Whose Body, Whose Choice? Evaluating birth control policies and reproductive rights of women in India

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Executive summary:

This policy report evaluates the consequences of birth control policies on female reproductive rights in India, shaped by their political history following their independence to date. Through a gendered lens, this piece aims to specifically analyse the impact on women, who disproportionately face the burden. Additionally, using an interdisciplinary approach, which delves into cultural and socio-economic norms, this report highlights the need for a stronger policy stance on a governmental level in order to address the stigma around contraception in India.

Introduction:

Despite India being the first country in the world to launch a National Programme for Family Planning in 1952, five years after its independence, women's autonomy and its future remain uncertain. Historically, India's family planning policies have been aimed at population control to stimulate economic development as opposed to advancing women's autonomy over their own reproductive health (Chatterjee and Riley, 2001). Consequently, the government's fears, reflected in its coercive policies and their corresponding impacts, remain very much prevalent in India today.

Most recently, the 2019 to 2021 National Family Health Survey (hereafter NFHS-5) highlights that more than 99% of married men and women in India aged 15-49 know about one modern method of contraception (International Institute for Population Sciences and ICF, 2021). Despite the usage of contraception rising, this has mainly been burdened upon females in the form of sterilisation, which has increased over the last five years (Pandey, 2022). However, male sterilisation is safer, and other contraception methods, such as condoms, are used by less than 1 in 10 Indian men (Pandey, 2022). The misconceptions for men in engaging with contraception, such as sterilisation and condoms, are associated with losing their masculinity and not being able to work in jobs that involve hard labour. Consequently, female sterilisation has remained the most popular form of contraception in India (Bansal et al., 2022). This is heavily attributed to the socio-economic norms embedded within the community, coupled with the coercive policies implemented, becoming the main drivers for India's contraceptive taboo. Ultimately, these factors serve as a proxy for India's unwanted pregnancies, with a major decline experienced in the intention to use contraception, falling from 90.19% to 18.5% (Singh and Singh, 2025).

As a result, there are wider implications for women's economic independence, ranging from access to higher education and the ability to attain formal jobs, whilst bearing the community's burden for *her* supposed actions. This policy brief comprehensively examines how the birth control policies in

India disproportionately affect women, evaluating how social norms influence access to contraception, and proposes detailed recommendations to ensure women can access contraception equitably. This advances the broader theme of the intersection of reproductive health and development in public policy, specific to an emerging economy.

The analysis shall address the following core questions:

1. What precedents have the birth control policies in India been based on, historically?
2. What have these policies meant for women and, in particular, how has limited male participation in contraception led to this conditioning?

   What are potential policy interventions needed to promote greater equity in contraceptive rights in India?

Background- History of India's birth control policies:

i) 1951-1956: First Year Five Plan:

In this period, India held the assumption that socioeconomic development would be hindered by rapid population growth. This led to the introduction of the National Family Welfare Programme. Here, their overall goal was to reduce the birth rate to stabilise the population and become an economically dominant nation.

Heavily referred to as a Gandhian approach, there was a great emphasis surrounding the impracticality and misuse of artificial birth control methods. This heavy influence of abstinence being the most appropriate method for Indians guided the clinical approach amongst health care facilities to provide contraceptive services to couples to reduce family size (Wang, 2019).

ii) 1956-1961: Second Five Year Plan:

The Second Five-Year Plan period was a continuation of the initial program; however, funding increased to 49.7 million rupees (Wang, 2019). Despite this, the Gandhian and clinical approaches remained ineffective, as citizens did not believe there was a need for family planning. Thus, the population census highlighted continuous population growth in India, with an annual percentage change in the population rising from 0.02% in 1960 to 2.43% in 1961 (Macrotrends, 2025).

iii) 1962-1977: Imperative and Target Oriented Period:

Over this period, the Indian population control policy gradually became more intensive. This overlapped with the 1961 to 1966 Third Five-Year Plan, with the Indian government considering a high birth rate to be the biggest barrier to their economic growth. Here, the government distributed condoms to communities, with family planning workers receiving monetary rewards for acquiring sterilisation cases for Indian families. Over the period from 1969 to 1974, the Fourth Five-Year Plan, sterilisation was the most prevalent strategy for the family planning scheme. Notably, cash incentives played a

universal role to encourage sterilisation, with official figures showing a positive relationship (Sur, 2017).

iv) 1974- 1979: Fifth Five Year Plan:

In the Fifth Five-Year Plan, Indian policy makers announced sterilisation as compulsory for family planning. From 1975 to 1977, Indira Gandhi declared that India was in an "Emergency", with the Central Government increasing the financial incentives for employees to conduct sterilisation (Scott, 2017). Ultimately, this use of coercion doubled the Central Ministry of Health and Family Planning's original figures across all of India's major states, excluding three (Gwatkin, 1979).

v) 1980-1985: Sixth Five Year Plan:

Following the discontent amongst the Indian population for the enforced sterilisation programmes, Indira Gandhi's government, which adopted this policy stance, was voted out in the 1977 elections. Due to the political fallout, the government relaxed compulsory sterilisations and promoted family planning as a core part of India's development agenda (Chaurasia and Singh, n.d.).

vi) The present:

After the Sixth Five-Year Plan, India's population and birth control policies have ranged from attempts to achieve demographic targets to reshaping policies for families to attain their reproductive goals. This has addressed health care infrastructures and reproductive health care, with the aim of empowering women. However, despite these policy changes, many socio-economic factors, ranging from poverty to the caste system, have played a role in the disproportional variation of women's reproductive rights and contraception usage in India (Sikdar and Bansod, 2025).

What do the policies mean for women?

Despite the implementation of the Sustainable Development Goals advocating for Gender Equality (SDG 5), India's birth control policies have continued to target women for mass sterilisations. Evident through the 2016 to 2017 family planning budget, India spent 85% of it on female sterilisation (De La Rupelle and Dumas, 2025). This has been sustained due to the deep-rooted, prevailing discourse in India, which considers women's lives as disposable (Wilson, 2018).

Notably, the Gandhian approach has pushed the neoliberal development framework pursued by India, which has shaped contemporary population control policies and influenced attitudes towards birth control. The history of coercive sterilisations is a form of institutional violence perpetrated by the state, and is amplified by the intersection of race, gender, and caste (Wilson, 2018).

i) Women's health:

Due to these sterilisation policies, women are at greater risk of health complications. This coercion and lack of autonomy have been reflected in a camp in Bhubaneshwar, Odisha, where 56 women were sterilised in one day by a doctor using a bicycle pump to inject air into their abdomens instead of the appropriate medical equipment, i.e., an insufflator, which would introduce carbon dioxide (Srinivasan, 2016). During an interview, the same doctor justified this as standard practice after performing 60,000 tubectomies using bicycle pumps (Srinivasan, 2016). The medical practices are highly indicative of a rather apparent violation of basic human rights for women to access basic health care safely.

This has been further evident by the state-run mass sterilisation campaign scandal in 2014 in Chhattisgarh. Here, more than 80 women underwent surgery for laparoscopic tubectomies, 60 of whom fell ill afterwards, and 11 of whom died from blood poisoning or from a haemorrhagic shock (Burke, 2014). Sold under the discourse that "it was a minor operation", witnesses described health workers "herding them like cattle" (Burke, 2014). Once again, India's birth control policies are under scrutiny for endangering women, shedding light on the dominant hegemonic modes of thinking reflected via the adopted policy stance.

ii) Cultural factors:

In many patriarchal Indian communities, particularly in rural villages, men are the primary decision makers regarding contraceptive use. This stems from socio-demographic factors and attitudes towards contraception, which consider it to be a "women's business." Notably, this is a major challenge, as 63% of the population resides in rural India (World Bank Group, 2025). Thus, the uptake of information surrounding birth control has been heavily influenced by the state, emphasising female sterilisation.

Myths and misconceptions surrounding male sterilisation impacting virility contribute to the burden of family planning disproportionately falling upon women, and the ideology that female sterilisation is superior (Hall et al., 2008). In addition, male engagement in India's family programmes has been significantly low, as men tend to use condoms unsafely or engage in heavy drinking, thus refusing to practice safe sex. Ultimately, the conditioning of women contributes to their limited autonomy over their reproductive health decisions, leading to unintended pregnancies. Between 2015 to 2019, 44% of the 48,500,000 total pregnancies in India were unintended (Guttmacher Institute, 2025).

iii) Female labour force participation:

In India, there is a gendered responsibility for caregiving, with women facing a double burden to undertake caregiving responsibilities of the family and paid work (Mazumdar et al., 2023). Consequently, this has partly contributed to India's lower rates of female labour force participation.

This is further exacerbated at the level of state policy, where in 2017, India passed the Maternity (Amendment) Bill, which increased the paid maternity leave for working women from 12 weeks to 26 weeks, becoming the third highest in the world. Whilst this is a seemingly generous maternity law, it only applies to women who work in a company with a minimum of 10 employees, merely benefiting 1% of India's women (World Economic Forum, 2019). Consequently, 70% of Indian women do not work at all, and 84% work in the informal sector or for companies with fewer than 10 employees (World Economic Forum, 2019).

To reflect, the legislations surrounding birth control policies are exacerbated by the intersection of unequal social norms and the poor use of contraceptives disadvantageous to women. Once they have their children, they are unable to secure economic independence, as the maternity laws do not consider women working in the formal sector.

Policy recommendations:

i) Community based engagement:

As discussed, the current policies implemented by India surrounding reproductive rights and birth control lack the specificity to address the wider implications on women's health, and the unintended consequences of pregnancy.

Greater community-based engagement is vital to educating and enhancing male engagement in family planning. This is crucial not only to protect women from unintended pregnancies but also to address stigmas around contraceptive usage, which is ubiquitous in India. Therefore, community-based interventions, such as hosting discussions amongst villages, are an important step towards attaining reproductive autonomy for women. Ultimately, these interventions can serve as catalysts for challenging the embeddedness of deep-rooted patriarchal beliefs, undermining the efficacy of policies (Lawrence and Hensly, 2023).

Not only should community-based interventions address older men and women who heavily influence the values of younger generations, but it is also vitally important that there is an emphasis on young boys and men. Men in India currently exercise reproductive power over women via a lack of family planning, but they are also critical and primary decision makers over female bodily autonomy (Diamond-Smith et al., 2024). This is vital to ensure India makes significant progress in women's access to sexual and reproductive health services, especially where, from 2019 to 2021, only 7.85% of women were able to make independent reproductive healthcare decisions, falling from 9.11% in 2015 to 2016 (Tayal et al., 2024). However, this relies heavily on government intervention, which sets the precedent for these steps of progression to occur.

ii) The importance of good government intervention:

India's government intervention has deeply shaped women's reproductive rights and bodily autonomy, reinforcing the patriarchal stance existing in India today. In pursuit of economic growth, India's government has left women marginalised through its history of reproductive policies.

Whilst women comprise over 48% of India's population, only 15% are represented in Parliament (Sharma, 2023). This lack of female representation in matters of reproductive female health has been reflected in the patriarchal policies. Government intervention is important for defining the legal foundation and framework for women's reproductive rights.

India's government has a pivotal role in shaping a rights-based intervention to safeguard women's autonomy, in order to attain its SDG targets by 2030 (Saggurti and Gupta, 2025). Thus, it is imperative to strengthen the coordination of programmes and monitor their progress to ensure adequate quality of care standards (Muttreja and Singh, 2018).

Addressing the current information gaps, with India's caste system playing a major role in legitimizing patriarchal norms, is important to target. Therefore, implementing initiatives to empower women to challenge social norms, devising awareness campaigns, and making it compulsory to learn about reproductive health in the education system from a young age, are all steps toward major changes, practicing good government intervention to move towards a more equitable society.

Conclusion:

To conclude, India's pursuit of growth since its independence has moulded birth policies and reproductive rights to meet its economic objectives. However, India's development discourse surrounding Neo-Malthusian populationism has been deeply implicated in the violation of women's rights and reproductive autonomy.

By adopting a gendered lens, this policy paper explored the wider implications of the patriarchal policies, which have been valuable in investigating the disproportionate consequences on women. This raises the question of who should be in control of reproductive rights, but also who actually makes the decision. Importantly, policymakers, health care providers, and community leaders must engage in a genuine collaboration to fully support women. Especially as birth policies have global implications that are vital to shape equity for generations to come.

However, the extent to which these changes can be implemented is debatable, as many of the problems discussed are systemic, intertwined with India's neoliberal agenda, all in the name of pursuing economic prosperity. This sheds light on the power doctrine, where the majority of men elected in the government make decisions about women's bodies, "for women." Hence, it is important to reflect and place responsibility upon the relevant actors and social dynamics to witness visible change for all women in India.

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