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CURATED VOICES

Gender and Family Planning: A Close Reading of Forty Years of India's Family Planning Policies (1977-2019)

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Gender And Family Planning: A Close Reading of Forty Years of India's Family Planning Policies (1977-2019)

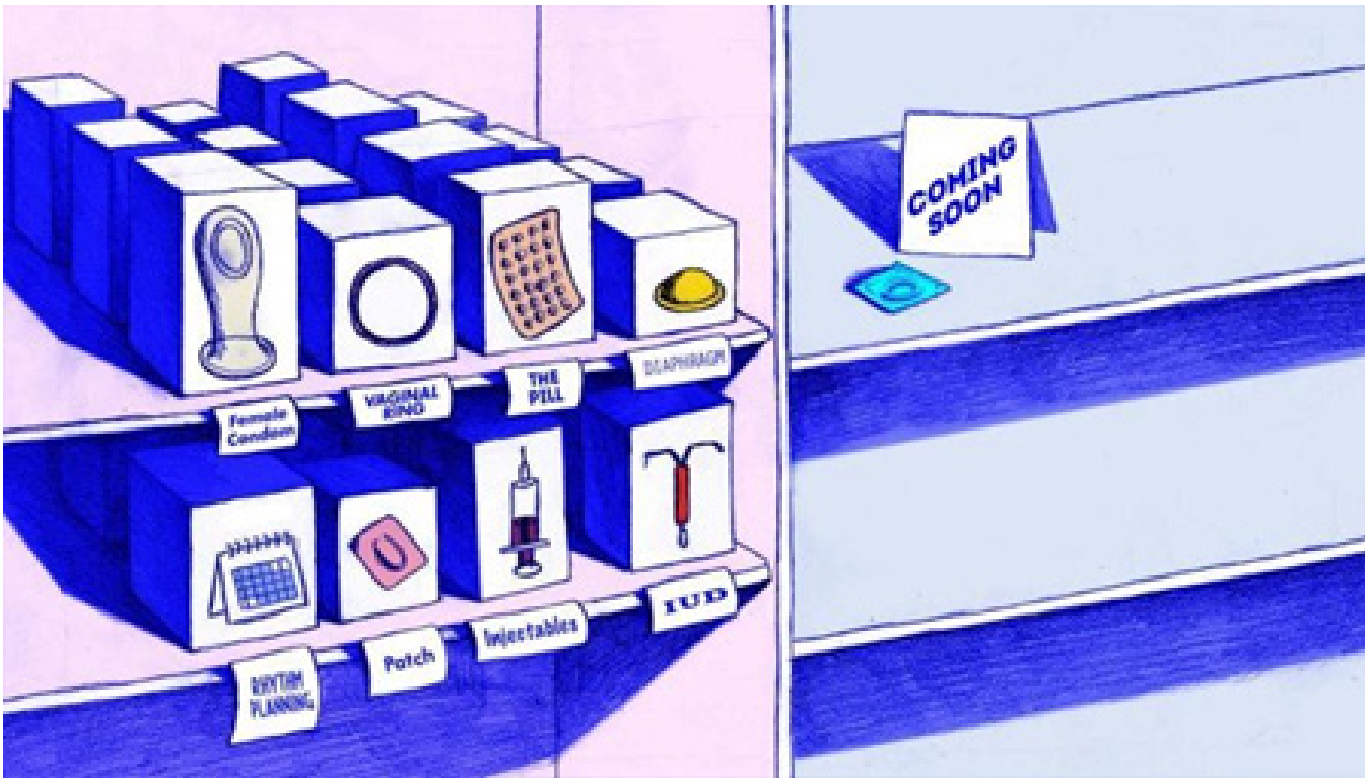
Arushi Sahay

ABSTRACT

This piece undertakes an in-depth and gender-sensitive investigation of over forty years of family planning policy in India (1977-2019). The findings indicate that despite an acutely gendered nature of contraceptive-usage in India, key policy documents display a relatively passive gaze of the state towards questions of gender equality and reproductive justice within family planning.

INTRODUCTION

Gender norms and gender-based discrimination are critical drivers of family planning (FP) outcomes in India and globally. With more than 70% of contraceptive-users worldwide being women, global contraceptive-use is gender-imbalanced (UNDESA, 2019). Family planning practices are further stratified in terms of reproductive justice, i.e., to what social group is reproduction a matter of freedom and choice, and to what degree is it a space of being under surveillance; this intersects with systems of racism, socioeconomic disparities, religious identity, and more.



In India, both these forms of critique are prominent and must be examined. Currently, India reports one of the highest rates of female sterilisation[1] in the world —¬ 36% of married or sexually active women and 29% of women of reproductive age (15-49) report it as their primary contraceptive method. On the other hand, the uptake of vasectomy[2] is between 0.2-0.3%. Within modern contraception methods, which exclude traditional methods like withdrawal and rhythm, the share of female sterilisation is 75.5% (NFHS-4: UNDESA, 2019). According to the recently-published NFHS-5 Phase-I data, female sterilisation continues to be the most prevalent modern contraceptive method in India, both in rural and urban areas. Out of the 22 states/union territories surveyed, only six areas do not report female sterilisation as the most prevalent modern contraception. In these states, though, the female pill and IUD (intrauterine device) emerge as the most common contraception, hence the responsibility still residing with the female body. States like Andhra Pradesh, Telangana, and

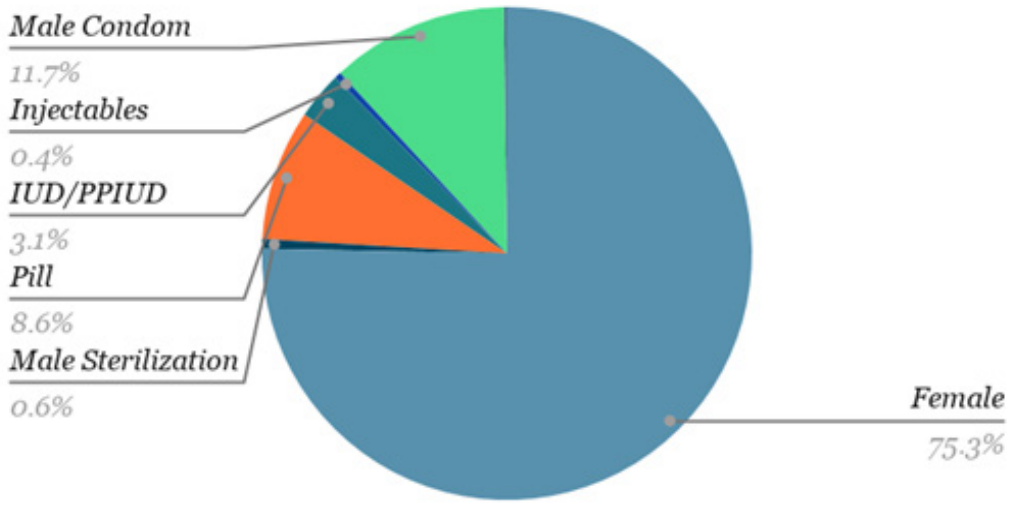
[1] Female sterilisation, also called tubectomy or tubal sterilisation, is a surgical process that blocks the fallopian tubes to prevent the egg released by the ovary from reaching the uterus.

[2] Vasectomy is a surgical procedure for male sterilisation, during which the male vasa deferentia are cut and tied, or sealed, to prevent the sperm from entering into the urethra.

Karnataka report a share of female sterilisation higher than 50% (NFHS-5)[3].

This gender disparity in the uptake of contraceptives is rooted in a sociohistorical context of how birth control originated in the country, and how it has since been a component of developmental and demographic policies. Birth control was introduced in the postcolonial countries during the mid-1900s amidst the emerging post-war population debate. Accordingly, the Global South's newly independent governments actively took to the family planning movement — and India was one of them. Here in India, the nationalist movement, and later the nation-building project, structured much of the family planning policies. As early Indian feminism remained overshadowed by narratives of budding nationalism and development, family planning flourished as an elitist project of population management (Ahluwalia, 2008), where lower-caste and working-class bodies were at once identified as 'fecund bodies' who needed increased surveillance of their reproductive and sexual behaviours (Rao, 2004; Devika, 2008)[4]. Thus, in India, the cause of gender within family planning and contraception was watered down at the very origins.

Figure 1: Modern Contraceptive Method Mix (for currently married women and sexually active unmarried women)



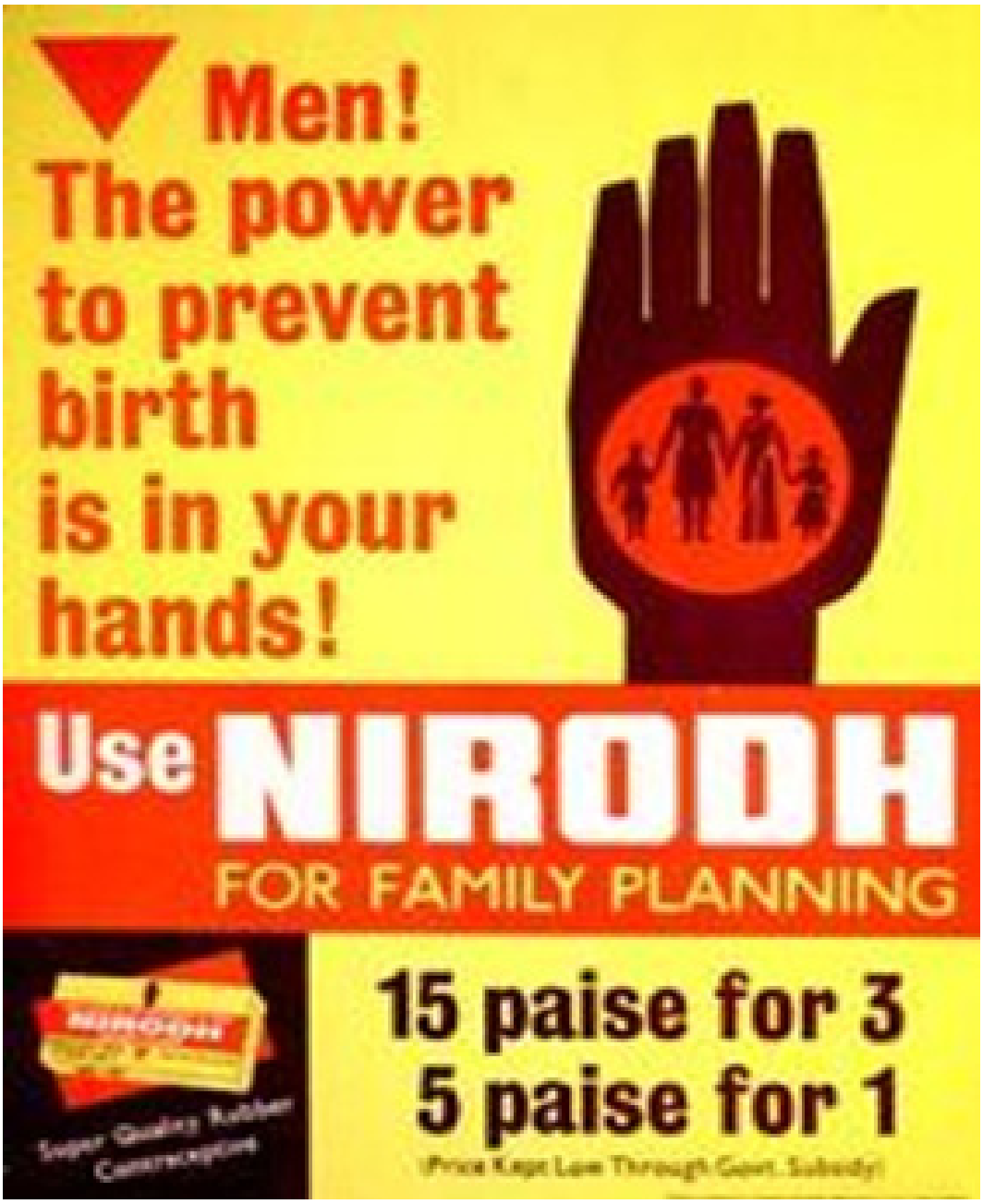
Source: NFHS-4, 2015-16

The nation-wide forced vasectomy camps carried out during the Emergency of 1975-77 saw a unique focus on men's bodies for contraception, owing to their roles as a families' primary decision-maker. Still, there was also an emergence of a strong, target-oriented, incentive-based family planning (Balasubramanian, 2018). The number of vasectomies conducted dropped post-Emergency drastically. Despite the Indian government participating in the global shift towards reproductive health and target-free family planning at the International Conference on Population and Development (ICPD) in 1994, the target-oriented approach persisted. Family planning practices continue to be reported

[3] Such state-wise variations require further research into what kind of sociocultural and regional variations influence contraceptive choices and FP services.

[4] Such a perspective on development is called a 'Malthusian' perspective. Derived from the ideas of economist Thomas Robert Malthus, it understands population growth as a barrier to quality of life and standard of living, hence making population control a priority strategy for governance and development.

as coercive and/or incentive-based, focusing on achieving demographic and numerical targets (Tarlo, 2003; Rao, 2017; HRW, 2012; Devika Biswas v. Union of India).

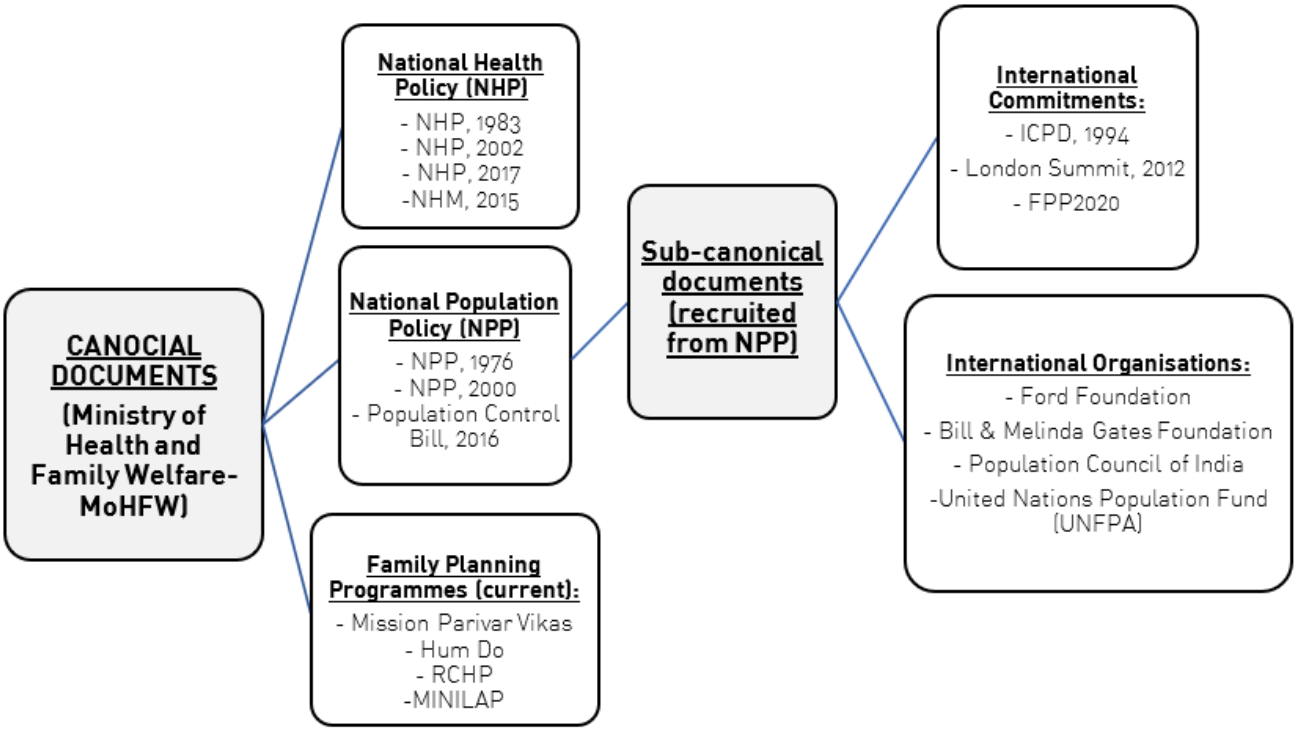


Due to the overwhelming uproar around the draconian family planning measures during the Emergency, that period has been extensively examined — even from a gender and policy perspective. However, there seems to be a lull in investigating the landscape of family planning in India post-Emergency. Presently, India struggles with high rates of unwanted fertility — 2.06 in urban and 2.98 in rural areas — with 17.9% of the total population reporting an unmet need for family planning (Patil et al., 2020). Additionally, with over 30% of its population being between 15-24 years in age (MoSPI, 2011), the Indian welfare state continues to frame population management and effective family planning as one of its main developmental components. In this context, gender-imbalance and reproductive justice in contraceptive-uptake become pertinent questions that need to be examined.

METHODOLOGY

This piece takes a unique approach towards tackling the issues outlined in the previous section. The state and governance role has been integral to the trajectory of family planning practices in India and continues to be so. A more in-depth and gender-sensitive investigation of the state's policy vis-a-vis family planning needs to be taken up, directly confronting the state's stance towards the question of gender equality and reproductive justice in India's family planning domain, particularly in the post-Emergency period. This paper examines key policy documents of the Indian State over forty years, in the aftermath of the Emergency, i.e., 1977-2019. These documents have been selected through a thorough process of identifying critical nodal agencies and bodies that influence India's family planning policy; Fig 2 displays the corpus examined:

Figure 2: Policy documents on family planning analysed



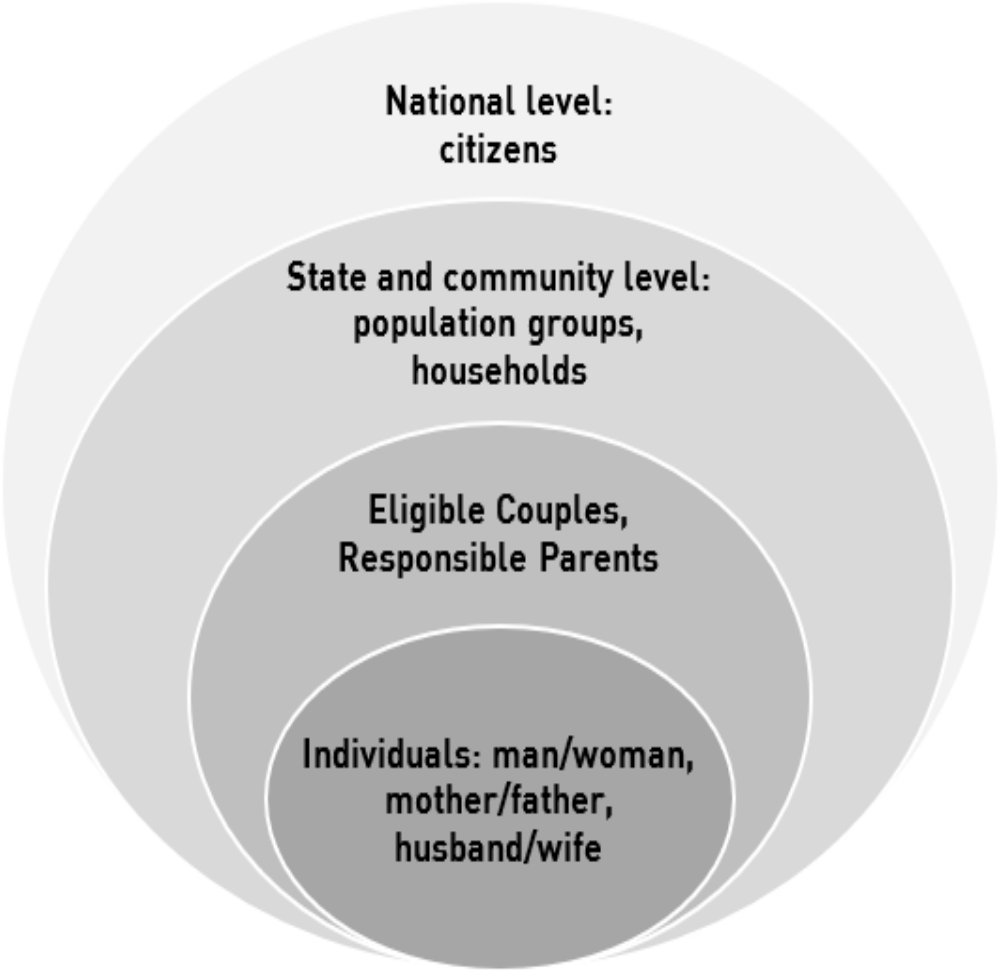
These set of documents aim to cover the local, national, as well as transnational levels of programming family planning services. It also indicates that family planning policies are primarily made as a part of population policies, even though it is ideally stipulated that these correspond to ministries working with women, children, and reproduction.

FINDINGS

Social Ecological Model

To understand such a vast corpus, first, we must try to explicate the various levels at which family planning policies are enacted by using a social-ecological model[5] (Fig 3). The idea is to understand that the question of 'gender' does not merely translate to the gender of an individual; it is rather essential in understanding how gender is represented at the various levels in which this individual's identity, as a contraceptive-user, is embedded. Table 1 elaborates on the model: systematically fleshing out the terms and the language used at each of these levels to articulate the policy's aims and targets. Sometimes this language is explicitly gendered, and sometimes not.

Figure 3: The Socio-ecological model



[5] A social-ecological model is used to explore levels of interaction between individuals and how embedded they are within surrounding social and environmental factors.

Table 1: Language at various levels of the model

Individual	Couples	Community-level	State-level	National-level
Male/female methods of contraception	Responsible parenthood	Small family norm	State discretion	Cooperation of the people
Incentivisation	Responsible citizens	Late marriages	Rural areas - outreach and access	National interests
Women's health mothers	Eligible couples	Higher education amongst youth	Decentralisation of FP programmes - local governance	Choice to citizens
Women's empowerment	Planned Parenthood	Group incentives	Locally sensitive	People centred programmes
Increased male involvement: husbands and fathers	Newlyweds	Mass movement	Urban slums	Public support Citizens
Beneficiaries	Contraceptive Prevalence (CPR)	Community involvement	Remote areas	
Acceptors	Couple Years Protection (CYP)	Reproductive age group	High fertility districts	
Clients		Households, doorstep delivery		
Citizens		ASHAs		

Individual level

Until the 1990s, when India followed a 'target-oriented approach' to family planning, there was little focus on individuals as contraceptive-users and more emphasis on demographic targets of decreased fertility rates. Individuals were mainly perceived as receivers and acceptors of incentives like cash, goods, bank loans etc., sponsored by the government for those who underwent sterilisation. They were also referred to as those who 'motivated' others to undergo sterilisation, such as medical practitioners or teachers (NPP, 1976).

Then, with its participation at the International Conference on Population and Development (ICPD) in Cairo, 1994, India shifted to a 'target-free approach' where the focus gravitated towards individuals' reproductive rights and voluntary choices, referring to contraceptive-users as 'beneficiaries' or 'clients'. The ICPD in 1994 also sought international focus on gender equality within the health and population agenda, raising issues of women's sexual and reproductive health (SRH), rights and services, female education, employment, and political representation. India's commitment to ICPD, released by Mr. Dalit Ezhimalai, Union Minister of State for of Health and Family Welfare (MoHFW) in 1999, stated the mission of attaining "women's welfare to women's development to women's empowerment."

The Government of India (GoI) launched an integrated Reproductive and Child Health Programme (RCHP) after the ICPD (1994), which included programmes

"Other policy imperatives are to increase the proportion of male sterilisation from less than 5% currently, to at least 30% and if possible much higher"

(NHP, 2017)

on safe motherhood. A draft National Policy for the Empowerment of Women was developed in 1996 to "eliminate gender based discrimination for promoting women's empowerment." Thus, women's empowerment was integrated with the state's socio-economic developmental agendas, making individual women (and gender equality) essential vectors in the narrative of development and progress. As India's commitment to the ICPD reads:

> *"...incorporation of gender perspective in population, reproductive and sexual health and overall development programme as well as women's empowerment…"*

GoI also recognises the lack of participation by men in FP and acknowledges the influence that male members of a family have on marriage, education, and usage of contraceptives. National Population Policy (2000) calls for an 'active cooperation' and 'acceptance' from men in the process of FP, urging their participation in "supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born and, finally, in being a responsible father." The lopsided amount of tubectomies is also accounted for, stating the need to 're-popularise' vasectomies — especially non-scalpel vasectomies (NSV) — as a quick and safe procedure.

"Introduction of NSV in the family welfare programme and its availability up to the peripheral level is expected to help men adopt male sterilization...promote male participation…. also shifts the responsibility of uptake of services from women to men...the government has encouraged the districts to ensure the availability of NSV services in their facilities on fixed day basis"
(FPP2020 commitment)

"...currently, over 97 percent of sterilisations are tubectomies and this manifestation of gender imbalance needs to be corrected. The special needs of men include re-popularising vasectomies, in particular non-scalpel vasectomy as a safe and simple procedure, and focusing on men in the information and education campaigns to promote the small family norm"

(NPP, 2000)

However, despite addressing the need to increase the proportion of vasectomies, this remains a marginal and peripheral FP agenda in India. Thus, while the MoHFW has developed programmes such as Antara and Chhaya since 2016 to roll out more contraceptives for women, no such programmes have been designed for the increased involvement of men as contraceptive-users or for the re-popularisation of vasectomies — this might be related to the continued negative public as well as political memory associated with vasectomies, due to the forced campaigns during India's Emergency.

Couples

To encourage sharing contraceptive responsibility and decision-making between heterosexual couples, India's Family Planning Programme (FPP) uses two consistent sets of representations: 'responsible parents' and 'eligible couples.' Responsible parenthood involves developing 'responsible reproductive behaviour amongst citizens' (NPP-1976), which includes maintaining a 'small family' through proper contraceptive-use, spacing methods, and practising of 'planned parenthood.' One of the flagship initiatives for this is 'Hum Do' (The Two of Us), which promotes a collective, equitable, and reciprocal process of making FP decisions between couples.

The Population Control Bill (2016) also proposes implementing a nation-wide two-child policy in India, stating that "no person shall procreate more than two living children… [this also] includes an adopted child". This idea resonates with

the common Hindi phrase of 'hum do, hamare do', which translates to 'the two of us, and our two children'.

'Eligible couples' is a more targeted way of categorising those couples who fall under the 'reproductive age' of 15 to 49 years, becoming the primary targets of FP services. Within this group, recently married couples form an even more specific target group. The Nayi Pahel programme (A New Beginning), launched by MoHFW in 2016, is designed explicitly for newlywed couples in high fertility districts. The programme provides such couples with a 'family planning kit' containing an information pamphlet on FP services, condoms, oral and emergency contraceptive pills, pregnancy testing kit, and a grooming/hygiene bag.

Marriage itself has undergone legislative interventions in the interest of effective FP, with early marriages seen as a critical obstacle. NPP (1976) had thus proposed increasing the minimum age of marriage for girls to 18, which would "not only have a demonstrable demographic impact, but will also lead to more responsible parenthood and help to safeguard the health of the mother and the child." This was further linked to educating girls and a women's ability to fully participate in economic, social, and intellectual life. Both early marriage and early childbearing patterns are identified as significant contributors to high infant and maternal mortality rates in India. NPP (2000) problematises the early marriages of girls and the consequent reproductive pattern — characterised as 'too early, too frequent, too many' — as a cause of high infant mortality rates. Subsequently, maternal mortality is deemed a matter of social injustice because of inequitable access to appropriate healthcare and nutrition services during pregnancy and childbirth (NPP, 2000).

The two globally prevalent indicators used by GoI for assessing met/unmet needs of FP are also centred around couples: contraceptive prevalence (CPR) and couple years protection (CYP). CPR (usually reported for married/in-union women aged 15 - 49) refers to the percentage of women, and their sexual partners, who are currently using at least one contraception method — regardless of the contraceptive method. CYP is "the estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period" (World Health Organisation as cited in Moiz et al., 2020). Indicators such as CPR and CYP ignore the gender-imbalance in using contraceptives. Their 'cookbook' approach also overlooks failure rates, sporadic use of contraception, quality of care, diversity of needs, age, access, etc. (Shelton, 1991), delinking contraceptive usage from the complex social nexus it operates within.

State/Community level

India is a vast and diverse country of 29 states, each with its own government, distinct sociocultural practices, and demographic features. According to the seventh schedule of India's Constitution, the subject of FP services falls under the concurrent list, i.e., decision-making powers over FP are shared by the federal and the state governments. Thus, while the population policy is formulated and enforced by a central ministry, the various programmes' implementation lies with state and local governments. This decentralisation of powers was further enhanced with the 73rd Amendment of India's Constitution, under which the central government delegated FP and health services to local government bodies or panchayats (Harkavy & Roy, 2000). Through this action, it

"It is a widespread perception that, over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of family welfare activities."

(NHP, 2002)

is believed that outreach and access widened, and the programme aims shifted to become more 'locally sensitive' — the aim was to "think, plan and act locally, and support nationally" (NPP, 2000).

FPP has consistently recognised the importance of community involvement, awareness, and support in creating sustainable norms through education and counselling. Thus, alongside individual incentives, FPP also proposes 'group incentives' (NPP, 1976) for villages to help meet sterilisation targets and practice effective FP. Under the target-free approach, policies have framed effective FP in terms of uniform access and quality of care, stressing on households as a unit and on doorstep availability of FP services (instead of national fertility-rate targets). In recent years, community outreach initiatives have only gotten stronger with improved access to mass media and social media facilities.

At the state level, underserved population groups are identified for the acceleration of FP. These include urban slums, remote areas such as hilly regions, tribal and migrant populations, and high fertility districts where the fertility rate is above the desirable average. For instance, Mission Parivar Vikas[6] (MPV) operates across 145 "high fertility districts." 'Men' and 'women' are also identified as homogenised population groups, the former as underserved and the latter in terms of maternal and reproductive healthcare where reduced maternal morbidity and mortality, along with infant mortality, become key state-level indicators for FP initiatives and healthcare services.

Two community-based initiatives are worth mentioning specifically. First, as part of the National Rural Health Mission, various Accredited Social Health Activists (ASHAs) have been instituted across villages in India. ASHAs are female community health workers trained by the state, to assist and engage with couples from rural India to make FP decisions. They have been reported to have considerable influence on women's contraceptive choices (Diamond-Smith et al., 2020), with India's 52nd Commission on Population and Development stating that "extensive engagement of the community health workers in distributing contraceptives to beneficiaries have improved access [of FP services]."

Second, under MPV, the Saas Bahu Sammelan scheme focuses on "improved communication between mothers-in-law and daughters-in-law through interactive games and exercises... to bring about changes in their attitudes and beliefs about reproductive and sexual health" (Mission Parivar Vikas, 2016). Launched in November 2016, these meetings are conducted by ASHAs in 145 rural districts across India. Both of these initiatives present a fascinating view of the role women play in FP, not only as contraceptive-users but as members of the family, community, and the state.

"If the future of the nation is to be secured, and the goal of removing poverty to be attained, the population problem will have to be treated as a top national priority and commitment"

(NPP, 1976)

However, at the state and community levels, it is rural areas, or the 'poor', that are primarily identified as target-groups for FP interventions.

"...media channels... (specially programmes aimed directly at rural audiences) ...include traditional folk media...puppet shows, folk songs and folk dances. The attempt is to move from the somewhat urban-elitist approaches of the past into a much more imaginative and vigorous rural-oriented approach…"
(NPP, 1976)

[6] This translates to 'Mission Family Welfare'

Hence, the core agenda is aimed to fix the urban-rural divide by achieving national uniformity of FP services. Unlike global data collection metrics on contraceptive-usage that the United Nations Department of Economic and Social Affairs (UNDESA) 2019 reports, metrics for programmes like MPV do not report a gender-wise distribution of contraceptive-usage, but only a district-wise distribution of fertility rates.

National level

Throughout the forty years of FP policymaking in India that this paper examines, there is a strong narrative around FP being a national project, being undertaken in the interest of national growth and development. NPP (1976) pronounces such a sentiment most explicitly, calling upon the cooperation of the country's people to meet critical national interests through FP — an aspiration of socioeconomic development of a young nation battling a population crisis.

"This package of measures will succeed in its objective only if it receives the full and active cooperation of its people at large. It is my sincere hope that the entire nation will strongly endorse the new population policy...for economic development and social emancipation...directed towards building a strong and prosperous India in the years and decades to come"
(NPP, 1976)

While calling upon the people's duty towards FP became less direct under the decentralised, target-free approach during the 1990s, FPP nevertheless continues to emphasise being a mass movement that must "enlist public support" (NPP, 2000) across state boundaries. Successful FP is considered a vital route to tackling the country's ongoing population problem, which is linked to issues of accessing healthcare and education, employment, crime prevention, etc. Thus, the central government frames FP as an important national, developmental goal that the country's future relies on.

"The immediate objective...is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR [total fertility rate] to replacement levels by 2010...The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection"
(NPP, 2000)

MoHFW is also directly involved with various international commitments to FP, which significantly influences the domestic policy. India's most recent commitment to the FP2020 mission (a product of the London Summit on Family Planning, 2012) reflects the government's current outlook to FP. With this and the ongoing commitment to ICPD (1994), India's national mission of FP has been swiftly integrated with a transnational, global effort towards population control and sustainable development. As Dr. Shashi Tharoor, Minister of State for External Affairs, iterated at ICPD's 15th anniversary, "resolute political will and concerted global action are needed to realise these goals."

Additionally, FPP2020 reflects a national commitment to population control and further uptake in contraceptive-usage, emphasising India's domestic FP infrastructure, investment in active contraceptive outreach, and increased

collaboration with civil society organisations and the private sector. Under this commitment, new contraceptives have been rolled out for women in India including a non-hormonal pill and an injectable MPA (Medroxyprogesterone acetate), where the latter has been reported to be administered across the country by "an army of 73,089 trained services providers" (FPP2020 Commitment, 2018-19). Hence, imbalances in the representation of gender also remain neglected within the international framework of global health itself, where developmental-aid for enhanced population control remains the pressing priority — particularly amongst postcolonial, developing nations (Adams, 2016).

NON-GENDERING OF FAMILY PLANNING

The above analysis demonstrates the Indian state's relatively passive gaze towards gender within family planning. In conclusion, it is imperative to reflect on what non-gendering of family planning means for women, children, and families at the centre of these state-driven contraceptive services. Three crucial implications here are:

Poor and underprivileged women as welfare objects

A naturalisation of women as contraceptive-users is further extended as the naturalisation of the poor and the underprivileged (women) as primary targets of FP. The NPP (2000) states, "...women are over-represented among the poor, [thus] interventions for improving women's health and nutrition are critical for poverty reduction." Conversely, there is an absolute erasure of what FP is like for India's urban, rich and middle-class women — as if FP is only a rural health objective, despite being a national interest project.

This is visible in various ways: the National Rural Health Mission's focus on FP; use of incentivisation provisions; assistance to the poor from ASHAs in taking contraceptive decisions (Diamond-Smith et al., 2020); International bodies such as the Bill and Melinda Gates Foundation concentrating FP funds in rural and poverty-ridden areas; the CHARM (Counselling Husbands to Achieve Reproductive health and Marital equity) toolkit, developed in the US to increase male participation in FP, implemented only in rural India (Yore et al., 2016).

This lopsided reproductive surveillance is not merely a matter of increased access, but points to the various assumptions the state makes regarding reproductive practices based on social class, despite adapting to a target-free voluntary and choice-based FP at ICPD (1994). The narrative of welfare and healthcare of poor citizens through enhanced FP subsumes the contraceptive autonomy and choice of women (and men) of rural India. Consequently, not only is there an erasure of urban family planning, but also a sidestepping of how people's reproductive decisions are closely linked to their identities of class, caste, ethnicity, and religion (Schuler et al., 1996; Bharadwaj, 2006; Char, 2011).

Women Empowerment through effective FP

An increased focus on women's sexual and reproductive health (SRH), rights, and quality access to contraception and FP services have become a part of the government's women empowerment package, especially after the ICPD. Recognising dynamic connections between sustainable development, demographic dynamics, human rights, and empowerment of women, the 2019

ICPD demonstrates a commitment towards enabling women as equal partners in development, stating that "gender equity and empowerment have been guiding principles in the development policies of the Government of India."
The GoI's programmes such as Beti Bachao, Beti Padhao (promoting girl child education) and Janani Suraksha Yojana (JSY, a safe motherhood intervention to encourage institutional delivery amongst poor pregnant women), while not being directly related to FP, have a demonstrable influence on contraceptive and FP practices. Sharma and Pandey (2020) report an association between increased education levels amongst women and decreased fertility rates in Uttar Pradesh. And JSY has been reported to (unintentionally) increase contraceptive-usage amongst women through cash-assistance and increased awareness (Sen et al., 2020).

However, even this discourse of women empowerment within family planning policy fails to engage with gender-imbalances in contraceptive practices, hence flourishing without being cognizant of the unfair share of the contraceptive burden that women carry and the social, emotional and bodily drawbacks that accompany this burden (Littlejohn, 2013; Polis et al., 2018). Instead, an increase in the use of contraceptives amongst women is only celebrated as their empowerment.

Non-gendering of the unborn child

Upliftment of maternal and child healthcare has been a priority area within FP services, touting healthy and empowered mothers as integral to the nation's development. However, FP policy simultaneously remains almost blissfully unaware and removed from son-preference and female foeticide practices prevalent in the country. Decisions of reproduction, contraception, and abortion are not independent of factors such as the gender of living and unborn children — the desire of a son or the lack of desire of a daughter critically influences reproductive decisions (McDougal et al., 2020; Holscher, 2020). For instance, the skewed sex ratio in China, with a high male ratio to females, has been attributed to the government's one-child policy (Ebenstein, 2008).

India's FPP excludes the consideration of such gender discrimination when addressing limited birthing, small families, and a potential two-child policy, severing the link between a patriarchal, gendered social world and reproductive decisions within which these female bodies operate. Consequently, not only are gendered identities of reproductive bodies rendered invisible, but gender inequalities relating to son-preference might also be perpetuated[7].

[7] India reported a sex ratio at birth of 900 females/1000 males in 2013-15, with some states like Haryana (831) and Uttarakhand (844) reporting much lower levels (NITI Aayog)

CONCLUSION

This piece aimed to look at the relationship between gender and family planning in India to understand the gender-disparity in contraceptive burden, the increasing rates of female sterilisation, and the often-coercive method of incentivisation through which contraception is disseminated etc. This paper also critically considers the role of the state since India's independence. The Indian welfare state has continued to stake family planning and reproductive governance as a significant developmental priority. In this scenario, the puzzle we are always left with is: where should policy strike a balance? Is it between population, health, reproduction, gender, and justice? It is an essential and urgent project to step back and reflect upon how sensitive a family planning policy is towards the questions of gender, reproductive justice and bodily autonomy. Family Planning Policy should also consider how these concerns weigh against the more persistent issues of population management, high fertility rates, and unmet family planning needs — problems that have become only more pressing during the last year, amidst the COVID-19 pandemic.

BIBLIOGRAPHY

Adams, Vincanne, (2016). Metrics: what counts in global health, Durham: Duke University Press.

Ahluwalia, Sanjam, (2003). "Rethinking Boundaries: Feminism and (Inter) Nationalism in Early-Twentieth-Century India." Journal of Women's History 14(4), pp. 188-195.

Ahluwalia, Sanjam, (2008). Reproductive restraints: birth control in India, 1877-194, Urbana: University of Illinois Press.

Balasubramanian, Savina, (2018). "Motivating Men: Social Science and the Regulation of Men's Reproduction in Post-war India." Gender & Society 32(1), pp. 34-58.

Bill & Melinda Gates Foundation, (n.d.). "Our work in India." Accessed 10th December, 2020. https://www.gatesfoundation.org/Where-We-Work/India-Office

Char, Arundhati, (2011). "Male Involvement in Family Planning and Reproductive Health in Rural Central India." Academic dissertation, University of Tampere, Finland.

Deshpande, Satish, (2003). Contemporary India: A Sociological View, New Delhi: Penguin India.

Devika, J., (2008). Individuals, Households, Citizens: Malayalis and Family Planning, 1930-1970, New Delhi: Zubaan.

Diamond-Smith, Nadia, McDonell, Claire, Sahu, Ananta B., & Giessler, Katie, (2020), "A Mixed-methods Evaluation of Person-centred Family Planning Intervention for Community Health Workers on Family Planning Outcomes in India." BMC Health Services Research 20(1139).

Ebenstein, Avraham, (2010). "The 'Missing Girls' of China and the Unintended Consequences of the One Child Policy." The Journal of Human Resources 45(1), pp. 87-115.

Family Planning, (2020). "India." Accessed 10 December, 2020. http://www.familyplanning2020.org/india

Fennell, Julie L., (2011). "Men bring condoms, women take pills: Men's and women's roles in contraceptive decision making." Gender and Society 8 25(4), pp. 496-521.

Ford Foundation, (n.d.). "India, Nepal, and Sri Lanka." Accessed 10 December, 2020. https://www.fordfoundation.org/our-work-around-the-world/india-nepal-and-sri-lanka/#:~:text=The%20foundation%20has%20been%20working,to%20nearly%201%2C250%20diverse%20institutions.&text=That%20principle%-20remains%20at%20the,Lanka%20and%20around%20the%20world.

Harkavy, Oscar, Saunders, Lyle, & Southam, Anna L., (1968). "An Overview of the Ford Foundation's Strategy for Population Work." Demography 5(2), pp. 541-

552.

Littlejohn, Krystale E., (2013). "'It's those Pills that are Ruining Me': Gender and the Social Meanings of Hormonal Contraceptive Side Effects." Gender & Society: official publication of Sociologists for Women in Society 27(6), pp. 843-863.

Ministry of External Affairs (n.d.). "Seventh Schedule (Article 246)." 10 December, 2020. https://www.mea.gov.in/Images/pdf1/S7.pdf

Ministry of External Affairs, (2009), "Statement by Dr. Shashi Tharoor, Minister of State for External Affairs during the Commemoration of the 15th Anniversary of the International Conference on Population and Development at the 64th Session of the UN General Assembly." Accessed 10 December, 2020. https://www.mea.gov.in/Speeches-Statements.htm?dtl/1269/

Ministry of Health and Family Welfare, (n.d.). "Hum Do." Accessed 10 December, 2020. https://humdo.nhp.gov.in/

Ministry of Health and Family Welfare, (n.d.). "National Health Mission." Accessed 10 December, 2020. https://nhm.gov.in/

Ministry of Health and Family Welfare, (1983). "National Health Policy: 1983." Accessed 10 December, 2020.

Ministry of Health and Family Welfare, (2000). "National Population Policy: 2000." Accessed 10 December, 2020. https://india.unfpa.org/sites/default/files/pub-pdf/NationalPopulation-Policy2000.pdf

Ministry of Health and Family Welfare, (2002). "National Health Policy: 2002." Accessed 10 December, 2020. https://www.nhp.gov.in/sites/default/files/pdf/nhp_1983.pdf

Ministry of Health and Family Welfare & International Institute for Population Sciences, (2017). "National Family Health Survey – 4." Accessed 10 December, 2020. http://rchiips.org/nfhs/nfhs-4Reports/India.pdf

Ministry of Health and Family Welfare, (2017). "National Health Policy: 2017." Accessed 10 December, 2020. https://www.nhp.gov.in//NHPfiles/national_health_policy_2017.pdf

Ministry of Health and Family Welfare, (2016). "Mission Parivar Vikas." Accessed 10 December, 2020. http://www.nhmmp.gov.in/WebContent/FW/Scheme/Scheme2017/Mission_Parivar_Vikas.pdf

Ministry of Health and Family Welfare & International Institute for Population Sciences, (2020). "National Family Health Survey - 5 Key findings from Phase 1." Accessed 20 December, 2020. http://rchiips.org/NFHS/NFHS-5_FCTS/NFHS-5%20State%20Factsheet%20Compendium_Phase-I.pdf

Morgan, L. M., & Roberts, E. F., (2012). "Reproductive governance in Latin America." Anthropology & Medicine 13(8), 19(2), pp. 241-254.

Narain, S. G. (1968). "India: The Family Planning Program Since 1965." Studies in Family Planning, 11, 1(35), p. 1.

Neji, O., & Nsemo, A.D., (2020). "Socio-demographic factors associated with contraceptives utilization among married women in a rural community in Cross river state - Nigeria." Journal of the Social Sciences 48(2), pp. 1633-1642.

Oudshoorn, N., (2003). The male pill: a biography of a technology in the making, Durham, N.C., London: Duke University Press.

Patil, V. P., Luck, J., Yoon, J., & Khanna, S., (2020). "Domestic Violence and Sterilization Skew in India: An Instrumental Variable Analysis." Journal of Interpersonal Violence 00(0), pp. 1-22.

Rao, M., (2004). "Abiding Appeal of Neo-Malthusianism: Explaining the Inexplicable." Economic Political Weekly, 39(32), pp. 3599-3604

Rao, M., & Mazumdar, V., (2018). The lineaments of population policy in India: women and family planning, London: Routledge, Taylor & Francis Group.

Robinson, Warren C., Ross, John A. (Eds.), (2000). The Global Family Planning Revolution Three Decades of Population Policies and Programs, Washington DC: The World Bank, pp. 301-324. http://documents1.worldbank.org/curated/en/259541468177850467/pdf/405350Familiy0101OFFICIAL0USE0ONLY1.pdf

Robinson, W. C., & Ross, J. A., (2007). The Global Family Planning Revolution Three Decades of Population Policies and Programs, Washington DC: World Bank.

Santhya, K. G., (2003). Population Council Knowledge Commons Changing family planning scenario in India: An overview of recent evidence, South & East Asia Regional Working Paper no. 17, New Delhi: Population Council.

Sen, Soumendu et al., (2020). "Unintended effects of Janani Suraksha Yojana on maternal care in India." SSM - population health 11, pp. 1-10.

Sharma, R. & Pandey, A., (2020), "Does Higher Percentages of Women With Higher Education Within District Impacts Individuals Use of Contraception in Uttar Pradesh?" International Journal of Statistics and Probability 9(4), pp. 1-78.
Shelton, J., (1991). "What's Wrong with CYP?" Studies in Family Planning 22(5), pp. 332-335.

Shri Prahlad Singh Patel, M.P., (2016). "Population Control Bill, 2016." Accessed 10 December, 2020. http://164.100.47.4/BillsTexts/LSBillTexts/Asintroduced/27LS.pdf

Sinding, S. W. (2000). "The Debate About Whether The Great Population Debates: How Relevant Are They for the 21st Century?" American Journal of Public Health 90(12), pp. 1841-1845.

Special Correspondent, (2020). "Rise in teenage pregnancy, higher anaemia rate in women: NFHS-5 phase data," The Hindu, 15 December 2020. https://www.thehindu.com/news/national/rise-in-teenage-pregnancy-higher-anaemia-rate-in-women-nfhs-5-phase-data/article33336112.ece

Tarlo, E., (2003). Unsettling memories: narratives of the emergency in Delhi, London: Hurst & Co.

Trinitapoli, Jenny et al., (2014). “Keeping the family in family planning.” The Lancet 2(7), pp. 383.

Tripathi, Paulomi, (2019). “52nd Commission on Population and Development.” Accessed 10 December, 2020. https://www.un.org/en/development/desa/population/pdf/commission/2019/country/AgendaItem3/india_en.pdf

United Nations Population Fund, (1999). “ICPD+5: Statement of India.” Accessed 10 December, 2020. https://www.unfpa.org/resources/icpd5-statement-india

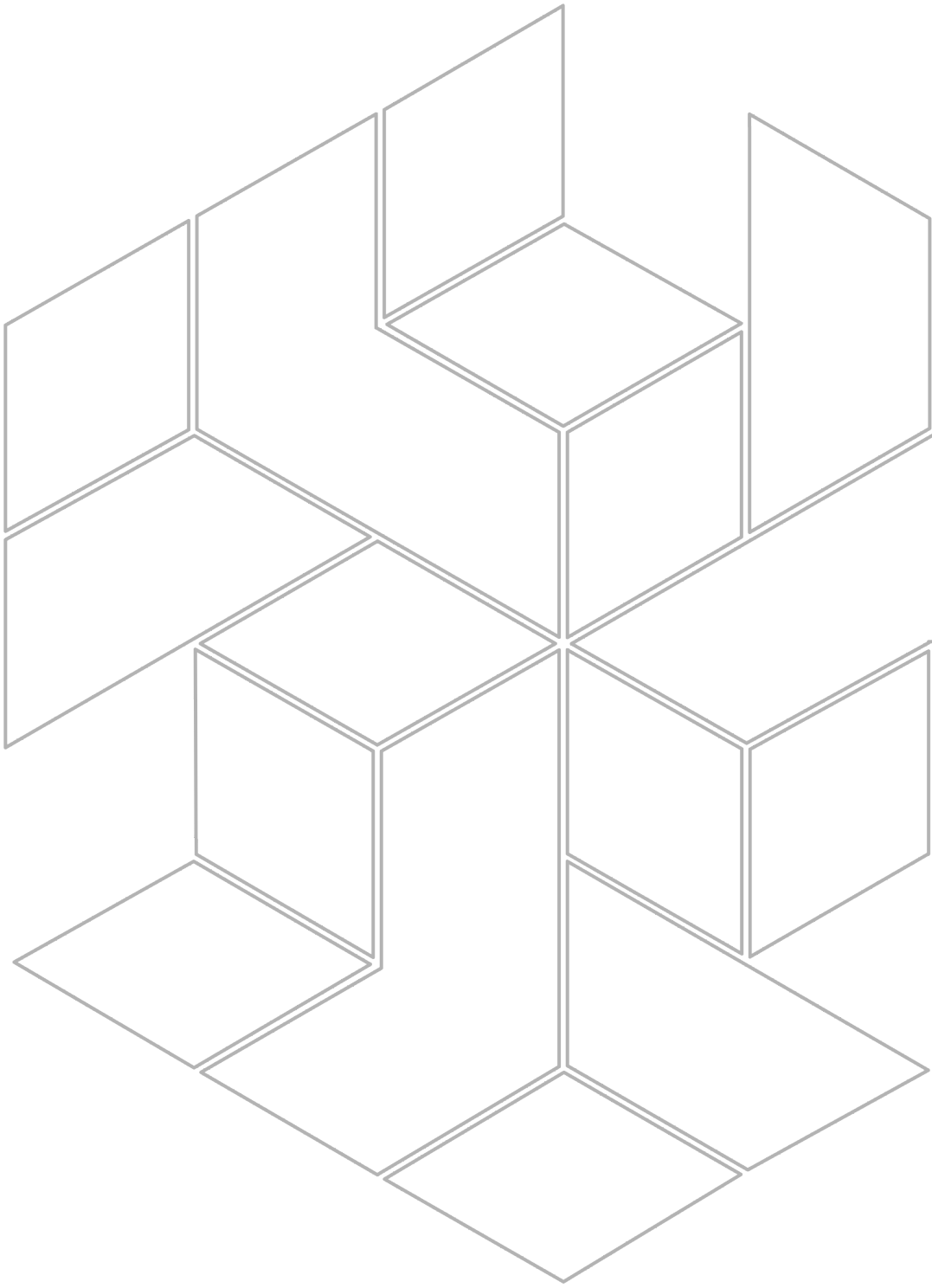
United Nations, (2019) “Contraceptive Use by Method 2019 Data Booklet,” Department of Economic and Social Affairs, Accessed on 8 April, 2020. https://www.un.org/en/development/desa/population/publications/pdf/family/ContraceptiveUseByMethodDataBooklet2019.pdf

Vora, K. S., Saiyed, S. & Natesan, S., (2020). “Impact of COVID-19 on family planning services in India.” Sexual and reproductive health matters 19(6), pp. 1-3.

Wolff, B., Blanc, A. K., & Ssekamatte-Ssebuliba, J., (2000). “The Role of Couple Negotiation in Unmet Need for Contraception and the Decision to Stop Childbearing in Uganda.” Studies in Family Planning 31(2), pp. 124-137.

Yadav, K., Singh, B., & Goswami, K., (2009). “Unmet family planning need: Differences and levels of agreement between husband-wife, Haryana, India.” Indian Journal of Community Medicine 34(3), pp. 188-191.

Yore, J. et al., (2016). “CHARM, a gender equity and family planning intervention for men and couples in rural India: Protocol for the cluster randomized controlled trial evaluation.” Reproductive Health 13(1), pp. 2-16.



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