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## Socio-Economic Status Of Women And Family Planning In India: A Case Study

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### Abstract:

Women's agency and social status affected their standing in family planning decision-making. Given the magnitude of the family planning programme in India, there is a need to strengthen the coordination of all its aspects, focusing on planning, programmes, monitoring, training and procurement. Women's intent of using family planning services/methods was influenced by multiple factors such as socio-demographic characteristics. Fear of side-effects of contraception methods, access to information and support, and cultural and religious beliefs hindered the use of modern methods of contraceptive. Undesirable attitudes of service providers influenced underutilisation of family planning services. Ineffective contraceptive choice counselling, particularly for poor section of the community and high-risk groups were reported. While considering inter-pregnancy interval, some of the women opted for induced abortion to terminate unplanned pregnancy however, had meagre acceptance for using modern contraceptive methods. There is a need for greater male participation both as enablers and beneficiaries and also address the sexual and reproductive needs of the youth. It is imperative for the government to ensure the prioritization of family planning in the national development agenda.

**Key words:** women, family-planning, socio-demographic, contraceptive, pregnancy

### INTRODUCTION:

At present, women's empowerment has emerged as a major theme on the international development agenda (Malhotra *et al.*, Reference Malhotra, Schuler and Boender<sup>2002</sup>). Further, the commitment to improve gender equality and women's empowerment was reiterated in the Third Millennium Development Goal (MDG3) and in the World Bank's World Development Report of 2012 as critical factors to improving health and reaching development goals (UN General Assembly, <sup>2000</sup>; Kabeer, Reference Kabeer<sup>2005a</sup>). Family planning is crucial for the achievement of the sustainable development goals, and subsequent efforts need to be made to improve access and strengthen quality of family planning services. A women's access to her chosen family planning method strongly aligns with gender equality. Birth spacing can have great implications on health, for instance, reduction in malnutrition (goal 2) and long-term good health (goal 3) for the mother and the child<sup>1</sup>. Access to contraceptives helps in delaying, spacing and limiting pregnancies; lowers healthcare costs and ensures that more girls complete their education, enter and stay in the workforce, eventually creating gender parity at workplace.

Women's empowerment – defined as 'the expansion of people's ability to make strategic life choices in a context where this ability was previously denied to them' (Kabeer, Reference Kabeer1999, Reference Kabeer2001b) – is increasingly considered a key factor affecting family planning and reproductive health outcomes among women. Central to understanding and supporting women's ability to make strategic life choices is examining the role of gender-based power as it affects sexual and reproductive health outcomes (Blanc, Reference Blanc2001). Over the years, social scientists have argued the relationship between demographic change and economic outcomes, and it is now well established that improving literacy and economic conditions for individuals lowers birth rates, while low fertility in turn plays a positive role in economic growth. Family planning (FP) programmes impact women's health by providing universal access to sexual and reproductive healthcare services and counselling information. FP also has far-reaching benefits which go beyond health, impacting all 17 sustainable development goals (SDGs)<sup>1</sup>; however, the focus is on goals 1, 3, 5, 8 and 10. FP has been recognized as one of the most cost-effective solutions for achieving gender equality and equity (goal 5) by empowering women with knowledge and agency to control their bodies and reproductive choices by accessing contraceptive methods<sup>1</sup>.

To control its rising population, India felt an urgency of Family Planning (FP) program in 1952 and became one of the first countries to launch the "National Programme for Family Planning" (NPFPP). Since its launch, the NPFPP has undergone various policy and implementation modifications and currently operating as part of Reproductive, Maternal, Newborn and Child Health and Adolescents Program (RMNCAH+).<sup>2</sup> In the initial period of NPFPP, the emphasis was on natural methods (e.g., rhythm method); subsequently the focus shifted on modern methods of contraception such as condoms, diaphragms, and intra-uterine devices (IUDs).

Between 1962 and 1977, India adopted target-based, mass sterilisation, monetary incentives and other coercive methods (e.g., male sterilisation).<sup>3</sup> In 1977, voluntary efforts of population control, extending the services to maternal and child health (MCH) and incorporating indirect methods of population control were executed. Consequently, the focus shifted on addressing the unmet needs of contraception.<sup>3</sup> Furthermore, India is now devoted to global initiatives that focus on the Sexual and Reproductive Health (SRH) and rights<sup>4</sup>, 5, 6 and Sustainable Development Goals (SDGs) e.g., goal no. 5 ("gender equality and empowerment of women/girl") and target no. 3.7 (ensuring universal access to SRH services). Today, the demographic dividend is in India's favour and FP can and should be used to leverage it. Longer lives and smaller families lead to more working-age people supporting fewer dependents.

This reduces costs and increases the country's wealth, economic growth (goal 8) and productivity of the people. Ultimately, these result in reduction in poverty (goal 1) and inequalities (goal 10) leading to the achievement of the SDGs through a multiplier effect. The United States Agency for International Development (USAID) estimates that 'every dollar invested in family planning saves four dollars in other health and development areas, including maternal health, immunization, malaria, education, water and sanitation'<sup>34</sup>. Thus, investing in family planning is the most intelligent step that a nation like India can take to improve the overall socio-economic fabric of the society and reap high returns on investments and drive the country's growth. Research shows that adequate attention to family planning in countries with high birth rates can not only reduce poverty and hunger but also avert 32 per cent of maternal and nearly 10 per cent of childhood deaths, respectively<sup>2</sup>. There would be additional significant contributions to women's empowerment, access to education and long-term environmental sustainability<sup>2</sup>.

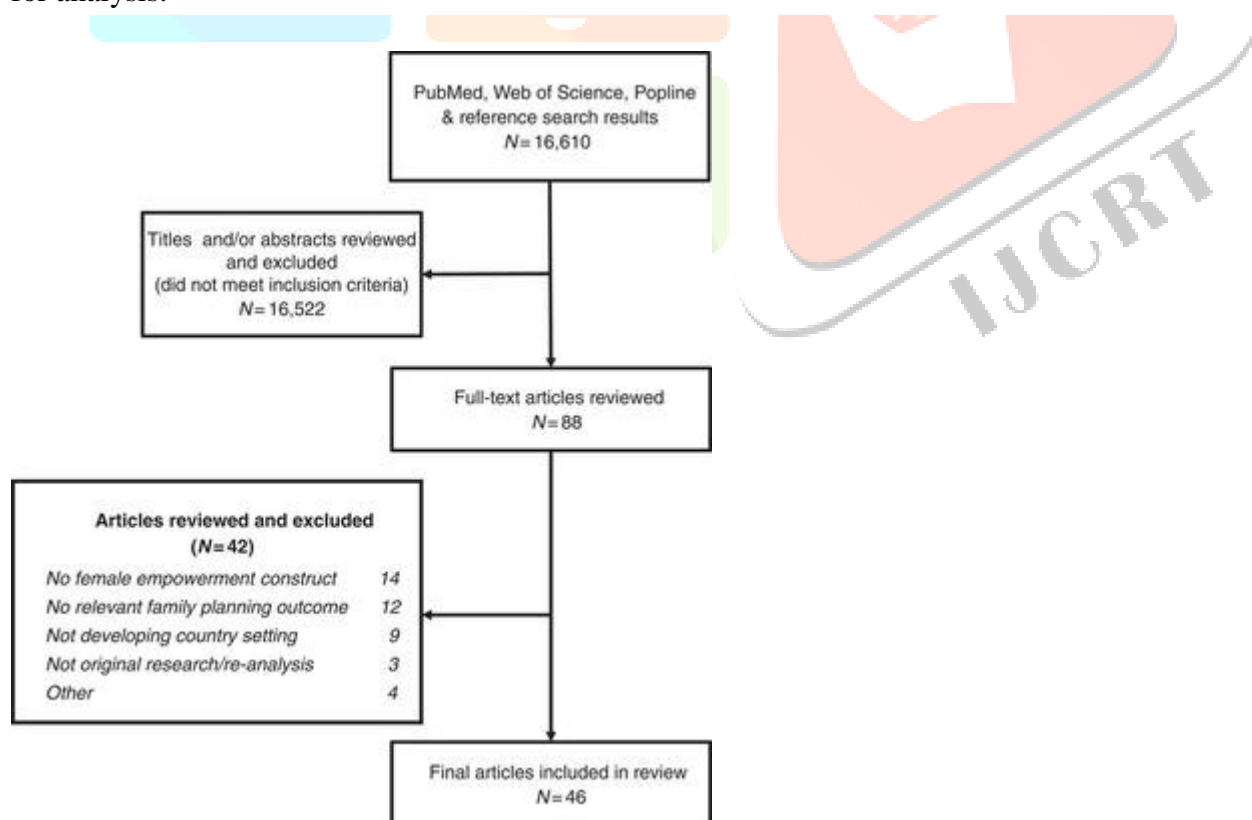
With over half of its population in the reproductive age group and 68.84 per cent of India's population residing in villages, opportunities are plenty but so are the challenges<sup>5</sup>. It is still an unrealized dream of the healthcare system to be able to reach the last mile, especially women belonging to scheduled castes and tribes (SC and ST) in distant and remote parts of the country. As a result, the mortality among these groups is high. Scheduled tribes in India have the highest total fertility rate (3.12), followed by SC (2.92), other backward class (OBC) (2.75) and other social groups (2.35)<sup>6</sup>. Contraceptive use is the lowest among women from ST (48%) followed

by OBC (54%) and SC (55%) while female sterilization is the highest among women from OBC (40%) followed by SC (38%), ST (35%) and other social groups (61.8%)<sup>6</sup>. There is an urgent need for universal and equitable access to quality health services including contraceptive methods.

## Methods

The conceptualization of women's empowerment in this review is based on Kabeer's definition in which empowerment is defined as the process of having the agency and resources needed to make life choices (Kabeer, Reference Kabeer1999). This definition allows a broader conceptualization of women's empowerment and mirrors the one included in a recent companion review on women's empowerment and fertility by Upadhyay *et al.* (Reference Upadhyay, Gipson, Withers, Lewis, Ciaraldi and Fraser2014).

The authors conducted searches using PubMed, Popline and Web of Science search engines in May 2013. The following terms were used alone or in various forms and combinations (and MESH Terms in PubMed): family planning, fertility, family size, ideal family size, contraception, birth spacing, birth intervals, abortion, reproductive health, unintended pregnancy, unplanned pregnancy, parturition, childbearing and number of children, to examine literature published between January 1990 and December 2012. Following this initial search, articles examining only fertility-related outcomes were removed for a separate review (Upadhyay *et al.*, Reference Upadhyay, Gipson, Withers, Lewis, Ciaraldi and Fraser2014); articles that included contraceptive-use outcomes were retained (see Fig. 1). A hand search of references in key articles supplemented the web-based search, allowing for inclusion of book chapters, reports and other published documents. Titles and abstracts were first reviewed, followed by full-text review of 88 retained articles. The full-text review process excluded 42 articles that did not meet inclusion criteria, leaving 46 articles retained for analysis.



**Fig. 1** Literature review flow chart.

To be included in this review the studies had to: 1) be published in English; 2) use quantitative analysis; 3) use an observational or experimental study design; 4) analyse data from lower- and middle-income countries; 5) examine at least one family planning outcome (current or ever use of family planning, unmet need, future intentions, participation in family planning decision-making, spousal communication regarding family planning (or other fertility and/or household matters) and other related family planning indicators); and 6)

examine women's empowerment as an independent variable and explicitly describe the process used to measure empowerment. Included articles had to either provide a theoretical framework or state the intention to use proxy variables as empowerment constructs. Several outcomes were grouped under other family planning outcomes (e.g. family planning approval, advocacy or knowledge; post-marital family planning use; correct use; effective use of contraception; combined family planning outcomes (multiple outcomes); and contraceptive behaviour composite scores) as detailed in the Results section. The US Preventive Services Task Force (USPTF) recommendations were used to assess the quality of the evidence in the studies, based on hierarchy of research design and typology from Type I to III, and a three-level rating system (good, fair, poor) was used to rate the internal validity of each paper (see [Table 1](#)) (Harris *et al.*, Reference Harris, Helfand, Woolf, Lohr, Mulrow, Teutsch and Atkins2001).

**Table 1** Typology and grade of evidence

Type of study	Grade	Description
Type I	Good, Fair, Poor	Evidence obtained from at least one properly randomized controlled trial
Type II-1	Good, Fair, Poor	Evidence obtained from well-designed controlled trials without randomization
Type II-2	Good, Fair, Poor	Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one centre or research group
Type II-3	Good, Fair, Poor	Evidence obtained from multiple time series with or without the intervention (dramatic results in uncontrolled experiments could also be regarded as this type of evidence)
Type III	Good, Fair, Poor	Opinions of respected authorities, based on clinical experience, descriptive studies and case reports or reports of expert committees

<sup>a</sup> This hierarchy was copied verbatim (with one parenthetical removed) from Harris *et al.* (Reference Harris, Helfand, Woolf, Lohr, Mulrow, Teutsch and Atkins2001).

For each article meeting the inclusion criteria, the authors: 1) identified the empowerment domain(s); 2) graded and tabulated each study based on the type, rating and family planning outcome; and 3) summarized the significance and direction of association between the empowerment domain and the family planning outcome. Studies often analysed more than one family planning outcome measure (i.e. 65 separate outcomes among 46 papers). Therefore, the authors tracked the number of papers that included analyses examining each domain and also tallied the number of analyses conducted per indicator within each domain. Almost all studies presented multivariable analyses with multiple control variables; unadjusted associations (or those with only one control variable; Sathar & Kazi, Reference Sathar and Kazi1997) were only counted in the rare cases in which no more adjusted results were presented and are highlighted in the Results section as 'bivariate' analyses (Sathar & Kazi, Reference Sathar and Kazi1997; Morgan *et al.*, Reference Morgan, Sharon, Smith and Mason2002; Khan *et al.*, Reference Khan, Turner, Pettifor, Van Damme, Rabenja and Ravelomanana2009; Peyman *et al.*, Reference Peyman, Hidarnia, Ghofranipour, Kazemnezhad, Oakley, Khodae and Aminshokravi2009).

The empowerment domain measures were those explicitly operationalized by the articles' authors and the level of association was based on analyses presented according to the statistical significance levels specified in the studies. For example, the authors' conceptualization of empowerment was deferred to, even when they relied on characteristics not typically considered empowerment proxies, such as urban/rural residency and household structure (Isiugo-Abanihe, Reference Isiugo-Abanihe1994; Chapagain & Matrika, Reference Chapagain and Matrika2005). Empowerment was measured in a variety of ways: use of single variables (e.g. education), creating summative scales in a single domain (e.g. sum score of household decision-making) and



combining variables across different domains to form ‘composite’ empowerment scales. Only a few of the reviewed studies used principal component analysis to create indices of empowerment (e.g. Zafar, Reference Zafar<sup>1996</sup>; Steele *et al.*, Reference Steele, Amin and Naved<sup>1998</sup>; Woldemicael & Beaujot, Reference Woldemicael and Beaujot<sup>2011</sup>). Empowerment domains were considered consistently associated with a family planning outcome if the total number of associations in a certain direction (positive, negative or null) exceeded 60% of the analyses conducted regarding that outcome. Results that were more evenly divided between significant and non-significant were deemed inconsistent.

### HIGH UNMET NEED FOR CONTRACEPTION:

An estimate done by the Ministry of Health and Family Welfare (MoHFW), Government of India, states that if the current unmet need for family planning is met over the next five years, India could avert 35000 maternal deaths and 12 lakh infant deaths<sup>7</sup>. If safe abortion services could be ensured along with increase in family planning, the nation could save approximately USD 65000 million<sup>7</sup>. Yet, the fourth National Family Health Survey (NFHS-4)<sup>8</sup> states that almost 13 per cent of women have an unmet need for family planning including a six per cent unmet need for spacing methods<sup>9</sup>. The consistency in these numbers since the NFHS-3 in 2005-2006<sup>6</sup> suggests that despite increasing efforts to create awareness on the subject, there is an existing gap between a woman's desired fertility and her ability to access family planning methods and services. Only two reviewed articles investigated the relationship between empowerment and unmet need for contraception (Khan *et al.*, Reference Khan, Turner, Pettifor, Van Damme, Rabenja and Ravelomanana<sup>2009</sup>; Woldemicael & Beaujot, Reference Woldemicael and Beaujot<sup>2011</sup>) (Table 5). These studies included five analyses ( $n=5/403$ ) pertaining to three empowerment domains: household decision-making, self-efficacy and spousal communication. Khan *et al.*'s (2009) cross-sectional study of pregnancy preferences and unmet need for contraception among sex workers in Madagascar found that low condom negotiation self-efficacy was associated with greater odds of unmet need for contraception (prevalence ratio (PR)=2.0, 95% CI: 1.4–3.0). In contrast, the study by Woldemicael and Beaujot (Reference Woldemicael and Beaujot<sup>2011</sup>) found that women with higher reported levels of spousal communication were also more likely to report having an unmet need for contraception (for spacing, OR=1.41,  $p<0.01$ ; for limiting, OR=1.87,  $p<0.01$ ; and overall, OR=1.50,  $p<0.05$ ).

As we go on doing the research we find a direct correlation between the number of contraceptive options available and the willingness of people to use them. As shown in Fig. 1A, it has been estimated that the addition of one method available to at least half of the population correlates to an increase in use of modern contraceptives by 4-8 percentage points. Fig. 1A shows a projection of the rise of modern contraceptive prevalence rate (mCPR) in India, based on the trends observed by Ross and Stover<sup>10</sup> and using the current mCPR of 47.8 for India (from NFHS 4)<sup>8</sup> as the base value.

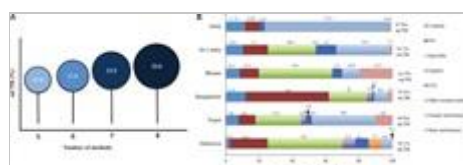


Fig. 1:

Expanding the basket of contraceptive choices led to an increase in overall contraceptive prevalence in Matlab, Bangladesh, where household provision of injectable contraceptives in 1977 led to an increase in contraceptive prevalence from 7 to 20 per cent<sup>11,12</sup>. As of 2015, injectable and pills together accounted for about 73 per cent of the modern contraceptive usage in Bangladesh, which has an mCPR of 55.6 per cent<sup>13</sup>.

In addition to Bangladesh, Fig. 1B shows the mCPR of other neighbouring South East Asian countries such as Bhutan, Indonesia, Nepal and Sri Lanka where the availability of seven (or more) contraceptive methods corresponds with a higher mCPR. India, with five available methods of contraception (as of 2015), recorded the lowest mCPR among these countries (Fig. 1B)<sup>8,13,14</sup>. Effect of number of contraceptive methods on modern contraceptive prevalence rate (mCPR). (A) The graphic is a projection of the rise in modern contraceptive prevalence rate (mCPR) in India with every additional contraceptive method. This estimation is based on the mCPR of 47.8 from the National Family Health Survey 4 (NFHS-4). *Source:* Refs <sup>8, 10</sup>. (B) Evidence on contraceptive method mix in developing countries South/South-East Asia. The mCPR has been represented on a scale of 100 percentage points to depict the distribution of contraceptive method mix for each country. *Source:* Refs <sup>8, 13, 14</sup>. Like any medical solution, contraceptive methods can also have side effects but it is imperative to note that the ability to access the available range of contraceptive choices is every woman's reproductive right. Implementation of pilot programmes is of utmost significance and relevance to generate further evidence on the efficacy of various contraceptives in different contexts.

It enables a better understanding of the impediments in introduction as well as sustained usage of new contraceptives. To prevent early discontinuation and also dispel-related myths and misconceptions, women will need proper counselling on the usage and side effects of contraceptives. In India, efforts have been made over the years by the government to create a favourable policy environment for family planning, in the form of several important policy and programmatic decisions. At the London Summit on Family Planning held in 2012, the Government of India made a global commitment to provide family planning services to an additional 48 million new users by 2020<sup>14</sup>.

According to the FP 2020 country action plan 2016<sup>14</sup>, the government aims at focusing on mCPR, keeping in mind the current annual mCPR increase rate of one per cent as compared to the 2.35 per cent annual increase required to reach the FP2020 goals for India<sup>14</sup>. As a signatory of the SDGs in 2015, India has committed itself to achieving good health and well-being (goal 3) as well as gender equality (goal 5) by 2030<sup>15</sup>. In 2015, the announcement of the introduction of three new contraceptive methods - injectable contraceptive, centchroman and progestin only pills by the government of India<sup>16</sup> indicated a much-needed shift from the terminal method of female sterilization, which accounted for two-thirds of contraceptive use in India until 2015-2016, to more modern limiting methods of contraception<sup>9</sup>. Introduction of new contraceptive methods has always been marred by controversies surrounding their efficacy, side effects and safety. Consistent efforts need to be made to educate not just the users but also the service providers in every aspect surrounding a newly introduced method so that their capacities are strengthened. The users will also benefit from the strengthening of service providers; they will have better, more accurate access to information surrounding various contraceptive options, enabling them to make more informed choices. The third and equally important partner is the media. Greater efforts need to be made by both the government and civil society organizations to educate media to promote unbiased reporting and avoid creating panic on introduction of new methods.

### **SAND REPRODUCTIVE NEEDS:**

Youth (15-34 yr) account for 34.8 per cent of the total Indian population, of which an enormous number still do not have access to contraceptives<sup>33</sup>. According to a 2006-2007 subnational youth survey in India, while most youth had heard of contraception and HIV/AIDS, there was lack of detailed information and awareness<sup>34</sup>. While 95 per cent of youth had heard of at least one modern method of contraception, accurate knowledge of even one non-terminal method was considerably low among young women, with only 49 per cent reporting positive knowledge<sup>34</sup>.

Likewise, while 91 per cent of young men and 73 per cent of young women reported having heard about HIV/AIDS, only 45 per cent of young men and 28 per cent of young women had comprehensive awareness of HIV<sup>34</sup>. The recently released findings of the UDAYA study in the States of Uttar Pradesh and Bihar by the

Population Council revealed low levels of knowledge regarding sexual and reproductive health across all adolescents<sup>3536</sup>. In both States, among older adolescents (15-19 yr), slightly less than a quarter of unmarried boys and girls and one in two married girls knew that a girl could become pregnant even when she had sex for the first time<sup>3536</sup>.

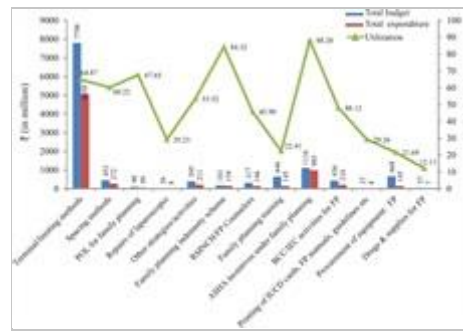
Correct knowledge of oral and emergency contraceptives was considerably low across all adolescent groups in both States which indicated an urgent need to improve awareness, strengthen service deliveries and evaluate outreach strategies. In its 2016 report, the Lancet Commission acknowledged the 'triple dividend' of investing in adolescents: 'for adolescents now, for their future adult lives, and for their children'<sup>37</sup>. According to an estimate by the Guttmacher Institute, 38 million of the 252 million adolescent girls aged 15 to 19 years in developing countries are sexually active and do not wish to be pregnant over the next two years<sup>38</sup>. These adolescents include a staggering 23 million with an unmet need for modern contraception<sup>38</sup>. It is more important now than ever to make a shift from one-size-fits-all approaches and cater to the needs of married and unmarried adolescents.

### **GROWING INVESTMENT IN FAMILY PLANNING:**

The National Health Policy 2017 talks of increasing public spending to 2.5 per cent of the GDP, which is a welcome sign<sup>39</sup>. However, much higher health allocations are necessary to take forward the nation's family planning agenda in favour of reproductive health and rights. The Government's newly launched Mission *Parivar Vikas* Programme focuses on improving access to contraceptives and family planning services in 145 high fertility districts in seven States<sup>40</sup>. In addition to higher health allocations, the government needs to ensure efficient and complete utilization of funds already allocated to family planning activities.

India spent 85 per cent of its total expenditure on family planning on female sterilization with 95.7 per cent of this money going towards compensation, 1.45 per cent on spacing methods and 13 per cent on family planning-related activities such as procurement of equipment, transportation, Information Education and Communication (IEC) and staff expenses in 2016-17<sup>41</sup>. According to our analysis of the National Health Mission (NHM) Financial Management Report<sup>41</sup>, the total budget available for family planning activities under the NHM was 12220 million in India during 2016-2017. Of the total money for family planning, 64 per cent was directed for providing terminal or limiting methods, nine per cent towards ASHA incentives for FP activities, 5.3 per cent for training, 5.5 per cent for procurement of equipment, 3.7 per cent for spacing methods and 3.6 per cent towards BCC/IEC activities for family planning (Fig. 2)<sup>41</sup>.

The total spending was 7415 million indicating that only 60.7 per cent of the total money available for family planning activities was spent during 2016-2017. Of the total expenditure for FP activities, 68 per cent was spent on terminal or limiting methods of which compensation for female sterilization constituted 92.7 per cent; 13.3 per cent was incurred for ASHA incentives, 3.7 per cent was incurred for spacing methods of which incentives to providers for post partum intrauterine contraceptive device (PPIUCD) insertion constituted 73.2 per cent and compensation for intrauterine contraceptive device (IUCD) insertion at health facilities constituted 14.2 per cent, 2.8 per cent on interpersonal communication (IPC)/BCC activities and two per cent was spent for training (Fig. 2).



**Fig. 2:**

Allocation, expenditure and utilization of FP budget 2016-2017. POL, petroleum oil and lubricants; RMNCH, reproductive, maternal, newborn, child, health; FP, family planning; bcc, behaviour change communication; IEC, Information, Education and Communication; IUCD, intrauterine contraceptive device. *Source:* Ref. <sup>41</sup>.

### Investing in behaviour change communication (BCC)

The above mentioned numbers suggest that although family planning programmes in India have made significant progress, the budgetary spending and allocation is still skewed towards terminal methods, with inadequate emphasis on training of service providers and investment in BCC/IPC. The issues surrounding family planning and sexual and reproductive health emerge from deep-seated social norms, which cannot be uprooted overnight. It is imperative to strategize effectively to work with communities to influence social norms.

Social and Behaviour Change Communication (SBCC) can address sociocultural norms such as sex selection, early marriage, unwanted pregnancies, domestic violence and gender inequality. PFI's transmedia edutainment intervention, *Main Kuch Bhi Kar Sakti Hoon - I*, (A Woman, Can Achieve Anything, MKBKSH) is one such example<sup>42</sup>. PFI's experience with MKBKSH Season 1 and 2 shows that entertainment education (EE) initiatives have tremendous reach and potential to change the knowledge, perception and behaviour among viewers. In addition to SBCC, interpersonal/spousal communication has the potential to significantly improve family planning use and continuation. In countries with high fertility rates and unmet need, men have often been considered unsupportive partners as far as family planning is considered<sup>32</sup> suggesting lack of adequate spousal communication. SBCC is a key avenue in the existing communication within the family planning programme in a country like India where frontline workers reach populations where other media cannot reach. It is the time to not just increase investments in health and family planning but to fully utilize the currently available budget and rearrange the existing allocations in favour of reversible contraceptive methods and SBCC to challenge and change existing sociocultural norms.

### FINAL ANALYSIS AND CONCLUSION:

The praxis of family planning is simple and the availability of a basket of contraceptive choices can play a crucial role in stabilizing population growth. An effective and successful family planning programme requires a shared vision among key stakeholders, which include the government, civil society organizations and private providers. These stakeholders should ensure that the sexual and reproductive needs of youth and adolescents in the country are fulfilled. In addition, greater male participation as active partners and responsibility bearers can certainly ensure increased use of contraception. Despite commonalities in overarching themes, we cannot apply the findings to population belonging to a higher socio-economic stratum because of paucity of data in this group of people. Almost 68.8% of India's population reside in villages<sup>11</sup> therefore, findings can be generalised to a larger population of the country. We paid more importance to the experiences and perceptions of people compared to the methodological issues of the included studies. Additionally, we could not categorise the studies based on study quality as measured using Critical Appraisal Skills Programme checklist (Additional file) therefore, we did not



use it while generating the findings of the review. The time to act is now. And this should begin with a concerted effort from everyone to empower women, expand family planning choices and strive for greater gender equality so that every individual can lead a dignified life. Most of the included studies did not report qualitative methodologies appropriately (e.g., type of qualitative data, details on analysis, positionality and reflexivity of researchers); therefore, we suggest future researchers to follow standard reporting guidelines and report a methodology that is reproducible. Furthermore, due to resource constraint, we restricted the studies to English language. The success of India's family planning programme is shouldered by researchers, policymakers, service providers and users, who will need to do their part to ensure equitable access to quality family planning services.

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