EXPANDING CONTRACEPTIVE CHOICE IN INDIA: ISSUES AND EVIDENCE

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INTRODUCTION
This paper aims to: (1) review the policy process and the design and implementation of the national programme, focussing specifically on expanding contraceptive choice; (2) examine barriers that have impeded contraceptive choice at the policy, programme, community, and household levels; and (3) suggest programme strategies for promoting expanded contraceptive choice in India.

India has the unique distinction of sponsoring the first national family planning programme in the developing world. Since the state-sponsored programme was initiated in 1951, India's demographic and health profile has changed radically. Between 1951 and 2001, mortality decreased by two-thirds, fertility declined by about two-fifths, and life expectancy at birth doubled. India's population has more than doubled since 1961. Mortality and fertility decline ran roughly parallel for many years, so that the population growth rate remained above 2 percent per year until 1991. By 2003, the annual population growth rate was 1.93 percent1, the crude birth rate was 25.8 per 1000 live births2, and the total fertility rate was 2.83.

Policy context
Although policy in India has undergone considerable change over time, demographic goals to reduce birth rates and stabilise population have remained its consistent feature. From its inception, the national programme has been dominated by efforts to achieve demographic goals. In the mid-1960s, the government introduced method-specific contraceptive targets to achieve these goals. Although successive five-year plans have stated that a 'cafeteria approach' should be implemented to provide clients with a choice of contraceptive methods, the concept of choice has not been implemented within the national programme to date. For the past several decades, female sterilisation has been the dominant method in the national programme.
even though it is widely acknowledged that an
over-riding emphasis on a single method is
unlikely to achieve the desired demographic
impact or meet clients’ needs.

Soon after the International Conference
on Population and Development (ICPD) in
1994, the Government of India set in motion
a process to translate the ICPD Programme of
Action within the national context.
This implied a major paradigm shift
which necessitated several policy changes.
The first significant step taken in April 1996
was to remove method-specific contraceptive
targets nation-wide. The removal of targets,
which had driven the programme for decades,
was a necessary pre-requisite for providing
contraceptive choice. The second major
initiative was to launch the Reproductive and
Child Health (RCH) Programme in October
was announced in February 2000 and the
National Commission on Population,
represented by multiple stakeholders
including the central and state governments,
non-government organisations (NGOs), the
private sector, the media, and others, was set
up soon thereafter to facilitate policy
implementation.

The immediate objective of the National
Population Policy was to address the unmet
needs of contraception in order to bring
the total fertility rate to replacement level
by 2010. Its long-term objective was to
achieve population stabilisation by 2045.
The Tenth Five Year Plan of the Government
of India outlined efforts in three broad
areas: 1) meeting the unmet need for
contraception; 2) enabling families to
achieve their reproductive goals; and 3)
reducing infant and maternal mortality.
Thus, national policy initiatives have
continued to place a major emphasis on
achieving demographic goals by addressing
contraceptive needs.

Until the mid-1990s, a top-down
population control approach had been
employed. A key feature of the programme
had been the achievement of method-specific
contraceptive targets. The paradigm change
espoused by the National Population Policy
required that the programme shift its focus
from controlling population to addressing
clients’ multiple reproductive health needs,
including contraceptive needs. To achieve this
goal two major challenges had to be
addressed. First, it was necessary to create an
understanding of the paradigm shift i.e. a
reconceptualisation of the population
problem by all stakeholders. And second,
service delivery programmes had to be
redesigned to effectively address clients’
reproductive health needs. An important
principle for action was freedom of choice for
each individual. Providing reproductive
choice necessitated that the target approach,
which had proved to be coercive and,
therefore, not compatible with the principle
of choice, be replaced by quality services to
respond to clients’ multiple reproductive
health needs. The Reproductive and Child
Health programme was designed to provide
need-based, demand-driven, high-quality,
integrated services to address clients’ needs.

When India became ‘target-free’ in 1996,
the government proclaimed that a ‘basket of
services’ would be provided to address
multiple reproductive health needs of clients.
The National Population Policy articulated
the ICPD principle of the right of couples and
individuals to decide freely and responsibly
the number and spacing of their children and
to have the information and means to do so.
The Reproductive and Child Health (RCH)
Programme aimed to translate these principles
into action.

After the RCH programme was initiated,
and after the National Population Policy was
enunciated by the Government of India,
several events took place at the state level
which resulted in a reversal in programme
direction. State governments began to
formulate state population policies that were contrary to the principles enshrined in the national policy. To be politically correct, state policies co-opted the ICPD language of reproductive health and rights, simultaneously encouraged the implementation of variants of the target approach using incentives and disincentives. For example, the population policy of Madhya Pradesh advocated debarring individuals marrying before the legal age at marriage from seeking jobs, getting admission in educational institutions, applying for loans, and contesting local body elections. Several states have enacted legislation that debars persons with more than two children from standing for panchayat and other elections. The rationale cited is that these elected members would serve as role models for their constituencies. In reality, such measures are both irrational and impractical because, it is not possible to implement such legislative measures when birth and death registration in the country is incomplete. Such legislation discriminates against women who do not decide the number of children that they will bear. Moreover, role models are not needed today when people no longer want large families. These political gimmicks, designed to play on the public’s perception and concern of the seriousness of the population problem, is intended to deflect attention from the real issue of providing information and services to people who want to limit family size and have an unmet need for contraception. Clearly, the priority of the national programme should be to provide information and services to address clients’ unmet needs. These serious contradictions between national and state population policies and between policy articulation and policy implementation by key decision-makers that the ‘target-free’ approach implemented by the government was flawed.

The government’s target-free manual for workers promoted a system called ‘client segmentation’ to guide method choice. This system placed clients (primarily women) into categories which determined the method they would be offered. This system also assumed that the provider knows what is best for the client. Yet another deeply entrenched belief that clients are illiterate and unable to make choices therefore providers must decide what is best for them has also impeded choice by clients. The government’s manual for field workers does not focus on clients’ preferences or choice. Nor does it provide information on method switching.

The “target approach” has become so deeply entrenched in the mind-set of policy planners and service providers that their commitment to the population control paradigm remains unshaken, believing the target approach to be the unequivocal answer to the problem.

The divergent views among key stakeholders — between the Ministry of Health and Family Welfare and the National Commission on Population (housed in the Planning Commission); between the central government and state governments; among various donors; as well as between demographers and women’s health activists. The National Commission on Population that was mandated to bring together different stakeholders did not dialogue to reach common ground. Instead of implementing the tenets of the National Population Policy and promoting reproductive choice, the leadership within the Secretariat of the National Commission on Population continued to actively promote the population control approach. Leadership within the Ministry of Health and Family Welfare has also begun to reinforce the population control paradigm. Thus, there is a growing consensus to promote the two-child norm and re-instate the target approach.

Demographic context
Over the past decade, needs for contraception have changed dramatically in India. Demographic transition has been underway and fertility has declined in all the states in the country. In several states (Kerala, Tamil Nadu,
Goa, Karnataka, Andhra Pradesh, Punjab, and Himachal Pradesh), the total fertility rate has reached or is close to reaching replacement level, Thus, couples no longer desire large families in most parts of the country. Most couples want to limit and/or space their births. Data from the National Family Health Survey-2 (NFHS-2) show that in 1998-99, 16 percent of married women had an unmet need for contraception of which more than half (8.3%) was for spacing births. Some estimates indicate that if all unwanted births were eliminated and the unmet need for contraception was adequately addressed, the total fertility rate in India would drop to replacement level.

The pace of fertility decline has been slower in the large, more populous northern states of the country which also depict gloomy statistics for other socio-developmenta indicators — low levels of education, low age at marriage, low women’s status, and high infant and maternal mortality. But couples in the northern states also no longer want large families. There is, in fact, a large unmet need for contraception in these states. Son preference is stronger as women’s status is low and girls are devalued in these states. The desire for small families coupled with son preference and the availability of ultrasound and other sex-selective technologies has resulted in a growing trend in female foeticide and declining sex ratios in the country. Sex ratios are more seriously distorted in the northern states where they are as low as 700-800 in some districts. It is indeed, ironic to observe that couples in India are exercising choice, not only in the number of children but also in the sex composition of their families.

**Contraceptive prevalence**

During the past decades, female sterilisation has been the mainstay of the national programme. In 1998-99, contraceptive prevalence was 48 percent in India. It was considerably higher in urban (58%) than in rural (45%) areas. Figure 1 shows contraceptive methods that couples were using in 1998-99. Female sterilisation accounted for 84 percent of contraceptive prevalence due to modern methods; it was 75 percent when all methods were included. Although reported by a negligible minority, female sterilisation was the most commonly used method even by married adolescents. A review of contraceptive behaviour of adolescents in Asian countries shows that India is the only country where such a pattern prevails.
Data from the National Family Health Survey 1 and 2 (NFHS-1 and 2) show that 82 percent of women sterilised had never used any other method before they underwent sterilisation indicating that female sterilisation has continued to dominate the method-mix in India. Although there has been an improvement in the knowledge of reversible contraceptive methods, these methods still account for a very small fraction of contraceptive use in India (15, 16). During the six-and-a-half year period between NFHS-1 and 2 there was a minimal increase (from 6% to 7%) in the proportion of couples using pills, IUDs, and condoms (Figure 2). Modern reversible methods accounted for 6 percent of contraceptive use by illiterate women and 35 percent of contraceptive use by women with at least high school education. Various studies based on NFHS-1 data show that even after controlling for the effects of other factors, education remained a key factor influencing contraceptive use (17).

NFHS-2 documents the dominance of the female sterilisation method in almost all states in the country. More than 90 percent of modern contraceptive method users were sterilised in the southern states. In Andhra Pradesh, of all modern method acceptors, 97 percent were women who had undergone sterilisation. The only exceptions were Delhi, Punjab, and a few northeastern states where the proportion of female sterilisation acceptors was lower, constituting 32-46 percent of modern method acceptors. This pattern prevailed throughout the 1990s.

Among the larger states, Bihar (25%) and Uttar Pradesh (28%) had the lowest levels of current contraceptive use, followed by Rajasthan (40%), Assam (43%), and Madhya Pradesh (44%). Low contraceptive prevalence in these states has important implications for future population growth because these states together account for more than 40 percent of India’s population. NFHS-2 showed a marginal increase in the use of reversible methods in Delhi and Arunachal Pradesh and a slight decline in the Punjab, West Bengal, Assam, and Meghalaya. In the Punjab and Delhi, 34 and 43 percent, respectively, of current contraceptive users used modern reversible methods. As expected, the use of reversible methods was higher among educated women and among those living in urban areas.  

**FIGURE 2**

*Trends in contraceptive methods use in India, 1992-93*

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Source: NFHS-2
Contraceptive choice

Currently, the method-mix in the public sector programme includes five official methods — female sterilisation, male sterilisation, IUD, pills, and condoms. Injectable contraceptives are available through the private sector. Feminist groups have opposed the introduction of provider-dependent methods such as injectables because they are concerned about their safety when provided through weak delivery systems that render poor quality of care in the public system. In 2001, the Government of India introduced emergency contraception within the RCH Programme. National guidelines for the use of emergency contraception were prepared and emergency contraceptive pills were made available through medical officers at the district and sub-district levels. In 2002, the Central Drug Controller granted approval to several private manufacturers for marketing emergency contraceptive pills.

Through the decades, the national programme has focussed on providing messages to promote the small family norm. Due to inadequate information provided by the programme, clients’ knowledge about contraceptives, their sources of supply, their side-effects, and effectiveness has remained limited. Data from NFHS-2 showed that few contraceptive users were provided with information necessary to make an informed choice. Only 15 percent of users of modern contraceptive methods were informed about at least one alternative method. Only one-fifth were informed about possible side effects at the time the method was adopted. Three-fourth of sterilisation users and two-fifths of users of other modern methods received follow-up services. Figure 3 shows that contraceptive users who were motivated by private sector workers were more likely to be given this information than those who were motivated by workers in the public sector.

As one female health supervisor commented, “we are now supposed to give them a choice, like those available in the market and let them choose whatever they want. But if we keep talking and give them counselling and tell them all the information about the different methods, no one may want to accept sterilisations or any method”.

It is clear that contraceptive choice has remained the choice of the provider and is not the choice of the client. If clients are to make informed choices they must have access to a range of options; be provided with information on where to obtain different contraceptives; and understand their advantages and disadvantages, as well as their levels of effectiveness and associated risks. This information should be provided in ways that can empower and enable clients to make informed choices.

Thus far, however, the public sector has not been able to establish an effective system to provide contraceptive choice primarily because it does not serve clients’ needs for reversible contraceptive methods. The programme claims to use a ‘cafeteria approach’ but in fact does not offer a choice of methods. Counselling and follow-up care are inadequate. Staff lacks the skills for providing reversible methods. Consequently, method safety remains problematic. Services are not in place to deal with method-related side-effects, nor are they designed to enable clients to switch methods when they are not satisfied with the method they are using. And important client groups, including married and unmarried adolescents and men, remain unserved or under-served by the programme.

Unmet need and unmet demand for contraception

Data from NFHS-2 show that 21 percent of births in the three years preceding the survey were unplanned. Of these, 12 percent were mistimed and 9 percent were definitely unwanted. Research also shows that the main reason for seeking abortion is to space births and limit family size. Infact, abortion is frequently
FIGURE 3
Contraceptive users informed about other methods

![Diagram showing contraceptive users informed about other methods.]

Source: NFHS-2

perceived to be an extension of the government's population stabilisation programme. These findings provide clear evidence that a substantial proportion of pregnancies are unwanted and/or unplanned and there is a large unmet need for contraception.

Some 40 million women in India have an unmet need for contraception. It is estimated that if all women who say they want to space and/or limit births were to use contraception, the contraceptive prevalence rate would increase from 48 percent to 64 percent. The RCH Rapid Household Survey conducted in the same year as NFHS-2, reported an even higher estimate of unmet need (25.3%) of which 10.7 percent was for spacing births and 14.6 percent for limiting fertility. Of particular interest was the finding that unmet need was higher among younger (25%) than among older (17%) women and that most of it was for spacing births. These findings underscore the importance of providing reversible contraceptive methods to young women.

In 1998-99, the programme addressed three-fourths of the contraceptive demand (the sum of met need and unmet need) of married women in the country; most (86%) for limiting births but only 30 percent for spacing births was met. Thus, the programme, addressed only a small proportion of the contraceptive demand for spacing births in India. In the southern states, 93 percent of the contraceptive demand for limiting and 30 percent for spacing births was met. In the northern and northeastern states, on the other hand, the programme addressed a much smaller proportion of the demand for both limiting and spacing births.

**Contraceptive needs of young persons**

A particularly disturbing finding was that the programme addressed a very small proportion of the contraceptive demand of young women, especially for those who had yet to begin a family or were in the process of family formation. Less than half (44%) of the total demand for contraception was met for young women; only 25 percent was met for those who did not have a child. In India, childbearing is concentrated in the 20-29 years age group. Women in this age group contributed 62 percent of total fertility. In 1998-99, 19 percent of total fertility occurred among 15-19 year old girls and as many as 44 percent of women with one child wanted to wait for two years to have the second child.
In 1998-99, a sizeable proportion of births to adolescents were unplanned, underscoring that there was substantial unmet need for contraception in this population sub-group. Married adolescents constituted the largest group with unmet contraceptive need, especially for reversible methods. More than one in four (27%) girls had unmet need of which 26 percent was for reversible methods. The corresponding figures for 20-24 and 25-29 year old women were 24 and 19 percent, respectively indicating that the programme failed to address the contraceptive needs of young women who wanted to delay the first birth and/or space births (Figure 4). These findings indicate a significant programmatic gap which is, however, not surprising given that the public sector programme has been designed essentially to provide female sterilisation services and not to serve the needs of younger women who are in the process of family formation.

These research findings indicate that adolescents and young people constitute a large, unserved population sub-group that the national programme has by-passed. These young people are sexually active mostly within, but increasingly outside marriage. More than 50 percent of the present cohort of girls 20-24 years of age were married before the age of 18 years. Almost one-half of married adolescents were mothers in 1998-99. While traditionally, societal norms have pressured girls to prove their fertility and have their first child soon after marriage, recent evidence indicates that a sizeable proportion of young couples want to delay their first births but do not have access to information and services to prevent pregnancy. Recent data from studies of first-time parents in Gujarat and West Bengal have shown that young couples wanted to spend more time together to get to know each other better before they had their first child.22 As many as 65 percent of these couples wanted to delay their first pregnancy for one to three years after marriage.23

Qualitative studies have documented that even among young couples who were aware of contraceptive methods, many did not have timely knowledge, especially during the initial years of their married life.24,25 For example, first-time pregnant women in Baroda and Kolkata had no knowledge of contraception before they became pregnant. If they had this information, they might have delayed their first pregnancy: "we talk, so one day he (husband) told me this (wanted a child after 2-3 years) and I also told him that I want a child"
after 2-3 years. But he told me that he does not know how to not have a child so he would ask someone but then next month only I came to know that I was pregnant” [18 year old first pregnant woman in Baroda]22. These studies highlight that the current programme does not address the reproductive health needs of this important, population sub-group.

On the other hand, it is clear that if the needs of young, married couples were addressed fertility decline could be significantly accelerated. Increasing the inter-generational gap by delaying the first birth is an important strategy to counter the population momentum effect which accounts for over 60 percent of population growth in India26. It is well documented that delaying the first birth, especially among young women also provides important health benefits to women and children. Maternal mortality is especially high among adolescent girls who are not ready for childbearing, physically and psychologically. They also experience poor pregnancy outcomes such as pre-term births, stillbirths and neonatal deaths27,28,29,30. Consequently, if their first birth was delayed, both maternal and infant mortality rates would decline in India.

Male involvement in reproductive health

Within India’s gender-stratified society, women with little power and voice, have continued to be targeted for achieving demographic goals. Their reproductive rights have thereby, been violated and reproductive choice has remained a mirage for women. There is ample research to document that men play a pivotal role in decisions related to sexual and reproductive health matters. Yet, available evidence suggests that men’s involvement in the practice of contraception has remained limited. Data from NFHS-2 showed that in 1998-99, one in ten currently married couples used male and/or couple dependent contraceptives including condoms, vasectomy, withdrawal, and periodic abstinence. Thus, 21 percent of couples who used contraceptives used these methods. A comparison of data from the NFHS 1 and 2 show that use of male and/or couple dependent methods has remained the same during the six-and-a-half year period between these two surveys (Figure 5).

In 1998-99 a small minority of currently married men used condoms or underwent vasectomy. The non-scalpel method of vasectomy has further simplified the safe

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**FIGURE 5**


Source: NFHS-1 and NFHS-2
procedure of male sterilisation. Despite the introduction of non-scalpel vasectomy and the associated campaigns to promote male responsibility in family planning by the government, the acceptance of vasectomy has remained negligible. Only 1.9 percent of currently married men underwent vasectomy in 1998-99. The use of condoms was also very low (3.1%) in all states except in Delhi and Punjab where 18 percent and 14 percent of currently married men, respectively, used condoms. Several studies have shown that men have inadequate and incorrect knowledge about condom use. Since, condoms can provide dual protection against both pregnancy and infection — HIV and other sexually transmitted infections — there is an urgent need to encourage the use of condoms in India.

Public-private partnerships to promote contraceptive choice

Available evidence indicates that the public sector programme has not been successful in providing contraceptive choice. Most (76%) of the users of modern methods of contraception — 83 percent rural and 60 percent urban — availed services from the public sector, primarily for female sterilisation. The private sector was the source of contraceptive supply for three out of four users of pills and condoms. Thus, while the government was the major provider of sterilisation services, a large proportion of reversible methods were provided by the private sector. Recognising its limitations, the government is now encouraging public-private partnerships. While the effectiveness of the private sector in providing quality reproductive health services has yet to be assessed, there are some examples of contraceptive social marketing and social franchising in the private sector that indicate its potential to play a significant role in addressing unmet need, especially for reversible methods of contraception.

One successful example of a social marketing and social franchising programme of selected reproductive health services is Janani in Bihar. Launched in 1996, Janani combines a strong marketing approach with a community-based distribution system. An extensive field distribution and promotional network of pharmacies, cigarette shops, grocery stores, and general merchants, has been established to provide quality services at affordable prices. A network of trained rural medical practitioners has been set up to run Titli (butterfly) centres that offer family planning advice, selected contraceptives, syndromic treatment for reproductive tract infections and referrals for clinical contraceptive methods. In addition, a network of non-specialist doctors under the Surya Clinic franchise provides clinical family planning services. Janani’s experience shows that couples are willing to pay for quality services that are within their reach. An evaluation carried out in 2001 showed that the programme was successful in serving poor, illiterate women including those who had not started childbearing, population segments very often overlooked by public sector providers.

Experience of Innovations in Family Planning Services, a project in Uttar Pradesh demonstrated that by forming NGO alliances, 23 million people who had little or no access could be reached with reproductive health information and services. This project established regular contact with clients, improved the contraceptive method-mix, and increased the use of reversible methods. There are other examples among NGOs that document that quality services with informed choice can be successfully provided to the poor in both urban and rural areas. Since there is a growing trend to involve the private sector, strategies employed and innovations tried by private sector providers should be examined. It is also important to rigorously evaluate accountability, cost-effectiveness, access and quality services provided through private sector initiatives.
Barriers impeding contraceptive choice
Several barriers impede contraceptive choice in India - at the policy, programme, community, and household levels.

Barriers at the policy level
Incompatible policies with inherent contradictions at the national and state levels have been a serious impediment for policy implementation. While national policy has advocated rights and choices, several state policies have promoted contraceptive targets, incentives and disincentives. This dissonance between national and state policies has impacted adversely on the delivery of services and the promotion of contraceptive choice.

Barriers at the programme level
While there is clear evidence of the growing need to provide reversible methods, especially to young couples so that they can delay the first birth and space subsequent births, the public sector programme has been designed to provide a single terminal method - female sterilisation. Reversible methods are not available to couples who need them. Providers continue to have a distinct bias towards sterilisation and, therefore, give inadequate and incomplete information on other contraceptives to clients. Strategies are not designed to empower clients to exercise informed choice even though there is evidence to show that when given complete and balanced information clients can and do exercise choice. Consequently, quality of care has remained problematic posing a major barrier at the programme level.

Barriers at the community level
To promote planning by the people, a system of community needs assessment has been implemented. Its aim is to develop capacity for local level planning. While decentralised participatory planning processes have been initiated, considerable refinement will be needed for participatory planning to become functionally effective. Panchayats (elected bodies) at the village level are expected to provide a voice to the community and make programmes accountable to people. The challenge is how to involve panchayats, which are yet nascent institutions. With 33 percent reservations for women, there are now almost a million women in panchayats. Potentially, they represent a strong political force in decision-making at the grassroots level. If their capacity for local governance could be strengthened, they could significantly impact the process of democratic decentralisation and local level decision-making. However, panchayats have yet to develop the capacity for monitoring programmes and generating community demand for quality services. For panchayats to generate awareness of rights and choices, including reproductive choice at the community level, there is a need to establish linkages of panchayats with support structures such as NGOs and also strengthen their systems of governance.

Barriers at the household level
There are several barriers at the household level including poverty, illiteracy, class, and caste, that have impeded contraceptive choice. In India’s male-dominated society, gender discrimination remains the most important barrier. The lack of women’s autonomy in reproductive decision-making compounded by men’s lack of involvement and responsibility in sexual and reproductive health matters lies at the heart of the problem. However, gender bias does not exist only at the household level; it permeates through all levels of society and through India’s health care system as well.

Conclusion
The national programme has been successful in achieving significant mortality and fertility reductions during the past four decades. However, several challenges remain. The quality of services continues to be problematic. A significant proportion of pregnancies are unwanted and unplanned. Contraceptive needs of a large proportion of couples are not met. Men’s involvement and participation in contraceptive use remains
negligible. Important population sub-groups, especially married adolescents, have not been reached by the programme. And contraceptive choice has remained a mirage.

There is, therefore, an urgent need to design strategies, including public-private partnerships, to address unmet need, especially for reversible contraceptive methods. Programmes should be designed and implemented to reach reproductive health services to the large population of married adolescents and young people so that they can delay their first births and effectively space future births. And finally, since men are key decision-makers in sexual and reproductive health matters, their active involvement and participation, as responsible sexual partners, husbands, and fathers, is necessary if reproductive choice for women, men, and adolescents is to be realised in India.

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