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# Despite Choices Women Shoulder the Burden of Family Planning

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India's population control policies continue to be women-centric, with female sterilisation being the largest mode of intervention at 36 per cent, while male sterilisation is a mere 0.3 per cent, according to data from the National Family Health Survey, 2015-16. File Photo: AP. AP

*The Indian state has for long propagated population control without sufficiently addressing overall and reproductive health concerns. From the initial emphasis on mass sterilisations to a later stage in which a basket of contraceptives became available there has been a progression in the methods of intervention. However, as* ***Manisha Chachra****, research scholar in Political Science, Jawaharlal Nehru University, New Delhi, points out in this article, the paradox of women shouldering the burden of family planning persists as is evident from the fact that despite availability of choices, female sterilisation accounts for 75 per cent of birth control measures.*

Sumati Devi, 25, was lured into a deal of Rs.50 to get her fallopian tubes cut and tied. Sumati was advised by the health officials to undergo this operation as it was the sole way to lift her out of her 'poor circumstances'. Poor women in India are often incentivised by the state to undergo sterilisation[1].

The Indian state's focus since 1947 has been to try and control an exploding population. This has meant that family planning has become a pivot for all population goals to be met. The initial Five Year Plans focussed on two aspects: firstly, reducing population as a developmental goal, and secondly, improving women's health through birth

control [2] . Mohan Rao, for instance, writes that family planning disassociated reproductive health from its social and economic context. Quite intriguingly, family planning in India has often been labelled as a 'cafeteria' planning programme, with a range of temporary available options like Intra-Uterine Devices (IUDs), pills, and condoms. However, the use of these remains almost negligible [3] .

**From vasectomies to sterilisation**

By the 1970s permanent birth control methods, like sterilisation, were sold to the poor using financial incentives. States competed with each other to conduct camps. For instance, Gujarat stole Kerala's thunder by achieving 160 per cent of its annual target in less than two months. Within several States, districts competed against each other sometimes to disastrous results [4] . In Gorakhpur in Uttar Pradesh, 11 men died of tetanus as a result of vasectomy procedures in 1972 [5] . An observed feature during this phase was the distribution of radio transistors to male members in exchange for vasectomies. Nonetheless, the government was forced to drop the policy of sterilisation, firstly, due to incidents of mortality as in Gorakhpur and secondly, because the camps consumed too much resources at the expense of other health-related priorities.

Further, the programme received ceaseless criticism from public health activists for forcing the poor into sterilisations. Forced mass sterilisation of poor men was among the major reasons for the Congress's loss in the General Election of 1977. The family planning programme shifted its focus from male vasectomies to female sterilisations in the 1980s. As the economy grew, so did the number of female sterilisations. According to a study by T.K. Sundari Ravindaran, female sterilisations which formed 46 per cent of all sterilisations in the 1970s, rose to 85 per cent in the 1980s [6] . The 'developmentalist' perspective of international institutions such as the World Bank and the United Nations Fund for Population became a role model for developing countries. However, there was serious neglect of reproductive health care. The stark reality was that many such operations were performed on women already carrying genital infections [7] . The sterilisations were performed without treating these problems, further damaging the women's reproductive health. Case studies from Tamil Nadu have shown that at least one out of three women had such infections. One major reason for this was that reproductive health was integrated within the broader policy of family planning, thus, separate resources which should have been dedicated to maternal health were restricted to ante-natal health care. However, as the pressure of criticisms by public health groups and women activists increased, the International Conference on Population and Development (IPCD) in 1994 effected a significant shift in its view of reproductive health. The main agenda of the IPCD was to take essential steps in improving reproductive health and empowerment of women. The result was an important shift from 'development' to 'reproductive and child health approach'.

**Contraceptives and freedom for women**

In the U.S., reproductive rights got linked to the women's rights movement which vehemently asserted the rights of women over their bodies, and especially underlined the female choice to carry pregnancies to term. Thanks to this assertion, there was a shift in the visualisation of women who were until then treated merely as bodies and reproductive machines. The 'free woman' advocated the use of contraceptives thereby presumably gaining control over her body. However, this also led to the rampant marketisation of contraceptives. As Mohan Rao writes, "the new reincarnations of old concerns, didn't camouflage the essential concerns of both World Bank and private funding agencies in the West". Therefore, what appeared on the surface to be 'empowerment' was just another subterfuge employed by vested interests to take over the entire gamut of reproductive issues. The actual and genuine concern for reproductive health was conspicuously absent. Nonetheless, at the Beijing Women's Summit in 1995, it was reiterated that women's concerns cannot simply be relegated either to the realm of reproductive rights or population control. Agnihotri and Mazumdar opined, "terms like empowerment, choice, reproductive freedom are being appropriated by forces inimical to the goals of women's movement" [8] .

In India, the transition from sterilisation methods to contraceptives, has been a tragic one. The family planning programme was and continues to be hugely dependent on sterilisation. State governments have carried these out without proper medical facilities or risk assessments. In a tragic instance in Chhattisgarh in 2013, 83 tubectomies were performed in five hours [9] . Women in the camps were herded like cattle, and an estimated 15 women died of anaemia and infections caused by the use of a single instrument to perform ten surgeries. The reason for the recklessness was to meet sterilisation targets or what is now euphemistically called the 'Expected levels of achievement' [10] . The current phase of neo-liberalisation has moved 'globalised India' towards a larger "basket" of contraceptive choices [11] . However, despite the basket of choices available, contraceptive use as a form of birth control is rising only slowly. The National Family Health Survey (NFHS) 2014-15, conducted in Indian households consisting of married women between the ages of 15 and 49, found that in all 47.8 per cent of all households practised some form of modern birth control. The sub-division of the methods was in this order: Female sterilisation, accounting for the biggest chunk, at 36 per cent (or around 75 per cent of total birth control methods), male sterilisation at 0.3 per cent and use of ipills and condoms at 4.1 per cent and 5.6 per cent respectively. Importantly, the survey registered a fall in the proportion of households practising birth control compared with the last survey conducted in 2005-2006.

In 2012, at the London Summit on Family Planning, which was a core partnership with the Bill and Melinda Gates Foundation, the Family Planning 2020 Initiative (FP 2020) was launched. While the FP2020 advocates a global figure of 120 million women to use contraceptives, India aims to target 48 million women to use contraceptives by 2020s. Such targets have often ended up putting the burden of rearing family and progeny on the women rather than actively advocating the use of condoms to prevent unwanted pregnancies.

Female contraceptives are available in the three categories of oral, injectables and insertables. While the oral are hormonal and non-hormonal pills, the injectables have been introduced recently. According to a recent Lok Sabha answer, injectable contraceptives introduced under the National Family Planning Programme, would be made available in a phased manner starting in medical colleges and moving up to district hospitals, community health centres and subsequently to primary health centres and sub-centres. However, from the standpoint of public health and women's rights the move has received huge opprobrium. First, the injectable contraceptive, technically known as 'Depo-provera', is known to cause such side effects in young women as prolonged bleeding, suppression of immune response, loss of bone mineral density, significant weight gain, depression and loss of libido. More dangerously, injectable contraceptives like Depo-provera are bound to increase dependency on female contraceptives rather than barrier methods, thereby, increasing the risk of HIV [12] .

Studies show that three out of four women have discontinued Depo-provera due to menstrual disruptions caused by it. [13] In the ultimate analysis, any policy execution cannot only be to meet a target: The task is not just to achieve a figure of 48 million but to take care of 'public health'. In order to take care of public health, it is pertinent to have adequately trained family health service providers. The case studies from Uttar Pradesh have explicitly shown that family health service providers remain ignorant about contraindications and adverse effects of many contraceptive methods. For instance, less than 9 per cent named genital tract infections as a possible adverse effect of IUD insertion, and more than 80 per cent said that tubal ligation had no adverse effects whatsoever [14] . Also, a substantive amount of evidence indicates the absence of counselling sessions before method introduction.

As a policy, the family planning programme in India has been more concerned with population reduction than the broader idea of public and reproductive health. Apart from the forced male vasectomies in the 1970s, the dependence on interventions on women's reproductive rights is evident from the herding of women in sterilisation camps, and the present attention to contraceptives, which are female-dependent and against gender equality. The Family Planning 2020 goal has neglected the role of men in contraception, the advertisements in television have tended to project ipills as an emergency rescue mechanism for women to avoid unwanted pregnancies and abortion. Instead of providing safe abortion services, the state services and campaigns often emphasise the

avoidance of abortion. The lack of a gendered approach in family planning is not the sole flaw; the bigger concern is the way the state has begun to control female bodies. The NFHS data, showing sterilisation at the top of birth control measures, confirm this harsh picture.

**Gender bias in choice of contraceptive**

Often a perception among youngsters is that the use of condoms could be intrusive, therefore, the only recourse left is that of pills. While on the one hand, deployment of contraceptives reveals a deeply embedded gender bias, on the other hand, the policies of the state have become a reflection of such understandings. In contemporary times, family planning has exclusively paid heed to the "basket of contraceptive choices" and its advantages in safeguarding maternal health. However, the unstated mission in pushing this appears to be to discipline and control women's bodies, and paradoxically to do so under the guise of "free choice for women".

The large basket of choices has ostensibly expanded the choices available to households in planning their families. Nonetheless subtle state propaganda is training families to get habituated to policies like the 'two-child' norm. Foucault has called this aspect of disciplining bodies and regulating fertility as 'bio-power' [15] . The campaigns such as '*Hum do, Humare do* (We two, our two), *Chota parivar*, *Sukhi parivar* (Small family, Happy family)' are compelling ways through which different State governments regulate the reproductive activities of their citizens. The question to ask, though, is not whether the state is right in doing so but whether people can resist this onslaught over their bodies.

**References:**


1.^ Bloomberg. [n.d]. "India's Poorest Women Coerced Into Sterilization". [Behind paywall.]
2.^ Rao, M. 1994. "The Writing on the Wall Structural Adjustment Programme and the World Development Report 1993: Implications for Family Planning in India." *Social Scientist,* Vol. 22, No. 9/12, September - December, pp 57 of 78. Last accessed May 29, 2017.
3.^ Salkeld, G. F. 1981. Communicating Family Planning in India. *India International Centre Quarterly*, 8(3/4), pp 278 of 288.
4.^ Rao, M. 1994. "The Writing on the Wall Structural Adjustment Programme and the World Development Report 1993: Implications for Family Planning in India." *Social Scientist,* Vol. 22, No. 9/12, September - December, pp 62 of 78. Last accessed May 29, 2017.
5.^ Ibid. pp. 62.
6.^ Ravindran, Sundari T.K. 1993. "Women and the politics of population and development in India." *Reproductive Health Matters,* Vol. 22, No. 9/12, May. p 27. Last accessed May 29, 2017.
7.^ Ibid. pp. 32.
8.^ Rao, M. 2000. "Family planning programme: Paradigm shift in strategy." *Economic and Political Weekly*, Vol. 35, No. 49, December 2-8, pp 4320. Last accessed May 29, 2017.
9.^ Pleasance, C., Tomlinson, S. 2014. "Sub-standard drugs now blamed for deaths of 14 women sterilised by Indian doctor who claims he is being made a scapegoat", *MailOnline*. November 13. Last accessed May 29, 2017.
10.^ Hartmann, B., and Rao, M. 2015. "India's Population Programme." *Economic & Political Weekly*, October 31, Vol. 50, Issue No. 44. pp. 10. October 31. Last accessed May 29, 2017.
11.^ Ibid. pp. 10.
12.^ Ibid. pp. 11.
13.^ Ibid.
14.^ Ravindran, Sundari T.K. 1993. "Women and the politics of population and development in India." *Reproductive Health Matters*, Vol. 1, No.1, May, pp. 33. Last accessed May 29, 2017.
15.^ Foucault, M. 1984. "The Foucault Reader, ed." Rabinow, P. New York: Pantheon, pp. 17. Last accessed May 29, 2017.



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