil al-Ghazī, *Kitāb nahar al-dhahab fī tārikh Ḥalab*, (Dar al-Qalam, Ḥalab), 1932. 448-451.

101 "Turkiyā wa-l-Arman: ṣafha ukhrā min mudhkirāt Ṭal'at Pāshā," *Al-Hilāl*, 460, February 1, 1930.

102 al-Ḥusayn ibn 'Alī, Sharif of Mecca. "Decree Issued in 1918 by the Sharif of Mecca for the Protection of Armenians." Armenian National Institute. April 29, 1918. Archived December 1, 2022.

saw as the world's "original" Christians.¹⁰³ Both Assyrians and Armenians resisted their transfer and guardianship as refugees under the international system, and the Arabs onto whose land they were temporarily resettled condemned the refugee camps as methods of reasserting colonial control with local collaborators. Structured through the League of Nations' Permanent Mandates Commission, local elite Arabs used the bureaucratic machinery to petition for their demands. This "protection" scheme was best embodied in Ba'qūba, a refugee camp north of Baghdad administered by the British from 1918 for Armenians and Assyrians. The camp took on the role of a state, rendering the refugee more or less dependent on their aid. At the same time, memoranda from camp authorities demonstrate how the British saw themselves as civilizing and saving these vulnerable people.¹⁰⁴ It also separated the two ethnicities from each other, and both from the surrounding Arabs and Kurds.¹⁰⁵ Though intended to be temporary with a view toward repatriation, Turkey's exclusive national ambitions brought Britain to recast Armenians and Assyrians as permanent ethnolocal enclaves that could collaborate to prop up weak European mandate governments.

The League of Nations assumed responsibility for establishing an international refugee regime in the wake of World War I, and these experiments in refugee protection introduced legal classifications of "refugee" that were inherently exclusive of most people fleeing persecution.¹⁰⁶

Though it originated in the 1685 flight of Huguenots from religious persecution in France, the term "refugee" only gained its modern legal sense as a way to describe Armenians and Russians after the collapse of the Ottoman and Russian Empires.¹⁰⁷ In 1921, the League of Nations appointed Fridtjof Nansen — who had been its High Commissioner for Prisoners of War in 1920 — as High Commissioner for Russian Refugees. In 1922, this appointed commissioner issued Nansen passports to stateless Armenian and Russian refugees. These were essentially guest worker passes that could help Armenians and Russians be matched with menial employment, but were primarily a method of documentation and state surveillance. The League of Nations "Arrangement of 12 May 1926" — formally defined refugees solely as denationalized Russians and Armenians without another nationality.¹⁰⁸ This form of statelessness is analogous to the definition of *muhājir* in the late Ottoman Empire. "Refugee" thus necessitated a nation-state, as it was premised on being stripped of one nationality or citizenship and hoping to acquire another by crossing international borders. Yet it was initially defined based on *specific* nationalities.¹⁰⁹

103 Robson, *States of Separation*, 10, 36.

104 H. L. Charge, A.P.O. *Memoranda on the Armenian and Assyrian Refugees At Present In Camp at Ba'quba, Mesopotamia*. Baghdad: Government Press, 1919. LON S14/14/8. In "Crisis in Iraq - Treaties between Iraq and England." United Nations Library & Archives Geneva.

105 Robson, *States of Separation*, 35, 46.

106 Stevens, "Shifting Conceptions of Refugee Identity and Protection," 74.

107 Hamed-Troyansky, *Empire of Refugees*, 8.

108 League of Nations, Arrangement Relating to the Issue of Identify Certificates to Russian and Armenian Refugees, League of Nations, Treaty Series Vol. LXXXIX, No. 2004, 12 May 1926.

109 Stevens, "Shifting Conceptions of Refugee Identity and Protection," 77.

Turkish, Arab, and Kurdish resentment increased as it became clear that the minority refugee groups were backed by British and French colonial interests. More than 10,000 Armenian and Assyrian survivors in various towns of southeastern Turkey were expelled to northeast Syria (under French mandatory control) in the late 1920s, though Christians were often forced to sign declarations affirming their voluntary migration.¹¹⁰ In 1920, Iraqi resistance organized a coordinated rebellion that cut Ba‘qūba off from Baghdad and forced its evacuation.¹¹¹ Nascent Iraqi nationalist leadership privileged Arabs and Sunnis, often suspecting non-Muslims for historical and inextricable associations with Europeans.¹¹² Ja‘far al-‘Askari wrote that “other groups, such as Jews and Christians, generally enjoy good social and economic status in Iraqi society,” surely because “they receive backing and material support from religious and missionary establishments abroad.”¹¹³ When, in 1923, nearly a hundred and fifty men from Mosul petitioned the British and Iraqi governments to eject Assyrian communities from the area, those communities turned to the British for support, reifying their “permanent” allyship.¹¹⁴ A decade later, the *mutassarif* of the Mosul *liwā’*, Khalīl ‘Azmī Bey, noted that the Assyrians were treated with patience by the government “specifically due to the humane and kind attitude of a kind government towards the refugees in her lands.” However, he threatened that they would not tolerate “anyone in the country ignoring the laws and order, under which all the subjects are bound” and that kind treatment would cease should Assyrians become disloyal subjects.¹¹⁵ In 1933, less than



"THE 1915 RELOCATION AND RESETTLEMENT LAW PROVIDED A LEGAL FRAMEWORK FOR DEPORTING CHRISTIANS. "

a year after Iraq’s independence, the country’s leadership carried out a massacre of Assyrians around the village of Simele. This prompted international commitments to remove Assyrians from Iraq altogether. Though many fled or were initially resettled to the upper Khābūr Valley in northeast Syria, starting in November of 1933, the League of Nations stepped in to facilitate the resettlement

110 Uğur Ümit Üngör. (2008) Seeing like a nation-state: Young Turk social engineering in Eastern Turkey, 1913–50, *Journal of Genocide Research*; Tachjian, “Expulsion of the Armenian Survivors,” 525 f.n. 6.

111 Robson, *States of Separation*, 49.

112 *Idem*, 50.

113 *Ibid.*

114 *Idem*, 51.

115 Khalil Azmi Bey, speech at Mutassarif residency in Mosul, July 10, 1933, LNA R3923 4/6523/3314. In Robson, *States of Separation*, 56.

of 10,000 Assyrians to Brazil.¹¹⁶

French support for Armenian refugee camps on the outskirts of Syrian cities created similar resentment among the Armenians being resettled and the local population rebuking this new form of imperialism.¹¹⁷ Syrian Arab nationalists quickly understood the resettlement initiatives to be a tactical French move for imperial power — they aroused “dangerous passions among the Moslems,” according to one report, and inspired several Muslim Arab attacks on refugee settlements.¹¹⁸ However, many Armenians in Syria and Lebanon were given citizenship by the French in the 1920s and became a prosperous middle class over the following decades.¹¹⁹

In the early days of the League of Nations, in addition to its interventions on behalf of Assyrians, the execution of the 1923 Greek-Turkish population exchange represented the ways

in which legal categories in the international system and Turkish language itself served to exclude. As part of the formation of ethnically homogenous nation-states and as a direct result of the Greco-Turkish War, the Treaty of Lausanne, administered by the Allies and the governments of Greece and Turkey, stipulated the forced relocations of at least 1.5 million Christians in Turkey to Greece and Muslims in Greece to Turkey.¹²⁰ Charles Howland, Chairman of the 1925 Greek Refugee Settlement Commission speaking as a Yale alumnus in the *Yale Daily News*, referred to these populations as “refugees” facing “the most sudden and catastrophic [expulsion] known to

history,” even compared to that of Jews and Muslims from Spain and Huguenots from France.¹²¹ However, neither the League of Nations nor the receiving governments considered them as such. Despite the name “Greek Refugee Settlement Commission” for Greece’s national efforts, the international law category applied to exchanged populations was “emigrant.” This entitled them to acquiring their new nationality (after losing their old one), property in the destination country (which was often the property



"THE LEAGUE OF NATIONS 'ARRANGEMENT OF 12 MAY 1926'- FORMALLY DEFINED REFUGEES SOLELY AS DENATIONALIZED RUSSIANS AND ARMENIANS WITHOUT ANOTHER NATIONALITY.."

116 Nansen International Office for Refugees. *Assyrian Refugees - Transfer of 10,000 Assyrians from Iraq to South America*. 1933. LON C1533/429/20A/80617/19093. United Nations Library & Archives Geneva.

117 Robson, *States of Separation*, 57, 60–61.

118 *Idem*, 62.

119 Lauren Banko, “Migrants, Residents, and the Cost of Illegal Home-Making in Mandate Palestine.” *Jerusalem Quarterly*, no. 84 (Winter 2020), 58; Katherine Mackinnon and Benjamin Thomas White, “What Becomes a Refugee Camp? Making Camps for European Refugees in North Africa and the Middle East,” 17, *Journal of Refugee Studies*, 2023.

120 Tachjian, “Expulsion of the Armenian Survivors,” 519–520.

121 C.P. Howland, “Post War Migration to Greece, Aided by League, Beneficial Rather Than Harmful—C.P. Howland,” *Yale Daily News*, November 17, 1927. *Yale Daily News Historical Archive*.

of the other group of people exchanged), and compensation for lost property.¹²² In Turkey, they are referred to not with the word *muhācīr*, but instead “*mübādīl*,” literally meaning “exchanged,” and thus not protected with the same considerations as the many Muslim refugees before them.¹²³

Turkish linguistic reforms, pioneered by Mustafa Kemal as part of modernizing, Westernizing, and secularizing the country, replaced the term *muhācīr* in 1933 with *göçmen*, a neologism meaning “immigrant,” “emigrant,” or “migrant.” The adoption of the Latin alphabet in 1928 and top-down purging of Arabic and Persian-derived words from the language represented a departure from what Turkey’s new elite considered to be the nation’s backwards, religious past.¹²⁴ *Göçmen* is today used to describe North Caucasians in Turkish scholarship.¹²⁵ To more directly refer to refugees, *göçmen* was later replaced by *mülteci*, derived from Arabic.¹²⁶

The word for “refugee” in modern Arabic, *lāji*’, directly replaces *muhājīr* in political and legal usage throughout the first part of the twentieth century, signaling the adoption of international law — rather than Islamic law — as determining the set of protections afforded to refugees. Though the word *malja*’, which shares a trilateral root with *lāji*’, occurs in verses 9:57, 9:118, and 42:57 of the Qur’ān, its meaning in all three cases is a physical and spiritual refuge from God, especially on the Day of Judgment.¹²⁷ Other formulations of the trilateral root, especially *laja*’, occur with a meaning of taking refuge, but not in a political sense until the late nineteenth and early twentieth centuries. “*Luju*’,” the modern word used for “asylum” derived from the same root, does not appear until decades after “*lāji*’.”

The term occurs once, centuries ago, in a similar sense to its present meaning, before re-emerging. Manfred Ullmann cites *al-Akḥṭal*, a seventh-century poet whose *Dīwan* was published in Beirut in 1891, as using the word *lāji*’ in the sentence “*atarka Qurayshun lāji’in wa-ghayruhum ilā kulli dif’in min janāhika wās’in*” (The Quraysh came to you as refugees and others, to every push from your spacious wing).¹²⁸ Given that Islam originated in the context of the community of Muslims seeking refuge *from* the

122 Convention Concerning the Exchange of Greek and Turkish Populations Signed at Lausanne, January 30, 1923. Republic of Türkiye Ministry of Foreign Affairs.

123 Emre Erol, “You Say ‘Muhacir’ and I Say ‘Mübadil.’” *The Lausanne Project*, January 13, 2023; Ferit Develliöglü, “Mübādīl.” *Osmanlıca-Türkçe Ansiklopedik Lûgat*. Ankara: Aydın Kitabevi, 2017.

124 Kaya Yılmaz, “Critical Examination of the Alphabet and Language Reforms Implemented in the Early Years of the Turkish Republic,” *Journal of Social Studies Education Research*. (2011): 59–82; Yasemin Gencer. “Pushing Out Islam: Cartoons of the Reform Period in Turkey (1923–1928).” In *Visual Culture in the Modern Middle East: Rhetoric of the Image*, edited by Christiane Gruber and Sune Haug-bolle, 189–213. Indiana University Press, 2013. Pro-reform cartoons depicting the triumph of the Latin letters over the Arabic letters often best capture this moment.

125 Hamed-Troyansky, *Empire of Refugees*, 85–86.

126 Ferit Develliöglü, “Mülteci.” *Osmanlıca-Türkçe Ansiklopedik Lûgat*. Ankara: Aydın Kitabevi, 2017.

127 Abou-El-Wafa, “The Right to Asylum between Islamic Shari’ah and International Refugee Law,” 312–313.

128 Ullmann, Manfred. *Wörterbuch der klassischen arabischen Sprache*. Wiesbaden: Otto Harrassowitz, 1970-. 237. Janāh here seems to have a connotation of protection. Ullmann also notes the appearance of the word *lāji*’ in the notable thirteenth-century dictionary, *Lisān al-‘Arab*, and in the *dīwan* of the well-known Abbasid poet Al-Mutanabbī, though its meaning refers to a man seeking a spiritual refuge in the first text and animals seeking refuge in the second.

Quraysh and the second person in the sentence is unspecified, it is unclear if this instance refers to any refuge related to Muslims. If so, it is a rare usage of the term that differs from a tradition that used the term *muhājir*. Regardless, this first documented use of the word *lāji* took the active participle form of the triliteral root meaning “to seek refuge” to mean “one who seeks refuge,” a refugee. The term does not appear to have re-emerged, at least with political connotations, until the turn of the twentieth century.

While resettlement in the late Ottoman Empire almost exclusively used the terminology of *hijra*, “*lāji*” appears in one letter dated to the early 1910s. Hajj Jan‘aq, a Chechen from Dagestan, wrote a letter to his brother who had emigrated and settled in Zarqā’ in Ottoman Transjordan. In it, he mentions *hijra* to the Ottoman Empire multiple times as a journey with religious significance, but also one that many in his village fear making.¹²⁹ He writes, however, that his father-in-law refused to let his daughter (Hajj Jan‘aq’s wife) become a *lāji*.¹³⁰ While the other references to *hijra* in his letter are explicitly linked to Islam, he believed it was an apt way to describe flight from persecution more neutrally.

The usage of *lāji* in Arabic-language newspapers demonstrates how it gradually became politically salient as a way to term “refugee” among journalists and civil society before the international community used it to entail a specific legal classification. An 1897 article in the Lebanese newspaper *Lisān al-ḥāl* uses the word *lāji* to term 28,000 refugees from Thessaly, Greece.¹³¹ *Al-Bashīr*, a Jesuit magazine in Beirut, published an article in 1903 mentioning Algerian *lāji*’ūn.¹³² *Lisān al-ḥāl* published an article in 1904 referring to Bulgarian villagers as *lāji*’ūn seeking the mercy of the Ottoman government in Rumelia.¹³³ These two newspapers, throughout the early 1900s, published other articles about *lāji*’ūn fleeing violence and persecution in places as close as Lebanon and Turkey,¹³⁴ and as far-flung as the Russo-Japanese War in Manchuria.¹³⁵ In Palestine, the influential newspaper *Al-Difā* published an article in 1937 about the Arab nationalist and Nazi Fawzi al-Qawuqji, who it referred to as a *lāji*’ *siyāsī* (political refugee) from Iraq.¹³⁶ Throughout the late 1930s, both *Al-Difā* and its rival newspaper, *Falastīn*, published articles about Spanish, German, Australian, Polish, and Hungarian refugees, among others.¹³⁷ Both newspapers had multiple articles about Jews fleeing various parts of Europe at the outset of World War II — in one example, *Al-Difā* notes the expulsion of Jewish *lāji*’ūn from France in July of 1940.¹³⁸

129 Hamed-Troyansky, “Imperial Refugee,” 448.

130 Letter B (c. 1910-12), Hajj Jan‘aq to Kerim-Sultan, F.F.S. Sultan Private Collection, al-Zarqā’, Jordan. Courtesy of Vladimir Hamed-Troyansky.

131 “Page 2.” *Lisān al-ḥāl*, August 16, 1897.

132 “Akhbār al-Barīd.» *al-Bashīr*. May 4, 1903.

133 “Rūm Ilī.” *Lisān al-ḥāl*. January 25, 1904.

134 “Laṣ Kabīr.» *Lisān al-ḥāl*. March 9, 1927.

135 “Aḥwāl Mūkdīn.” *Lisān al-ḥāl*. September 27, 1904.

136 “Qā’id al-Thawra.” *Al-Difā*. January 24, 1937.

137 “‘Alf Lāji’ Isbānī Yughādirūn Faransā.” *Al-Difā*. October 6, 1937; “Mi’at ‘Alf Lāji’ Yuṣbiḥūna Junūdān.” *Al-Difā*. April 15, 1938; “‘Asharat ‘Ālaf Lāji’ Yaṭlubūna al-Dukhūl ilā Ustīrāliyyā... wa-Hādhihi Takhsāh Ziyādat ‘Adad ‘Ummāliḥā al-‘Āṭilīn!” *Falastīn*. July 19, 1938.

138 “Ikhrāj Lāji’ in Yahūd min Faransā.” *Al-Difā*. July 7, 1940.

Around the time of the emergence of “*lāji*’,” the term *hijra* is used to mean secular “migration” or “immigration,” a meaning devoid of legal status and still maintained today. In 1933, *Falasṭīn* published a piece advocating for stopping *al-hijra al-yahūdiyya* (Jewish immigration).¹³⁹ Newspapers in Palestine from the mid-1930s through 1947 would discuss Jews as both *lāji’ūn* and *muhājirūn*, demonstrating the divergence of the terms as well as the political stances of their users. After the British White Paper of 1939 called for limiting Jewish migration to 75,000 for five years, as well as the admission of 25,000 Jewish refugees, the Arab Higher Committee for Palestine (the central political organ for Palestinians during the British Mandate) responded using both “*muhājirūn*” and “*lāji’ūn*.” It called for complete prohibition on Jewish *hijra* (meaning “migration”) and the rejection of Jewish national home policy. Furthermore, the response paper asserted that the plight of the Jewish *lāji’ūn* was one that originated in Europe and thus should not implicate Palestinians.¹⁴⁰ The term was used in this case to engage in dialogue about specific types of migrants with the British government, and to exclude them from protections.

Though I show that the use of the term “*lāji*’” predates the establishment of an international “refugee regime” to protect Armenians and Assyrians, specifically at Ba’qūba, I do not find references to these groups of people as *lāji’ūn* until after 1948. A 1929 article in *Al-Jāmi’a al-‘Arabiyya*, a nationalist newspaper in Jerusalem, refers to Armenian refugees in Syria with the term *hijra* and compares their migration to that of Jews to Palestine. It describes how the French Republic was keen to free Armenians

from “the clutches of persecution and claws of death,” while Jews had the support of the Balfour Declaration, the League of Nations, and major charitable organizations. While it saw both projects as colonial, the article sees Armenians as “peaceful and honest,” and Jews as the opposite.¹⁴¹ It demonstrates both that political goals (in this case, anti-Zionism) trumped consistent application of moral standards for people fleeing persecution, and that,

though the British and French saw Armenians as refugees, that perception was not necessarily shared by the Arab public.

The term “*lāji*’” is used to describe another early internationalist intervention in the region, the Middle East Relief and Refugee Administration (MERRA). In 1942, the British established MERRA to coordinate the temporary resettlement of tens of thousands of civilians from Poland, the Balkans, and Greece escaping Axis-occupied Europe. MERRA ran camps in Syria, Egypt, and Palestine, which recorded refugees through



"THE WORD FOR 'REFUGEE' IN MODERN ARABIC, LĀJI , ... COMES FROM A SIMILAR IDEA TO MUHĀJIR OF SHELTER FOR THOSE IN DISTRESS..."

139 “Lā ‘Atruk al-Sāq Illā wa-Qad Amsakta Sāqan, Hijrat al-‘Arab, Qaḍiyyat Falasṭīn al-Kubrā.” *Falasṭīn*.

140 “Bayān al-Lajna al-‘Arabiyya al-‘Ulyā li-Filasṭīn Raddan ‘alā al-kitāb al-abyaḍ allaḥī aḥdarat-hu al-ḥukūma al-Birṭāniyya fī 17 Ayyār/Māyu 1939 (Kitāb Mākdūnāld al-abyaḍ).”

141 “Hijrat al-Arman ilā Suriyā: Aqwāl Jarīdat al-Asfat.” *Al-Jāmi’a al-‘Arabiyya*. April 15, 1929.

identification cards and records on demographic details. The cover photo on the January 11, 1942 edition of the Palestinian magazine *Hunā al-Quds* shows a woman distributing clothing and food to a group of children. The caption reads “*Tawzī’ al-aṭ’ima wa-l-thiyāb fī Sūriyā ‘alā al-lāji’īn min bilād al-Yūnān*” (“food and clothing distribution in Syria to refugees from Greece”).¹⁴² Refugees did receive medical examinations and had the opportunity to work, but in many camps, they were only allowed to exit with British permission. MERRA came under the umbrella of the United Nations Relief and Rehabilitation Administration (UNRRA), which had replaced the Nansen International Office for Refugees, in 1944. A year later, complaints about the quality of care and restrictions on movement, as well as the end of World War II, led to their dissolution.¹⁴³

The term “*lāji*” was used by Arab governments themselves as they tried to leverage the term “refugee” before the advent of international protections for Palestinians. Newspaper records show that “*lāji*” was used to describe Jewish refugees to Palestine until at least June 1947.¹⁴⁴ After the Partition of Palestine through UN Resolution 181, adopted in November 1947 and the ensuing “civil war,” Israel declared independence on May 14, 1948. Five Arab nations invaded immediately, and on May 15 released a statement “on the Occasion of the Entry of the Arab Armies in Palestine” which said that more than a quarter of a million displaced Palestinians have “sought refuge” in neighboring Arab countries. The term used is “*iltijā*,” which shares its trilateral root with *lāji*.¹⁴⁵ This demonstrates that, in dealing with international powers, Arab leaders chose to distance themselves from the religious *muhājir*. The document also called for the application of the provisions of the Covenant of the League of Nations and the United Nations, including the right of Palestinians to self-determination. Four months later on September 9, *Al-Ahrām*, Egypt’s most widely circulating daily newspaper, published the headline “Presenting the Refugee Problem to the United Nations,” prominently using the word “*lāji’īn*” to call for their return to Haifa and Jaffa under UN supervision.¹⁴⁶ Later that month, a letter from the League of Arab States to the Secretary-General detailed the numbers of refugees in Egypt and Palestine and their dire situation. The Egyptian government had established what it termed the High Commission for Palestinian *Muhājirīn*, though in the temporary camp in al-Qanṭara, refugees were called *lāji’ūn*.¹⁴⁷ Despite its provision of medical care and food, the refugees are “badly in need of warm

142 “*Tawzī’ al-aṭ’ima wa-l-thiyāb fī Sūriyā ‘alā al-lāji’īn min bilād al-Yūnān*.” *Hunā al-Quds*. January 11, 1942.

143 Banko, “Migrants, Residents, and the Cost of Illegal Home-Making in Mandate Palestine,” 59.

144 “180 ‘Alf Lāji’ Yahūdī Yurīdūna Dukhūl Filasṭīn.” *Falasṭīn*, June 21, 1947.

145 “Bayān Ḥukūmāt al-Duwal al-‘Arabiyya al-‘Aḍā’ fī Jāmi’at al-Duwal al-‘Arabiyya Bayna Yaḍī Zaḥf al-Juyūsh al-‘Arabiyya ‘alā Filasṭīn.” al-Mawsū‘a al-Tafā’uliyya li-l-Qaḍiyya al-Filasṭīniyya. May 15, 1948. In Muhammad Izzat Darwaza, *On the Modern Arab Movement: History, Memoirs, and Commentaries* (Sidon, Lebanon: Al-Maktaba Al-Asriya, 1950-1951), Vol. 5, pp. 207-211.

146 “‘Arḍ Mushkilat al-Lāji’īn ‘alā Hay’at al-Umam.” *Al-Ahrām*. September 9, 1948. In Dhākira Falasṭīn.

147 “al-Jāliyyat al-Filasṭīniyya fī Jumhūriyyat Miṣr al-‘Arabiyya.” *Dā’irat Shu’ūn al-Lāji’īn Munazzamat al-Tahrīr al-Filasṭīniyya*. May 16, 2018; Oroub el-Abed, “al-Mujtama’ al-Mansī: al-Filasṭīniyyūn fī Miṣr.” *Al-Shabaka*. June 11, 2011.

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"BY USING THE TERM
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clothing, footwear, blankets, and other supplies.”¹⁴⁸ While not explicitly mentioned, the clear purpose was to request help from the UN.

By using the term “refugees” rather than “displaced peoples” or “migrants,” Arab states strategically attempted to claim the rights connected to the term. The Constitution of the International Refugee Organization (IRO), only a year earlier, defined refugees as victims of Nazi or Fascist regimes or their allies, Spanish Republicans, and Armenians and Russians, who were considered refugees before World War II.¹⁴⁹ It set up a mechanism for people who wished to be considered refugees to express “valid objections” to returning to their previous country based on persecution.¹⁵⁰ By using the term “refugee,” therefore, Arab leaders could invoke its usage to describe the victims of World War II, likening the Palestinian refugee crisis to the modern crises in Europe rather than the antiquated Ottoman context. “Refugee” as “*lāji*” was tied to a UN system that professed guarantees of comprehensive rights and protections. Arab states believed that leveraging this system could help their Palestinian brethren become classified under a protection framework based on their persecuted status. The reality would be one of exclusion, in part because of Arab states themselves.

Vesting the word *lāji* with the legal meaning of “refugee” in international law for the first time, the UN system addressed the Palestinian refugee crisis, creating the category of “Palestine Refugee” which would exclude Palestinians from protections afforded to all other refugees. UN General Assembly Resolution 212 (III) on November 19, 1948 established the UN Relief for Palestine Refugees (UNRPR) to provide the emergency relief the Arab League had requested.¹⁵¹ Less than a month later, on December 11, the General Assembly adopted Resolution 194, which created the UN Conciliation Commission for Palestine (UNCCP).¹⁵² Upon its failure to achieve a political solution to the refugee problem, the UNCCP recommended the creation of another UN agency. Thus, on December 8, 1949, the General Assembly adopted Resolution 302 (IV), establishing the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

UNRWA established the legal term “Palestine Refugee” (*al-lāji ʿī falasṭīn*) as a person “whose normal place of residence was Palestine during the period 1 June 1946 to 15 May 1948, and who lost both home and means of livelihood as a result of the 1948 conflict.”¹⁵³ Descendants of male Palestine Refugees are also eligible for the status, and all those eligible had to be officially registered.

148 Abdul Rahman Azzam, Secretary-General of the League of Arab States. *Letter dated September 1948 from the League of Arab States to the Secretary-General regarding the condition of Arab refugees from Palestine*. New York: UN, October 7, 1948. S/997/Add.1. United Nations Digital Library.

149 United Nations, Constitution of the International Refugee Organization, United Nations, Treaty Series, vol. 18, p. 3, 15 December 1946. Annex 1, Section A, para. 1.

150 *Idem*, Annex 1, Section C, para. 1.

151 Qarār 212 (al-Dawra 3), al-Jamʿiyya al-ʿĀmma li-l-Umam al-Muttaḥida. November 19, 1948. al-Mawsūʿa al-Tafāʿiliyya li-l-Qaḍiyya al-Falasṭīniyya. New York. Translated from English.

152 Notably, this occurred one day after the General Assembly adopted the Universal Declaration of Human Rights, a non-binding foundation of international human rights law that stated that “everyone has the right to seek and to enjoy in other countries asylum from persecution.”

153 Consolidated Eligibility and Registration Instructions (CERI). United Nations Relief and Works Agency for Palestine Refugees in the Near East. January 1, 2009. III. A. 1.

Though they were eligible for UNRWA services, Palestinians who were registered in categories like “Jerusalem Poor,” “Gaza Poor,” and “Non-Refugee Wives” could not become Palestine Refugees.¹⁵⁴ Suffering “significant loss and/or hardship for reasons related to the 1948 conflict in Palestine” — meeting a standard of persecution — was not enough to qualify.¹⁵⁵ As the refugee crisis expanded through further conflicts and became ossified (in many ways for political purposes), registration and categorization became more complex. Refugees from the 1967 War are referred to in Arabic as *nāziḥūn* (displaced), not *lāji’ūn*, and are only eligible for emergency, temporary humanitarian assistance if they are “in serious need.”¹⁵⁶ UNRWA provides relief services, food and cash subsidies, and various social and educational programs — all of which is carefully segmented for refugees who meet even more specific criteria.¹⁵⁷

Critically, in addition to the many classifications within UNRWA’s system, beneficiaries of its programs (Palestinian refugees) were cut out of UNHCR assistance by the 1951 Refugee Convention. In its introductory note, it states that, although they might otherwise qualify as refugees, the Convention “does not apply to those refugees who benefit from the protection or assistance of a United Nations Agency other than UNHCR, such as refugees from Palestine who fall under the auspices of United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).”¹⁵⁸ Many Arab and Muslim-majority state leaders did not sign onto the Convention or its Protocol, as they wanted to keep Palestinians under UNRWA’s mandate to ensure their treatment remained distinct from other refugees. UNHCR’s prioritization of resettlement and local integration threatened the perceived right of Palestinians to return to where their homes had been before 1948.¹⁵⁹ UNRWA — as opposed to UNHCR — status, meant that Palestinians would not be internationally recognized refugees, have no right to asylum, lack legal protections, and are usually ineligible for naturalization in neighboring countries. While I have explored how changing terminology has entailed different statuses, protections, and guarantors, this example shows that adding a place-based qualification (“Palestine”) to a term (“refugee”) can also create a category of exclusion. Still, there are local adaptations of terminology beyond their legal meanings — *lāji’* has come to colloquially refer to internally displaced Palestinians as well as those who have crossed international borders.¹⁶⁰

Though it did not apply to Palestinians, the 1951 Refugee Convention was the first time the category of refugee was made available to any person who faced individualized persecution in a country and a resulting inability to return. However, the Convention

154 Idem, III. A. 2.

155 Ibid.

156 Idem, III. B.

157 Ibid.

158 1951 Convention Relating to the Status of Refugees, 189 UNTS 137, Introductory Note.

159 For more information about Palestinian refugee legal status and Arab states’ role in demarcating it from UNHCR protections, see Susan M. Akram, “Palestinian Refugees and Their Legal Status: Rights, Politics, and Implications for a Just Solution.” *Journal of Palestine Studies* 31, no. 3 (2002): 36–51.

160 Nur Masalha, ed. *Catastrophe Remembered: Palestine, Israel and the Internal Refugees — Essays in Memory of Edward W. Said (1935–2003)*. London and New York: Zed Books, 2005.

only applied to Europeans displaced before January 1, 1951, and was not formally geographically or temporally expanded until the 1967 Protocol Relating to the Status of Refugees. Its precise legal definition of “refugee” requires individuals to meet the stringent criteria of a “well-founded fear of being persecuted” based on one of five characteristics.¹⁶¹

Though the term *lāji*’ was not directly imposed by Western states, the increasing popularity of its political usage, cemented by the UN response to Palestinian refugees in 1948, represents the transition from a religiously-based system to a secular, international system. It had advantages: *lāji*’ comes from a similar idea to *muhājir* of shelter for those in distress, but it does not carry religious or historical baggage, and preserves *hijra* as a set of terms with religious and Ottoman connotations. It also provided semantic clarification by offering another Arabic way — beyond *hijra*/*muhājir* — to conceptualize and differentiate those who move permanently from one place to another. The history of modern Middle Eastern refugee crises, especially from the mid-nineteenth century to the mid-twentieth, shows how refugee protections rooted in Islam became replaced by those rooted in secular international law. Yet, despite what modern scholars and Muslim leaders allege, it is not as if Islamic protections — at least in the Ottoman case — proved to be inclusive and generous. In this section, I have demonstrated that political leaders before, during, and after their cooperation with the international system, employed terms for refugees in the Levant and Anatolia to demarcate protections.

Modern Refugee Regimes in the Middle East

As demonstrated through the usage of the term *lāji*’, all multilateral political considerations of the issue of refugees in the Middle East after 1948 are structured by international law. This section will briefly review international engagements, national laws, and religious perspectives. Islamic concepts are invoked to inspire generous attitudes toward refugees, even if legal terminology follows international standards. A series of regional instruments sought to protect refugees through frameworks generated from within the Muslim-majority world, but they were largely non-binding and had little effect. These do not represent failures in international law or Islamic law, but rather in political commitment when theory became tested in its implementation.

The 1965 Casablanca Protocol of the Arab League intended to grant Palestinian refugees rights to work, education, and freedom of movement while still preserving their right to return, but most Arab states did not apply its provisions.¹⁶² Crucially, however, it is a key part of Arab states’ international resistance to UNHCR classification for Palestinians. The 1969 Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems

161 1951 Convention Relating to the Status of Refugees, 189 UNTS 137. Article 1. A. (2).

162 Brütükül Mu’āmalat al-Filasṭīniyyīn fī al-Duwal al-‘Arabiyya: Brütükül al-Dār al-Bayḍā’, Jāmi’ al-Duwal al-‘Arabiyya. September 11, 1965. al-Mawsū’a al-Tafā’uliyya li-l-Qaḍiyya al-Falasṭīniyya. Casablanca.

in Africa expanded the 1951 Refugee Convention definition to include those escaping “external aggression, occupation, foreign domination or events seriously disturbing public order.” It is a rare example of limited success in ratification and operationalization in the courts and laws of several African states, including in North Africa.¹⁶³ In 1981, the Islamic Council of Europe drafted the 1981 Universal Islamic Declaration of Human Rights (UIDHR), attempting to expand the 1948 Universal Declaration of Human Rights. Though it allegedly uses *fiqh*, in reality it mixes in modern, secular concepts like *lujū’* (asylum), and was largely symbolic rather than adopted by a group such as the Organization of Islamic Cooperation (OIC).¹⁶⁴ A state-level analog to the UIDHR was the 1990 OIC Cairo Declaration on Human Rights, which intended to frame human rights within Islamic law. Though Article 12 proclaimed a universal right to freedom of movement, it articulated only a right to seek asylum, compared to modern Islamic law constructions that require the provision of asylum to all who seek it.¹⁶⁵ It may be used internationally as a tool of rhetoric, but it did not result in any measurable improvement in refugee protections. Two years later, in 1992, the Declaration on the Protection of Refugees and Displaced Persons in the Arab World recognized a need for cooperation with UNHCR and adherence to international norms to actually establish a refugee protection framework in the region.¹⁶⁶ Its lack of legal force meant that it did not create new obligations. Taking inspiration from the success of the 1969 OAU Convention, the 1994 Arab Convention on Regulating Status of Refugees in the Arab Countries attempted to inaugurate a formal refugee framework, but was never fully ratified.¹⁶⁷ Following this failure, the 2003 OIC Resolution on the Problem of Refugees in the Muslim World, through Islamic terms, encouraged more collaboration with UNHCR and improved refugee protection, yet it too had little impact.¹⁶⁸ The 2012 Ashgabat Declaration restates the Islamic tradition of providing asylum, again mixing the language of Islam with modern terminology such as *lujū’*.¹⁶⁹

While international mechanisms have been toothless, national laws do not prove to be much more implemented. Modern constitutions of Muslim-majority states reflect ideas common in articulations of both international and Islamic law, such as generous obligations towards asylum seekers, non-refoulement, and right of return.¹⁷⁰ Many, including Saudi Arabia’s Basic Law,

163 Organization of African Unity (OAU), 1969 Convention Governing the Specific Aspects of Refugee Problems in Africa (“OAU Convention”), 1001 U.N.T.S. 45, September, 10, 1969. Article 1.2.

164 al-Majlis al-Islāmī. al-Bayān al-‘Ālamī ‘an Ḥuqūq al-Insān fī al-Islām. September 19, 1981. Paris.

165 Islamic Conference of Foreign Ministers, *Cairo Declaration on Human Rights in Islam*, Organization of the Islamic Conference (OIC), 5 August 1990. Article 12.

166 Arabic-Islamic States, *Declaration on the Protection of Refugees and Displaced Persons in the Arab World*, Regional Refugee Instruments & Related, 19 November 1992.

167 League of Arab States, Arab Convention on Regulating Status of Refugees in the Arab Countries, 1994.

168 Resolution No. 15/10-P (IS) on the Problem of Refugees in the Muslim World: Adopted by the Tenth Session of the Islamic Summit Conference Putrajaya, Malaysia, 16–17 October 2003, *Refugee Survey Quarterly*, Volume 27, Issue 2, 2008, 91–93.

169 Regional Treaties, Agreements, Declarations and Related, *Ashgabat Declaration of the International Ministerial Conference of the Organization of Islamic Cooperation on Refugees in The Muslim World*, May 12, 2012.

170 “English translation of the Syrian Constitution of 1950.” Extracted from: Helen Miller Davis. *Constitutions, electoral laws, treaties of states in the Near and Middle East*. 2nd ed., rev. and enl. Durham,

Libya's 2011 constitution, and Egypt's 2014 constitution, presume a right to asylum for all who seek it, not just for those who fit broad definitions of fear of persecution.¹⁷¹ Despite the growth of constitutional Islamic supremacy clauses — which were more often responses to colonialism and liberalization — articulations of refugee protections are done with modern, secular terminology.¹⁷²

Regardless of what exists in principle, few Middle Eastern countries actually have formal domestic refugee legislation or asylum processes, and many rely on UNHCR to register, document, and determine refugee status, as well as provide aid and seek longer-term solutions.¹⁷³ Furthermore, Arab states tend to monitor exit and entry as a method of practicing refugee protections — in Jordan, asylum is mainly given to people who need a safe haven, while in Lebanon, receiving asylum through the formal legal system is so bureaucratic that nearly all refugees are more informally protected.¹⁷⁴ Despite a strong focus on Palestinian refugees in multilateral Arab discussions, Egypt and other states have, in practice, restricted the rights and privileges afforded to Palestinians.¹⁷⁵ The governments of Lebanon, Jordan, Turkey, and the Gulf states today often use terminology like *nāziḥūn* to refer to Syrians, as they understand that it entails fewer international law obligations.¹⁷⁶ In Egypt, Syrian refugees have been illegally detained and forcibly deported under the pretext of involvement in the Muslim Brotherhood.¹⁷⁷

Muslim-majority states sometimes use Islamic law as an excuse for not abiding by international protection standards, but lack of adequate protections is most often not an issue of the overstep of international law — especially when states have agreed to certain measures. Instead, many of today's lackluster protections for the world's most vulnerable people are due to an absence of political will or public popularity.¹⁷⁸ Protection regimes rooted in Islamic law — such as M. Nazif Shahrani's endorsement of a system reliant on community leaders, Zaat's proposal to provide a firmer articulation of Islamic protection principles, or Hossameldeen Mohammed and Ray Jureidini's support for the UNHCR Zakat Fund — may marginally improve protection. However, based on recent history, the solution to modern refugee crises, contrary to what scholars like Muḥammad Anas Rizwan argue, is not Islamic law.

N.C.: Duke University Press, 1953. Article 20; Constitute Project. "Jordan's Constitution of 1952 with Amendments through 2016."

171 Constitute Project. "Saudi Arabia's Basic Law of 1992 with Amendments through 2013"; Constitute Project. "Libya's Constitution of 2011 with Amendments through 2012"; Constitute Project. "Egypt's Constitution of 2014 with Amendments through 2019."

172 Dawood I. Ahmed and Tom Ginsburg, "Constitutional Islamization and Human Rights: The Surprising Origin and Spread of Islamic Supremacy in Constitutions," *Virginia Journal of International Law* 54, no. 3 (Summer 2014): 615-696.

173 Stevens, "Shifting Conceptions of Refugee Identity and Protection," 82.

174 *Idem*, 83.

175 el-Abed, "al-Mujtama' al-Mansī."

176 Stevens, "Shifting Conceptions of Refugee Identity and Protection," 86; Nizar Saghih and Ghida Frangieh, "The Most Important Features of the Lebanese Policy Towards the Issue of Syrian Refugees: From Hiding Its Head in the Sand to 'Soft Power.'" *Heinrich-Böll-Stiftung*, December 30, 2014.

177 Stevens, "Shifting Conceptions of Refugee Identity and Protection," 88.

178 Mashood A. Baderin, *International Human Rights and Islamic Law*. Oxford: Oxford University Press, 2003. 30. See also Zaat, "The protection of forced migrants in Islamic law," 5.

The lofty vocabulary of international law protections for refugees, often void of substantive requirements, is also engaged in by today's religious discourse in the political sphere. *Fatāwā* refer to refugees as *lāji'ūn*, drawing inspiration from Islamic tradition but eschewing its language. A 2021 *fatwā* from al-Azhar Islamic Research Academy confirms that *lāji'ūn* and *nāziḥūn dākḥiliyyan* (internally displaced persons) fall into four of the eight *zakāt* categories (poverty, destitution, debt, and wayfarer) cited in Qur'ān 9:60, and thus are eligible to receive *zakāt al-fitr*.¹⁷⁹ This demonstrates that engagement in the politics of refugees, even from a religious perspective, often demands usage of secular terminology and its classifications.

While “*muhājir*” has today lost its political and legal meaning as “refugee” (it is now the general term for “migrant”), individual Muslims still use the term to signify a religious tradition. Pakistanis reflect on their hosting of Afghans with words *anṣār* and *muhājirūn*.¹⁸⁰ Among these Afghan refugees, self-definition as *muhājirūn* is empowering, as it frames migration as resistance to oppression.¹⁸¹ Iraqis who fled during the first and second Gulf Wars of 1991 and 2003 might use the word *lāji'* to reflect their legal status and *muhājir* to construct a more empowering internal identity tied to Islam.¹⁸² An ethnographic study of refugees in Jordan suggests that individuals only self-label as “refugees” when receiving services from UNHCR.¹⁸³ In a viral video posted by the Jordanian news channel “Al-Mamlaka TV” in 2024, a Syrian refugee refers to himself as a *muhājir* and praises his Jordanian hosts as *anṣār*.¹⁸⁴

Conclusion

This paper has argued two main points. First, that the transition in the usage of the term *muhājir* to that of *lāji'* for refugees in legal and political contexts in the Levant illustrates Arab leaders' uptake of the international refugee regime and distancing from the Ottoman regime. Second, that international law did not replace a better refugee protection framework that we should return to, but rather, that these systems — whether based on religion or nationality — were designed to exclude unwanted individuals and, in doing so, bolster the power of state leaders. While finite resources for refugee protections often require certain exclusions, most often it is not a lack of funding or ability, but a lack of political will, that leaves the most vulnerable individuals

179 al-Idāra al-'Āmma li-Shu'ūn Majlis al-Majma' wa-Lijanihi. “al-Ra'y al-Shar'i Ḥawl Jawāz Tawzī' Zakāt al-Fitr fī Šūra Musā'adāt Naqdiyya li-Mustahqqihā min al-Lāji'īn wa-l-Nāziḥīn Dākḥiliyyan.” *Majma' al-Buḥūth al-Islāmiyya*, al-Azhar al-Sharīf. March, 2021.

180 Kamal Matinuddin, “Afghan Refugees: The Geostrategic Context.” In *The Cultural Basis of Afghan Nationalism*, ed. Ewan Anderson and Nancy Hatch Dupree, 217-230. London: Pinter. 1990.

181 M. Nazif Shahrani. “TEN. Afghanistan's muhājirin (Muslim “Refugee-Warriors”): Politics of Mistrust and Distrust of Politics” In *Mistrusting Refugees* edited by E. Valentine Daniel and John Chr. Knudsen, 187-206. Berkeley: University of California Press, 2023.

182 Dallal Stevens, “Legal Status, Labelling, and Protection: the Case of Iraqi ‘Refugees’ in Jordan,” *International Journal of Refugee Law*, Volume 25, Issue 1, March 2013, 18–19.

183 Hanna Berg, *We Are Not Going Anywhere: An Ethnographical Study of (Im)mobility in Jordan* (Master's thesis, Stockholm University, 2018).

184 AlMamlaka TV, “Wasat bukā' wa-farḥa wa-imtinān... Süriyyūn yu'abbirūn 'an farḥatihim bi-l-'awda ilā waṭānihim ba'da ṭūl intizār.” Facebook video, 2:36, December 11, 2024.

without support. Terminology, especially as it gains political and legal meaning, is a way to track these distinguishing categories of qualification and provision.

Whereas modern scholarship partial to Islamic law judges its theoretical refugee protections against the practical failings of international law, I use history in Anatolia and the Levant to compare the two in practice. What emerges is not just a moment of shifting legal statuses, protections, and guarantors, but many case studies in which both Islamic and secular regimes categorize, exclude, and pursue political ends that leave refugees without the guarantees they are often promised. Muslims as a particular group lost a status in refugee regimes in the region after World War I, making it more difficult to acquire refugee protections as they may have during the Ottoman regime. However, the old categories and the new — regardless of positive treatments for particular groups — served the political interests of state and international leadership. Today, the West's guiding philosophy of refugee protection is providing material aid and distancing refugees from its borders. Beyond serving as a population through which states project humanitarianism, refugees can be made useful for the state's goals, and are often too at-risk to protest.

Protection — whether in the form of acquiring status, resettlement, or material aid — is never without a cost to the refugee. Aid is often a mode of control, especially in situations of physical containment like the Ba'qūba refugee camp. More strongly enforcing states' compliance with aid provision would surely lead to the improved welfare of some refugees, but it might also empower the state to further control their new subjects. Attempting to expand the refugee regime with more legally-defined terminology to empower increasingly varied categories of migrants may backfire.¹⁸⁵ Classifications used to enhance protections can also be used to divide and restrict. As Hamed-Troyansky highlights, in the last decade of the Ottoman Empire, refugee relief and ethnic cleansing came together.¹⁸⁶ Similarly, the processes of categorization used to inaugurate nation-building are also those that cause refugee movements.¹⁸⁷ Locating access to rights in the place where they are most likely to be violated — the state — is dangerous but seemingly inevitable. Even if we grant non-governmental organizations and local communities the resources to provide refugee protections, the state is still the custodian of those rights. As Hannah Arendt writes, “contrary to the best-intentioned humanitarian attempts to obtain new declarations of human rights from international organizations,” international law still operates between states.¹⁸⁸

A pragmatic approach to upholding refugee protections must work somewhere inside this structure, with inspiration from individually-granted refugee protections. Indeed,

185 Kristy Siegfried. “Lāji’ am muhājir: hal hān al-waqt li-tasmiyya jadīda?” *The New Humanitarian*, June 15, 2015.

186 Hamed-Troyansky, *Empire of Refugees*, 85.

187 Gil Loescher. *The American Political Science Review* 84, no. 3 (1990): 1072–73.

188 Hannah Arendt. *The Origins of Totalitarianism*, Houghton Mifflin Harcourt Trade & Reference Publishers, 1973. 298.

responsibility for state policy does not rely on “the state” conceived with personhood, but rather with individual policymakers who would do well to understand the role of language in classifying people. Though some acted for individual gain, examples of Syrians welcoming Armenians and Jordanians hosting Syrians demonstrate the underlying interpersonal humanity that can guide better protection frameworks. This is partly why the theorized Islamic law protections sound appealing — because they do not necessitate a state as a provider. But in practice, they have. However, in all of the state schemes I have examined, it is the individual responses to refugee flight that become instructive. Furthermore, though I did not thoroughly examine how refugees become agents during their journeys and upon arrival in new lands, drawing from self-conceptions of those fleeing persecution is an area for future study. Finally, reframing refugee protections as place-based rather than state-based should be explored more fully.¹⁸⁹

189 See Parekh, S. (2020). Reframing the refugee crisis: from rescue to interconnection. *Ethics & Global Politics*, 13(1), 21–32. and Zaha Hassan, Daniel Levy, Hallaamal Keir, and Marwan Muasher, *Breaking the Israel-Palestine Status Quo* (Washington, DC: Carnegie Endowment for International Peace, 2021).

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Invisible Daughters: The Impact of the Family Planning Narrative on Infanticide and Sex-Selective Abortion (SSA) in Post-Colonial India (1980-

They are missing—not by accident, but by design. The 1995 United Nations Children's Fund (UNICEF) Annual Report, *The Progress of Indian States*, examines sex-selective abortion (SSA) and gender discrimination in India, focusing on the large-scale disappearance of girls from the population.

The report estimates that 40 to 50 million women and girls are “missing” from India’s demographic records, a number that reflects widespread practices of sex-selective abortion and neglect of female children.¹ The 2020 United Nations Population Fund (UNFPA) *State of the World Population* report adopts similar language, defining “missing females” as those absent due to sex-selective abortion and excess female mortality.² This way of framing infanticide and feticide as “missing girls” bodes as a stronger critique: it not only attributes responsibility to society for their absence but also highlights the Indian state’s failure to safeguard the health and survival of female children. By viewing

1 J.E. Rohde, A.K.S. Kumar, and U. Shanker. *The Progress of Indian States* (New Delhi, India: UNICEF, 1995), <https://nl.ircwash.org/sites/default/files/802-IN95-15093.pdf>.

2 *State of World Population 2020*. (United Nations Population Fund, 2020), 45, <https://www.unfpa.org/publications/state-world-population-2020>.

infanticide and feticide through this lens, UNICEF and UNFPA emphasize not only the scale of gender-based violence but also the lack of institutional intervention. The language implies that these girls should have been part of the population but were deliberately eliminated, reinforcing the moral and political urgency of the issue. Rather than presenting violence against women as a statistical anomaly, the reports frame it as a crisis with real human consequences.

As Professor of Law Nehaluddin Ahmad remarks, “India is a patrilineal, patriarchal, and patrilocal society.”³ The socio-cultural landscape of India reflects a complex interplay of gender dynamics, spanning from historical practices like infanticide to modern phenomena such as sex-selective abortion (SSA). From the colonial era’s enactment of legislation like The Infanticide Act of 1871 to the contemporary implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, both colonial and postcolonial states have attempted to address the ethical, legal, and moral implications of gender-based violence against female fetuses and infants. Despite legislative interventions and public health campaigns, the persistence of female infanticide and SSA underscores the challenges in addressing the continuing and deeply entrenched societal preferences for male progeny. This paper examines the post-sterilization Indian state: I will use

historian Mytheli Sreenivas’s work on state-led sterilization efforts, which largely ended in the 1970s, to frame the state’s actions of the 1980s. I argue that state-driven population control initiatives, often championed by both the Indian state and elite-run multilateral organizations, remained rooted in eugenic principles of cost-laden desirability. These efforts promoted a government-backed ideal of a gender-neutral two-child family, yet they failed to acknowledge nor address gender inequality and violence. In the

1980s, SSA festered in an environment of continued economic disempowerment, a lack of consensus in the Indian state’s approach to gender in social policy, and the affordability and availability of ultrasound technology. As a result, feticide emerged as a modern continuation of infanticide, exacerbating violence against girl children. In this paper, I will first discuss the roots of infanticide within the framework of “missing girls” in colonial India and provide context of the general Indian history in which infanticide and feticide is situated. I will then shift to population control debates in the post-colonial state and analyze the contested discourse around reproductive inequality by examining parliamentary debate and case law. Finally, I will consider the how the fragmented state approaches and implementations have failed to address the structural inequality and social norms within which SSAs have flourished.



" ... 40 TO 50 MILLION WOMEN AND GIRLS ARE 'MISSING' FROM INDIA'S DEMOGRAPHIC RECORDS "

3 Nehaluddin Ahmad, “Female Feticide in India,” in *Issues in Law & Medicine* 26, no. 1 (HeinOnline, Summer 2010), 14, <https://heinonline.org/HOL/P?h=hein.journals/ilmed26&i=17>.

Colonial India

The concept of “missing girls” has historical roots in colonial India. During British rule, female infanticide was widespread, particularly among high-caste, land-owning communities, such as the Jats and Rajputs in the northern, western, and central regions of India. Anthropologist Bernard Cohn argues that the British, maintaining a distance from their Indian subjects, failed to engage closely with local communities in ways that could have provided deeper insight into their practices.⁴ Yet, the British documented cases of infanticide dating back to 1789, recorded in officials’ travel diaries on the Rajkumar Rajputs of Jaunpur.⁵ Initially, colonial records attributed the practice to ancient Hindu texts and anecdotal evidence from elite castes, reflecting Orientalist assumptions and racialized notions of “innate characteristics.”⁶ In 1857, English chaplain John Cave Browne published *Indian Infanticide: Its Origin, Progress, and Suppression*, arguing that infanticide among the Jats was driven by “Malthusian motives”: a strategy to limit the female population and secure male heirs for warfare.⁷ Although eugenics as a discipline developed in the early twentieth century, infanticide had overtly eugenic foundations that appeared as early as the nineteenth century, shaping colonial interpretations of gender and population control in India.⁸

In 1835, British official James Thomason encountered infanticide firsthand while addressing a group of landowners in Uttar Pradesh. When Thomason referred to one man as the son-in-law of another, he elicited a sarcastic laugh from the group, prompting a bystander to explain that such a relationship was impossible as there were no daughters in the village. Thomason was informed that the birth of a daughter was regarded as a severe misfortune, and girls were rarely permitted to survive.⁹

4 Bernard Cohn, “Colonialism and its Forms of Knowledge: The British in India” in *The New Imperial Histories Reader* (Routledge, 2020), 117-124.

5 Ahmad, “Female Feticide in India,” 15.

6 Josephine Kipgen, “Abortion and Sex-Selective Abortion in India: History, Law, and Policy” in *Reproductive Politics in India: The Case of Sex-Selective Abortion* (Springer International Publishing, 2023), 41-72; David N. Livingstone, “Tropical Climate and Moral Hygiene: The Anatomy of a Victorian Debate” (*The British Journal for the History of Science* 32, 1999), 93–110.

7 John Cave-Browne, *Indian Infanticide: Its Origin, Progress, and Suppression* (United Kingdom: W.H. Allen and Company, 1857), 122.

8 However, modern scholars have questioned Browne’s claims, noting that he based his findings on hearsay. See Kipgen, “Abortion and Sex-Selective Abortion.”

9 Barbara Miller, *The Endangered Sex: Neglect of Female Children in Rural North India* (Ithaca: Cornell University Press, 1981). Scholars and historians have documented that, for centuries, the birth of daughters has not been welcomed in Indian society. Women are often regarded as goddesses, rarities, or objects, reflecting the contrast of their revered yet marginalized status. This idea is encapsulated in the Sanskrit blessing given by priests to young married women: “Ashta Putra Saubhagyavati Bhava,” urging them to “be a Mother of Eight Sons,” highlighting the emphasis on male progeny. See Ahmad, “Female Feticide in India,” 14. The birth of a son is equated to “a sunrise in the abode of gods,” and “to have a son is as essential as taking food at least once a day.” In contrast, the birth of a daughter is a cause for great sadness and disappointment. See Asha Ramanamma and Usha Bambawale, “The Mania for Sons: An Analysis of Social Values in South Asia” in *Social Science & Medicine. Part B: Medical Anthropology* 14, no. 2 (1980), 107-110. The significance of sons is further rooted in religious texts such as the Atharva Veda that includes mantras meant to change the sex of a fetus from female to male. It is also featured in the Mahabharata, with Gandhari’s granted boon of one hundred sons. This symbolizes the importance placed on male offspring, further emphasized when Gandhari later “wailed” as she was “[f]illed with anger at the slaughter of all her sons and grandsons.” See Chakravarthi Narasimhan, *The Mahābhārata: An English Version Based on Selected Verses* (United States: Columbia University Press, 1998), 188. The moral outrage that Gandhari feels at the loss of her clan is not echoed in the occurrence of female infanticide due

Imperial policies, particularly those implemented during British colonial rule, exacerbated gender disparities by reinforcing male inheritance and perpetuating son preference. Imposed economic reforms and taxation increased land prices while designating men as the sole proprietors of such property, further marginalizing women.¹⁰ Even post-independence legal reforms aimed at empowering women, such as the Hindu Succession Amendment Act of 1956, faced resistance, as families refused to grant daughters their rightful inheritance for fear of losing ancestral land.¹¹ These structural inequalities, combined with dowry practices and religious ideals, fostered what scholars have termed a “pathologically severe preference for sons” across castes, tribes, and trades as men “were the only avenue to status, wealth and employment.”¹² This preference has persisted throughout time and has withstood intervention during various periods. Notably, modernist and nationalist figures, like Amrit Kaur and Jawaharlal Nehru, remained largely silent on the issue of infanticide.

Colonial officials rarely accused individuals or families of infanticide due to the difficulty of proving such cases in British courts. Instead, they attributed blame to entire clans or social groups. The British, reluctant to alienate Indian nobility such as the Rajputs, often downplayed female infanticide, citing undercounting and age misreporting to explain skewed sex ratios. Consequently, female infanticide was frequently regarded as a “statistical crime.”¹³ However, the stark contrast between India’s sex ratio of 940 females to 1000 males (940:1000) and those observed in Western nations eventually drew attention.¹⁴ Recognizing that this imbalance stemmed from systemic violence against female infants, the British passed the Infanticide Act of 1871, formally banning the practice in its entirety. The Act punished perpetrators of infanticide with a death sentence or transportation for life.¹⁵

to the perceived sanctity of sons. This is just one example of cultural practices that historical actors have used to perpetuate anti-women reproductive matters.

10 Veena Talwar Oldenberg, *Dowry Murder: The Imperial Origins of a Cultural Crime* (New York: Oxford University Press, 2002), 4.

11 Kippen, “Abortion and Sex-Selective Abortion.”

12 Oldenberg, *Dowry Murder*, 160. The practice of dowry, though outlawed, continues to persist in various forms, acting as arguably the main contribution to the devaluation of women and reinforcement of son preference. Dowry rates have skyrocketed, leading to an “epidemic of female feticide” in the last few decades, as families seek to avoid the financial burden associated with having daughters. See Ahmad, “Female Feticide in India,” 15. According to Indian culture, the bride’s family must pay for the wedding ceremony, and the dowry is valued based on the groom’s earnings, caste, and familial needs with the bride’s status being rendered irrelevant. Lower socioeconomic status parents of daughters hence have a greater economic burden. On the other hand, a male child is an asset who collects a dowry. See Ahmad, 17-18.

13 Cohn, “Colonialism and its Forms of Knowledge: The British in India,” 11.

14 Proposed theories included a supposed genetic predisposition among Indians to favor sons and deliberate under-reporting of women by families wary of British intentions. One commissioner even suggested that “male births increase in proportion to the warmth of the climate.” See Miller, *The Endangered Sex*.

15 Ahmad, “Female Feticide in India,” 15. Similarly, Indian abortion laws were initially derived from the British Penal Code of 1861, also known as the 1861 Offences Against the Person Act (OAPA), which criminalized induced abortions. See Tulsi Patel, *Sex-Selective Abortion in India: Gender, Society and New Reproductive Technologies* (India: SAGE Publications, 2007). Under OAPA, procuring or assisting in abortion was deemed a felony punishable by penal servitude for life. See Parliament of the United Kingdom of Great Britain and Ireland, Offences Against the Person Act 1861, <https://www.legislation.gov.uk/ukpga/Vict/24-25/100/enacted/data.pdf>. The Indian Penal Code of 1862 mirrored this, punishing both women seeking abortion and abortionists, except when necessary to save the woman’s life. These laws persisted until 1971, despite mounting pressure for change beginning in 1964 due to high maternal mortality rates from unsafe abortions. Under these laws, abortionists and women could face imprisonment for providing or seeking abortion, with an exception made for the health of the pregnant woman. See Kippen, “Abortion and Sex-Selective Abortion.”

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The legislature was difficult to enforce, however, as births were usually done at home and without any registration.¹⁶ Based on nineteenth century judicial records and government documents, the decade following the promulgation of the Act resulted in 333 prosecuted female infanticide cases. Of those, only sixteen perpetrators were sentenced to death with only three sentences carried out, while most were either acquitted or imprisoned.¹⁷ Despite legal prohibitions, families continued the practice through strangulation, poisoning, abandonment, drowning, burying alive, starvation, and other folk remedies.¹⁸ Mothers often exacted the crime with the support of other women in her network. Following independence, the maximum penalty for infanticide was reduced from a death sentence to ten years of imprisonment, reflecting the increased leniency towards the crime given its cultural foothold.¹⁹

Indian Population Control Precedent

During the 1950s and 1960s, global concerns about a looming “population bomb,” with South Asia at its core, drove aggressive external and internal population control initiatives in



**"AS PROFESSOR OF LAW
NEHALUDDIN AHMAD
REMARKS, 'INDIA IS A
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India.²⁰ The Indian state included population control and family planning into its first two five-year plans from 1952-1962.²¹ These programs disproportionately targeted lower-caste, lower-class women, positioning them as central to curbing population growth. India's population was scrutinized by the international community,

16 Ahmad, “Female Feticide in India,” 15.

17 Pramod Kumar Srivastava, “Female Infanticide in 19th-Century India: A Genocide” (SCRIP, 2014), <https://www.scrip.org/journal/paperinformation?paperid=52493>

18 In Punjab, one particularly grotesque custom was that an infant girl would be killed, followed by a piece of gur (jaggery) being placed in her mouth and cotton in her hand. The mother would then chant, “Feed on the gur, and spin the cotton. Come into the world no more but send brothers.” See Srivastava, “Female Infanticide in 19th-Century.”

19 Srivastava, “Female Infanticide in 19th-Century.”

20 Paul Ehrlich, *The Population Bomb* (United States: 1971).

21 N.A. Sarma, “Economic Development in India: The First and the Second Five Year Plans” (*IMF Staff Papers*, 1958), <https://doi.org/10.5089/9781451949636.024.A002>.

particularly by organizations like USAID, the Asian Development Bank, and the World Bank, as a case study in the perceived link between overpopulation, poverty, and development aid. Concerns over demographic “explosions” and rapid population growth fueled anxieties among both Global North and Global South elites, framing female reproductive bodies, especially Indian bodies, as sites of demographic crisis and necessary policy intervention.²²

Internally, the Indian government set ambitious contraceptive use targets and provided financial incentives for compliance, enlisting middle-class women as advocates in the state’s family planning agenda. Middle-class women served as ideal representatives to promote family planning, tasked with “educating” poorer women on limiting family size. Groups such as the Family Planning Association of India (FPAI) and the All India Women’s Conference (AIWC) mobilized female volunteers to present family limitation as a path to better health, respect, and leisure for poor women. The AIWC argued that family planning would not only free women from exhaustive domestic roles but would ultimately contribute to a new era of progress for Indian women.²³

The FPAI promoted the view that reduced fertility was crucial to economic growth and framed population control as a matter of national “self-respect.”²⁴ Meanwhile, sterilization became a preferred state-sponsored method for regulating the reproductive capacities of marginalized communities, with cash incentives offered for the procedure in places like Madras. Lower-caste individuals and the poor were encouraged to see sterilization as a viable means of escaping poverty, and by the time of the 1975 Emergency,²⁵ sterilization had become an instrument of state power, often coercively enforced as a prerequisite for access to housing, employment, and healthcare.²⁶ The eugenic ideals of sterilization as a method of poverty elimination did not cease in the 1960s and 1970s, but rather manifested in a new form: family planning propaganda.

Foreign funders played an active role in India’s family planning initiatives, working alongside the Indian government to promote population control measures. Organizations like the Ford Foundation were particularly eager to contribute, with their first population control grant aimed at educating the public about family planning and advancing the “small-family norm.”²⁷

The “happy family” ideal became a prominent theme in

22 Kalpana Wilson, *Race, Racism and Development: Interrogating History, Discourse and Practice* (United Kingdom: Bloomsbury Publishing, 2013).

23 Mytheli Sreenivas, *Reproductive Politics and the Making of Modern India* (Seattle: University of Washington Press, 2021), 126-129.

24 The group advocated for widespread intrauterine device (IUD) use, particularly among the middle class, emphasizing its benefits for both the household economy and national development. This is a very specific means of depicting poorer women in their supposed inability to utilize the pill, construing the IUD as the more appropriate biotechnical intervention. See Sreenivas, *Reproductive Politics*, 127.

25 From June 1975 to March 1977, India underwent a 21-month period during which emergency powers were imposed across the country under the authority of Prime Minister Indira Gandhi of the Indian National Congress (Congress Party). See Gitanjali Roy, “The Emergency,” (Encyclopedia Britannica, February 18, 2025), <https://www.britannica.com/event/the-Emergency-India>.

26 Sreenivas, *Reproductive Politics*, 158-162.

27 Sreenivas, 166-167.

Indian government propaganda. A 1964 pamphlet by the Ministry of Information and Broadcasting, *Methods of Family Planning*, depicted the ideal family as a conjugal unit: a husband, wife, and two children (typically a boy and a girl). A popular slogan usually also followed: “*hum do, hamare do*” (we two, our two). This image, which represented a modestly prosperous nuclear family, was central to public media campaigns, including films screened in movie theaters, radio broadcasts, and posters. The notion of a “happy family” drew on eugenic, Malthusian ideas, associating large families with poverty and promoting smaller families as a pathway to upward mobility. This alluring promise, which ties heterosexual marriage and reproductive control to emotional satisfaction and financial well-being, was a prevalent theme in Indian family planning discourse.²⁸

These pamphlets often suggested that small families could provide educational opportunities for children and participate more fully in a modern economy.²⁹ Many women were illiterate due to limited access to education and were hence generally unable to secure high-paying jobs and remain financially dependent on the men in their families. Consequently, families have viewed minimizing the number of daughters as an economic advantage.³⁰ However, for many impoverished families, the ideal of a middle-class childhood centered on schooling may have been out of reach or even unappealing, regardless of family size. In many villages, even basic primary education was unavailable, and children’s access to schooling was shaped more by factors such as class, caste, and gender than by the number of siblings they had. This sits in tension with the economic drive of the 1950s and 1960s where there was a state-driven movement to increase women’s literacy and participation in the economy.³¹

A 1964 poster produced by the Directorate of Advertising and Visual Publicity, along with the Indian Ministry of Health, illustrates early family planning ideals by portraying a nuclear family—a heterosexual couple with two children, one boy and one girl—under the slogan, “A small family is a happy family” (Figure 1). However, upon closer look exists stark inequalities within this idealized vision of family life. The wife is seated on the floor while her husband, positioned higher in a chair, instructs her on family planning, reinforcing his authority and role as the bearer of knowledge and prosperity. This hierarchy extends to their children as well. The son, placed prominently in the foreground, is absorbed in reading large books, symbolizing both literal and figurative access to education and opportunity. In contrast, the daughter is relegated to the background, nearly imperceptible at first glance. Unlike her brother, she holds no books but instead plays with toys, suggesting her exclusion from the intellectual and economic advantages promised by the small-family model. This raises a fundamental question: whose happiness is truly prioritized in this vision of the “happy family”? And when the government promotes

28 Sreenivas, 171-176.

29 Sreenivas, 181, 183, 185.

30 Patel, *Sex-Selective Abortion*.

31 Sreenivas, *Reproductive Politics*, 185.

educational opportunities, who is actually meant to benefit?

A similar 1992 poster from the India Ministry of Health and Family Welfare shows two panels: one of a larger, economically sparse family and another as a smaller, economically prosperous one (Figure 2). The smaller family features a female child with a bag, presumably with scholarly materials for her studies. This feature implies that the state-sponsored messaging regarding family planning is that of improving female educational opportunities through smaller family size.³² Thus, population control, in lieu of improving reproductive health measures or access to services, has shaped the state's population policies, despite India being lauded as the first country to form state-led family planning programs and the first to legalize abortion in the Global South.³³



"IMPERIAL POLICIES [...] EXACERBATED GENDER DISPARITIES BY REINFORCING MALE INHERITANCE AND PERPETUATING SON PREFERENCE."

32 Lexi Krock, "Population Campaigns" (Public Broadcasting Service, 2004), <https://www.pbs.org/wgbh/nova/article/population-campaign/>.

33 Navtej Purewal, "Sex Selective Abortion Neoliberal Patriarchy and Structural Violence in India" (Feminist Review, 2018), 20-38. While *Roe v. Wade*, a 1973 decision, was considered a progressive judgment for its time, India legally ensured the right for safe abortion two years prior with the passing of the Medical Termination of Pregnancy (MTP) Act. Dr. S. Chandrasekhar played a pivotal role in the abortion bill's passage. He advocated for the liberalization of abortion laws according to three fundamental rationales: as a eugenic measure to prevent the birth of deformed children, as a humanitarian action towards victims of sex crimes and mentally ill women, and as a general health measure. See Mohan, "Abortion in India," 142. The bill aimed to regulate and provide accessibility to safe abortion, legalizing it in all areas of India except in Jammu and Kashmir. See Siddhivinayak Hirve, "Abortion Law, Policy and Services in India: A Critical Review" (Reproductive Health Matters, 2004), 114-21. However, historians have viewed its passage as means to combat population growth issues, particularly in lower socioeconomic areas, rather than because of the women's movement in India. See Shivani Deshmukh, "A Comprehensive History of Abortion Laws in India: 1971-2021" (Feminism in India, 2022). As scholar Raj Pal Mohan describes, "It seems that liberalization of Indian abortion laws in 1971 was profoundly influenced by the consciousness of pressing and critical population problems, otherwise such a liberal attitude would never have attained the status of law in a country which has been so steeped in tradition and orthodoxy." See Mohan, "Abortion in India," 143.



Figure 1. A 1964 poster created by the Directorate of Advertising and Visual Publicity and the Indian Ministry of Health prioritizing smaller families for economic and educational prosperity. Courtesy of the Rockefeller Archive Center.³⁴

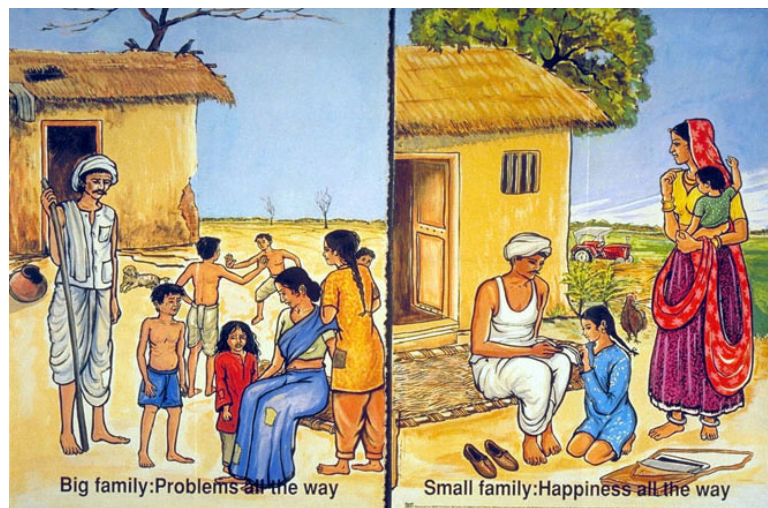


Figure 2. A 1992 poster from the India Ministry of Health and Family Welfare demonstrating the prosperity that follows intentional family planning efforts. Courtesy of the Medical Materials Clearinghouse at the Johns Hopkins University Bloomberg School of Public Health/Center for Communication Programs.³⁵

³⁴ Population Council Collection Rockefeller Archives Center, Sleepy Hollow, NY.

³⁵ Krock, "Population Campaigns."

This propaganda generally avoided engaging with the persistent son preference in India and practices of female infanticide or sex-selective abortion. Pamphlets often depicted families with one daughter and one son, subtly implying that gender was irrelevant to the happiness and stability of the small family unit, though they did not address whether families with two daughters were “happy.” The state implied a future of family parity without confronting the difficult effort necessary to realize it. Yet, this ideal ignored the older, ongoing process of female infanticide, a form of culturally embedded eugenics that the state neither actively addressed nor sought to disrupt. By focusing on the small family model as a forward-looking solution, the state effectively overlooked and, to some extent, tacitly accepted these persistent forms of gender-based violence. The promotion of a heteronormative small family model can be framed as a biological intervention aimed at addressing the ingrained cultural preference for sons. This approach, endorsed by the state, hinged on the belief that limiting family size can shift priorities toward valuing all children, regardless of gender, to achieve economic stability. By positioning smaller families as economically advantageous, reducing the financial strain associated with raising multiple children and potentially educating daughters, the state attempted to align cultural change with economic rationality. Yet, the state was interested in a specific form of cultural change and did not engage with the existing societal norms.³⁶

Introduction of Fetal Ultrasound Technology

Once abortion in India was effectively legalized in 1971,³⁷ the advent of prenatal diagnosis followed as a method for detecting fetal abnormalities; but its use quickly shifted to accommodate sex-selective abortion (SSA) practices. According to gender studies scholar Malavika Karlekar, the definition of SSA is, “A practice that involves the detection and abortion of a female fetus due to the preference for male babies and from the low value associated with the birth of females.”³⁸ Many Indian historians view the contemporary practice of SSA as a continuation of female infanticide, with some religious justification supporting abortion as a comparatively more ethical alternative.³⁹ The invention of

36 Interestingly, the 1995 UNICEF Annual Report notes that this anti-female bias is not confined to poor families but is prevalent among wealthier states like Punjab and Haryana, which have some of the worst female-to-male ratios. In these states, wealthier families are often more likely to engage in sex-selective abortions, reflecting how economic prosperity does not necessarily correlate with gender equality, conflicting with Sreenivas’s prior argument. See Rohde, *The Progress of Indian States*.

37 In the mid-1960s, the Indian government formed a committee led by Dr. Shantilal Shah, Minister of Public Health, Law, and Judiciary, to examine abortion from various angles, including societal, legal, and medical perspectives. The Shah Committee, as it became known, recommended legalizing abortion in 1966 to protect women’s health and lives, rejecting claims that it aimed to curb population growth. The committee’s report in December 1966 led to the passage of the Medical Termination of Pregnancy (MTP) Act by the Indian parliament in 1971. Ancient and classical Indian texts not only mention abortion but offer opinions on its morality and severity. From the *Rig Veda* to the *Mahabharata*, various writings condemn abortion as a grave sin, reflecting a deeply ingrained moral stance. See Raj Pal Mohan and Raj Pa Mohan, “Abortion in India” (Social Science, 1975), 141.

38 Malavika Karlekar, “The Girl Child in India: Does She Have Any Rights?” (Canadian Woman Studies, 1995), 55-56.

39 The *Garbha Upanishad*, a Sanskrit work from the second-third century CE whose title translates to

prenatal sex determination technologies has been the impetus for SSA as it is based upon the physician or technician making a sex determination before birth.⁴⁰ In fact, Indian medical professionals advocated for the role of prenatal diagnosis in SSA use as they believed it would result in happier marriages, fulfill the desire for a son, make women's lives easier, and curb the practice of female infanticide.⁴¹ This growing cultural and medical justification for sex-selective abortion coincided with the development and increasing availability of prenatal diagnostic techniques, which provided the tools necessary to implement such practices more broadly.

Amniocentesis was the first prenatal diagnostic technique introduced to India in 1974. It is an invasive procedure in which amniotic fluid is sampled, as it contains fetal cells, to ascertain birth defects *in utero* and to determine fetal sex.⁴² Similarly, chorionic villus sampling became popular in the 1980s as another invasive prenatal diagnostic technique, involving the procurement chorionic villus biopsy to test for chromosomal abnormalities. Both amniocentesis in the 1970s and chorionic villus sampling in the 1980s were widely advertised and used in urban areas for sex-selective abortions. Studies during this time, such as one conducted from 1976 to 1977 in a Western India urban hospital, published that 96% of amniocentesis-identified female fetuses were aborted, while all identified male fetuses were born, regardless of detected genetic defects.⁴³ Similarly, data from an abortion center in Mumbai during 1984–1985 showed that nearly 100% of the 15,914 abortions following sex determination in 1984–1985 were of female fetuses.⁴⁴

The adoption of ultrasound in India occurred in parallel with global advancements in the technology. Ultrasound's origins lie in the military applications developed during World War II, when sonar technology used for submarine detection was repurposed for medical purposes. The early medical uses of ultrasound were focused on detecting brain hematomas and later for monitoring fetal development. By the 1950s, B-mode (Brightness mode) ultrasound, which produced two-dimensional images, became the standard, and real-time imaging was introduced in the 1960s, further improving diagnostic capabilities. By the 1980s, ultrasound technology had become integral to clinical practice worldwide—particularly in obstetrics, where it allowed for non-invasive monitoring of fetal growth and the early detection of potential complications.⁴⁵

This technology's introduction marked a significant shift

"Human Womb," indicates that the soul and embryo unite in the seventh month after conception, marking a significant stage in fetal development. The text details the emergence of the head after two months, the feet after three months, the ankles and stomach after four months, the back and spine after five months, the eyes, ears, and nose after six months, the fetus joining the soul after seven months, and the completion of the person after eight months. See Ganga, "Hindu Views on Euthanasia," 101. In this understanding, sex-selective abortion removes the stain of sin and guilt, serving as morally preferable to infanticide.

40 Kipgen, "Abortion and Sex-Selective Abortion."

41 Kamlesh Madan and Martijn Breuning, "Impact of Prenatal Technologies on Sex Ratio in India: An Overview" (Genetics in Medicine, 2014), 425-432.

42 Ahmad, "Female Feticide in India," 18.

43 Ramanamma, "The Mania for Sons," 107-110.

44 Sneha Lata Tandon and Renu Sharma, "Female Foeticide and infanticide in India: An Analysis of Crimes Against Girl Children," (International Journal of Criminal Justice Sciences, 2006).

45 Arvind Rajamani, and others, "A historical timeline of the development and evolution of medical diagnostic ultrasonography" (Journal of Clinical Ultrasound, 2024).

in India's medical landscape, particularly in the fields of obstetrics and gynecology. In the late 1970s, India's medical imaging was predominantly reliant on X-ray technology and, to a lesser extent, CT scans, with ultrasound remaining largely unexplored. It was during this period that Dr. P.B.Pai, working at the Bombay Port Trust Hospital, became the first medical professional in India to install and utilize an ultrasound machine, driven by professional curiosity rather than initial clinical need.⁴⁶ This relatively small, isolated use of ultrasound in the late 1970s laid the foundation for what would soon become a dominant medical practice across the country.

The 1980s saw a more structured and concerted effort to incorporate ultrasound into Indian medical practice. Dr. Amrish Dalal, after training in ultrasound imaging in the United States, returned to India and established a private practice in Mumbai, where he began to apply ultrasound technology for clinical diagnostics. His work played a pivotal role in advancing ultrasound's integration into mainstream medical practice in India. Around the same time, other prominent institutions, such as Jaslok Hospital in Mumbai, founded by Dr. Mukund Joshi, set up cutting-edge ultrasound

departments. These centers were instrumental in making ultrasound a fixture of modern healthcare in India. At Jaslok Hospital, Dr. Joshi and his colleagues, including Dr. Keshav and Dr. GN Mansukhani, contributed significantly to the advancement of ultrasound technology in obstetrics, cementing their roles in the inception of ultrasound as a cornerstone of diagnostic medicine.⁴⁷

The expansion of ultrasound technology in India was not confined to major urban centers. Dr. Joshi worked extensively across India, promoting the technology's adoption in remote areas. While initially confined to wealthier urban areas, ultrasound technology universally diffused to other regions, albeit gradually, with widespread availability and affordability outside major cities only becoming a reality in the 1990s and early 2000s.⁴⁸ However, state-of-the-art technology rarely gets diffused and adopted by rural spaces or made affordable. Portable ultrasound machines, capable of being deployed in regions with minimal infrastructure, facilitated unprecedented rural and underserved access to medical services, enabling healthcare professionals to travel to the most remote villages, devoid of basic amenities such as electricity and running water.⁴⁹ As such, ultrasound technology became not only a



"DESPITE LEGAL PROHIBITIONS, FAMILIES CONTINUED THE PRACTICE THROUGH STRANGULATION, POISONING, ABANDONMENT, DROWNING, BURYING ALIVE, STARVATION, AND OTHER FOLK REMEDIES."

46 "Dr Mukund Joshi: Father of Ultrasound India" (Express Healthcare, 2014), <https://www.express-healthcare.in/archive/dr-mukund-joshi-father-of-ultrasound-in-india/3935/>.

47 "Dr Mukund Joshi."

48 "Changes in Son Preference, Ultrasound Use and Fertility" (Pew Research Center, 2022), www.pewresearch.org/religion/2022/08/23/changes-in-son-preference-ultrasound-use-and-fertility/#f-nref-70378-14.

49 Madan and Breuning, "Impact of Prenatal Technologies," 425-432.

diagnostic tool, but as a means of democratizing healthcare access, particularly for maternal health.

In India, ultrasound technology was particularly appealing due to its non-invasive nature and its relatively low cost compared to other imaging modalities like X-rays and CT scans. Its affordability and ease of use made ultrasound an attractive option for Indian healthcare providers, especially in comparison to more expensive and invasive diagnostic techniques. The widespread availability of ultrasound machines in India was further accelerated by international companies such as General Electric (GE) and Siemens, who played a significant role in supplying these machines across the country, including in rural areas. The cost of an ultrasound scan, typically around \$8, was within reach for a large proportion of the population, further driving the technology's dissemination into even the most remote locations.⁵⁰

While ultrasound's introduction in India was initially aimed at improving healthcare, its widespread availability quickly transcended medical diagnostics to include prenatal sex determination, particularly in wealthier sectors, thereby catalyzing the emergence of what came to be known as the "avoid a daughter industry" in India.⁵¹ As ultrasound technology became more common, particularly in urban and peri-urban areas, it was increasingly used to determine fetal sex, a practice that, despite being banned, would later contribute to the rise of SSA in India. The affordability of ultrasound scans and the societal preference for male children, especially in rural regions, created an ideal environment for the exploitation of ultrasound for gender-biased sex selection.

The United Nations implicates ultrasonography for the prevalence of missing girls in Asia,⁵² while a 2011 Lancet study estimates there to have been 4.2-12.1 million SSA of female fetuses that occurred from 1980-2010, with underreporting especially prevalent in states like Punjab, Haryana, Rajasthan, Gujarat, Delhi, and Maharashtra.⁵³ This trend is reflected in the declining child sex ratio (CSR) over the decades, with SSA estimated to kill upward of one million female fetuses in India annually.⁵⁴ A 1992 study conducted among middle-class Indians in Punjab unearthed widespread support

for using sex determination technology in families without a son and with more than two daughters. According to the study, 63% of women and 54% of men believed that amniocentesis should be



"DURING THE 1950S AND 1960S: GLOBAL CONCERNS ABOUT A LOOMING 'POPULATION BOMB,' WITH SOUTH ASIA AT ITS CORE."

50 Peter Wonacott, "India's Skewed Sex Ratio Puts GE Sales in Spotlight" (The Wall Street Journal, 2007), <https://www.wsj.com/articles/SB117683530238872926>.

51 Ahmad, "Female Feticide in India," 18.

52 Malathy Iyer, "Ultrasounds to Blame for Skewed Sex Ratio in India" (Times of India, 2011), timesofindia.indiatimes.com/india/ultrasounds-to-blame-for-skewed-sex-ratio-in-india-un/article-show/10272061.cms.

53 Prabhat Jha and others, "Trends in Selective Abortions of Girls in India: Analysis of Nationally Representative Birth Histories from 1990 to 2005 and Census Data from 1991 to 2011" (The Lancet, 2011), 1921-1928.

54 Ahmad, "Female Feticide in India," 13.



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performed under these circumstances. If the test indicated the fetus was female, 73% of women and 60% of men supported aborting it. The top three reasons cited for such decisions were “a male-dominated society” (23%), “the social stigma attached to having a daughter” (19%), and “the difficulty of affording a dowry” (17%).⁵⁵ The magnitude of the issue is punctuated by Indian Prime Minister Manmohan Singh’s condemnation that described the prevalence of female feticide as a “shame on our society,” and emphasized the imperative of gender equality for societal progress.⁵⁶ Moreover, the financial scale of the sex-selective abortion industry, estimated at Rs. 1000 crore (\$120 million) highlights the economic incentives driving this practice.⁵⁷

Historian Pramod Kumar Srivastava argues that while female feticide technically falls outside the strict definition of genocide, it is certainly a “crime against humanity.”⁵⁸ The persistence of son preference is evident in the 2019-2021 National Family Health Survey (NFHS), which shows that a notable percentage of women desire more sons than daughters. Despite the 1994 Pre-Natal Diagnostic Techniques (PNDT) Act banning sex-selective testing, 78% of women still undergo ultrasound scans during pregnancy.⁵⁹ Studies have shown that SSA practices were disproportionately high in certain states, such as Punjab and Haryana, where son preference has long been ingrained.⁶⁰

The emergence of ultrasound in India also intersected with global debates surrounding the ethical implications of the technology. In the early stages, companies like General Electric (GE) maintained that their machines were intended solely for legitimate medical purposes and not for sex determination. However, as widespread reports emerged of ultrasound machines being used in unregulated private clinics for sex-selective purposes, concerns grew about the complicity of these companies in perpetuating gender imbalance. Despite efforts by GE to implement safeguards, such as requiring affidavits from customers and conducting periodic audits, these measures have largely proven ineffective in curbing the use of ultrasound for sex determination in many parts of India.⁶¹

Historical Use of Sex Ratios

55 Susheela Singh and others, “Abortion and Unintended Pregnancy in Six Indian States: Finding and Implications for Policies and Programs” (Guttmacher Institute, 2018), <https://www.guttmacher.org/report/abortion-unintended-pregnancy-six-states-india>.

56 Sonalde Desai, “Gender Inequalities and Demographic Behavior: India” (Population Council, 1994).

57 UNICEF India, “Female Feticide in India” (UNICEF India), <http://www.unicef.in/PressReleases/227/Female-foeticide-in-India>.

58 Srivastava, “Female Infanticide in 19th-Century.”

59 “Changes in Son Preference.” In 1994, the Parliament of India passed the Prenatal Diagnostic Techniques Act to address the decline in child sex ratio and regulate the usage of ultrasound tools and prenatal sex determination. See Government of India, Standard Operating Guidelines for District Appropriate Authorities, Pre-Conception, and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection Act), (Ministry of Health and Family Welfare, Government of India, UNFPA, 1994).

60 Iyer, “Ultrasounds to Blame.”

61 Wonacott, “India’s Skewed Sex Ratio.”

The use of the sex ratio as a tool for state control in India originates in British colonial rule. In the nineteenth century, colonial administrators documented cases of female infanticide and “missing women” in official reports, district gazetteers, and the Census of India, framing these patterns as part of their broader strategy to exert dominance in South Asia.⁶² Over time, the sex ratio evolved into a key metric for both colonial and postcolonial governance, not as a means of promoting gender equity or rights, but as a mechanism for regulating reproduction and optimizing economic management. It does, however, remain as the key comparative metric for determining the potential prevalence of SSA and gendered violence in general.⁶³

The sex-ratio imbalance in India is particularly stark among children aged 0-6, where discrimination begins early in life and manifests in differential access to nutrition, healthcare, and education. For example, a 1988 study conducted in Ludhiana found that 65% of children visiting outpatient departments were boys, compared to only 35% girls. Furthermore, boys accounted for 84% of hospital admissions, while girls represented only 16%, despite their higher mortality rates.⁶⁴ A similar study from 2009 in rural Uttar Pradesh found that households with female newborns reported significantly lower perceptions of illness compared to those with male newborns. While healthcare utilization was similar for both genders, households with male newborns spent nearly four times more money on neonatal healthcare (Rs 243.3 vs Rs 65.7). Families with female infants tended to use more affordable public healthcare, while those with male infants preferred private providers they believed offered better care.⁶⁵ These data demonstrate that girls are not only less likely to receive medical attention but are also more likely to die when they do fall ill, due to delayed or inadequate treatment.⁶⁶

To account for these potential inequities that result from post-natal gender-bias, social scientists use the metric “sex ratio of children” based on systematically-collected census data regarding age and sex distributions. These studies can determine potential disregard of girls that cause their deaths in childhood and the extent of “excess female mortality.” In a study published in the *Lancet* by Alkema and others, India was found to have the highest value of excess female mortality in the world: 13.5 out of 1,000 female

62 Lalita Panigrahi, *British Social Policy and Female Infanticide in India* (India: Munshiram Monharlal, 1972).

63 One example of the sex ratio metric in action is within the 1995 UNICEF Annual Report. This document notes that while in most countries women typically outnumber men due to their stronger biological constitution, in India the opposite is true. Census-based estimates from 1981 revealed that female mortality exceeded male mortality in 224 out of 402 districts in India. The Sample Registration System for 1992 further showed that infant mortality rates were higher for girls than boys in 8 out of 17 Indian states, despite biological evidence that girls have a higher probability of survival. See Rohde, *The Progress of Indian States*.

64 Rohde, *The Progress of Indian States*.

65 Jeffrey Willis and others, “Gender Differences in Perception and Care-seeking for Illness of Newborns in Rural Uttar Pradesh, India” (*Journal of Health, Population, and Nutrition*, 2009), 62.

66 UNICEF critiqued India’s health system, given their contemporaneous campaigns toward growth monitoring, oral rehydration, breastfeeding, and immunization (GOBI) as means of selective primary care in developing countries. Their 1989 annual report included their initiative towards educating women and mothers on how to avoid infant mortality and garner literacy among the female population. See United Nations Children’s Fund (UNICEF), UNICEF Annual Report 1989 (New York: UNICEF, 1989), <https://www.unicef.org/media/93611/file/UNICEF-annual-report-1989.pdf>.



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AND THE FIRST TO
LEGALIZE ABORTION IN
THE GLOBAL SOUTH."

births, hence attributing 1 in 9 deaths of females below age 5 to intentional postnatal neglect.⁶⁷ One manifestation of this trend is that young girls often receive smaller portions or less desirable foods compared to their brothers due to son preference and the higher valuation of male children's lives.⁶⁸ Data also indicate that in some communities, girls are breastfed for shorter durations than boys, placing them at an increased risk for protein-calorie malnutrition. This practice often reflects parents' desire to wean daughters sooner, allowing mothers to resume menstruation and attempt another pregnancy with the intent of producing a male child.⁶⁹

The 1995 UNICEF report, referenced in the Introduction, also drew attention to regional disparities in gender discrimination across Indian states. Life expectancy at birth for a girl in Uttar Pradesh was 54.6 years, nearly 20 years lower than that of a girl born in Kerala, where the life expectancy was 74.4 years.⁷⁰ The report explains that these statistics stress the broader failure of Indian society to ensure equal opportunities and care for all its children, particularly girls. Historical differences in health infrastructure and governance help explain these stark contrasts.⁷¹

State Approaches and Initiatives Against SSA and Their Contestations

The Indian state's approach to curbing sex-selective abortion (SSA) in the 1980s and 1990s was fragmented and heterogeneous, shaped by a series of legislative and judicial interventions that failed to address structural inequalities. While laws such as the 1994 Prenatal Diagnostic Techniques (PNDT) Act and its 2003 amendment, the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, signaled official recognition of the issue, I argue that their enforcement was inconsistent, hampered by weak regulatory oversight and cultural biases. Parliamentary

67 Leontine Alkema and Jin Rou New, "Global Estimation of Child Mortality Using a Bayesian B-Spline Bias-reduction Model" (*The Annals of Applied Statistics*, 2014), 2122-49.

68 Vulimiri Ramalingaswami, Urban Jonsson, and Jon Rohde, *The Asian Enigma: The Progress of Nations* (New York: UNICEF, 1997); Lincoln Chen, Emdadul Huq, and Stan d'Souza, "Sex Bias and the Family Allocation of Food and Healthcare in Rural Bangladesh" (*Population and Development Review*, 1981), 55-70.

69 Seema Jayachandran and Ilyana Kuziemko, "Why Do Mothers Breastfeed Girls Less than Boys? Evidence and Implications for Child Health in India" (*The Quarterly Journal of Economics*, 2011), 1485-1538.

70 Rohde, *The Progress of Indian States*.

71 Kerala, which historically benefited from similar public health measures and local administrative commitment to sanitation, contrasts sharply with states like Uttar Pradesh, where long-standing underinvestment in health infrastructure continues to impact health outcomes. The influence of historical public health approaches in states like Kerala and Mysore has contributed to a sustained advantage in health outcomes, revealing how a history of proactive health policies, public responsiveness, and administrative investment can shape regional differences in life expectancy and gender-based health disparities. In the colonial era, health and sanitary measures were initially left to local authorities in the Princely States, who often lacked both adequate funding and experience, while the Central Government's role was largely limited to enacting legislation. However, certain Princely States, such as Mysore and Travancore, developed strong foundations for public health, setting examples in sanitation, vaccination, and administrative efficiency. For instance, Mysore, after transitioning from British rule to governance by local Rajas in 1881, prioritized a medical service staffed by qualified local practitioners. This effort, particularly in urban centers, laid the groundwork for enduring public health initiatives. The Mysore government also demonstrated responsiveness and administrative agility, as seen during the influenza epidemic, when it provided timely data to British India and took decisive action to mitigate the impact. See Waltraud Ernst and others, *Health and Medicine in the Indian Princely States: 1850-1950* (United Kingdom: Taylor & Francis, 2017).

debates and judicial rulings from this period communicate a reliance on gender-neutral legal discourse that obscured the patriarchal structures underpinning SSA. Judges, policymakers, and legislators framed the issue as a matter of medical ethics and technological misuse rather than systemic gender discrimination, leading to perfunctory policies that emphasized penalizing individual actors rather than dismantling the broader social and economic incentives for son preference. International pressure from organizations such as UNICEF and the United Nations Population Fund (UNPF) pushed the Indian government to act, but many reforms remained symbolic rather than substantive. Instead of addressing the root causes of SSA, state interventions often reinforced reproductive surveillance, failing to contest the social hierarchies that devalued female life.

Legislative and Policy Approaches

In 1994, the Parliament of India enacted the Prenatal Diagnostic Techniques (PNDT) Act to combat the declining child sex ratio and to regulate the use of prenatal sex determination technologies.⁷² The Act aimed to prevent the misuse of techniques for prenatal sex determination, particularly leading to female feticide. Although the Act did not explicitly declare sex-selective abortion (SSA) illegal, the government used fear tactics to convince the public into thinking it was.⁷³ Nonetheless, it prohibited the use of sex detection for identifying fetuses at high risk of sex-linked diseases or recessive gene inheritance, such as hemophilia and color blindness.⁷⁴

Subsequently, in 2003, the Act was amended and renamed the Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act, expanding its scope to include pre-conception practices and banning selection techniques both before and after conception.⁷⁵ Despite these legislative efforts, illegal usage of ultrasound persists due to poor regulation within the medical community and insufficient governmental agency supervision.⁷⁶ The Indian government has taken steps to enforce the Act through correctional measures, including imprisonment, fines, suspension of medical licenses, and permanent bans from medical practice, targeting doctors, clinic owners, and advertisers, but not pregnant women.⁷⁷ Efforts to curb illegal ultrasound use include stiffer penalties and sting operations, resulting in high-profile arrests of doctors.⁷⁸

Other legislative efforts during this period aimed to address broader patterns of gender-based violence and inequality

72 Kipgen, "Abortion and Sex-Selective Abortion."

73 Government of India, *Standard Operating Guidelines for District Appropriate Authorities, Pre-Conception, and Pre-Natal Diagnostic Techniques* (Prohibition of Sex Selection Act), (Ministry of Health and Family Welfare, Government of India, UNFPA, 1994).

74 Kipgen, "Abortion and Sex-Selective Abortion."

75 Government of India, *Handbook on Pre-Conception and Pre-Natal Diagnostics Techniques Act and Rules with Amendments* (2006).

76 Tulsi Patel, "Experiencing Abortion Rights in India Through Issues of Autonomy and Legality: A Few Controversies" (Gobal Public Health, 2018), 702-710.

77 Government of India, *Annual Report of Department Health and Family Welfare*, (Ministry of Health and Family Welfare, 2017-2018), main.mohfw.gov.in/sites/default/files/23Chapter.pdf.

78 "Changes in Son Preference."

that bolstered SSA. The Dowry Prohibition Act of 1986 sought to eliminate the practice of dowry, which often resulted in violence and abuse against women. Section 304B specifically addressed dowry deaths, making it a criminal offense if a woman died under suspicious circumstances within seven years of marriage due to dowry-related harassment.⁷⁹ Similarly, the Family Courts Act of 1984 established specialized courts to handle marital and family disputes. These courts were intended to offer speedy, accessible justice in cases involving divorce, child custody, and domestic violence, with an emphasis on conciliation.⁸⁰ Despite punitive enforcement efforts, the state's fragmented approach and weak oversight reflected a broader pattern of disjointed policymaking, as seen in the emerging but inconsistent discourse in the Lok Sabha.

The May 12, 1989, Lok Sabha debate “Atrocities on Women” served as a noteworthy moment in the Indian government's evolving discourse on gender-based violence, including female infanticide and sex-selective abortion (SSA).⁸¹ That this debate occurred at the national level in the Lok Sabha exhibited the growing, albeit uneven, central governmental recognition of these pressing issues. The discussion unfolded against the backdrop of international reports, such as those from UNICEF, which brought global attention to systemic atrocities facing Indian women and girls. However, the debate revealed that cultural norms significantly influenced the Indian state's response, often obstructing meaningful reform.⁸²

There was both resistance and contestations in the making of state policy against SSA during the 1980s and 1990s. Balwant Singh Ramoowalia, a Member of Parliament representing Sangrur and serving on the Committee on Public Undertakings, began the conversation in the Lok Sabha in May of 1989. His words accentuated the tension between cultural ideals of women's reverence and the grim realities of violence and discrimination they face. By framing the issue in terms of government failure, Ramoowalia critiqued the lack of effective administrative action, proposing measures such as independent authorities and special courts to investigate and prosecute crimes against women. His appeal for institutional reforms reflected an acknowledgment of the need for systemic change, yet his reliance on symbolic rhetoric about women's societal value mirrored the same cultural tropes that often perpetuate inaction. This duality of outrage tempered by a failure to interrogate the cultural roots of the problem permeated much of the debate.⁸³

Kumari Mamata Banerjee, a member of Parliament from

79 Government of India, *Indian Penal Code*, § 304B (inserted by Act 43 of 1986, s. 10, effective November 19, 1986), Act No. 45 of 1860, [https://www.indiacode.nic.in/show-data?actid=AC_CEN_5_23_00037_186045_1523266765688&orderno=342#:~:text=India%20Code:%20Section%20Details&text=%5B304B.,19%2D11%2D1986\).](https://www.indiacode.nic.in/show-data?actid=AC_CEN_5_23_00037_186045_1523266765688&orderno=342#:~:text=India%20Code:%20Section%20Details&text=%5B304B.,19%2D11%2D1986).)

80 Government of India, *The Family Courts Act*, 1984, Act No. 66 of 1984, https://ncwapps.nic.in/acts/The_Family_Courts_Act_1984.pdf.

81 As per the provision of Article 79 of the Indian Constitution, the Lok Sabha (House of the People) is the lower house of Parliament. Composed of representatives chosen by direct election based upon adult suffrage, it holds a maximum strength of 552 members.


82 India, Lok Sabha Debates, *Eighth Lok Sabha, Thirteenth Session, May 12, 1989* (New Delhi: Lok Sabha Secretariat), https://eparlib.nic.in/bitstream/123456789/500/1/lsd_08_13_12-05-1989.pdf.

83 India, Lok Sabha Debates, *Eighth Lok Sabha*.

West Bengal, interjected to support Ramoowalia's speech, bringing evidence of how cultural norms of son preference and female devaluation had infiltrated even elite and educated circles. She cited the case of a Congress member of the Legislative Assembly (MLA) in Rajasthan accused of killing his newborn daughters to avoid raising them, a horrific example of how SSA and infanticide were not confined to rural or economically marginalized contexts. Banerjee's rhetorical question, "Why has he not been put behind the bars and convicted of murder?" emphasized the complicity of power structures and influential figures in perpetuating these crimes. Her remarks showcased not just governmental inaction but the broader erosion of accountability when perpetrators belong to the political or administrative elite. Shockingly, when Banerjee mentioned the MLA's violence towards female children in the Lok Sabha, several members of Parliament erupted into laughter. Margaret Alva, then Minister of State for Women and Child Development, bluntly rationalized this reaction: "because it is female infanticide they are laughing."⁸⁴

Margaret Alva then situated SSA within the larger context of patriarchal policymaking. Her condemnation of Union Energy Minister Vasant Sathe's defense of sex-determination tests exposed the insidious ways that cultural ethos were rationalized by policymakers. Sathe's argument, that aborting female fetuses

could correct the gender ratio and lead to "bride price" rather than dowry, epitomized the dangerous intersection of bias and policy justification. Alva's pointed critique features how even government leaders could frame the devaluation of female life as pragmatic policy, further normalizing gender-based violence. As she noted, these comments are not only an affront to women's dignity but also reflect a



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moral abdication by the state.⁸⁵

The debate also disclosed how governmental responses to SSA and infanticide were shaped by international scrutiny. UNICEF reports documenting violence against women had brought global attention to these issues, forcing the Indian state to confront its failure to act decisively. Yet, these failures were often attributed to "the failure of administrative machinery" rather than a reckoning with the cultural values driving such violence. Brajamohan Mohanty, a member of Parliament from Odisha, critiqued the limited reach of reforms, arguing that the benefits of policies aimed at women's advancement were confined to a

⁸⁴ India, Lok Sabha Debates, *Eighth Lok Sabha*.

⁸⁵ India, Lok Sabha Debates.

privileged few.⁸⁶ By advocating for women's inheritance rights and economic independence, Mohanty emphasized structural change, but in his words he relied upon symbolic references to mythological figures like Sita and Draupadi, underscoring how cultural narratives continued to shape governmental rhetoric often at the expense of substantive policy action.⁸⁷

While the central government's shift in the burden of proof under the Dowry Death Act and the passage of the Family Courts Act of 1984 reflected attempts at reform, Alva's remarks in the debate further unveiled the persistent gap between legislation and implementation. She lamented that only five family courts had been established since the Act's passage, attributing this inertia to state governments and male-dominated decision-making processes. These failures of enforcement demonstrated a broader pattern of the Indian state's reactive rather than proactive approach to gender violence—a pattern that often left the root causes of SSA and infanticide unaddressed.

What emerged from the Lok Sabha debate was a complex picture of governmental engagement with gender-based violence. On one hand, the debate signified a growing acknowledgment of atrocities against women, driven in part by international pressure and public outcry. On the other hand, it undressed how deeply cultural principles of son preference, female devaluation, and patriarchal pragmatism had infiltrated policymaking, often undermining the very reforms intended to address these issues. The debate also exposed the disjointedness among policymakers, as members of Parliament oscillated between calls for stricter enforcement, indifference, and at times, outright complicity in the very practices they claimed to regulate. Some officials framed SSA as a moral and legal crisis demanding urgent intervention, while others rationalized or even trivialized the issue, as seen in dismissive interruptions and laughter during discussions of female infanticide. This fragmentation displays how both state-building and state-crafting are shaped not by a unified vision, but by competing and contradictory impulses: some reformist, others reinforcing existing hierarchies. The state perpetuated women's identities as limited to reproductive roles, implicitly paving the way for SSA practices to continue. The discourse surrounding SSA and infanticide therefore reflected both the promise and the limitations of the Indian state's efforts to confront gender-based violence via legislative efforts.

The 1994 International Conference on Population and Development (ICPD) in Cairo marked a turning point in India's reproductive health policies, driving a shift from state-led initiatives to NGO-driven interventions, with the country's skewed sex ratio and the "girl child" crisis at the forefront.⁸⁸ The conference solidified

86 India, Lok Sabha Debates.

87 Sita and Draupadi are central female figures in the ancient Sanskrit epics the *Ramayana* and the *Mahabharata*, respectively. Sita, as the wife of Rama, is upheld as an ideal of marital fidelity and self-sacrifice, while Draupadi, as the shared wife of the five Pandava brothers, embodies a more complex vision of duty within marriage. Both women's stories emphasize their roles as wives and mothers, reflecting broader historical ideals of womanhood, family, and dharma in early Hindu society. See Narasimhan, *The Mahābhārata and Subba Rao, Valmiki's Ramayana: The Great Indian Epic* (India: Amar Chitra Katha, ACK Media, 1975).

88 Mohan Rao and Vina Mazumdar, "Report of the Committee to Study the Question of Legalisation

an alliance between liberal feminists advocating for reproductive rights and neo-Malthusian population control supporters, resulting in a policy framework that emphasized “rights” and “empowerment” while maintaining a focus on population regulation. This shift led to increased international scrutiny of India’s reproductive health policies, particularly regarding SSA, as global organizations pressured the Indian government to act. The state responded by engaging more actively with international multilateral organizations and integrating demographic monitoring into its approach. With agencies like the United Nations Population Fund (UNPF) tracking sex ratios and linking reproductive technologies to declining female births, India’s response to SSA became entangled in broader efforts to balance reproductive autonomy with population control. This is a continuation of the eugenic approaches to population since the 1960s.

Outside of Parliament, other Indian governmental entities have crossed paths with and attempted to address prevalent gender health issues. The National Health Policy (NHP) of 2002, created by the Ministry of Health and Family Welfare, marked India’s first major health policy revision since its 1983 inception.⁸⁹ The 1983 policy emerged as a governmental response to the Alma-Ata vision of “Health for All” by 2000, including potential goals of universal and accessible healthcare for all Indians.⁹⁰ While the 2002 policy positioned itself as a step toward decentralization, equity, and accessibility in healthcare, its treatment of women’s health was notably superficial, reflecting the broader trend of nationalist rhetoric



"ULTRASOUND'S INTRODUCTION MARKED A SIGNIFICANT SHIFT... PARTICULARLY IN OBSTETRICS, WHERE IT ALLOWED FOR NON-INVASIVE MONITORING OF FETAL GROWTH AND THE EARLY DETECTION OF POTENTIAL COMPLICATIONS."

of Abortion” in *The Lineaments of Population Policy in India* (India: Routledge India, 2017), 226-262.

89 Ministry of Health and Family Welfare, Government of India, *National Health Policy 2002* (New Delhi: Ministry of Health and Family Welfare, 2002), https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/national_health_policy_2002.pdf.

90 Aakriti Grover and R.B. Singh, “Health Policy, Programmes, and Initiatives” (Urban Health and Wellbeing: Indian Case Studies. 2020), 251-266. The Alma-Ata Conference on Primary Health Care (PHC) was held in September 1978 in Almaty, Kazakhstan. The resulting Alma-Ata Declaration underscored that health is intrinsically linked to broader socio-economic development. The attainment of “Health for All” could not be achieved in isolation from other sectors such as education, housing, nutrition, and clean water. The Declaration called for a multi-sectoral approach to health, where improvements in social conditions would directly contribute to better health outcomes. This interconnectedness meant that health was not solely the responsibility of the health sector but required the collective action of governments, international agencies, non-governmental organizations, and the global community at large. See UNICEF, “Primary Health Care”; United Nations Children’s Fund (UNICEF), “Primary Health Care and the Alma-Ata Declaration” (UNICEF, 1978). <https://www.unicef.org/reports/primary-health-care-and-alma-ata-declaration>; and World Health Organization, “Declaration of Alma-Ata” (Alma-Ata: International Conference on Primary Health Care, 1978); “The Origins of Primary Health Care and Selective Primary Health Care” (American Journal of Public Health, 2004), 925-931.

rather than appreciable reform. In a document meant to address the nation's most pressing health concerns, women's health received only two paragraphs, acknowledging that women faced significant disadvantages in accessing healthcare but offering little in terms of concrete solutions. The policy aimed to expand primary health infrastructure to improve women's access to basic care, yet it failed to address the systemic cultural and social barriers that contributed to gender disparities in health outcomes. For example, while the policy noted widespread micronutrient deficiencies among women and girls, it attributed this solely to biological factors such as low birth weight rather than recognizing the pervasive gender norms that deprioritize female nutrition, as discussed earlier with food portions and breastfeeding. Furthermore, the glaring omission of any discussion on female feticide, despite growing contemporary evidence of sex-selective abortion, attests to the policy's failure

to confront gender biases within India's healthcare system. The state's policy addressed gender as simply a checkbox without proposing meaningful structural change, reinforcing the limitations of policy measures that focus on broad stroke principles without addressing the specific socio-cultural forces driving inequality.⁹¹

Judicial Approaches

In the same vein of legislative and policy initiatives, state approaches in the judicial realm of SSA regulation have fallen short given their fragmented messaging and inadequacy in addressing structural inequities

throughout the 1980s and 1990s. The legal cases surrounding SSA in India display the state's complex and often contradictory role in regulating reproductive technologies. The PCPNDT Act, intended to curb SSA through restrictions on ultrasound usage and sex disclosure, reflects a top-down approach that frames the issue as one of legal enforcement rather than addressing the root causes that drive the practice. Furthermore, as evidenced in legal proceedings, enforcement remained highly inconsistent at the local and state levels, raising questions about the actual efficacy of the law.

For instance, in *Dr. Varsha Gautam W/O Dr. Rajesh Gautam vs State Of U.P.* (2006), the Allahabad High Court upheld that sex selection is not limited to determining the sex of an embryo or fetus but extends to any procedure, test, or technique that increases the probability of an embryo being of a particular sex.⁹² This ruling clarified the scope of the PCPNDT Act and reinforced the

91 Ministry of Health and Family Welfare, Government of India, *National Health Policy* 2002.

92 *Dr. Varsha Gautam W/O Dr. Rajesh Gautam v. State of U.P.*, High Court of Allahabad, May 26, 2006. <https://indiankanoon.org/doc/1055558/>.



"96% OF AMNIOCENTESIS-IDENTIFIED FEMALE FETUSES WERE ABORTED, WHILE ALL IDENTIFIED MALE FETUSES WERE BORN, REGARDLESS OF DETECTED GENETIC DEFECTS.."



"THE WIDESPREAD AVAILABILITY OF ULTRASOUND SCANS AND THE SOCIETAL PREFERENCE FOR MALE CHILDREN, ESPECIALLY IN RURAL REGIONS, CREATED AN IDEAL ENVIRONMENT FOR THE EXPLOITATION OF ULTRASOUND FOR GENDER-BIASED SEX SELECTION."

state's commitment to curbing SSA. However, it also highlighted a significant gap between the legal standards set by the judiciary and the real-world application of these laws. Enforcement remains highly inconsistent, as evidenced by the fact that despite the court's affirmation of the law's comprehensive scope, the practices of sex determination and selective abortion continues to persist in local clinics, sometimes under the guise of medical procedures. While the legal framework aimed to address SSA, the actual enforcement often prioritizes symbolic measures over addressing the cultural conditions that fuel the practice. Thus, the gap between legislation and its implementation serves as a microcosm of the state's broader approach to reproductive regulation: one that focuses more on performative actions than on enacting profuse social change.

This legal framework also exposed a tension between the judiciary's ethical reasoning and its reinforcement of elite perspectives on SSA. The court rulings analyzed in these cases elevated concerns about the "misuse" of ultrasound technology while sidelining the voices of women who seek abortions for a range of personal and socio-economic reasons. In *Vinod Soni And Anr. vs Union Of India* (2005), the petitioners argued that sex selection should be recognized as part of personal liberty under Article 21 of the Indian Constitution,⁹³ suggesting a right to determine the composition of one's family. However, the Bombay High Court firmly rejected this argument, emphasizing that even the broadest interpretation of Article 21 cannot extend to include such a right as it violated the unborn child's right to life and full development.⁹⁴ The state's approach implicitly distinguished between "legitimate" and "illegitimate" abortions, often reinforcing a paternalistic attitude toward reproductive decision-making. This selective protection of reproductive rights is evident in the court's emphasis on preserving the "sanctity of life" without fully engaging with the economic and cultural pressures that drive SSA in the first place. The privileging of elite, urban, and institutional perspectives marginalized the lived experiences of women, particularly those from lower socio-economic backgrounds who may face coercion from both family structures and state policies. It also demonstrated that elite Indians are aiming to manipulate the law to continue their practice of SSA.

Moreover, the court's reasoning in these cases reflects a broader ethical framework that positions the state as the arbiter of moral decision-making in reproductive health. This is evident in judicial statements that frame SSA as a societal ill requiring firm legal prohibition rather than a symptom of structural gender inequities. The case *Vijay Sharma and Mrs. Kirti Sharma vs Union of India* (2007) included the petitioner's argument that,

⁹³ Article 21 asserts that no person shall be deprived of their life except according to the procedure established by law. This means that every individual has the right to live, and their life cannot be taken away except in accordance with the prescribed legal procedures. The right to life encompasses various aspects, including the right to live with dignity, the right to livelihood, and the right to a healthy environment. Article 21 also protects the personal liberty of individuals. It states that no person shall be deprived of their personal liberty except according to the procedure established by law. Personal liberty includes the freedom to move freely, the freedom to choose one's place of residence, and the freedom to engage in any lawful occupation or profession. See India, *The Constitution of India* (1950), art 21.

⁹⁴ *Vinod Soni and Anr. v. Union of India* (UOI), Bombay High Court, June 13, 2005. <https://indiankanoon.org/doc/457104/>.

“If the country is not advanced socially and economically to accept a female child, it is better such children are not born. The highly advanced treatment should be accepted and utilized for achieving [a] positive mindset.”⁹⁵ This perspective suggests that in certain circumstances, sex-selective practices may be viewed as a necessary evil to avoid bringing a female child into a society that is not yet ready to value her equally. Sharma’s words imply that until broader social change occurs, sex selection could be perceived as a tool for safeguarding the well-being of the child, particularly in environments where gender biases dominate.

Sharma continued, “As long as the patriarchal system exists the craving for a male child is likely to be there and one cannot erase the said issue from the mindset of the people.”⁹⁶ This was an acknowledgement of the persistent societal preference towards sons. He further argued that it is necessary to balance the family with both a male and female child if financial, social, and other circumstances allow. This statement reflects the pragmatic, albeit controversial, viewpoint that families may be justified in pursuing sex selection to maintain equilibrium in a world still largely influenced by gender biases. The notion of “balancing the family” reflects an internalization of original family planning propaganda that proliferated ideals of a two-child family, often consisting of one boy and one girl child. This approach speaks to a longstanding inclination for gender symmetry within the family structure, where a perceived “ideal” family dynamic includes both a male and a female child. Such discourse perpetuates the notion that a male child is essential for societal or familial fulfillment, reinforcing the very gender inequalities that fuel the demand for sex selection.

However, the Bombay High Court fundamentally disagreed with Mr. Sharma, and in their decision asserted that, “If [the] patriarchal system or economic and social backwardness is responsible for female foeticide, efforts should be made to rectify the system and improve the socioeconomic status of the society. But this Court cannot accept it as a *fate accompli*, permit an abject surrender to it and allow sex selection or misuse of the said techniques leading to female foeticide.”⁹⁷ While this statement recognized the systemic roots of SSA, it ultimately shifted responsibility away from the state’s failure to provide adequate social reform and instead emphasized a rigid prohibitionist stance. The judiciary further justified its approach:

That society should not want a girl child; that efforts should be made to prevent the birth of a girl child and that society should give preference to a male child over a girl child is a matter of grave concern. Such [a] tendency offends [the] dignity of women. It undermines their importance. It violates woman’s right to life. It violates Article 39(e) of the Constitution which states the principle of state policy that the health and strength of women is not to be abused. It ignores Article 51A(e) of the Constitution

95 Mr. Vijay Sharma and Mrs. Kirti Sharma v. Union of India (UOI), Bombay High Court, September 6, 2007. <https://indiankanoon.org/doc/1542440/>.

96 Mr. Vijay Sharma and Mrs. Kirti Sharma v. Union of India (UOI).

97 Mr. Vijay Sharma and Mrs. Kirti Sharma v. Union of India (UOI).

*which states that it shall be the duty of every citizen of India to renounce practices derogatory to the dignity of women. Sex selection is therefore against the spirit of the Constitution. It insults and humiliates womanhood. This is perhaps the greatest argument in favour of total ban on sex selection.*⁹⁸

The rationale reveals the judiciary's concern with population-level consequences rather than the autonomy of individuals navigating these reproductive choices. By emphasizing the societal ramifications of sex selection, the court foregrounded the broader implications of such practices. It explained that the preference for male children is not only a violation of women's dignity but also a direct attack on the foundational principles enshrined in the Constitution. This view reinforced that individual reproductive choices should not be made in a vacuum but rather in consideration of the long-term societal impacts: namely the gender imbalance and the devaluation of women.

Moreover, the court's decision explained how such practices, though personal in nature, are intertwined with systemic, moral issues such as gender discrimination, violence against women, and social inequality. By invoking constitutional principles, the judiciary elevated the issue beyond personal autonomy to the realm of national welfare and gender justice, asserting that the collective dignity of women and the societal fabric must be prioritized over individual proclivities. This perspective posits that the state's role is not simply to regulate reproductive choices but to ensure that those choices do not perpetuate harm or reinforce discriminatory practices. In this way, the judiciary's stance on sex selection is positioned not only as a legal matter but as a moral and social imperative. While individual freedoms are critical, the court's ruling recognized that when such freedoms conflict with the rights and dignity of others, there must be intervention to preserve the broader societal good.

In examining the implementation of the Pre-Conception and Pre-Natal Diagnostics Techniques (PCPNDT) Act, its enforceability at the local and state levels remains questionable. While high-profile cases create an impression of strict oversight, the actual enforcement mechanisms are weak, with low conviction rates and significant loopholes that allow SSA to persist. The case of *Dr. Arvind Pal Singh Gambhir vs State of Punjab and Another* (2012) exhibited the Punjab-Haryana High Court's emphasis on strict enforcement of the PCPNDT Act, citing the intent of the law to prevent female feticide and uphold gender equality. Dr. Gambhir disclosed that his patient had two girls already and had just learned via ultrasound testing that she was pregnant with another female child. The test result prompted her to undergo medical termination of her pregnancy. This rhetoric, rooted in family planning rationale, demonstrates an embedded preference for male children, which is often reinforced by state-backed family planning policies. These policies, while aimed at regulating population growth, inadvertently contribute to sex-selective abortion practices by fostering societal

98 Mr. Vijay Sharma and Mrs. Kirti Sharma v. Union of India (UOI).

pressures that prioritize the birth of sons.⁹⁹ The judiciary's justification for stringent enforcement of the PCPNDT Act also drew on constitutional morality, as initiated in the *Sharma* ruling. While this reasoning presents SSA as a fundamental violation of women's dignity, it simultaneously reinforces a legalistic and moralistic approach that fails to consider the lived realities of those most affected by the law's restrictions.

These cases illustrate the ways in which the state intervenes in SSA not necessarily to protect women's autonomy, but to maintain a particular vision of social order. By amplifying certain voices—like those of legal authorities, medical professionals, and policy-makers—while excluding those of women who undergo SSA, the state has continued to construct a narrative that obscures the structural conditions driving the practice. This dynamic reinforces existing hierarchies, where elite perspectives shape the discourse on reproductive health while marginalized voices remain largely unheard.

The judicial response to SSA is marked by internal inconsistencies and competing priorities. Court rulings often present themselves as decisive measures against gender-based violence, yet their implementation is fractured, their ethical reasoning selective, and their reliance on disciplinary solutions ultimately ineffective. Some legal decisions reflected a formal commitment to curbing SSA, while others exposed the judiciary's own entanglement with patriarchal norms, treating reproductive control as a problem to be managed rather than a symptom of deeper structural inequities. The law, rather than serving as a transformative force, becomes a site of negotiation where conflicting interests like state authority, medical ethics, and social conservatism collide. It is further situated within the larger heterogeneous approach of the Indian state. This uneven legal landscape discloses the limits of judicial intervention in addressing SSA as a fundamental social issue.

Quotidian Experiences of Reproductive Inequality and the Contemporary Manifestation of SSA

India's approach to reproductive governance exhibits a stark disjuncture between national policy and local realities, where legal frameworks and state-led initiatives exist alongside quotidian gender inequality. While there has been a growing emphasis on women-led development, state institutions, which function in varied and sometimes contradictory ways, have made little effort to change social norms. The fragmented nature of healthcare regulations, bureaucratic inefficiencies, and medical biases have shaped the discontinuous accessibility of abortion services. At the same time, laws meant to curb SSA have often reinforced barriers to reproductive care rather than addressed the underlying cultural and economic forces that sustain son preference. Policies that promote smaller family sizes are frequently framed as beneficial

99 Dr. Arvind Pal Singh Gambhir v. State of Punjab and Another, Punjab-Haryana High Court, July 3, 2012. <https://indiankanoon.org/doc/59981959/>.

for girls' education and empowerment, yet they also align with SSA practices, which prioritize male heirs and limit female births. The coexistence of pro-girl initiatives and restrictive family planning goals color the contradictions within India's reproductive policies, where the language of empowerment is often at odds with the structural realities shaping women's reproductive choices.

Despite many states aligning with the central government's regulations on medical abortions, there are variations in interpretation, application, and accessibility throughout the country.¹⁰⁰ Some states, aiming to ensure safety and prevent unsafe abortions, impose additional non-essential procedures, leading to administrative delays and unnecessary controls. For instance, Maharashtra mandates the presence of a blood bank within five kilometers of any abortion facility, an impractical and unnecessary requirement. Similarly, Delhi and Haryana require detailed architectural plans and provisions such as car parking for hospital registration.

A significant deficiency in India's abortion policy lies in the absence of clear guidelines regarding good clinical practice and research. Despite the publication of national technical guidelines

in 2001, which do not align with WHO's international standards, approved abortion facilities often fail to uphold acceptable clinical practices.¹⁰¹ As a result, procedures like sharp curettage and the use of general anesthesia persist in a significant percentage of facilities.¹⁰² India has yet to implement improved and safer abortion practices informed by ongoing research and advancements in reproductive technology.¹⁰³

The liberal nature of India's abortion law, akin to those of Denmark and Sweden, is overshadowed by bureaucratic hurdles and strong medical bias, often placing decision-making power in the hands of doctors rather than women themselves.¹⁰⁴ By requiring and prioritizing medical approval, the law delegates significant authority to doctors in determining women's reproductive choices and access to safe abortion services.¹⁰⁵ A woman must justify her need for abortion by demonstrating efforts to prevent pregnancy or changes in



"THE SEX-RATIO IMBALANCE IN INDIA IS PARTICULARLY STARK AMONG CHILDREN AGED 0-6, WHERE DISCRIMINATION BEGINS EARLY IN LIFE AND MANIFESTS IN DIFFERENTIAL ACCESS TO NUTRITION, HEALTHCARE, AND EDUCATION."

100 Kippen, "Abortion and Sex-Selective Abortion."

101 Government of India, *Guidelines for Medical Officers for Medical Termination of Pregnancy up to Eight Weeks Using Manual Vacuum Aspiration Technique*. (New Delhi: Maternal Health Division, Department of Family Welfare, Ministry of Health and Family Welfare, 2001); World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*. (Geneva: WHO, 2003).

102 S. Barge, "Situation Analysis of Medical Termination of Pregnancy in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh." in *MTP workshop, Ford Foundation* (1997).

103 Hirve, "Abortion Law, Policy and Services," 114-21.

104 Amar Jesani and Aditi Iyer, "Abortion: Who is Responsible for our Rights?" in *Our Lives, Our Health*. (New Delhi: Coordination Unit, The World Conference on Women, 1995); Raj Pal Mohan and Raj Pa Mohan, "Abortion in India" (Social Science, 1975), 142; Hirve, "Abortion Law, Policy and Services," 114-21.

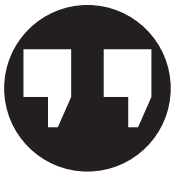
105 Jesani and Iyer, "Abortion: Who is Responsible."

circumstances making it unwanted. This can create pressure for women to falsely claim contraceptive failure to fit within legal parameters, lending to a culture of dishonesty surrounding abortion justification. Additionally, informal fees levied by providers in both public and private sectors exploit women's vulnerability and lack of awareness of their rights, spotlighting systemic issues of transparency and accountability within the healthcare system.¹⁰⁶

Due to societal stigma, medical bias, practitioner insistence of spousal consent, high prices, intrusive regulatory processes, or lack of access in rural areas, many women are dissuaded from seeking abortions altogether. But, according to a 2018 study by the Guttmacher Institute, 50% of pregnancies in the six largest Indian states were unintended. Consequently, many women resort to outside means of abortion, such as home remedies and unlicensed practitioners, further endangering their health and well-being.¹⁰⁷ The consequences of these abortions are dire, with maternal mortality rates exacerbated by complications arising from dangerous procedures, particularly among unmarried women ages 15-19 who face significant shame and legal repercussions for out-of-wedlock pregnancies. The Abortion Assessment Project-India, conducted between 2002-2004, revealed that a staggering 56% of abortions in India were unsafe, with approximately 3.6 million out of 6.4 million annual abortions conducted through risky practices, thus serving as the third leading cause of the country's high maternal mortality rates.¹⁰⁸

Moreover, India's efforts to curb SSAs through legislation like the PCPNDT Act face significant challenges and criticisms. Despite strict laws, SSA persists, and punishments are not enforced because of SSA's clandestine nature.¹⁰⁹ For example, officials in Uttarakhand recently launched an investigation into possible SSAs after government data revealed that not a single girl had been born in 132 villages over the previous three months.¹¹⁰

On the other hand, strict enforcement of the PCPNDT Act creates barriers to abortion access. While law aims to prevent the misuse of prenatal tests for sex determination, it also deters service providers from offering termination services due to fears of legal repercussions imposed by state authorities. These concerns, both real and perceived, lead to reluctance among providers and crackdowns on



"SOCIAL PRESSURE AND IMPLICIT THREATS SHAPED THEIR DECISIONS."

106 A. Banerjee, "Rapid Assessment of Abortion Clients: A Qualitative Case Study in Selected Districts of Orissa" in *Orissa State-level Workshop on Making Abortion Safe and Accessible* (Parivar Seva Sanstha, 2001).

107 Shivani Deshmukh, "A Comprehensive History of Abortion Laws in India: 1971-2021" (*Feminism in India*, 2022); Singh and others, "Abortion and Unintended Pregnancy."

108 Deshmukh, "A Comprehensive History"; Ravi Duggal and Vimala Ramachandran, "The Abortion Assessment Project—India: Key Findings and Recommendations" (*Reproductive Health Matters*, 2004), 122-129.

109 Ahmad, "Female Feticide in India," 13.

110 Bilal Kuchay, "India Probes as No Girl Is Born in Three Months in 132 Villages" (*Al Jazeera*, 2019), <https://www.aljazeera.com/news/2019/7/23/india-probes-as-no-girl-is-born-in-three-months-in-132-village>.

abortion centers, driven by efforts to prevent SSA. The Act also fails to address the root causes of the “missing girls” phenomenon or the cultural preference for male children. Critics argue that anti-SSA measures disproportionately affect lower-income women, whereas higher-income individuals are more likely to practice sex-selective abortion, a continuation of development discourse from the 1950s.¹¹¹ Economic growth and education, often cited as solutions, have not significantly improved the situation, as discrimination against girls and SSA remain prevalent across all socioeconomic strata.¹¹²

Moreover, top-down multilateral organizational efforts expose significant flaws in combating SSA. Work like the 1995 UNICEF Annual Report is intended for both domestic and international audiences, including policymakers, development professionals, and international donors. This may introduce certain biases into the report’s analysis, particularly in its framing of the issue as a universal moral crisis rather than one that is rooted in specific historical, cultural, and economic conditions unique to India. By presenting India’s gender imbalance this way, the report aims to draw global attention to the issue and potentially secure funding and support for interventions aimed at reducing gender discrimination. This construal as a moral and developmental crisis echoes the language of aforementioned courts.



" THE INDIAN STATE'S APPROACH TO CURBING SEX-SELECTIVE ABORTION (SSA) IN THE 1980S AND 1990S WAS FRAGMENTED AND HETEROGENEOUS, SHAPED BY A SERIES OF LEGISLATIVE AND JUDICIAL INTERVENTIONS THAT FAILED TO ADDRESS STRUCTURAL INEQUALITIES."

However, the UNICEF report’s strong advocacy on enforcing legal interventions, such as the 1994 Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act, demonstrates an approach that emphasizes a partiality toward top-down solutions, which may not always align with the needs and preferences of local communities.

Historically, in addition to legal measures, the Indian government has implemented initiatives to promote the care and survival of female children, such as cash incentives at birth and most recently the “Beti Bachao Beti Padho” (BBBP) (Save the Girl Child) campaign launched by Prime Minister Narendra Modi in 2015.¹¹³ Various states have introduced financial support schemes, including conditional cash transfers and scholarships for girls at different stages of life, aiming to address the potential economic disadvantage of having female children.¹¹⁴ Maharashtra, with a low sex ratio of 966:1000, has proposed incentivizing families to have a third child if it is a daughter, offering financial rewards and

111 Kipgen, “Abortion and Sex-Selective Abortion.”

112 Madan and Breuning, “Impact of Prenatal Technologies,” 425-432.

113 Kipgen, “Abortion and Sex-Selective Abortion.”

114 Christophe Guilamoto, *Sex Imbalances at Birth: Current Trends, Consequences and Policy Implications* (Bangkok, Thailand: UNFPA Asia and the Pacific Regional Office, 2012).

support for her education. Kamayani Bali Mahabal, a lawyer and human rights activist, acknowledged that while such measures may encourage behavior change in the short term, they fail to promote informed choice and contradict a rights-based approach. Activist Sabu George critiques the policy's practicality, noting that few families want a third child, especially if they already have daughters. He argues the initiative is more about creating a facade of action rather than addressing systemic issues, accusing policymakers of subverting laws and policies under the guise of progress.¹¹⁵

At the same time, there exists a tension between the various governmental approaches to uplift women. Movements like BBBP exist within the context of family planning initiatives but also within frameworks of female autonomy. SSA lies within this patchwork of competing discourses—family planning, cultural expectation, and women's autonomy—that are often at odds with each other. The language of gender equity can clash with the imperatives of reproductive control, and the desire for “ideal” families may distort the promise of women's freedom and choice. At the policy level, smaller family models are frequently promoted as a means to secure a better future for daughters. Advocates argue that fewer children make it more feasible for families to invest in each child's education, particularly for girls who may otherwise be deprioritized. The desire for a particular family composition, especially one that privileges male children, emerges not merely as an aberration within family planning, but perhaps as an extension of it. This is similar to the argument made in *Vinod Soni And Anr. vs Union Of India* where the petitioner envisioned a right to determine the composition of one's family. However, this idealized vision of the small family as a liberating structure masks a darker outcome: it can actually facilitate SSA, as families pressured to have only one or two children may prioritize male heirs, thereby disenfranchising women and entrenching patterns of gendered violence.

While couples rarely resort to sex determination with their first child, the practice becomes more common with subsequent pregnancies, especially after the birth of one or more daughters.¹¹⁶ This highlights a cultural predilection for sons, exacerbated by the pressures of modern family planning ideals that prioritize smaller families. The ideal of a planned family, reduced to a particular “perfected” form, suggests a eugenics-adjacent logic that operates even at the most local levels. This logic is often cloaked in rhetoric that emphasizes family improvement or rational family size; but in practice it can impose subtle or overt pressures on families to conform to gendered expectations in their reproductive choices. In this way, SSA can be seen as both a product and a perversion of the family planning movement's own ideals.

The notion that small families lead to better educational opportunities for girls sits uneasily beside the reality that SSA—a practice aligned with achieving smaller, “optimized” families—continues to curtail the very lives that these policies claim to uplift, as previously demonstrated by the studies examining the girl child's postnatal neglect. This contradiction lays bare the limited reach of

115 Saira Kurup, “The Return of Ultrasound” (Times of India, 2011).

116 Rohde, *The Progress of Indian States*.

pro-girl initiatives when framed within restrictive family planning goals. Instead of fostering female empowerment, the small-family ideal often perpetuates a form of reproductive discrimination, with SSA becoming an unintended yet pervasive byproduct. This alignment between SSA and family planning reflects a broader pattern in which policies ostensibly aimed at empowering women inadvertently reinforce patriarchal structures. The language of “autonomy” and “freedom” surrounding family planning can obscure the coercive aspects of SSA, where the freedom to choose the composition of one’s family results in the systemic devaluation of female lives.

While women are often framed as the decision-makers in family planning, in reality they are often navigating a constrained space where social, economic, and familial pressures dictate their choices. A rural, community-based study conducted by the KEM Hospital Research Center in western Maharashtra (1996–1998) found that women who sought SSA were significantly more likely to come from joint families and be better off economically, owning property such as a house with a separate kitchen and irrigated land, than those who had abortions for other reasons.¹¹⁷ Yet, despite this relative affluence, these women played a diminished role in family decision-making, demonstrating that economic security does not necessarily translate into personal agency.

The study revealed that decision-making about SSA often involved extended family members, particularly in joint households that included the male spouse’s family living together. In this study, mothers-in-law were more likely to be aware of SSA procedures than abortions for other reasons. Fathers-in-law and sisters-in-law followed similar patterns, demonstrating the degree to which SSA was a family-level decision rather than an individual reproductive choice. The data further dictated that SSA was most frequently sought in families with only one or two children, reinforcing the contradiction that smaller families, while framed as a way to empower girls, often intensify son preference. In reference to obtaining a sex determination test and abortion, one woman exemplified this idea and stated, “Once you have decided that you don’t want to increase your family size, then there is no alternative other than going for [SSA].”¹¹⁸

Women’s testimonies also demonstrated how social pressure and implicit threats shaped their decisions. One woman, whose mother-in-law pressured her into SSA, recalled, “My mother-in-law used to say: ‘I won’t say anything, but tomorrow if my son starts feeling that he should have a son and if he thinks about remarrying, then don’t blame me at that time.’” Another recounted that, although her husband remained silent, she ultimately followed the will of her family elders: “What can I say? I do whatever elderly people in the family say.” In some cases, women did not initially seek out SSA but were encouraged to do so by community members, doctors, or family members. Fifteen percent of women in the study were planning to have an abortion

117 Bela Ganatra, Siddhi Hirve, and V.N. Rao, “Sex-selective Abortion: Evidence from a Community-based Study in Western India,” (*Asia-Pacific Population Journal*, 2001), 109-124.

118 Ganatra et al., 109-124.

for non-sex-related reasons but were advised to undergo a sex-determination test first. As one woman recalled, “The doctor said: ‘You [should] check [the sex] first. Why should you go for [the abortion] if it is a boy!’”¹¹⁹ Thus, SSA exists within a web of policy goals and cultural expectations that ultimately reinforce gendered violence, rather than eliminating it. The push for smaller families as a means of empowering girls may paradoxically deny women their fundamental rights and structurally entrench gender biases.

The role of medical providers in facilitating SSA exemplifies how the practice persists despite legal restrictions, further demonstrating the limited reach of the state. The vast majority of sex-determination tests in this study took place in the private sector, and providers deliberately avoided written documentation that could serve as evidence of their involvement.¹²⁰ Some women even recounted exploitative interactions, such as one doctor who refused to disclose fetal sex until he was paid, reinforcing how SSA has become a lucrative industry within the private medical sector. This complicity demonstrates that SSA is both an advancement and abuse of family planning ideals; rather than safeguarding reproductive autonomy, medical institutions frequently reinforce and profit from gendered reproductive coercion.

While the 1995 UNICEF report rightly advocates for the promotion of gender equality and the empowerment of women, it does not sufficiently explore grassroots initiatives or local feminist movements that are already working to combat gender discrimination in innovative and context-specific ways. In the words of the former Indian Health Minister Harsh Vardhan in October 2014: “It is clear that the focus on the providers of sex selection services has not worked through 20 years. We need to go into the root cause and build up a social movement.”¹²¹ Vardhan did not expand on specificities of what this social movement should look like, rather his vision is a continuation of the amorphous notions of “change.”

Moreover, the UNICEF report’s reliance on quantitative data may not fully capture the lived experiences of women and families in India. While statistics about sex ratios and mortality rates are crucial for understanding the scope of the problem, they do not provide a nuanced view of how cultural, religious, and economic factors shape individual decisions regarding family planning and reproductive health. For instance, the report highlighted the misuse of ultrasound technology without fully exploring the ethical dilemmas that families may face when confronted with the pressures of having a daughter in a society that values male heirs. Additionally, the report’s emphasis on wealthier states like Punjab and Haryana could imply that the problem of sex-selective abortion is more prevalent among affluent families. While this might be statistically accurate, it also risks overshadowing the ways in which gender discrimination operates across different socioeconomic classes and regions in India. The

119 Ganatra et al., 109-124.

120 Ganatra et al., 109-124.

121 Sanjeet Bagchi, “Indian Health Minister Convenes Experts to Tackle Fetal Sex Selection” (The British Medical Journal, 2014).

report's heavy emphasis on the correlation between wealth and gender bias might divert attention from other regions and social strata where these issues are just as pressing but less visible in the data. For instance, Dr. Puneet Bedi, an obstetrician/gynecologist, questioned the absence of middle-class outrage over sex-selective practices, attributing it to the pervasive preference for boys and the widespread availability of diagnostic technology.¹²² Activist Sabu George explained that while discrimination traditionally targeted second or third-born daughters, this bias has intensified, with many families now unwilling to have even a first-born daughter.¹²³ The growing preference for sons has spread to regions like Kashmir and the northeast, which historically has shown less gender prejudice.

Another potential issue is the report's framing of the problem as primarily that of discrimination against girls, without sufficient attention to the broader context of reproductive rights and the limitations faced by women in making autonomous decisions about their bodies. By focusing on the negative outcomes of sex-selective abortion, the report may inadvertently reinforce narratives that position women as victims of cultural and technological forces, rather than as active agents capable of making complex reproductive choices. This narrative can obscure the ways in which women navigate oppressive social structures, balancing the competing demands of tradition, modernity, and economic survival.

Epilogue

The persistence of sex-selective abortion (SSA) in India underscores the enduring tension between legal interventions and entrenched socio-cultural norms. Despite the enactment of policies such as the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, the structural preference for male offspring continues to shape reproductive decision-making, uncovering the limitations of state mechanisms in eradicating gender-based violence. As this paper has demonstrated, the rise of SSA in the 1980s was not an aberration but rather a continuation of long-standing practices of infanticide, compounded by the increasing accessibility of ultrasound technology and the socioeconomic constraints imposed on Indian families. State-led population control initiatives, often advanced by elite-run multilateral organizations, framed the two-child family as a progressive ideal while simultaneously failing to interrogate the patriarchal underpinnings of reproductive governance. Instead, these policies reproduced eugenic logics, enabling a transition from infanticide to feticide without meaningfully addressing gendered violence. The trajectory of SSA in India hence illustrates the broader dissonance between state-driven biopolitical interventions and the persistence of cultural structures that systematically devalue female life. This imbalance is starkly evident in India's population sex ratio, with 106.453 males per 100 females, resulting in a surplus of 45 million

122 Kurup, "The Return of Ultrasound."

123 Kurup, "The Return of Ultrasound."

men as of 2024.¹²⁴

The repercussions extend beyond skewed demographics, posing significant societal challenges. The shortage of marriageable women could lead to increased mental health issues, violence against women, and sexually transmitted diseases spread, exacerbating existing social problems.¹²⁵ This scarcity of potential brides may result in girls being married at increasingly younger ages. The rise in child marriages would further exacerbate the low status of women, as young brides are less likely to complete their education or acquire job skills before marriage. Additionally, early marriages and childbirth increase the risk of morbidity and mortality for both young mothers and their children.¹²⁶

These consequences have prompted the Indian government to recently implement incentives to promote the health and wellbeing of the girl child. One key example of this is BBBP. In January of 2025, on the ten-year anniversary of this program, Prime Minister Modi reflected, “The success of the [BBBP] scheme lies in the policy shift to mainstream empowerment of women through a holistic Whole of Government approach. We have now moved ahead from women’s development to women-led development.”¹²⁷ The BBBP initiative, despite its ambitious goals of addressing gender disparities in child survival, education, and social participation, has been largely ineffective in achieving widespread impact, as demonstrated by an India Policy Insights (IPI) analysis. The IPI study highlights that some of the most crucial indicators—such as sex ratio at birth, institutional births, and women’s education—are slow-moving, suggesting that the BBBP’s efforts have failed to generate the necessary systemic change. While the program aimed to prevent sex-selective abortion and encourage community participation of girls, the persistence of gender-based disparities accentuates the limitations of an awareness-driven approach without stronger policy enforcement and structural interventions. BBBP functions as a kind of gendering governance and, ultimately, the data suggest that while BBBP might have raised awareness, it has not effectively translated into tangible improvements in gender equality, particularly in historically disadvantaged regions.¹²⁸

124 “Gender Ratio in India” (StatisticsTimes.com, 2024).

125 Ahmad, “Female Feticide in India,” 22-23.

126 Patel, “experiencing Abortion Rights in India,” 702-710. This scarcity has already fueled bride trafficking, a lucrative industry in India, with reports of thousands of girls being bought or brought from rural areas of Himachal Pradesh, Uttarakhand, Odisha, Bihar, Jharkhand, West Bengal, Kerala, Assam, Uttar Pradesh, and Andhra Pradesh into states like Haryana for marriage, often subjected to exploitation and abuse. See Jamejaya Samal, “The Unabated Female Feticide is Leading to Bride Crisis and Bride Trade in India” (*Journal of Family Medicine and Primary Care*, 2016), 503-505; and Aditya Ghosh, “Fewer Children Up for Adoption in Mumbai: Longer Wait for Prospective Parents; Over 150 Families Already on This Year’s Waiting List; Hindustan Times Special” (*The Hindustan Times*, 2008), <https://www.proquest.com/historical-newspapers/fewer-children-up-adoption-mumbai/docview/2676909593/se-2>. In 2015, the Indian minister for women and child development stated that 2,000 girls are “killed every day” due to the preference for sons. Failure to address these issues could result in further trafficking, child marriages, maternal mortality, and an increase in sexual partners, posing a significant threat to the safety of women and female children in India. See Kuchay, “India Probes”; and UNICEF India, “Female Feticide in India.”

127 Ministry of Health and Family Welfare, Government of India, “Press Release” (2025) <https://mohfw.gov.in/press-info/8234>.

128 Harvard University, Geographic Insights Lab, *Beti Bachao Beti Padhao* (BBBP) Policy Brief, (Cambridge, MA: Harvard University, 2020), https://geographicinsights.iq.harvard.edu/files/geographicinsights2/files/beti_bachao_beti_padhao_bbbp_policy_brief.pdf. The study’s Key Performance Indicators (KPIs)—which measure progress across critical areas such as sex ratio at birth, maternal healthcare, institutional births, female school attendance, and women’s education—reveal stark inter-state and in-

Another fundamental flaw of the BBBP initiative is its failure to address the structural sources of SSA. Rather than being merely a form of discriminatory violence that can be remedied through awareness campaigns or financial incentives, Navtej Purewal, a scholar of political sociology and development, argues that SSA is a manifestation of deeply embedded, gendered violence reinforced by neoliberal state patriarchy. She claims that the control of female bodies operates through two contradictory but interconnected patriarchal mechanisms: the need to “protect” women from external threats, such as public harassment, and the simultaneous erasure of female lives within the family through sex-selective abortion. On one hand, women are restricted under the pretense of safeguarding them from external patriarchal forces, while on the other, their existence is deemed expendable to maintain familial and societal stability through the birth of sons. This tension reflects a broader conflict between neoliberal economic structures, which pull women into the workforce and public life, and traditionalist discourses that seek to reassert control by confining them to domestic roles. Sex selection emerges at the intersection of these forces, representing both an act of violence, by eliminating female fetuses, and a perceived means of maintaining social “peace” by reinforcing male dominance. This paradox highlights how patriarchal power adapts within both modern capitalist frameworks and entrenched cultural traditions, ensuring that gendered oppression persists under different labels.¹²⁹

Other central government enterprises include the National Scheme of Incentives to Girls for Secondary Education, the Rajiv Gandhi Scheme For Empowerment Of Adolescent Girls-SABLA Yojana, and the Kasturba Gandhi Balika Vidyalaya Scheme.¹³⁰ Various states have introduced financial support schemes, including conditional cash transfers and scholarships for girls at different stages of life, aiming to address the economic disadvantage of having female children.¹³¹ Moreover, health activists have taken legal action to challenge the government’s failure to enforce the PCPNDT Act, resulting in Supreme Court directives to enhance enforcement and public awareness efforts against prenatal sex determination.¹³² Despite these multifaceted efforts, there remains

ter-district variations, indicating that the program’s effectiveness has been uneven at best. Kerala, Goa, and Mizoram emerged as the highest-scoring states on the KPI index, with Kerala leading at 0.863 (on a scale from 0 to 1, where 1 represents the best performance). Yet, even in these relatively successful regions, significant gaps remain. Nearly one-fourth of females in Kerala, for instance, still do not complete ten years of schooling. On the other end of the spectrum, states like Bihar (0.207), Jharkhand (0.296), and Nagaland (0.302) scored among the lowest, reflecting persistent challenges in improving female education and survival outcomes. For more on gendering governance, see Roy, Srila. “Chapter 20: Feminist politics and neoliberal governmentality: from co-option to counter-conduct.” In *Handbook on Governmentality*, (Cheltenham, UK: Edward Elgar Publishing, 2023), <https://doi.org/10.4337/9781839108662.00031>.

129 Purewal, “Sex-Selective Abortion, Neoliberal,” 20-38.

130 Ministry of Education, Government of India, “Incentives” (2016). <https://www.education.gov.in/incentives>; Ministry of Education, Government of India, “Kasturba Gandhi Balika Vidyalaya (KGBV),” <https://samagra.education.gov.in/kgbv.html>; District Administration Chhindwara, Government of India, “Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) – SABLA,” <https://chhindwara.nic.in/en/scheme/rajiv-gandhi-scheme-for-empowerment-of-adolescent-girlsrgseag-sabla-the-scheme>.

131 Guilimoto, *Sex Imbalances at Birth*.

132 This has included the mandate of quarterly reports on SSA, ultrasound machine companies directed to disclose their clinic sales, and both seizure and legal action against those using unregistered ultrasound machines. Additionally, films have been produced to raise global awareness of the issue. See Madan and Breuning, “Impact of Prenatal Technologies,” 425-432.

the persistence of illegal ultrasound activity.¹³³ While such legislative measures may be necessary, they reflect an external pressure to impose legal solutions without fully addressing the underlying social and cultural beliefs that perpetuate son preference. By centering the discussion on policy, law, and Western biomedicine, the government simplifies the issue and overlooks the everyday realities faced by women and families who navigate these decisions in a diverse landscape with various avenues for healthcare and technology. These policies are built on an idealized notion of the elite Indian family that assumes state intervention alone can shift gendered reproductive choices while failing to account for the deeply embedded, ongoing gender-based eugenic practices that shape reproductive choices.

Scholars suggest that indirect interventions, such as media messaging and gender-equality laws, may be more effective in reducing sex-selection than bans. Bans often lead to harsh treatment of unwanted daughters and their mothers, as evidenced by empirical studies in China and India.¹³⁴

There has been a recent resurgence of female infanticide after the legal restriction on SSA.¹³⁵ In 1995, midwives interviewed in Bihar confessed to killing approximately 50% of the girls they delivered.¹³⁶ The prevalence of female infanticide alongside the persistence of sex-selective abortion (SSA) in India reveals the enduring challenges in combating gender-based violence against female fetuses and children.

Despite legislative interventions like the PCPNDT Act and public health campaigns, the socio-cultural landscape remains complex, reflecting preferences for male progeny. From historical practices to modern phenomena, India continues to grapple with ethical, legal, and moral dilemmas surrounding gender dynamics. As technology continues to advance, the misuse of scientific advancements, as seen with female feticide, emphasizes the urgent need for ethical application. As Ahmad describes, "...[I]t is necessary to understand that while progress in science and technology is mandatory for the progress of a nation, what matters most is its beneficial application. Female feticide reflects what happens when technologies are misused to serve tragic ends."¹³⁷ Moving forward, addressing the root causes of gender bias and promoting gender equity through holistic interventions will be crucial in fostering a society where every life is valued equally.

133 Ahmad, "Female Feticide in India," 28.

134 Monica Das Gupta, "Is Banning Sex-Selection the Best Approach for Reducing Prenatal Discrimination?" (Asian Population Studies, 2019), 319-336.

135 Madan and Breuning, "Impact of Prenatal Technologies," 425-432.

136 Rita Banerji, *Sex and Power* (India: Penguin Books Limited, 2008).

137 Ahmad, "Female Feticide in India," 29.

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Shots and Cigars: The Side Effects of Castro's Medical-Military Diplomacy (1959-1980's)

In the mid 20th century, tensions between capitalism and communism were high. Communism thrived on a platform that blamed imperialist countries, who owned Latin American exports, for poverty in their country and sought to defend the rights of people of all classes.

The 1960's and 1970's saw proxy wars between the U.S. and the U.S.S.R. and many U.S.-supported coups d'état to overthrow communist leaders. Cuba was governed by U.S.-backed dictator Fulgencio Batista (1901-1973) who supported U.S. capitalist interests. Out of this wave of anti-imperialism rose the 26th of July Movement (known as "M-26-7"), a guerilla group that initiated the Cuban Revolution with financial support from the U.S.S.R. The M-26-7 was led by Fidel Castro (1926-2016) a charismatic young lawyer.

In 1955, Castro met Ernesto "Che" Guevara, a charismatic young physician, and invited him to join the M-26-7. The two shared many ideas about a communist future for Cuba. A keystone of Guevara's vision was a revolution in healthcare, with universal access for all Cubans; but to facilitate that, a revolution in government was necessary. In 1959, Castro, Guevara and the M-26-7 successfully overthrew Batista and established a one-party communist Cuba. Castro, the new prime minister, began implementing changes to Cuban healthcare along the lines of Guevara's revolutionary vision.

That revolutionary vision involved nationalizing private

property and eliminating the private practice of medicine. (Consequently, nearly half of Cuba's doctors - middle and upper class, disproportionately from Havana - fled.) First on Castro's public-health agenda was reforming the calcified institution of medical school. Castro devised a plan to produce more loyal doctors quickly by shortening the time to diploma and accelerating exposure to practice (meanwhile adding classes on Marxist-Leninism). There were benefits and risks. In original speeches that I refer to, translate, and cite throughout this thesis, Castro boasts about the success of his changes, but declassified CIA documents recount testimony from Cubans who fled that health care was no better than it had been before the revolution.

The idea of medical diplomacy, or exporting medicine and medical aid to countries in need, was a natural extension of Castro and Guevara's vision. I refer to "proletarian internationalism," which contemplates a global struggle of the working class against the upper class. Proletarian internationalism begged medical diplomacy to third-world countries whose resources had been exploited by imperialism. And hand-in-hand with that support was the overthrow of local governments through military aid. By these tandem tracks, Cuba could not only spread communist ideology but also show the world that it had the supplemental resources to provide aid, implying the revolution's success.

Cuba supplied medical aid through missions to poor or disaster-stricken countries and by training foreign students with scholarships in Cuban medical schools. Communist values were preconditions for selecting both aid-recipient countries and medical students. Likewise, doctors dispatched abroad were selected for revolutionary values and even participation in the revolution.

The result was the "Revolutionary Doctor," an altruistic hero willing to risk their life for the health and freedom of others. While the earliest foreign missions were primarily military (not medical), Dr. Guevara himself famously led them, becoming a role model for the revolutionary doctors on future missions with much greater emphasis on medical diplomacy.

Many physicians who did not identify as "revolutionary doctors" objected to the revolution not only because it transformed their livelihoods but also on the basis of patient rights. While nominally advocating for the rights of patients of all classes, Castro also assassinated political opponents and sentenced objecting doctors to concentration camps. Many fled to the U.S. but faced almost insurmountable legal hurdles to practice, particularly passing "el foreign," the last of three exams administered by the U.S. Educational Council for Foreign Medical Graduates.

There is also evidence of a widespread underground illegal practice, particularly in Miami, Florida, where most Cuban



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expatriates took refuge. Both legal and illegal practice shaped U.S. medicine. As for legal practice, surrounded by the surfeit of trained-but-unlicensed refugee doctors and a critical demand among a burgeoning refugee patient community, the University of Miami established an unprecedented program in “modern American medicine” to prepare doctors for *el foreign*. This federally funded program expanded beyond training Cuban refugees who remained in Miami, to visiting physicians from all over Latin America who returned to practice in their home countries. While comparing the Miami and Cuban programs is beyond the scope of this paper and probably not a fair exercise, the relative success of the Miami program without diversion from domestic resources, is perhaps worth noting.

And as for the illegal practice of medicine by Cuban refugees, it played an outsized role in the local administration of healthcare as the Cuban immigrant community sought Cuban doctors for care that was approachable and accessible. Unlicensed practitioners (whom Castro bemoaned as the worst of traitors) populated store-front and home-based *clínicas* throughout Miami’s Little Havana and Hialeah neighborhoods that modeled pre-revolution privatized Cuban healthcare. This was healthcare by and for Cuban refugees. The evidence is that it was widespread and effective and, while underground at the time, presaged the prepaid clinic that is now a mainstay of present U.S. healthcare today.

I start by examining how Castro placed healthcare at the top of his agenda for revolutionary Cuba, focusing on his unprecedented expansion of rural healthcare and wholesale reform of medical school. I then assess these changes, finding that there were serious setbacks, including overcrowded hospitals, lack of medication and poor sanitation. I connect this to his visions for medical diplomacy, the practice of sending doctors to countries susceptible to Cuba’s ideological and political missions. The doctors who went abroad were sometimes referred to as extensions of the Cuban military, and I consider what it meant to be a doctor who represented the Cuban military.

Using primary source materials (some of which were untranslated), including apparently unexamined contemporaneous accounts and recently declassified CIA intelligence, I examine the very first Cuban medical missions to evaluate the degree of military involvement doctors had and the consequences. I establish that Castro was sending medical aid abroad at the expense of the health of Cubans on the island, worsening the condition of life in Cuba and resulting in the continued exodus of Cubans. I then turn to Cubans who left Cuba for the United States. Doctors and patients made their own Spanish-speaking and community-oriented healthcare system that modeled pre-revolution prepaid clinics, rather than trying to penetrate the overburdened and inaccessible U.S. system. This had fascinating impacts on local the refugee community and points to obvious lessons for today about accessibility and administration of healthcare to refugee populations.

In this paper I argue that Castro’s medical diplomacy had bad and good side effects. Medical missions required doctors to risk their lives and the healthcare of Cubans on the island was

disturbingly neglected in the process. A remarkable side-effect however was the creation of a community of Cuban refugee doctors, who had fled Castro for Miami, setting up informal private practices. While largely unlicensed, they filled a dire need of the local refugee population for Spanish-speaking healthcare in a cultural format to which they had been accustomed.

Chapter 1: Creating the Comrade-Doctor Visions for Cuban Medicine

Before the Cuban revolution, access to healthcare in Cuba was markedly unequal. Under Batista, sanitation, working conditions, electricity, and access to food and water were all poor for those who were not members of the elite. When people were sick, they went to *quintas* which were clinics that provided a variety of in- and out-patient care for a prepaid monthly fee. In Che Guevara's 1960 speech "On Revolutionary Medicine" addressed to the Cuban militia in Havana, he posits a society in which preventative medicine or social medicine is what keeps most people healthy, with specialized medicine treating the rarer cases. Castro enacted this vision and just a few years later would claim that preventive medicine was already in effect. Guevara said:

Some day, therefore, medicine will have to convert itself into a science that serves to prevent disease and orient the public toward carrying out its medical duties. Medicine should only intervene in cases of extreme urgency, to perform surgery or something else which lies outside the skills of the people of the new society we are creating. The work that today is entrusted to the Ministry of Health and similar organizations is to provide public health services for the greatest possible number of persons, institute a program of preventive medicine, and orient the public to the performance of hygienic practices.¹

A preventative strategy aligns with the communist ideas of equal access to free health care, in contrast to the distribution of care before the revolution when two-thirds of hospitals were in Havana. Guevara's vision of healthcare describes a society with proper health infrastructure that would prevent disease, and Castro announced having fulfilled this vision in his 1966 speech at a medical convention:

...not only have the figures for beds, hospitals and economic resources risen extraordinarily, but also practically the whole concept of public medicine has been revolutionized in recent years. And so - as you all know full well - special emphasis began to be placed on preventive medicine.²

1 Che Guevara, "On Revolutionary Medicine," (1960).

2 Fidel Castro, Acto Clausura del XI Congreso Medico y VII Estomologico Naacional, (Speech, Chaplain Theater, Havana, February 27th, 1966), Discursos e Intervenciones del Comandante en Jefe Fidel Castro Ruz, Presidente del Consejo de Estado de la República de Cuba, Latin American Network Informa-



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Castro's philosophy on how Cuba should approach health reforms directly echoed Guevara's, both emphasizing preventative medicine and community values. Socialism and bettering the health of the population went hand in hand.

There is evidence that the general health of the Cuban population improved significantly in Castro's early years. With economic support from the Soviet Union beginning in the early 1960's, Cuba was able to make infrastructural changes that led to improved health of the population in these areas and even in housing and working conditions.³ By 1965, the number of hospitals increased from 87 before the revolution to 159.⁴ Health markers like infant mortality decreased by fifty percent during the seventies and life expectancy at birth increased.⁵ Another significant change was the sectorization of Cuba into areas which would each have a polyclinic – a medical center with a variety of outpatient medical care - finalized by 1976.⁶ These widespread infrastructural changes coupled with the mass training of new doctors led to Cuba's reputation as a world medical power. *But was the stress on preventative medicine realistically enough to prevent the need for more doctor visits?*

American journalists who visited Cuba in the 60's and 70's seemed to answer positively. Ernest A. Bates of Sun Reporter, a San Francisco newspaper, wrote an article praising Cuba's "remarkable progress in health care." Bates reports the eradication of malaria and the near eradication of polio, tuberculosis, and intestinal disease from parasites. Bates also describes the structure of the Cuban health care system, noting differences from the U.S. such as nurses having more responsibilities, frequency of house calls, and how primary-care physicians would accompany patients to visits with a specialist.⁷

Almost all medical students prior to the revolution were coming from the urban middle class, and medical school was not oriented toward clinical experience.⁸ To achieve social medicine, changes had to be made in the medical school to produce doctors who were better prepared in terms of clinical skills and revolutionary values. Che Guevara clearly states the reason for a revolutionized medical school in "On Revolutionary Medicine" as the need for people who come from the lower classes to be trained in medicine

tion Center, <http://www.cuba.cu/gobierno/discursos/1966/esp/f260266e.html> and Castro, Fidel. Closing Ceremony of the Medical-Dental Congress, (Speech, Chaplain Theater, Havana, February 27th, 1966), Castro Speech Database, Latin American Network Information Center, <http://lanic.utexas.edu/project/castro/db/1966/19660227.html>.

3 Pol De Vos, "'No One Left Abandoned': Cuba's National Health System Since the 1959 Revolution," *International Journal of Health Services* 35, no. 1 (2005), 191, <http://www.jstor.org/stable/45138293>.

4 Fidel Castro, Acto Clausura del XI Congreso Medico y VII Estomologico Naacional, (Speech, Chaplain Theater, Havana, February 27th, 1966), Discursos e Intervenciones del Comandante en Jefe Fidel Castro Ruz, Presidente del Consejo de Estado de la República de Cuba, Latin American Network Information Center, <http://www.cuba.cu/gobierno/discursos/1966/esp/f260266e.html>

5 Julie M. Feinsilver, *Healing the Masses: Cuban Health Politics at Home and Abroad*, (Berkeley and Los Angeles, California: University of California Press, 1993), 95-96.

6 Ibid, 192.

7 Ernest A. Bates, "The Black Press Visits Cuba: Remarkable Progress in Health Care," *San Francisco: Sun Reporter*, August 14th, 1976. <https://www.proquest.com/docview/370741163?sourcetype=Newspapers>

8 "La Nueva Promocion Medica: Llevaron sus diplomas el galardón de la renuncia del ejercicio privado de la profesión," *Noticias de Hoy*, (Havana, Cuba: September 12, 1964), trans. Paulina Tein. <https://dloc.com/AA00022089/06969/images/11>.

and then go help their “brothers”:

What would have happened, simply, is that the peasants (“campesinos”) would have run, immediately and with unreserved enthusiasm, to help their brothers. They would have requested the most difficult and responsible jobs in order to demonstrate that the years of study they had received had not been given in vain. What would have happened is what will happen in six or seven years, when the new students, children of workers and peasants, receive professional degrees of all kinds.⁹

Guevara explains that granting members of the lower classes the opportunity to study medicine would produce altruistic doctors who would bring medical care back to their communities that had previously lacked access to care. These doctors would possess revolutionary values and thus be of better character than those who fled Cuba following the revolution. Other factors were likely to have motivated the call for more medical students. In “Fifty Years of Cuba’s Medical Diplomacy: From Idealism to Pragmatism,” (2013) Julie M. Feinsilver explains that “[Cuba’s leaders] soon took this ideological commitment [to universal healthcare] to the extreme and contended that the health of the population was a metaphor for the health of the body politic,” or the physical health of the Cuban population represented their satisfaction with post-revolution Cuba; and Cuba’s notion of “debt to humanity for support it received from others during the revolution.”¹⁰ What was masked in “On Revolutionary Medicine” as a general call for



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comradery had perhaps more complex political motives. If access to healthcare was a representation of the wellbeing of the body politic, then this meant that Castro and Che were highly concerned with the reception of the revolution by Cubans and worldwide. Further, Castro was eager to begin medical diplomacy in the few years directly following the revolution, and rapidly producing more doctors would expedite his internationalist agenda. These motivations produced doctors that rejected privatized medicine of the past, possessed revolutionary values, and saw themselves as servants of the people.¹¹ Thus becoming a doctor meant fulfilling

⁹ Che Guevara, “On Revolutionary Medicine,” (1960).

¹⁰ Julie Feinsilver, “Fifty Years of Cuba’s Medical Diplomacy: From Idealism to Pragmatism,” *Health Travels: Cuban Health(care) On and Off the Island*, edited by Nancy J. Burke, PhD, (San Francisco: University of California Medical Humanities Press in partnership with California Digital Library, 2013), 106.

¹¹ “La Nueva Promoción Médica,” *Noticias de Hoy*.

the revolution.

Fidel Castro touches on all of these motivations for reforms to medicine in his speech inaugurating the new institute for science advancement and preclinical studies. This speech, like “On Revolutionary Medicine,” emphasized the need for doctors who would “run to help their brothers.” He made an analogy to a tumor and calls the mass of doctors who defected the “pus.” The “body,” Cuba, felt a lot better having extracted the pus. He said these runaway doctors would never be allowed to return to Cuba, however he did not ban doctors who wanted to leave from doing so, as they too would be pus that is best extracted. Instead, he proclaimed,

*Cuban society, in the future, will not produce that kind of men, the ones who left. The men who, in the midst of a society of corruption and selfishness, remained pure, surely have great human quality and can serve as seeds and teachers... And who will give the country the contribution of a new mentality and a new concept of the function of a doctor; a function which like the teacher's, the people must hold in the highest esteem. The highest esteem! It is clear that bad doctors conspire against the good opinion that the people should have of the doctor.*¹²



"FOREIGN STUDENTS RECEIVING SCHOLARSHIPS TO STUDY IN CUBA, LIKE LOCALS, WERE REQUIRED TO TAKE CLASSES ON MARXIST-LENINIST PHILOSOPHY AND THE CUBAN PERSPECTIVE ON WORLD HISTORY."

With the pus extracted, Castro began to produce revolutionary doctors. Here, Castro makes a clear statement on the moral “goodness” of supporting him and the Cuban

revolution.¹³ This made it clear that the revolutionized medical school was only for supporters of the revolution. (In fact a 1964 article in the Cuban newspaper *Noticias de Hoy* mentioned that most of the recent medical school graduates “participated in the clandestine fight against tyranny.”¹⁴) It became apparent that all doctors were responsible for the wellbeing of the Cuban body as well as the body politic, and thus had to carry revolutionary values.

Revolutionized Medical Education for All

12 Castro, Fidel. “En La Apertura Del Instituto De Ciencias Basicas Y Preclinicas ‘Victoria De Giron’,” (Speech, Marianao, October 17th, 1962), Discursos e intervenciones del Comandante en Jefe Fidel Castro Ruz, Presidente del Consejo de Estado de la República de Cuba, Latin American Network Information Center, <http://www.cuba.cu/gobierno/discursos/1962/esp/fl71062e.html>. And Fidel Castro, *Speech at the Ceremony Inaugurating the Basic Science and Preclinical Institute at Cubanacan*, (October 17th, 1962).

13 Ibid.

14 “La Nueva Promocion Medica” *Noticias de Hoy*.

Manifestations of these visions were well underway by 1963. Medical school was much cheaper than before. At this early stage, medical school was not yet entirely tuition-free, although scholarships were widely available, encouraging enrollment by students of all classes. In medical school, students took classes on Marxist philosophy and guerilla warfare.¹⁵ Until 1965, the “pre-internship” programs were shortened by as much as two years to accelerate production of new doctors. There was also an increase in the number of teaching hospitals and hospital internship became a requirement of medical students, whereas in the past, students could have graduated without ever treating a patient. Lastly, the curriculum incorporated public health and other useful topics in preparation for the rural medicine service.¹⁶ From 1958 to 1965, the number of doctors and dentists went from 1,375 to 6,797. By 1963, there were 122 medical centers and 42 hospitals built in rural areas that previously lacked access to care.¹⁷

Castro implemented a new requirement for recent medical school graduates that was effectively socialism in practice, but the socialist values medical students had made fulfilling this requirement easy. Mandatory rural medical service in which doctors would be required to live and provide care in rural areas of Cuba for around one to two years successfully brought medicine to parts of Cuba that never had access to it before. Under Batista, the

rural and urban populations of Cuba were very unequal especially in terms of access to healthcare; more than half of Cuba’s physicians were in Havana, and many residents of rural areas were malnourished and lived far from any medical facility.¹⁸ In a 1966 speech Castro says:

Up until 1958, the campesinos completely lacked any medical assistance. Not only was

there not a single rural hospital, but they did not have access to the services of a doctor, not even a private one. That is to say, rural medicine did not exist at all in our country, and almost 50% of our population lived in rural areas. After the triumph of the revolution, medical assistance for the campesinos was extended to practically all rural areas through 95 hospital centers and dispensaries.¹⁹



"THE ACADEMIC AND TECHNICAL PROGRAMS TYPICALLY DEAL WITH COMMON THIRD WORLD PROBLEMS AS BASIC EDUCATION, PUBLIC HEALTH, AGRICULTURE, AND INFRASTRUCTURE DEVELOPMENT."

15 Ross Danielson, *Cuban Medicine* (New Brunswick: Transaction Books, 1979), 140.

16 Ibid, 135 and “La Nueva Promoción Médica,” *Noticias de Hoy*.

17 Danielson, 133.

18 C William Keck and Gail A Reed, “The Curious Case of Cuba,” *American Journal of Medicine*, August 2012, <https://pmc.ncbi.nlm.nih.gov/articles/PMC3464859/>

19 Fidel Castro, Acto Clausura del XI Congreso Médico y VII Estomológico Naacional, (Speech, Chaplain Theater, Havana, February 27th, 1966), Discursos e Intervenciones del Comandante en Jefe Fidel Castro Ruz, Presidente del Consejo de Estado de la República de Cuba, Latin American Network Information Center, <http://www.cuba.cu/gobierno/discursos/1966/esp/1260266e.html>, trans. Paulina Tein.

This drastic increase in rural hospitals was staffed by a new crop of doctors who from humble origins with revolutionary values. Recent medical graduates were quoted in a 1964 article in the Cuban paper *Noticias de Hoy* saying, “We are physicians at the service of the people...With pride we will go to the mountainous regions to provide medical attention to the “*campesinos*”.”²⁰ Castro was setting up a system that was life-changing for the rural population in which “*campesinos*” themselves were running to help their “brothers,” and this was just as he had promised to do. For most rural citizens, Castro was undeniably improving their access to healthcare and right to longevity.

Though Cuba claimed these rapid and radical advances were underway, evidence suggests the population’s health was neglected in the process. A 1968 Central Intelligence Agency report titled “The Truth about Public Health in Cuba” logged in the Congressional Record bemoaned concerning rates of morbidity, pre-natal deaths, mental illness, and water pollution caused by infrastructural faults and insufficiently trained doctors. The report cited Cuban nurse Jose Antonio Guethon Lahera “who until March 1968, was in charge of the laboratory in the Santiago de Cuba general hospital in Oriente province.” Guethon Lahera cited examples suggesting widespread failure:

*Out of every 100 tests made for hepatitis, 30 per cent were positive in 1966; in 1967, 33 per cent were positive; between January and March of 1968 40 per cent were positive. This is due to poor or non-existent hygiene in homes, overcrowding everywhere and the absence of medicines to treat the disease in its early states. Hospitals are so over-crowded that except in the most severe cases, the diagnosed patient is returned to his home, thus spreading the disease to other members of his family. The blood bank also spreads infections.*²¹

This testimony rings in stark contrast to Castro’s claims in his speeches and even what was reported by US journalists. While some diseases were near eradication, others threatened to become epidemic. Crowded health care centers had been an issue, but it was expected to be resolved as the physical infrastructure caught up with the conceptual plans and more space was created. According to Guethon Lahera, overcrowding was still an issue to the point where it was affecting the health of others. The report also documented an interview of psychiatrist Dr. Lisandro Diaz Torres who said that the “uncertainties of daily life,” like looking for food and clothing, contributed to an increase in mental illness, while a lack of psychiatric medication and inability to remove the patient from the stressful environment kept morbidity high.²² The record also claimed that “Recent and current medical and dental graduates cannot be considered doctors or dentists by any accepted standard.” Medical training was a series of “crash courses” in medical school,

20 “La Nueva Promocion Medica: Llevaron sus diplomas el galardón de la renuncia del ejercicio privado de la profesión,” *Noticias de Hoy*, (Havana, Cuba: September 12, 1964).

21 Central Intelligence Agency, “The Truth about Public Health in Cuba,” *Congressional Record – Senate*, September 11th, 1968, approved for release December 14, 2005, <https://www.cia.gov/readingroom/docs/CIA-RDP70B00338R000300180008-8.pdf>.

22 Ibid.



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"

then “a sort of on-the-job training without professional supervision, turning out ‘new doctors’ whose poor patients pay the price- often with their life,” indicating that Castro’s goal of rapidly producing more doctors was undermined by the fact that these “new doctors” were poorly trained.²³ These testimonies put other accounts of the status of the medical system into question and made it seem like the large and radical changes Castro made were done hastily.

Radical Changes Continue

Regardless of these shortcomings, Castro wanted to extend the reach of revolutionary medicine beyond the *campesinos*. Just a couple years after the revolution, Castro already planned to send doctors abroad to help people who had also been exploited by imperialist countries. Medical aid missions could last months, but they were not permanent. Cuba extended the longevity of its aid by providing medical training scholarships to foreign students at Cuban universities, an opportunity it continues to offer today. “The Truth about Public Health in Cuba” outlines ambitious plans to extend training to foreigners:

In general, Havana has a long-range view of its investment. Cuban-educated returnees rarely achieve leadership positions at once, but they tend to act as goodwill ambassadors for Cuba, publicizing Havana’s commitment to Third World development. They also return home with skills for which their countries depend largely on foreigners. Cuban-trained native doctors, agriculturalists, and teachers have replaced foreigners in Angola, Mozambique, and south Yemen.²⁴

This CIA report identified that training foreign students was a great way to promote communism through proletarian internationalism. Further, medical training programs acted as a kind of advertisement for Cuba’s strides in medical education. In 1977, there were 341 medical and 40 dental foreign students enrolled in Cuban schools.²⁵ A 1980 CIA report on the topic found that foreign students receiving scholarships to study in Cuba, like locals, were required to take classes on Marxist-Leninist philosophy and the Cuban perspective on world history.

In addition to medical training, Cuba offered other academic scholarships. Foreign student enrollment exploded in the late 1970’s when more schools were built: 21 of 60 schools in Cuba were dedicated to foreigners. In the year 1984, there were an estimated 26,000 students from aid recipient countries studying in

²³ Ibid.

²⁴ Central Intelligence Agency, “Cuban: Educating Future Third World Leaders,” November 3, 1980, approved for release April 18, 2008, 8, <https://www.cia.gov/readingroom/docs/CIA-RDP-91B00135R000500820066-6.pdf>.

²⁵ Ibid, 6-7.

Cuba, typically on full scholarship.²⁶ The program educated people on Cuban ideas that students could apply at home:

*The academic and technical programs typically deal with common Third World problems as basic education, public health, agriculture, and infrastructure development. Up to 500 students are enrolled in programs that emphasize ideology, political organization, journalism, and propaganda.*²⁷

Students who came to Cuba with applicable knowledge on how to help their communities, but also with an appreciation for the communist ideologies that enabled Cuba to provide this free education.

However, this did not always yield a positive response. The same 1980 report explained: “Disaffected students from Sierra Leone recently occupied their embassy in Havana to protest living conditions in Cuba. A few weeks ago, Dominica refused to accept Cuban scholarships for the 1980-81 school year because it feared that students were being propagandized.”²⁸ The rejection of Cuban education based on fear of indoctrination of communist values echoes reasons why Cubans defected starting years prior.

The impact of the mass training of doctors was felt not just on the island, but perhaps even more so abroad. The ideology of the Cuban revolution involved not just community for Cubans, but extended to other countries that had supported the revolution or were experiencing similar struggles. For the doctors themselves, going abroad felt as meaningful as serving the Cuban population because it meant they could demonstrate the success of Cuba and even contribute to similar revolutions abroad. For some, medical school was postponed due to the turbulent environment leading up to the revolution. But thanks to the revolution’s success and its commitment to improving the population’s health and access to care, those already looking to attend medical school (in addition to many more) were able to do so. Doctors recognized that the revolution was what enabled them to have their career, and some felt even indebted to it. That is why some chose to participate in missions before even knowing where they would be going or what that would entail.

Chapter 2: "Wherever the Revolution Needs Me"

Motivations for Diplomacy

Che Guevara was a main actor in the Cuban revolution alongside Castro, but his agenda was always bigger than just one country’s revolution. Though he technically held government positions until 1965, he was already planning how to spread the

²⁶ Central Intelligence Agency, “Castro’s Reach into the Third World,” 4-5.

²⁷ Ibid, 5.

²⁸ “Cuban: Educating Future Third World Leaders,” 3; 8.

revolution to other Latin American countries before then, while turning his attention away from internal matters resulting from the Cuban revolution.²⁹ Further, his inability to comply with “practical policies” recommended by the Soviet Union seemingly made it easy for Castro to “drop” him.³⁰ Following the success of the Cuban revolution he assumed the roles of President of the National Bank and Minister of Industries. By 1963, the Cuban economy was at its lowest since the Castro regime began, and it was evident that Castro needed to turn to other advisors and scale back on Guevara’s industrialization plan.³¹ Thus in 1965 he went to Congo to pursue revolutionary action, but not entirely without the support of Cuba. Guevara had participated in Cuban medical aid missions previously, but this time he would be leading a mission with its primary focus on overthrowing the local government with support from Cuban doctors (and militants/soldiers?).

To the public, Castro emphasized the motives for sending doctors abroad as paying a debt to humanity (proletarian internationalism) and showing the world Cuba’s success in an excerpt from his 1962 speech:

Figures show that life [expectancy] in the United States averages 74 or 75 years, while that of Asia and Africa is 30 years... The cause of this is simply poverty and the lack of basic necessities. This means that a large part of humanity is virtually murdered by the exploiters... Unscrupulous people like the reactionaries have tried to injure our pueblo in that field. It is very logical that we Cubans take great interest in reducing child mortality rates and in increasing the average lifespan of each citizen. There can be no more legitimate

aspirations than these... That is why we, when talking with the students, told them that there is a need for fifty volunteer doctors to go Algeria and help the Algerians (Applause)... Today we can send fifty; within eight or ten years we do not know how many, and we can help our brother pueblos because with each passing year we will have more doctors and with each passing year more students will enter medical school because the revolution has the right to harvest what it plants and has the right to gather the fruits it has planted. (Applause)³²



"DR. HECTOR VERA ACOSTA DESCRIBES LIFE IN CONGO AS MONOTONOUS. EACH MORNING, DOCTORS WOULD SEE PATIENTS IN A SIXTEEN SQUARE METER SHACK. DOCTORS SLEPT IN HAMMOCKS IN SHACKS AND FOOD WOULD BE COOKED OVER FIREWOOD AND STONES..."

29 The National Security Archive. *The Death of Che Guevara: Declassified, National Security Archive Electronic Briefing Book No. 5: The Death of Che Guevara: A Chronology*. Compiled by Paola Evans, Kim Healley, Peter Kornbluh, Ramón Cruz, and Hannah Elinson. Accessed April 1, 2025. <https://nsarchive2.gwu.edu/NSAEBB/NSAEBB5/index.html>.

30 Central Intelligence Agency, “The Fall of Che Guevara,” October 18, 1965, <https://nsarchive2.gwu.edu/NSAEBB/NSAEBB5/docs/doc01.pdf>

31 *Ibid.*

32 Castro, Fidel. “En La Apertura Del Instituto De Ciencias Basicas Y Preclinicas ‘Victoria De Giron’,” <http://www.cuba.cu/gobierno/discursos/1962/esp/fl71062e.html> and Fidel Castro, *Speech at the Ceremony Inaugurating the Basic Science and Preclinical Institute at Cubanacan*, (October 17th, 1962).

Castro expresses concern for the short life expectancy in foreign countries as compared to that of the U.S.. Castro interpreted this difference as an act of murder committed against citizens of countries in the global south and stands in solidarity with them, having just achieved freedom from the grasps of western imperialism that had led to poverty and poor health. He believed that the right to health was the same as the right to live which is why he had to intervene. His ambitious plans to rapidly increase medical aid to foreign countries foreshadowed the years of medical diplomacy that would follow and followed his agenda of proletarian internationalism. However, in his speeches, Castro left out the military role that doctors played in these missions.

Castro also did not explain to the public other motives for sending foreign aid such as economic and political ones. A CIA report explains:

Although political rewards are difficult to quantify, they sometimes manifest themselves immediately in foreign support for Havana's foreign policy goals in international organizations. Cuba's allies, for example, have circulated propaganda in their countries denouncing the Cuban refugees in the United States and the US presence at Guantanamo Bay. The extent of this type of influence, however, is limited. The leadership in Havana also is aware that timely offers of assistance can produce a financial return at some later date. For example, Mozambique has granted Cuba fishing rights off its coast in exchange for the education of its students.³³

This indicates that there were some other benefits to sending aid, but also implies that it was easy for missions to appear altruistic. However, financial assistance was not Cuba's primary goal. To quote Guevara in "On Revolutionary Medicine" yet again, "...that much more definitive and much more lasting than all the gold that one can accumulate is the gratitude of a people. And each doctor, within the circle of his activities, can and must accumulate that valuable treasure, the gratitude of his people."³⁴ Cuba typically sent technicians for free, paying for their salary while the host country would provide a stipend, food, and other accommodations.³⁵ The political rewards, though "difficult to quantify" aligned

with Castro and Guevara's proletariat internationalist vision and were the primary focus of aid missions.

Countries received Cuban services in medicine, military assistance, construction, and education.³⁶ Military assistance was often reserved for countries with Marxist regimes such as Angola, Ethiopia, and Nicaragua, or as in the case of Congo, Cuban soldiers

33 Central Intelligence Agency, "Cuban: Educating Future Third World Leaders," 6-7.

34 Guevara, "On Revolutionary Medicine."

35 Central Intelligence Agency, "Castro's Reach into the Third World: The Cuban Economic Assistance Program," May 1985, approved for release January 11, 2010, 8, <https://www.cia.gov/readingroom/docs/CIA-RDP86T00586R000300410004-9.pdf>.

36 Ibid, 2.



"DR. AMADO ALFONSO DELGADO RECALLS BEING REGULARLY ATTACKED IN GUINEA BISSAU AND EVEN SPENDING A FULL DAY OUTRUNNING NAPALM PLANES."

attempted to replace the current government with a socialist one.³⁷ While some countries received exclusively medical aid, it was perhaps more common for medical providers to accompany soldiers on military aid missions. In 1984, there were over 19,000 Cuban technicians in thirty-two countries, with Marxist countries receiving several thousand technicians. The CIA estimated that over three quarters of technicians were serving in non-military roles.³⁸ The CIA estimated a value of \$400 million dollars in aid given from 1975-84.³⁹

Cuba was already relying heavily on the Soviet Union financially, so limiting hard currency costs was ideal. In sending medical personnel and other aid workers abroad instead of money, Cuba was spending mostly just the salary of each worker.⁴⁰ Doctors abroad typically received a stipend from Cuba and the host country would provide them with “housing,” which in some cases was quite humble depending on the mission. While in most instances, Cuba provided aid at no cost to the recipient countries, a push from the Soviet Union to become financially independent meant some of these missions paid. Cuba even received as much as \$100 million in a year from providing several forms of aid to countries rich in oil, including Algeria, suggesting that not only were there financial motives to providing aid, but Cuba was perhaps spending more than it should, given the state of health on the island.⁴¹ Overall though, this was a net loss financially for Cuba, meaning there were other motivations that Cuba valued more.



"DR. OMAR PRUDENCIO MARTÍNEZ HERRERA... DESCRIBES SEEING A YOUNG MAN WHO HAD TO HAVE THREE LIMBS AMPUTATED AND LOST HIS VISION. HE WAS ABLE TO OPERATE ON HIM AND SAVE HIS LIFE... PEOPLE SPEAK OF WAR WITHOUT KNOWING WHAT THE GREAT TRAGEDIES AND HORRORS MEAN FOR THOSE WHO SUFFER FROM IT."

In 1962, Cuba issued a decree that would allot \$247 million a year to the military, a near \$200 million increase from Batista's regime's budget. In the years following, Castro installed forty-three guerilla training camps.⁴² By 1968, funds that should have been used for housing, hospitals, sewage systems, and water supply were diverted to the military budget.⁴³ Post-revolution Cuba had a dedication toward its military, which did not only serve the island of Cuba but provided military aid to other countries. Proletarian

37 Ibid, 7.

38 Ibid, 2-4.

39 Ibid, 9.

40 Ibid, 9 and Feinsilver, "Fifty Years of Cuba's Medical Diplomacy," *Health Travels*, 113.

41 Central Intelligence Agency, "Castro's Reach into the Third World," 11.

42 <https://www.cia.gov/readingroom/docs/CIA-RDP70B00338R000300180008-8.pdf>

43 Central Intelligence Agency, "The Truth about Public Health in Cuba."

internationalism, the Marxist concept that describes the universal struggle of proletarian classes as one single struggle, was the motivation for sending free aid to other nations that supported the Cuban revolution or were experiencing similar political struggles. While sometimes Cuba sent medical aid specifically to areas experiencing a disaster or outbreak of disease, medical aid also accompanied military aid in areas of combat. Medical aid in these situations represented Cuban revolutionary success and bolstered a strengthened military. Though delivering medical services was not always the primary goal of these missions, doctors did make an impact on the people they treated and on Cubans at home.



"TODAY, CUBAN DOCTORS WHO TRAVEL ABROAD ARE PAID THE EQUIVALENT OF \$125-325 PER MONTH. BUT EVEN THIS LOW SALARY IS A RAISE FROM THE TYPICAL \$15-30 RANGE FOR DOCTORS ON THE ISLAND, SHINING LIGHT ON A MOTIVATING FACTOR FOR GOING ABROAD..."

The question of which doctors went abroad was a matter of character and experience. While rural medical service was required, going abroad was seen as a special privilege and was reserved for those committed to the revolution's values. In *Historias Secretas*

de Médicos Cubanos (2005), Hedelberto López Blanch, a Cuban journalist known for his work about Cuba and its relation to other countries, documented interviews of Cuban doctors who participated in the very first medical missions. Interviewees acknowledged physical, emotional, and intellectual challenges, and even the fact that they were often risking their lives, but they expressed that they felt it was worth it to serve the country that enabled them to be doctors. Some were selectively interviewed at the Ministry of Public Health and told they would be going to provide care outside of Cuba but with few other

details. These missions were confidential and planned amongst high-ranking government officials; from these interviews, it seems missions were simply referred to as "*la misión*" without any official title. It at least the first mission to Congo, Fidel and Raúl Castro even personally interviewed doctors upon their return about the successes and failures of the mission.⁴⁴ Dr. Rafael Zerquera Palacios, one of just a few doctors who went to Congo in 1965 who worked closely with Guevara, explained that when he filled out his registration for the mandatory rural medical service he had to indicate where he preferred to fulfill his service. He simply put "wherever the revolution needs me," and explained that because the Cuban revolution enabled him to graduate medical school and become a doctor, he was willing to go wherever he could to give back to the revolution.⁴⁵ The interviews in this book detail a variety of experiences abroad but all with the theme of the doctor as a revolutionary hero.

44 López Blanch, *Historias Secretas de Médicos Cubanos*, Havana: Centro Cultural Pablo de la Torriente Brau, 2005, 38-39 trans. Paulina Tein.

45 Ibid, 22.

As discussed in chapter one, there were new revolutionary incentives for becoming a doctor. Many students were already enrolled in medical school when Castro came to power, but their studies were put on hold during the turmoil of the revolution; they credited Castro for their return to studies. Many students began their medical career *because of* the revolution. Castro not only enabled students to return to medical school but gave out scholarships and stipends to encourage new students to enroll. Dr. Julián Álvarez Blanco, an interviewee in *Historias Secretas de Médicos Cubanos* (2005) by Hedelberto López Blanch, was a member of the revolutionary military before he was a medical student. Dr. Álvarez Blanco joined the 26th of July Movement and led the attack on April 9th, 1958. He was motivated by the killing of Cubans during la Limpia del Escambray and the Bay of Pigs to attend medical school but simultaneously maintained a job at an electric company. In 1963, he heard that he could receive a stipend from the government to go to school and left his job.⁴⁶ Dr. Álvarez Blanco is an example of the many people who were both motivated by and enabled to attend medical school because of the revolution and would go on to be a revolutionary doctor. Moreover, he was one of many doctors who had a military role. While Castro made it seem like the first medical missions were purely to help those less fortunate, they were primarily to provide medical care to Cuban and local soldiers fighting abroad.

Roberto Fong Sorribes documented the stories of Cuban doctors in *Médicos Combatientes* (2004). The name of the book, which translates to “fighting doctors,” itself supports the notion that these doctors did not just go abroad to provide medical care, rather they were a component of missions to overthrow local governments. This notion of “fighting doctors” seemed to be unique to Cuba and developed because Guevara was posed as a role model. In the book, Sorribes wrote that Castro emphasized that Che Guevara was a model for Cubans. In a speech memorializing Guevara soon after his assassination, Castro says: “If we want to express how we aspire our revolutionary fighters, our militants, our men to be, we must say without any hesitation: that they be like Guevara.”⁴⁷ This speech, addressed to “*el pueblo*,” or all Cubans, identifies Guevara as a role model. Evidently from interviews with doctors, they too saw Guevara as a role model. Furthermore, Guevara emphasized that doctors must work not for money, but to be fulfilled by knowing that they helped someone in need. With Guevara posed as the ideal, doctors would be inclined to abide by his call for doctors working for gratitude rather than money.

Life on a Medical Mission

In early missions, doctors would often be unaware of the specific military goals of their missions. López Blanch asked interviewees if they went through any form of training before

⁴⁶ Ibid, 87.

⁴⁷ Guevara, “On Revolutionary Medicine,” qtd in Roberto Fong Sorribes, *Médicos Combatientes*, (Santiago de Cuba: Edital Oriente), 2004, 86, trans. Paulina Tein.

embarking on their mission, and many said no. Dr. Zerquera Palacios recounts finding out that the Patrice Lumumba's Liberation Movement had requested help from Cuba once he was already in Congo.⁴⁸ On the other hand, some were already military doctors.⁴⁹ The primary purpose of the Congo mission (1965), one of the first official Cuban medical missions, was to overthrow Moise Tshombe and support Mobutu in becoming the next leader. Once there, doctors would sometimes be on the battlefield.⁵⁰ The secrecy attached to being onboarded to such missions and the fact that Guevara had doctors follow him onto the battlefield reveal that the role of doctors in early missions was to attend to those wounded in battle in addition to providing general care for locals. Further, in Che Guevara's *Congo Diary* (published 1997) Guevara describes Dr. Zerquera had military-like responsibilities such as being "on the alert," and he included a letter addressed to both him and Dr. Zerquera with updates about an attack.⁵¹

Sometimes however, life was more calm, but Dr. Hector Vera Acosta wanted to be a part of the action. Dr. Hector Vera Acosta describes life in Congo as monotonous. Each morning, doctors would see patients in a sixteen square meter shack. Doctors slept in hammocks in shacks and food would be cooked over firewood and stones, Dr. Vera remembers. They would go to the river every fifteen days to bathe and wash clothing. They would also learn French in the evenings to better communicate with patients.⁵² The daily routine of breakfast, treating patients, evening meal, French, and sleep felt very monotonous for Dr. Vera. With monotony and lack of progress toward Congolese liberation, Dr. Vera and a few others even decided to ask Guevara to be moved closer to the fighting or to Vietnam. Gradually they began to do physical training, though mostly for fun, but eventually Guevara commissioned Dr. Vera to a new mission.⁵³ Dr. Vera's ambition confirms his drive as a revolutionary doctor to risk his life for the revolutionary missions.

Dr. Zerquera describes the lack of happy moments in Congo. He recalls, "In Congo, there was no joy at all."⁵⁴ Zerquera says that the single happy moment for him was when he first saw Guevara and found out it was really him; Castro had told Zerquera he would receive a surprise in Africa, and this was it. He continues to say that he also felt happiness when Guevara miraculously recovered from sickness.⁵⁵ While early missions were serious, it seems later missions became more horrific. Dr. Amado Alfonso Delgado recalls being regularly attacked in Guinea Bissau and even spending a full day outrunning napalm planes. He sincerely thought he was about to die.⁵⁶ Dr. Omar Prudencio Martínez Herrera went to Angola and describes seeing a young man who had to have three limbs amputated and lost his vision. He was able to operate on him

48 López Blanch, 28.

49 Ibid, 155.

50 Ibid, 61.

51 Che Guevara, *Congo Diary*, 49 and 169.

52 López Blanch, 44.

53 Ibid, 46.

54 Ibid, 37.

55 Ibid.

56 Ibid, 143 and 145-146.

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and save his life. Dr. Martínez Herrera tells López Blanch: “That is why I repeat to you that sometimes people speak of war without knowing what the great tragedies and horrors mean for those who suffer from it.”⁵⁷ From these stories it becomes apparent that these were not just people who called themselves military officers but actually experienced the horrors of war. Dr. Zerquera recalls an interview with Raúl Castro upon his return to Havana. Raúl says to him, “It wasn’t easy. You had never been anywhere.” Dr. Zerquera responded, “No commander, I’m not a military officer.”

“Well you weren’t a military officer.”

“Yes, that’s right. I’m very happy, I don’t have any problems. And further, I’m going to be one of the few officers who joined the army directly through you.”⁵⁸

Dr. Zerquera’s acceptance of his new title shows how the missions changed the definition of “doctor.” Dr. Zerquera agreed to go abroad without knowing what challenges he would face, but he was so passionate about and grateful to the revolution’s values that he was willing to go anyway. After a journey filled with close to no happy moments and seemingly no reward, the mission felt like a failure. But Guevara’s writing helped Dr. Zerquera realize that this mission was not just for Congo, it was to inspire the people of other African countries who did eventually succeed in their fight for liberation.⁵⁹ Cuban doctors followed in Guevara’s footsteps as a soldier-doctor who helped others in many ways.

Outcomes

In 1977, in six countries over half of all physicians were Cuban.⁶⁰ Among these countries were Guinea-Bissau, which was facing political instability that would lead to a 1980 coup d’etat, and South Yemen, which also faced internal political tensions and was strongly influenced by Soviet Marxism. These were and still are among the poorest countries.⁶¹ In countries such as Ethiopia, Cuba was also providing military support.⁶² The Congo mission was largely considered a failure. Guevara himself opens his *Congo Diary* by saying so. While the doctors were able to care for many locals, that the primary purpose was military meant that there was no success absent change in government. In Nicaragua however, Cuba assisted the establishment of the revolutionary *Sandista* government, and “hundreds of Cuban personnel have been placed at the central decision-making level in nearly every other sector of

57 Ibid, 191, trans. Paulina Tein.

58 Ibid, 39, trans. Paulina Tein.

59 Ibid, 37.

60 Paul Grundy and Peter Budetti, *The Distribution and Supply of Cuban Medical Personnel in Third World Countries*, 1980, Public Health Briefs, 718.

61 In 1977, according to UN estimates, Guinea-Bissau was the 133th poorest country and South Yemen was ranked 180th. Cuba was ranked Number 75. At least some of this data appears to have been self-reported. Via Nations, United. 2025. “Metadata - AmaWebClient.” Un.org. 2025. <https://unstats.un.org/unsd/snaama/Metadata/?countrycode=192&groupid=101..>

62 Grundy and Budetti, 718.


Nicaraguan society.”⁶³

There is an overarching dichotomy between the humanitarian aid given to people in foreign countries and the human rights violations of Cuban citizens. This dichotomy leads one to question the motives of giving aid, which appears to be an effort to write a narrative about Cuba that describes it as a success and a power. For many, the ability to send medical aid to a foreign country is a sign of the revolution’s success. This coupled with Guevara’s agenda of inspiring revolutionary ideas in the people of the countries receiving aid indicates that the objective of medical missions was purely for the benefit of Cuba’s reputation as an autonomous communist country capable of being on the same playing field as imperialist countries. Further, the missions should not even be considered medical missions since often doctors were only there to accompany Cuban military troops.

Given the financial burdens Cuba was already facing at home, it is no surprise that the doctors were paid extremely low salaries, and that has continued to be the case to present day. Today, Cuban doctors who travel abroad are paid the equivalent of \$125-325 per month. But even this low salary is a raise from the typical \$15-30 range for doctors on the island, shining light on a motivating factor for going abroad.⁶⁴ Of course this criticism comes

from a capitalist lens: *But how then are these doctors rewarded for their efforts?*

Doctors interviewed by López Blanch would probably say they would do the work they did for any amount of money. Doctors today are sometimes going abroad as volunteers, only provided with a living stipend by the host country. In an interview, Dr. Rotceh Rios Molina recalls finding out that volunteers from other countries or sent by



"'ENEMIES OF THE STATE' WHO REFUSED TO PARTICIPATE IN CASTRO'S POLICIES COULD HAVE THEIR LIBRETA (RATION CARD) TAKEN AWAY... MANY SPOKE OF 'DISCONNECTING THE MIND' AS A WAY TO COPE WITH LACK OF GOOD FOOD AND LIVE IN A CONSTANT STATE OF STRUGGLE."

the World Health Organization were actually receiving a salary while he was working for free during the Ebola outbreak in 2013. Dr. Jose Angel Sanchez reveals that the doctor’s salary would sometimes go directly to the Cuban government, which he found out after a 2015 mission to Venezuela. Doctors were sent abroad with the promise that they would return home (to a new car, as some were promised) and be regarded as heroes by their country, which echoes the same ideology as the early missions.⁶⁵

Values of patriotism and proletarian internationalism echo

63 CIA, “Castro’s Reach into the Third World.”

64 Harvard International Review, “Medical Servitude: The Other Side of Cuban Medical Diplomacy,” *Harvard International Review*, last modified April 7, 2025, <https://hir.harvard.edu/medical-servitude-the-other-side-of-cuban-medical-diplomacy/#:~:text=Wages%20for%20those%20overseas%2C%20from,going%20to%20the%20Cuban%20government>.

65 ReasonTV, “Cuban health care is a catastrophe,” April 18, 2022, <https://www.youtube.com/watch?v=FeRKlsc3zNg>

from early Cuban medical internationalism to today's missions. But analyzing present-day missions also enables a better understanding of the past. There is still much that remains unclear about what it was like for doctors participating in early missions, and the sources that do exist come from sources that may not be at liberty to disclose all details given that they come from a country with censorship on media and intends to continue medical diplomacy programs. Regardless, the doctors Cuba sent abroad in the 1960's who were willing to risk their lives for revolutions in Cuba and elsewhere are a far cry from the doctors who use medical diplomacy to defect from Cuba.

Chapter 3: Runaway Doctors

A Cuban Exodus

In 1963, Dr. Gustavo Mestas escaped Cuba with his daughter on a boat headed toward Florida. When asked why he left, Dr. Mestas explains, "When Fidel started this revolution, even the churches were ringing the bells. Everybody was so happy. But after a while, you saw there was no salute. You said, 'Jesus, this is not good for my children.'" Dr. Mestas was an orthopedic surgeon in Cuba before he defected by means of escape, which included hiding from the Soviet guard.⁶⁶ Only about 60 of 900 applicant physicians were permitted to leave Cuba each year.⁶⁷ Once in the U.S. he worked in a tomato field, cleaned in a motel, and at night walked 57 blocks to medical school.⁶⁸ When Dr. Mestas arrived in the U.S., he was not able to practice as a surgeon until he learned English, passed the exam for foreign medical graduates ("*el Foreign*") and redid residency.⁶⁹ Dr. Mestas was unsure if he would even be able to practice medicine in the U.S. at all, but the risks and sacrifices he made to take his family out of Cuba show that for some, the revolution did not yield a better Cuba.

While Cuba extended the fruits of its revolution to healthcare abroad, not everyone benefited at home. It became more apparent that Cuba was sending aid at the expense of its own people. In one of the most blatant instances of sacrificing the health of Cubans for foreigners, in a time of medication scarcity, Cuba sent away American medicines to Algeria:

... in 1964 the Cuban ship Sierra Maestra sailed from the port of Matanzas to Algeria, loaded with American manufactured medical supplies, much of which was given to Cuba in 1962, and 1963 as ransom in the exchange of Bay of Pigs, prisoners for

66 Rene Montagne interview with Dr. Gustavo Mestas and Ileana Smith, "Cuban Doctor Found Home, Healing in U.S.," NPR Story Corps, August 15, 2008, <https://www.npr.org/transcripts/92650667?ft=nprml&f=93597183>

67 Special to *The New York Times*, "Cuban Physicians in U.S. Increasing: Some Exiles Study in Spain to Escape Costs Here," *New York Times* (1923-), Dec 10, 1969, <https://www.proquest.com/newspapers/cuban-physicians-u-s-increasing/docview/118488169/se-2> (accessed April 6, 2025).

68 Montagne, "Cuban Doctor Found Home, Healing in U.S."

69 "Gustavo A. Mestas, Esteemed Physician," *Cape Gazette*, January 24, 2018, <https://www.capegazette.com/article/gustavo-mestas-esteemed-physician/149945>.

*medicines. While the ship was being loaded, stevedores tore open some of the cartons and found medicine so desperately needed for the Cuban people, protested, and were taken away to one of Castro 87 concentration camps.*⁷⁰

From this story, Cuba was not helping Algerians because it had excess resources, rather it was doing so by neglecting its own people it had promised to care for. The report continues to explain that Cuba stopped issuing health statistics because they had declined in recent years.⁷¹ Just a few years later, the Inter American Commission on Human Rights (IACHR) came out with a report that found Cuba to be in violation of several human.⁷² Beginning in 1963, Castro implemented a draft for all men aged eighteen to forty-five. Not everyone was trained to become a military officer, instead some were required to do physical labor. In 1965, Fidel and Raúl Castro implemented Military Units to Aid Production (UMAPs) which were forced labor camps for those who objected to Fidel Castro and communism, presented as part of the queer community, or of certain religions.⁷³ The IACHR report also holds Cuba accountable for the assassination of political prisoners, maltreatment of prisoners including women and minors, and the harvesting of blood from prisoners just before their death.⁷⁴ Military draftees and laborers were also required to give 300 grams of blood every three months. Cubans did not significantly benefit from the blood bank as plasma was normally shipped to the communist Democratic Republic of Vietnam.⁷⁵

Those who left avoided two financial crises that would have exacerbated these concerns. But a failed sugar production plan caused an economic crash in the 70's and led to another wave of immigration and the Mariel Boatlift (1980). Since 1962, Cuba has had a food rationing system in which each citizen receives a "*libreta*" or card to obtain a minimal amount of food.⁷⁶ "Enemies of the state" who refused to participate in Castro's policies could have their *libreta* taken away.⁷⁷ Often but especially following economic crashes this ration is insufficient to prepare Cuban cuisine, which many interviewees point to as crucial to their identity. Purchasing food outside of the ration was referred to as *la lucha* ("the struggle") and involved shopping at markets (going from market to market for multiple hours) but also the black market where people could purchase food meant to be served to tourists at hotels. She said many interviewees spoke of "disconnecting the mind" as a way to

70 Central Intelligence Agency, "The Truth about Public Health in Cuba."

71 Ibid.

72 Comisión Interamericana de Derechos Humanos, "Capítulo Uno: Violaciones de los Derechos Humanos en Cuba," Informe Sobre la Situación de los Derechos Humanos en Cuba, <https://www.cidh.org/countryrep/cuba67sp/indice.htm>.

73 Julie Marie Bunck, *Fidel Castro and the Quest for a Revolutionary Culture in Cuba*, (Penn State Press, November 1, 2010), 134-135.

74 Comisión Interamericana de Derechos Humanos, "Capítulo Uno: Violaciones de los Derechos Humanos en Cuba."

75 Central Intelligence Agency, "The Truth about Public Health in Cuba."

76 Hanna Garth, "Disconnecting the Mind and Essentialized Fare: Identity, Consumption, and Mental Distress in Santiago de Cuba," essay in *Health Travels: Cuban Health(Care) on and off the Island*, edited by Nancy J Burke. (San Francisco, California: University of California Medical Humanities Press in partnership with California Digital Library, 2013).

77 Central Intelligence Agency, "The Truth about Public Health in Cuba."

cope w lack of good food and live in a constant state of struggle.⁷⁸

As previously discussed, U.S. research found that the health statistics in Cuba were not only exaggerated but overlooked other markers that showed major setbacks in public health.⁷⁹ Cubans living in the US sometimes sent medicine to their relatives on the island.⁸⁰ Despite this, continue doing medical missions abroad since they were “low-cost.”

Cubans fled to the U.S. for political, economic, geographic, and legal reasons. Hernandez and Perry identify four waves of Cuban immigration to the U.S., each characterized by different reasons for leaving and often associated with different races. The first two waves, defined in a 2024 journal article, “Early Cuban Exiles” (1959–1962) and “Freedom Flights,” (1965–1973) were mostly white people of all classes, whereas the second two waves involved people of all races and lower-class people, as they were not satisfied by the reforms.

The U.S. was typically the destination for defection because, at certain points, Cubans could claim refugee status and there were specific programs for doctors to gain citizenship. Other Latin American countries had their own turmoil and/or were targets of Cuban aid missions which made them unfavorable destinations. Cuban doctors sacrificed a lot to come to the U.S.; like Dr. Mestas, they would often work non-medical jobs while becoming recertified in the U.S. or doing refresher courses. Medical students still had to pay tuition to complete their studies, some even went overseas to Spain for cheaper tuition and living costs only to return to the U.S. again and practice there.⁸¹

Re-certification and Illegal Practice in Miami

While the first two waves of post-revolution immigration consisted of mostly white and upper-class Cubans, those who came around the time of the Mariel Boatlift (1980) were largely people of color, queer people, convicts, or patients of mental institutions.⁸² For this wave of immigrants, access to care once in the U.S. would be difficult, especially given the increasing number of Cuban refugees that medical and social infrastructure was not yet ready to accommodate. Further, even many immigrants who were well-off in Cuba arrived in the U.S. as escapees who had to leave belongings behind. In *Culture in the Clinic* (2022), Catherine Mas explores what access to healthcare and the healthcare workforce was like for Cuban refugees. Mas explains that the burden on the medical system in Miami was a driving factor for the Department of Health, Education, and Welfare to sponsor a “refresher course” for Cuban

78 Garth, “Disconnecting the Mind and Essentialized Fare,” *Health Travels*, 63-65.

79 Central Intelligence Agency, “The Truth about Public Health in Cuba.”

80 Feinsilver, *Healing the Masses*, 204.

81 Special to *The New York Times*, “Cuban Physicians in U.S. Increasing: Some Exiles Study in Spain to Escape Costs Here.”

82 Hernandez and Perry, “Latiné immigrant heterogeneity: Striking health differences among Cuban refugee/migration waves to the United States.”



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physicians planning to take the Foreign.⁸³

The Program for Foreign Medical Graduates in preparation for the Foreign was a twelve-week course that was free for Cubans. The program was taught by both Cuban and American professors, had English and Spanish components making it an appealing program for international students. By the mid 1970's, close to half of the enrolled doctors were from other Latin American countries who planned to return to their home countries as a better physician afterwards. Participating in the program meant they gained knowledge in modern medicine and were a more "competent" doctor.⁸⁴ This program is similar to the educational, vocational, and medical training Cuba offered to elementary through university students from the countries that received aid.

As thousands of Cubans and others participated in the Program for Foreign Medical Graduates in preparation for the Foreign, the program became itself an example of medical internationalism. While Cuba was developing its socialist agenda through international medical missions and training, the U.S. was responding directly to the doctors that rejected such ideas by creating its own comparable program. Thus, even though these doctors might not have participated in Cuban medical missions, they were still on the front lines of medical internationalism. In contrast with Cuban medical internationalism, doctors who participated in the Program for Foreign Medical Graduates were never required to be involved in the military and were free to choose where they practiced their acquired knowledge. Doctors would be exposed to modern American medicine but not be tied to promoting any specific ideology or cause. Moreover, the program served to enable doctors to practice in the US where they would earn the salary of a US doctor, rather than return home to a communist country where they would continue working for a similar salary.

While the U.S. program did not explicitly educate students on political ideology and propaganda, one might expect they would have been exposed to it by living in the U.S. Indeed, this program was based out of Sheraton hotel in Miami where students studied and were housed.⁸⁵ They were not only focused on absorbing modern medicine but also enjoyed the luxury of a capitalist country. Cuban and U.S. programs for educating foreigners were unique in their primary goals but overlapped in their objective to impress students with the fruits of their political and economic systems. The U.S. did so without risking the lives and livelihood of its own people.

However, since many Cubans felt like they would return to Cuba as soon as Castro's regime fell (and they thought it would,) some were not willing to spend the time it took for recertification. Though the Program for Foreign Medical Graduates was relatively short, it could take years for them to be fully licensed for U.S. practice. To take the medical board exams in some states one had to be a U.S. citizen, which required five years of residency. And in 41 states, doctors had to serve in a one-year internship plus three-

⁸³ Mas, 20 and Special to The *New York Times*, "Cuban Physicians in U.S. Increasing: Some Exiles Study in Spain to Escape Costs Here."

⁸⁴ Mas, 15.

⁸⁵ Mas, 35-36.

to-four years of residency to practice a specialty.⁸⁶ All of this time would equate to lost salary. Those who felt this was not worth the sacrifice took on lower-level medical jobs, or sometimes, practiced illegally.

What we can learn from Little Havana

Though fleeing communism, Cuban doctors retained the value of caring for their community. Many Cubans living in the U.S. gradually adopted a healthcare system that mimicked pre-Castro Cuban healthcare. Before Castro's reforms, healthcare was usually accessed through private clinics and patients would pay a monthly fee that would cover unlimited care. Mas explains that Cuban healthcare providers, sometimes including doctors who had not participated in the Program for Foreign Medical Graduates (called *clandestinos* since they were unlicensed in the U.S.), opened similar private clinics, or *clínicas*.⁸⁷ Mas found that these *clínicas*, first opened in the early 1960's, were servicing around 200,000 to 300,000 patients in the 1980's.⁸⁸ The benefit to these *clínicas* was community-based, affordable, Spanish language care. In a 1975 *New York Times* article, the father of a four-year-old describes the benefits of his *clínica*:

"[Ten weeks ago,] I took him to the emergency room of an American hospital," the father said. "We waited for 30 minutes until a nurse came and asked whether I had insurance, and for about two hours more until a doctor came to see my son.' Last week, the boy cut himself while playing with a sharp instrument. "This time," Mr. Correa said, "we went to our Cuban clinic, where they attended my son right away and did not ask whether we were members; until the doctor finished dressing the wound, which required; three stitches."

This anecdote not only highlights the efficiency and accessibility of Cuban clinics, but the lack thereof in U.S. healthcare.

However, due to the lack of regulation among *clínicas*, there were flaws that in any clinic today would be considered malpractice. Mas refers to issues like faulty machinery, pressuring people on the street to enroll at the clinic, and failure to inform patients that their plans dropped them after age 65 or in cases of serious illness.⁸⁹ In 1973, The Health Maintenance Organization Act passed and enabled Cuban clinics to register with a state-issued license. But by 1975, only a few did so. Many of them were run by U.S.-licensed doctors but had "assistant physicians," typically older unlicensed doctors, responsible for patient care as well. Yet out of this chaos, 20 of the clinics formed a Cuban Clinics Council to regulate their operations and attempt to reduce malpractice. Still,

86 Special to The *New York Times*, "Cuban Physicians in U.S. Increasing: Some Exiles Study in Spain to Escape Costs Here."

87 Mas, Chapter 4, "Americanizing the Cuban Clinic."

88 Ibid, 112 and *New York Times*, "28 Clinics Serve Cubans in Miami: Health Units Reestablished in U.S.," May 5, 1975, <https://www.nytimes.com/1975/05/05/archives/28-clinics-serve-cubans-in-miami-health-units-reestablished-in-us.html>.

89 Ibid, chapter 4.

only one of those clinics actually registered as a health maintenance organization with a state-issued license. Despite the malpractice and lack of regulation, the existence of these *clínicas* had an impact on the U.S. healthcare system not just for Cubans, but for policy in general. Mas explains, “In fact, as the AMA’s political influence waned in the late 1960’s, health policy makers looked to Miami’s flourishing *clínicas* as a potential model for restructuring and financing health care to better serve low- and middle-income patients.”⁹⁰

While in from 1960’s to the 1980’s medical missionaries were mostly loyal doctors, by the early 2000’s, Cuban doctors began to use international medical missions to defect. In the early years of the medical international program, this was not common for several reasons. Many doctors had already fled the country, and as evident in his speech, Castro invited them to leave. Further, the doctors who went abroad were specifically selected for and represented revolutionary ideals, many of whom not only supported but participated in the revolution. And as new doctors trained, they took classes on communist ideology. But as time went on, Cubans began to view the medical profession differently. By the twenty-first century, prospective students were not actors in the revolution but rather children born into a post-revolution Cuba that was already facing its second financial crisis. The Department of Homeland Security launched the Cuban Medical Professional Parole Program in August 2006,⁹¹ when there were around 40,000 Cuban medical personnel abroad.⁹² Similar to its historical counterpart, the Cuban Adjustment Act of 1959, it helped over 1,000 Cubans come to the U.S. in its first year. In an interview for the *South Florida Sun-Sentinel*, successful defector Beny Alfonso Rodriguez said, “The medical missions are the only safe escape.”⁹³

Conclusion: The Legacy of Castro’s Medical Revolution

Cuban medical internationalism continued well into the 1990’s and beyond. In the early 2000’s, Operation Miracle was an outstanding Cuban medical diplomacy program that provided over 2 million free vision restoration operations throughout Latin America, the Caribbean and Africa.⁹⁴ Cuba has been on the “front lines” of many medical emergencies since its medical international missions began over 60 years ago and has been recognized by many

90 Mas, 29 and *New York Times*, “28 Clinics Serve Cubans in Miami: Health Units Reestablished in U.S.”

91 U.S. Citizenship and Immigration Services, “Cuban Medical Professional Parole (CMPP) Program,” <https://www.uscis.gov/humanitarian/humanitarian-or-significant-public-benefit-parole-for-aliens-outside-the-united-states/cuban-medical-professional-parole-cmpp-program>.

92 Tal Abbad, “Hundreds of Cuban medical workers defecting to U.S. while overseas,” *South Florida Sun-Sentinel*, (October 10, 2007)

<https://coha.org/hundreds-of-cuban-medical-workers-defecting-to-us-while-overseas/>

93 Ibid.

94 Emily Kirk “Operation Miracle: A New Vision of Public Health?,” *International Journal of Cuban Studies* 3, no. 4 (2011): 366–81. <http://www.jstor.org/stable/41945963>.

as selfless and successful. At home and abroad, they are regarded as heroes, and they have indeed earned that title.

Today, Cuban medical schools are respected around the world, even in the United States. Indeed, dozens of U.S. citizens attend medical school in Cuba every year. Cuba's medical system developed despite the U.S. blockade, which had only increased anti-U.S. sentiment in Cuba. But now, Cuba lets students from underprivileged communities in the U.S. attend medical school there for free.⁹⁵ Cuba offers full scholarships to these students with the intention that they will return to their communities and improve access to healthcare within them. Students express their gratitude for being able to attend medical school without the student loans and appreciate the values of community and preventive medicine that Cuban medical school emphasizes.

It is ironic that previous generations of Cuban doctors fled to the U.S. but had to resort to practicing illegally, if at all; while today, American routinely graduate from Cuban medical schools and return to the U.S. for licensure and practice. A parallel, but tragic irony is that for an average Cuban on the island, medical care is first-class but their standard of living is decidedly dire. De Vos cites the Cuban joke, "We live like the poor but we die like the rich."⁹⁶ Healthcare is a basic human right, but that involves many more things than access to a doctor. While infrastructure did improve under Castro, it also later worsened again after two severe financial crises in the 70's and 90's. Today Cuba still sends doctors abroad but they earn close to nothing compared to doctors from other countries, meanwhile they risk their lives to provide care. Many doctors on the island have access to running water for as little as an hour a day.⁹⁷ For some, the title of "hero" is enough, but for others it is not.

Many early missions were for military and diplomatic purposes, not medical. Che Guevara was the face of them. By going on these medical missions, doctors were converted into military officers. They represented their country and risked their lives, often supporting military interventions in foreign countries. They also provided much needed care to people who did not have access to it, regardless of Cuba's political agenda or desire to spread communism. For these doctors, being a member of the military does not imply they were involved in any violence, they were just an extension of the political agenda of Cuba. Just like any soldier, they gave back to the country that provided opportunity and liberation, but these "revolutionary doctors" were unique in that they gave back to more than just their own people. They saw that people anywhere in the world faced similar struggles; they saw the humanity in people that were often overlooked.

95 BreakThroughNews, "Meet the U.S. Students Studying Medicine for Free in Cuba," February 2, 2022, <https://www.youtube.com/watch?v=h7g2T3BWg9E>.

96 De Vos, 193.

97 Our Human Planet, "The Secret Behind Cuba's Extraordinary Healthcare," December 11, 2018, <https://www.youtube.com/watch?v=zBC5w2O4jVI>.

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