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Cross-Cultural Comparative Analysis of Family Planning Policy within India and China

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Introduction

All social issues are intrinsically related to people, hence the 'social' component of the term. It is people who are impacted, and the reason why there are documents such as the Universal Declaration of Human Rights (UDHR) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Issues arise when population growth no longer feeds economic growth, but instead feeds into societal issues. At a certain point, a country becomes unbalanced, unable to sustain the sheer growth of its citizens. This can present itself through lack of food, infrastructure, education, and even physical space in the case of urban areas. Family planning is one means of curbing population growth and avoiding this progression of events (Li-Wen & Milhaupt, 2013; Simmons, 2010).

In 1968, Paul Ehrlich, an American biologist, known for his warnings about the dangers of population growth, stated that, "[t]he battle to feed all of humanity is over. In the 1970s hundreds of millions of people will starve to death in spite of any crash programs embarked upon now. At this late date nothing can prevent a substantial increase in the world death rate" (p. 1). His quote embodies the fear of global catastrophe from a growing world that existed at that time.

Ehrlich was not alone in this fear and this paper explores family planning in the context of population control in India and China, through a cross-cultural analysis of family planning policies. Fear of overpopulation drove these countries to adopt extreme measures to curb population growth. First, the separate historical contexts and current legislation will be

analyzed. Throughout these sections, it will be evident that gender plays a significant role. After the separate analysis of both countries, these areas will be compared, with additional focus placed on the overall implications of family planning policies.

China

Historical Analysis

In the 1950s, population issues sparked the global birth control movement (Chaurasia & Singh, n.d.). This is in part because of economic growth around the world and it was the first time in history where there was a global conversation about population. In addition to the global spread of knowledge, there was also the spread of information and the beginnings of global concern regarding population growth (Bu & Fee, 2012). From the 1950s through the 1960s, population globally grew at roughly 2 percent annually (EngenderHealth, 2002).

As global recognition of population grew, two main viewpoints manifested on the role of contraceptive programs (Wang, 2014). One focused on the voluntary use of contraceptives with little to no role from the government. An example of this would be an NGO operation to educate families on contraceptive options within clinics. The focus here is on voluntary use and an individual's choice regarding contraceptives and family planning. The second view established the role of government in mandating reproductive limits for the overall benefit of the country. This latter view became predominant in China (Howden & Zhou, 2015). This is in part due to the collectivist norm within China that states that the country is of more importance than individual rights of citizens (Feng, Cai, & Gu, 2012). This norm is a combination of traditional and communist values that tie together the importance of family,

community, and ultimately the good of the country (Xie, 2013). It was these values that resonated in China during the 1950s and 1960s, when the country began experiencing difficulty feeding the growing population (Wang, 2014).

It was during this time period that Mao Zedong was the Chairman of the Communist Party of China (CPC). He ruled from 1945 until 1976 and was instrumental in the steps towards the creation of China's fertility reduction policy, also known as the one-child policy (Bu & Fee, 2012). In this thesis, this document will be referred to as the fertility reduction policy, because it is a more accurate translation of the policy itself and does not carry the same negative connotation tied to the one-child policy title. There were two main events during the Chairman's rule that precipitated the implementation of the policy. The first was China's Great Leap Forward from 1958-60 and the second, the Cultural Revolution of 1966-76 (Liu, 2014).

The Great Leap Forward, which lasted two years, was a failed attempt at changing the traditional agricultural industry to a modern industrial framework through the collectivization of the Chinese economy. The intent was to improve the economic status of China by making private agriculture illegal (Liu, 2014). While this was not successful in its goal, the Chinese government created the Birth Planning Commission in 1961 as an early attempt to understand the issues of population and begin the brainstorming process of solution-making and eventual implementation. The intent of the Commission was to assess the situation and create policies that would positively influence the Chinese economy (Howden & Zhou, 2015).

In 1966, Chairman Mao Zedong began the Cultural Revolution. In contrast with the Great Leap Forward, the Cultural Revolution managed to create some reform, but again failed to meet the extensive needs of a growing population, including the availability of contraceptive

options and the proper infrastructure, such as public facilities, to accommodate a growing country (Feng et al., 2012). A concrete plan from the Birth Planning Commission was not established until 1971, when the reduction of the population also became part of China's five-year plan, with an overall goal of reducing population by 1 percent in urban locations and 1.5 percent in rural locations (Howden & Zhou, 2015).

As the 1970s began, China began to engage in more global communication regarding population growth, as evident from their attendance to the UN's first World Population Conference in Bucharest in 1974. Ironically, the conference resulted in the Chinese denouncing population control, despite their decade of population analysis through the Birth Planning Commission. The Chinese government stated at the conference that family planning and population control were part of a western imperialist agenda (Feng et al., 2012). Coinciding with this was the shift towards mandatory family size enforcement after the China's State Council approved a report on birth control in 1971 (Whyte, Feng, & Cai, 2015). This shift introduced the campaign, 'later, longer, and fewer'. As the precursor to the later fertility reduction policy, this campaign increased the effort to ensure later marriage (Wu & Li, 2012). This resulted in states working towards ensuring that men married after 27 or 28 and women after 25 years of age. The longer aspect refers to birth-spacing, with a preferred four-year space, while fewer laid the groundwork for limiting the number of births per family to three for rural families and two for their urban counterparts (Whyte et al., 2015).

The Cultural Revolution of 1976 had left China economically devastated and in need of change. The post-Mao leadership was in desperate need of economic development. This development was measured by per capita GDP growth, and population control became a

perceived primary component in generating an increased GDP. In September 1977, the Chinese government created a goal in a Working Report to reduce the annual population growth to below 1 percent in a mere 3 years. While this goal was not achieved within the time limit, it was reached in 1998 (Feng et al., 2012).

In 1979, three years after the death of Chairman Mao and on the cusp of a new period in China's history, the People's Republic of China was suffering economically and Chinese leaders were in the process of reestablishing their political reign as well as governmental legitimacy. After the death of Chairman Mao, focus shifted towards the need for economic growth and population as a pivotal factor toward that growth. In order to elevate the economy, population needed to be addressed (Bu & Fee, 2012). Thus 1979 saw the implementation of the fertility reduction policy.

According to Feng et al. (2012), three factors allowed the sustained implementation of the fertility reduction policy. The first was the cultural view that citizens were subject to their governments. This cultural mindset viewed the overall health of China as paramount and superior to individual rights (Wang et al., 2013). The second was the fact that the post-revolutionary period saw birth control and family planning as the heart of Chinese political legitimacy and overall mission. This is because, at the time, family planning was acknowledged as the solution to their economic decline. Lastly, Feng et al. (2012) stipulate that the policymaking process in China and the fact that it lacked transparency was a pivotal factor in the policy's success. By not providing a citizen platform for discussion or a legislative text, governmental officials were able to operate without the accountability on the side of the Chinese population.

It was not until 1978 that a one child fertility reduction concept was officially introduced at a national level. Family planning methods were already in place at this point, evident from national goals on population growth from 1971 and the 'later, longer and fewer' campaign (Whyte et al., 2015). A Central Committee of the Communist Party (CCP) document in June of 1978 stated it was "encouraging couples to have one child, at most two" (Chinese Communism Subject Archive, 1981). This is the first concrete recording legal introduction of advising a one child family model. The policy was adopted in more than 10 provinces and used means such as a reward system for families that complied and punished of families with two or more children (Liao, 2013). In January 1979, news outlets began publishing propaganda pieces to promote one-child households. These were evident in two local Chinese news groups, the *People's Daily* and the Xinhua News Agency. The economic planning sections of government were highly involved in the promotion of this new family make-up. This shows the perceived correlation between population control and economic stability (Bu & Fee, 2012).

In 1979, the fertility reduction policy was not put into law, but instead stated as an open letter to the members of the Chinese Communist Party and the Communist Youth League. There was resistance within China's legislative body regarding the creation of a national law, which resulted in the open letter compromise. Unfortunately, the open letter is not available to the public. All information gathered on the content was gathered after the fact and should be considered subject to bias (Whyte et al., 2015). The open letter was used to advocate measures to ensure a smaller population by encouraging each province to create their own requirements to encourage families to adopt a one-child framework (Howden & Zhou, 2015). As evident from above, this open letter was an alteration of the earlier 'later, longer and fewer'

campaign. The letter acknowledged the sacrifice of such action and promised to change the policy within 25-30 years. Within the open letter, possible consequences acknowledged included sex imbalance, future labor shortages and quality of life for the aging population (Feng et al., 2012).

After the death of Chairman Mao in 1976, the primary leader for China became Deng Xiaoping. While Xiaoping was never the leader of the Communist Party of China, he was the de facto power in politics from 1978 until 1989. Xiaoping was a primary figure behind the development of the Open Letter and the later implementation of policy. He continued to hold political significance until his death in 1997 (Liu, 2014). During his de facto reign, fertility fluctuated throughout this decade. The beginning of the 1980s saw an increase in fertility, only for it to drop and rise periodically, despite the recent implementation of the fertility reduction policy. In 1983 alone, there were 20.7 million sterilizations, 14.4 million abortions, and 17.8 million IUD insertions in China. Much of the initial fertility decline had actually occurred before the implementation of the 1979 policy, as a result of the 'later, longer, fewer' campaign (Whyte et al., 2015). Fertility rates had already decreased from almost 6 children per family in 1970 to roughly 2.7-2.8 by the end of the 1970s and the implementation of the fertility reduction policy. There had already been government efforts to enforce birth limits, economic modernization, and contraceptive use. Steady fertility rate reduction did not begin until the end of the 1980s and has continued to the present (Whyte et al., 2015; Xie, 2013).

The Open Letter promise to revisit the policy within 25-30 years was met. In December 2001, the Population and Family Planning Law of the People's Republic of China (Order of the President No.63) was adopted at the 25th Meeting of the Standard Committee of the Ninth

National People's Congress and went into effect on September 1, 2002. This document was created as a result of the promise given to the Chinese population to reassess family planning. One major factor in the steady decline of population was the shift in responsibility after the implementation of the policy from birth planning workers to party officials within the government. This meant that government officials now had to meet annual performance ratings for fertility measures (Whyte et al., 2015).

Current Legislation

A July 2015 estimate placed the Chinese population at 1.36 billion (CIA, 2016). The 2001 Population and Family Planning Law is the most recent legislation that contains the current state of family planning legislation, aimed at reducing this impressive number. The law has seven chapters, and pertinent chapters will be discussed to further understand the dynamics of family planning by the Chinese government.

First and foremost, it should be recognized that family planning is considered a fundamental state policy, according to the People's Republic of China, evident from Chapter I, article 2. Article 2 recognizes overpopulation as an issue in China. The first chapter depicts the role of the Chinese government as one that upholds a quality of life for the general population through population control. This chapter also stipulates the increased access to education and rights, instead of the restriction of personal freedoms. However, the document does not specify where focus should be towards increasing educational access and rights. The vernacular used acknowledges the strength of the government, but also states that the rights and interests of citizens are taken under consideration. While Chinese laws dictate the rights and autonomy

of citizens, this does not mean that actions taken by states or provinces meet the stated criteria. At no point in the document are the terms 'rights' and 'autonomy' explained, as these may differ between countries. Because the reality of fertility reduction did not change after the introduction of this new text, rights and autonomy have not changed for Chinese families.

Cultural norms, including norms within family planning, and the historical influence of the open letter in China and the previous 1970s campaign have influenced how each province has chosen to implement the fertility reduction policy. For example, rural families are still held to different standards and are often allowed more than the one-child model. This also holds true for minority groups, who can, in some cases, have as many as four children, depending on provincial location. Essentially, Chinese who are not part of the Han (majority) ethnicity are not held to the same criteria for family planning. This is due to government recognition of their minority status, since the Han ethnicity account for 92% of the Chinese population (Huang et al., 2012).

Chapter II, article 13 states the need for sexual education within schools. Chapter III is centered around the regulations of reproduction. Article 17 has an inherent conflict, as it stipulates that families have reproductive rights, but then also states that they have an obligation to practice reproduction in accordance to the law (Population et al., 2001). Essentially, this law has room for misinterpretation because law dictating the number of children allocated to each family violates reproductive rights. The original open letter was never a true law and was not upheld to public scrutiny. So while article 17 states the law of family planning, there is no clear set of articles to describe the consequence of having a second child. The financial fine varies by individual province, and is not a national decision. Article 18

states that specific measures are still in the control of the standing committees for each individual province or municipality, subject to change by the People's Congress (Population et al., 2001). Essentially, the national desire for smaller families has become a primary factor in provincial action of this law.

Chapter III, article 20 encourages the use of contraceptive methods by couples and states that unwanted pregnancies should be reduced and prevented, indicating the use of abortion services. The following article, 22, condemns the discrimination against daughters. Within the article, discrimination towards daughters is paired with the illegality of discrimination against women who are infertile ("Population and Family Planning Law", 2001). Having these two points within the same article implies some similarities between them. There is both discrimination of gender at birth, but also towards women who cannot fulfill their expected role of mother. The text only acknowledges the existence of discrimination present under these two contexts.

Gender roles are integral to the understanding of family planning. Family within China differs from an individualistic western model, as Chinese families encompass not only the immediate family, but also the extended, including the grandparents and often relatives from a patrilineal line (Xie, 2013). When a woman is married in China, she is removed from her family's family tree and placed within her husband's family. Even with the woman placed within a new family tree, she is often considered an outsider within that system. For example, the woman keeps her last name, but her children adopt their father's family name (Xie, 2013). This shows the traditional alienation of women within their family after marriage. It is also important as parents may prefer a son because he is able to continue the family name.

With the introduction of the fertility reduction policy and the implementation of a one-child framework, the effects of a patrilineal system were amplified. While arranged marriages are no longer a norm within China, parental influence and even influence from grandparents still impacts marriage decision-making. Previous to the policy's implementation, families were able to continue their lineage through male heirs, but also had daughters. With child restrictions, gender preference along with the importance of family name and economic stability became primary factors in sex-selection (Yang et al., 2013).

Elimination of any pregnancy, yet especially for the purpose of sex-selective abortion, is a key moral component that is consistently brought up through media and international entities such as the United Nations. Comparable only to sterilization, abortion in the context of family planning in China is a clear example of the shift from sexual and reproductive autonomy to governmental control of female bodies. Between 1962 and 1972, there were a reported 26.69 million abortions; abortion rates declined by 21% between 1996 and 2003, but there was still a reported annual rate of 7.2 million abortions (Wang, 2014). This rate has continued in recent years, with a rate of roughly 7 million abortions annually (Huang et al., 2012). Abortion is legal across China and there is no stigma attached to abortion, compared to that of the United States. Despite this, these numbers should be assessed as conservative because China is conscious of the global image of abortions and the recognition of sex-selective abortions as an issue (Huang et al., 2012).

This has increased the gender disparity within China. In 2015, the gender disparity reached 943 women per 1000 men. With a current population of over 1.36 billion people, this gender inequality is staggering (CIA, 2015). By 2020, the Chinese government estimates that

there will be 30 million more men than women. These numbers impact both Chinese women and men. With a growing number of men, there is also a growing bachelor generation that is unable to find partners and have families (Feng et al., 2012).

There are other important cultural norms, such as one where women 'marry up'. Since Chinese women have gained educational opportunities and are more likely to enter the workforce, age has become a new means of 'marrying up'. Overall, marriages are occurring later. The average age of marriage is now 26 or older, while a 23-year-old Chinese woman would have been considered behind schedule for marriage in in the 1980s (Xie, 2013; Yang et al., 2013). Men who are older are more likely to have more money or status (Xie, 2013). Gender norms within China place men as the head of households.

Men are also impacted by gender norms. As the breadwinners, men are expected to spend more of their income to support their elders (Xie, 2013). There is also the growing influence of individualism that is influencing the norm that children are no longer obligated to care for their elders. This western norm is shifting the current view of family in China from one of an extended family framework to one of only immediate family and a decreased responsibility of younger members to their older counterparts (Yang et al., 2013). These changing norms are placing increased stress on old age health security (Dai, 2015). These services were not as influential in previous years because of the social norms of family support. In addition, there is a cultural responsibility for sons to financially care for parents and sometimes grandparents. As family size decreases, the number of available children to care for elders also dwindles. This is directly linked to the change in family size and the increase in one-child households (Xie, 2013; Yang et al., 2013). With recent changes to this, there are

inadequate resources available for the growing elderly population. This is especially true for the roughly 60% of the elderly population located in rural areas (Dai, 2015).

Implications towards women, men and the elderly all connect to the implementation of family planning policy. Chapter IV addresses the rewards and social security related to following family planning methods. Article 25 grants longer maternal leave, nuptials, and welfare benefits to citizens who delay having children and/or marry. Article 28 explicitly states that families in poverty who adopt family planning methods will be given priority in poverty-alleviation loans, social assistance and various other relief projects. Article 35 prohibits sex-selective abortions and the use of technology to determine fetal sex (Population et al., 2001).

The last major chapter is VI – legal liability. This section focuses on primarily the health care professionals and legal orchestrators of family planning. Articles 41 and 42 are the only articles in this chapter that directly address citizens who fail to adhere to family planning (Population et al., 2001). These articles concern the birth of children above the encouraged number, stated in article 18. When this article is violated through the birth of a second or in some cases, third or more children, the parents are liable to a social maintenance fee. If the parents are unable to pay the fee, an additional fee is imposed, further impacting the parents financially. This financial strain may impact a family's decision to claim the child. In these cases, the child is stateless, meaning that they do not have a birth record and legally does not exist according to the Chinese government (Liao, 2013).

As stated in the legislative text discussed above, there are benefits and repercussions involved in the family planning system. When families adhere to the one-child framework,

benefits include child allowances, priority access to various levels in education, land ownership, tax cuts, and welfare benefits (Wenyao et al., 2014). Again, these vary depending on location. This is also true for punishments. Overall, the penalty for having an additional child is roughly a 10-20 percent pay cut for 3-14 years, again dependent on province. The punishments are more extreme for government officials, as they are supposed to serve as models for the Chinese population. Because of this, they are also more likely to be demoted or lose their position, in addition to severe pay cuts (Liao, 2013).

China operates their family planning policy on more than a reward and punishment-based system. Sex education is another component that has proved integral in reaching married couples. Sex norms have changed in China, and understanding that change is integral to the understanding of current family planning. After the implementation of the fertility reduction policy, sexual education was focused towards newly married couples. The concept of premarital sex was foreign and abnormal. One of the pivotal impacts of family planning was a growing economy (Zhou et al., 2013). Alongside this came new developments and changes to traditional attitudes towards sex. As part of the 1979 family planning initiative, the idea of sex was targeted. Sex was no longer simply a means to have children. Clinics began handing out condoms and the public idea of sex for pleasure spread across the nation. Couples began postponing marriage and spending more time cohabitating or in a prolonged relationship before engagement, thus increasing a higher prevalence of pre-marital sex. Initial sexual education tactics were successful because the targeted group, married couples, were the population engaging in sexual activities, but this is no longer the case (Jeffreys & Yu, 2015).

In one example, sexual norms have impacted graduate students, who are unlikely to be married at this point in their lives. A recent study found that 20% of graduate students experienced an unintended pregnancy. Undergraduate student rates were even higher, between 23% and 32%. Graduate students were more likely to choose abortion (97%), compared to their undergraduate counterparts (79%) (Zhou et al., 2013). This study captures a glimpse of the changing dynamics of Chinese society and the need for dynamic changes to legislation. For the purpose of this section, the key element is that sexual norms are changing among the younger generation and that there is a lack of sexual education targeting this new demographic (Jeffreys & Yu, 2015).

For married couples, family planning does have positive implications. Family size is intrinsically tied to maternal and child health. Fertility rates dropped from 5.9 in 1970 to 1.8 in 2002 (Wu & Li, 2011). Collectively between 2011 and 2015, the World Bank found that the fertility rate in China has dropped to 1.6 (2015). Reduction in family sizes positively impacts child health and components such as child malnutrition and Body Mass Index (BMI) (Ma, Chen, & Tan, 2015). This is also true for mothers, who are less likely to have low blood pressure or being underweight (Wu & Li, 2012; Zheng et al., 2013). This can be particularly impactful for rural families in poverty, who are more likely to have larger families. By tightening family size, lower income families are impacted more significantly than their higher socio-economic counterparts, who are already more likely to have a smaller family. In terms of skilled and unskilled labor, family planning restrictions reduce income inequality and skill premium. This change decreases the supply of unskilled laborers and in turn increases future wages. With more children pulled into skilled labor because of increased education and money allocated by

parents, the unskilled sector benefits and the wage gap between skilled and unskilled labor decreases (Liao, 2013).

India

Historical Analysis

India was the first country to enact an official family planning policy and ultimately create a family planning program in 1952. The development of family planning policy in India was the result of various factors, one of them being the Bengal Famine in 1943, which killed between two and four million people. Streets were filled with bodies in the region now recognized as Bangladesh and Eastern India. Despite the severity of the event, it was caused not by crop failure, but instead the result of an increase in food prices due to urban demand, an economic boom, and the absence of proper safeguards to protect those in poverty. Essentially, food was exported from rural agricultural areas to be sold at increased rates to the urban population. With this rise in price and movement of agricultural produce, the rural population was unable to afford the produce they cultivated (Kaur, 2014).

The Bengal famine instigated public concern of the government's responsibility to protect its citizens. With such a high death toll, the government was seen as unable to protect citizens and the public shifted towards an interest in increased government oversight to ensure safety of a growing population. This sparked the beginnings of public desire for affordable family planning services in order to reduce population growth. The Bhore Committee of 1946 was a health care-oriented committee that assessed the current state of affairs and published a report of recommendations for the government, including recommendations for a family planning program on a national scale. In India's first Five Year Development Plan, from 1952-

57, India sought to address the increase in population and its possible ramifications on resources (Nayar, 2010).

Planning for such a program began in the early 1950s, after India's independence in 1947 (Nayar, 2010). In 1951, India launched the national Family Welfare Programme, for which the overall objective was to stabilize the population growth and reduce birth rates in order to positively impact the economy (Simmons, 2010). The Indian Family Planning Program began in the early 1950s and provided contraceptive services within clinics, including condom handouts and both female and male sterilizations. These services were educationally themed and aimed to provide information on a community-level. The second Five-year Development Plan (1957-61) promoted a family limitation population control program (Chaurasia & Singh, n.d.). By the mid-1960s, the model of family planning had evolved to include family planning employees placed in existing primary health facilities (Simmons, 2010). India also strove to ensure that there was a primary health center in each community development block. Unfortunately, this block would consist of a population ranging in size from 60,000 to 100,000 people. The late 1960s and early 1970s marked a point in which population became recognized as a major social issue. India reached an all-time high in their average annual population growth between 1961 and 1971, roughly 25 percent in this decade (Chaurasia & Singh, n.d.).

Family planning in the 1970s shifted from an educational framework to an incentive and target-driven strategy. In 1971, family planning was connected to population control as a possible strategy for achieving population stability. Instead of focusing on the long-term benefits of education and contraceptives, more efforts were focused on sterilizations as mass treatment for the family planning goal of reduced population (Nayar, 2010). In the fourth Five-

year Development Plan (1969-1974), concrete targets for sterilizations, contraceptives and IUDs were directly stated, including the national plan to avert 18 million births by 1973-74 (Chaurasia & Singh, n.d.). In order to even attempt to achieve these targets, the Department of Family Planning was created within the Ministry of Health and Family Welfare. This shift from quality to quantity in family planning care impacted the services provided, evident in the Emergency Period of 1975 to 1977 (Williams, 2014).

In order to understand India during the 1970s, it is necessary to comprehend the Emergency Period from 1975 until 1977, which lasted a total of 21 months. In 1971, Indira Gandhi had won the mid-term national election by a large majority. Unfortunately, the election was quickly followed by crises, including the economy, political instability, monsoons, political corruption and rising oil prices. By 1974, the socialist campaigner Jayaprakash Narayan started an anti-corruption movement against the government. In June 1975, evidence was found that exposed electoral malpractice on the part of Indira Gandhi from the 1971 election. The ruling from the case demanded that Gandhi leave her position and refrain from entering Parliament for a minimum of six years. A governmental appeal allowed Gandhi to retain her position with certain criteria. There was an overall negative public reaction, and on June 25th, 1975, an opposition rally marched through New Delhi streets. Indira Gandhi used the opposition rally and movement as a motive to declare a state of emergency on the same day (Williams, 2014).

Once under Indian martial law, Indira Gandhi and her Congress party created economic development programs with the intent to remove poverty. There were two main overarching programs. The first was the slum clearance program, which involved the demolition of slum areas. The second was an extensive family planning and sterilization project. This second

project prioritized sterilization as a prime method of population control. For some people impacted by sterilization during this time, the Emergency was remembered as *nasbandi ka vakt* or 'the time of sterilization' (Pachauri, 2014; Williams, 2014). In two years after the Emergency and through multiple efforts through various point programs, over 11 million people were sterilized, primarily men and primarily through coercion (Singh, Ogollah, Ram & Pallikadavath, 2012; Williams, 2014).

After Indira Gandhi's political struggles and subsequent loss of power in 1977, a revised population policy was introduced in 1977. This policy clearly outlawed compulsory sterilizations and restored the aims of family planning policy to the previous educational mindset, with additional focus on reproductive autonomy and consent over their family planning methods. The National Family Planning Program was also renamed the National Family Welfare Program (Williams, 2014).

During the 1980s, the focus for sterilization shifted from men to women. This was in part related to the historical backlash regarding forced male vasectomy campaigns, especially during the Emergency. Ever since 1977, sterilization has been targeted towards women as a direct result of the Emergency. Towards the end of the 1980s, strategies shifted again and moved toward the target approach with incentive programs for smaller families. This meant that families with fewer children had correlated increases in benefits and in some cases, small amounts of funds (Singh et al., 2012). Contained in the seventh Five-year Development Plan (1985-1990) were the goals for 31 million sterilizations, 14.5 million contraceptive users as well as 21.25 million IUDs insertions (Chaurasia & Singh, n.d.).

Indian family planning in the 1990s changed by focusing on three main areas: female education, high quality contraceptive services, and social development. During this time period, the responsibility for coordinating family planning services devolved again from the federal government to individual states. Method-specific contraceptive targets were removed from family planning in 1996, and in 1997, the Reproductive and Child Health (RCH) Program was adopted. This new program aimed to address both the quality of reproductive health and to decrease the overall population. For example, part of this program encouraged women to utilize government facilities for childbirth as well as encouraging smaller family sizes (Simmons, 2010). After 1996, India began to look not only at fertility, but other factors from a community and systems-based perspective. More focus was placed on maternal and child health (Pachauri, 2013). The National Population Policy was adopted in 2000, which stated a need for population stability and its relationship to sustainable development of countries, aiming to reach a stable population number by 2045 (Simmons, 2010).

Current Legislation

The most recent statistic from India, in 2011, found that there were roughly 926 women for every 1000 men in India's total population (CIA, 2011). The ratio was more severe for the gender ratio at birth from 2011, which numbered 892.9 women per 1000 men. This indicates that the younger population has a higher gender imbalance than the older population. This may also imply that the situation is worsening, given that the at-birth ratio is comparatively higher in relation to the gender ratio of the Indian population between the age of 55 and 64, which is 990 women per 1000 men (CIA, 2011). In New Delhi alone, the gender imbalance among children

from birth to 6 years changed from 868/1000 boys to 866/1000 boys between 2001 and 2011 (Bhagat et al., 2012).

The National Population Policy from 2000 stated the need for a holistic multifaceted approach for family planning. The only concrete goal from this policy was to have a national average of fertility rate of 2.1 by 2010. Within the 'preface' of the 2013 Manual for Family Planning Indemnity Scheme, a major issue identified was quality of services. If the quality of services is inadequate, families will not seek out these services or utilize them (Abeyratne, 2014). Current family planning schemes in India, such as the Accredited Social Health Activist (ASHA) scheme, recognize the importance of maternal and infant care (Ministry of Health & Family Welfare, n.d.).

India has various legislative schemes that address family planning and the country's current pressing need of family planning. Both the overarching family planning program as well as underlying schemes use indicators measured by each state that reflect the need among communities for contraceptives and reduced fertility rates. The Indian government recognizes factors that influence a growing population, including age of marriage, first childbirth, unmet need of family planning, and birth spacing. Focus towards these areas have impacted the reduction in fertility rate from 2.9 children in 2005 to 2.4 in 2012. The latter statistic has held steady. From a generalist overview of the current family planning status in India, there is a clear focus towards not only lowering population, but a growing focus towards maternal and infant mortality (Government of India, 2015).

Permanent and non-permanent family planning methods are the means used in the Indian family planning program and subsequent schemes. The current underlying goal has shifted to include not only reaching a sustainable population growth rate, but also increasing focus towards child and maternal health. These two factors can be used to understand changes in contraceptive usage and where schemes are still needed. Child survival, for example, is associated with increased birth intervals between children (V. & Kumar, 2013). Increased birth intervals also result in less physical strain on mothers. Despite an attempted focus towards maternal and child health, it is again implementation that has failed to meet the needs of women and children. In the state, Uttar Pradesh, 73% of pregnant women failed to attend three or more antenatal visits and 79% did not deliver their most recent child in a health facility (Yadav & Dhillon, 2015). So, while schemes have been created to increase child spacing and incentivize utilization of government hospitals and facilities, implementation has failed to meet these goal (Chor et al., 2012).

While many policies have been enacted in India, this does not mean that this legislation has been implemented successfully, only that the schemes exist in writing. For context, India has the longest constitution in the world, addressing equality and a variety of rights all people should, in theory, have. Even with this extensive text, India has a history of violations of rights related to women, children, labor rights, migrant rights, the rights of people with disabilities, and a multitude of other human rights infractions (Abeyratne, 2014). Gender in particular is clearly recognized in legislative texts and noted as an issue in regards to family planning (Ministry of Health & Family Welfare, January, 2015). Despite this difference between law and implementation, it is still necessary to analyze the existing laws in order to accurately

conceptualize the goals of the government. For India, the laws in place act more as idealistic goals and less as realistic texts for sustainable change, especially when gender is taken into account.

Understanding India and gender requires an understanding of norms within the family and specifically dowry. Dowry is the payment given by the bride's family to the groom. This practice, although illegal through anti-dowry laws in India, is still common among Hindu and non-Hindu families alike. During this practice, the bride is often weighed or judged by the gifts given and said gifts are displayed publicly during the wedding for attendees to appraise (Jeffrey, 2014). This practice makes daughters a financial burden in comparison to sons, who receive dowry through marriage. India does not have concrete legislative family size restraints, but families do need to be conscious of how many daughters they have in comparison to sons. The trick is to ensure that there is either a financial wash, by possibly having the same number as sons and daughters, or having slightly more sons and therefore more financial gain. The issue is that the gender of children is chance-based and it is then up to the parents to take measures to ensure a particular make-up of the family. This is accomplished through technological use of sex-selective abortion and in extreme cases, infanticide (Pachauri, 2014; Prusty, 2014).

Sex-selection is when a person or group choose to have a child of a specific sex. If the fetus or infant is of the undesired sex, sex selection is the action of abortion or in extreme cases, infanticide. With the availability of clinics and ultrasound services, abortion is the current preferred method of sex-selection in India. While family planning schemes have not focused specifically on sex-selection, there is another piece of legislation that does. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act of 1994 (PC-

PNDT) specifically outlaws the use of technology for purposes of sex-selection (Verma, 2014). This act was a response to recognition of sex-selection related to the cost of women as a result of dowry. Dowry is illegal, but persists as a normal practice. The act addresses multiple facets of sex-selection. The primary goal of the act is that it makes the use of technology, including ultrasounds for the purpose of sex determination, illegal. The Act has been altered to accommodate new technology. The PC-PNDT Act outlines the criteria for the use of technology that can also tests the sex of the fetus. When such technology is allowed, medical professionals cannot inform the parents on the sex of the fetus. This act was passed as an attempt to curb sex-selection, with little to no impact. The first doctor to be charged as violating this act was in 2006, and this was the first case under the act that resulted in jail time. The doctor in question served two years (Public Health Foundation of India, 2010; Verma, 2014).

In addition to understanding how acts and schemes interact in Indian society, it is also important to understand the structure of family planning. Schemes addressing family planning change fall under the Ministry of Health and Family Welfare. This ministry is comprised of four departments, one of which is Health and Family Welfare. The Department of Health and Family Welfare is responsible for areas related to maternal health, reproductive health, education, family welfare, communication and child health. The Department is also responsible for the International Institute for Population Sciences (IIPS) in Mumbai, the National Institute of Health and Family Welfare (NIHFW) in South Delhi and population research centers across India (National Informatics Centre, 2015).

This department is responsible for the expenditure of funds for family planning schemes. For example, in 2013-2014, the Indian government spent 2.3 billion rupees on the

supply of contraceptives (condoms) and one million rupees on contraceptives other than condoms. This translates to roughly 35 million U.S. dollars. After monetary conversion, India spent an additional 1.65 million U.S. dollars on social marketing for contraceptives other than condoms. This number is shocking because the Reproductive and Child Health Project spent only 1.6 million U.S. dollars, while the cumulative expenditure of contraceptive dispersal and marketing adds up to 36.65 million U.S. dollars (National Informatics Centre, 2014). From this, it is clear that the policy idea is that if the means are approved, the population will adopt the measures. This has not been entirely unsuccessful. Among sexually active unmarried persons, 98% of men and 72.4% of women have used a condom. However, among married women, only 9.8% in urban areas and 3.2% in rural areas are current condom users. This statistic does not clarify the definition of condom users or the frequency of condom use versus non-condom use during sexual activities (Donta, Begum, & Naik, 2014).

Among schemes and Indian family planning efforts, there are two main categories of family planning: spacing methods and permanent methods (Government of India, 2014). Spacing methods include, oral contraceptives, pills, condoms, and IUD insertions. Oral contraceptive projects are implemented on a village level, but also extend higher through national government oversight of implementation. In 2013, there were only 3.98 million oral contraceptive users, lower than the 6.24 million users in 2012. So, while there has been implementation of projects aimed at encouraging the use of oral contraceptives, implementation success has varied (Government of India, 2013). Condoms have been more successful, with 8.88 million users in 2013. Condom schemes have varied and have even aimed towards breaking down the stigma regarding contraceptive use. In one scheme, female sex

workers were targeted to increase the use of female condoms by that population. While these schemes have proved successful in educating female sex workers about sexually transmitted infections and safe sex, they have also created stigma through their implementation. By creating this scheme, a stereotype was also created in linking female condoms to female sex workers (Donta et al., 2014). This example amplifies the importance of understanding the holistic impact of programs across societal groups. So, even when implementation was achieved, this does not mean that improvement within a subsection of society in turn created improvement to India as a whole.

Another form utilized by India in their family planning is IUD insertions for women incentivized through payment to women receiving services. In one scheme from January of 2014, 150 rupees were paid to service providers for every IUD insertion. This particular scheme was designed for rural locations, but can also be used in urban areas where an Accredited Social Health Activist (ASHA) is in place. ASHA's mission is to provide every village with a trained female community health activist (Ministry of Health & Family Welfare, n.d.). This project has been coupled with many family planning schemes because these communities already have a specialized health activist in place who can work towards proper implementation of schemes. In 2013, there were roughly 5 million IUD insertions across India, according to the government annual report from 2013-14 (National Informatics Centre, 2014).

The second main form of family planning in India are permanent methods, such as sterilization. The current schemes centered on sterilization recognize that women are predominantly using these services and the need for this to be reversed to male use. The political scheme recognizes how history has impacted women and in this case, how history has

impacted men. Sterilization is driven by the historical consequences that India is still working towards repairing, specifically the Emergency period (Williams, 2014). The current sterilization schemes focus on compensation for patients receiving sterilization services in public facilities. Sterilization compensation has been available comprehensively across India since 2007, but began as early as 1981 (Chaurasia & Singh, n.d.). This measure is an attempt to incentivize the procedure and compensate for the day of work loss. In 2014, acceptors from 11 states averaged 600 rupees of compensation for a tubectomy and 1,100 rupees for a vasectomy. This price disparity exists as an attempt to increase the number of men receiving sterilization services (Ministry of Health & Family Welfare, December 20, 2014).

Sterilization has been and continues to be gender-driven because of the historical context of vasectomy campaigns during the Emergency. While this instigated the shift towards female sterilization, gender worth also played a component in the process of maintaining that shift in sterilization towards women, even after technological advances in the procedure for men. In one study of women in Bangalore who were given tubectomies, 73.9% of these women had not practiced any other means of contraceptives before sterilization (V. & Kumar, 2013). This implies that the procedure was used instead of other methods such as spacing, birth control medication or condoms. There is also the implication that the provider of the tubectomy did not explore additional methods with the women before the procedure, or if so, the women did not choose to explore alternative options before the tubectomy (Samal & Dehury, 2015; V. & Kumar, 2013).

Male perception of sterilization and misinformation are also important in the utilization of sterilization services by men. Misperceptions include the possible side effects of decreased

libido and loss of strength, which is in fact incorrect (Chaurasia & Singh, n.d.; Prusty, 2014). This misinformation damages the legislative financial incentives that attempt to encourage men to undertake sterilization instead of their wives. In one 2015 family planning proposal, one of the objectives was a focus on vasectomy services. Within phase one of the proposal, the goals conflicted with the governmental stance that there should be a shift in the rates of vasectomies and tubectomies. This would be encouraged by identifying and targeting facilities that exceed 200 deliveries monthly, 50 sterilizations and facilities lacking personnel able to provide services despite having the proper training. The purpose of this identification is to ensure that facilities that exceed these specifics are operating ethically and reaching the appropriate population groups, as well as gender (Ministry of Health & Family Welfare, January 2015). The proposal does not focus on the need for vasectomies. Within the text, there is only a note stating that all facilities should have at least one trained provider for vasectomies. If this is stated in a legislative text, there is the heavy implication that current facilities are not all equipped to provide vasectomy services, exemplifying the sheer imbalance of gendered sterilizations. At the conclusion of the strategy, the text does call for emphasis towards the operationalization of vasectomy services and increase in rates of use. For high delivery facilities, the project calls for at least one provider in each facility completing 25 vasectomies monthly, which compares to half of the 50 required tubectomies (Ministry of Health & Family Welfare, January 2015).

Sterilization is not inherently a violation of human rights, but the act of sterilization of women in India becomes ethically blurred when the reasoning for female sterilization is partially impacted by gender inequality. This is evident within the context of misinformation about sterilization effects, such as loss of libido and strength. These two criteria are

stereotyped as masculine and if these misinformed impacts are thought of as accurate, then there is also a valuing system that places men at more risk in these two areas. For libido, this persists through a misperception of sexual drive and desire among women. For strength though, both genders are impacted. Yet with gendered stereotypes of strength as masculine, women are put at risk. The reality of the situation is that sterilization does not lower libido or decrease the strength of the individual. What is true is that women are more likely to experience complications from the procedure and have a longer healing period, while male vasectomies carry fewer medical risks and the procedure is shorter in terms of time and easier for physicians to perform (Singh et al., 2012).

Communities across India are impacted by these influences of misperception and history, in regards to sterilization. In a qualitative study of changing social norms among a tribe in Tamil Nadu, women within that community have become more likely to utilize measures such as a tubectomy, in part because of a perceived need for gender equality (Yadav & Patil, 2014). Women who have fewer children have less housework and more leisure time and opportunities for employment (V. & Kumar, 2013). There is this blurred line between measures that negatively impact women and measures that can empower women. This distinction can be difficult to find. On one side, it makes sense to switch from tubectomies to vasectomies, but women can also use this procedure as a means of sexual autonomy. The clear ethical violation occurs in the case of coercion and bribery of women to use services, given that many medical facilities have quotas for sterilizations. In the case of quotas, practitioners who are having difficulty filling these quotas can resort to coercion, bribery or the targeting of sensitive groups who are more vulnerable (Yadav & Patil, 2014).

Sterilization is in part determined by socioeconomic status, meaning that those in poverty are more likely to utilize sterilization services because of financial incentives. There are not sufficient data in the reasoning behind sterilization and whether there is significant coercion or bribery involved in this reality. Legally, there is a compensation wage for persons receiving sterilization services and this compensation translates to roughly 10 U.S. dollars (Ministry of Health & Family Welfare, 2015 January). This incentivizing of services as a whole should be analyzed to gauge the possible ethical faults for communities in extreme poverty or duress.

Sterilization is also more than the immediate act as there are long-term implications on an individual scale. In a 2006 study, 81% of women reported being sterilized before the age of 30 and the median age was 25 years of age (Singh et al., 2012). These data were collected during the National Family Health Survey and the subsequent survey in 2015-16 either did not inquire about this information or the information has not been processed as of yet. Within the 2015-16 survey, the use of any contraceptive method decreased from 61.4% in 2005-6 to 53.2% in the recent survey. Female sterilization went from 55% to 49.4%, male sterilization from 0.4% to 0.0, IUD use from 2.1% to 1.9, contraceptive pill use stayed stagnant at 0.2% and condom use plummeted from 2.3% to a mere 0.8%. Given the overall negative shift in contraceptive utilization, there may have been issues with collection of data. Overall, 4,800 men were interviewed in this survey, as compared to 29,000 women (National Family Health Survey, 2006; 2016). Regardless, the statistics are representative of the lack of proper utilization of family planning methods.

The Manual for Family Planning Indemnity Scheme from October 2013 is the most recent comprehensive scheme available for public viewing. The scheme was created by the Family Planning Division of the Ministry of Health and Family Welfare. This manual is not only a reference, but also a guide for the proper implementation of family planning services. The text begins by acknowledging prior success in encouraging families to space their children and the need for sterilization services and the availability and use of modern contraceptive measures (Government of India, 2013).

In the context of quality service, quality of care is necessary for proper implementation of family planning, due to lack of public trust in public services, such as hospitals and clinics. In late August of 2015, a woman who gave birth to a child in a government hospital in Guntar was informed that her child was attacked by rats. The rodents had attacked the face and hands of the child, who died shortly afterwards (Boyle, 2015). Instances such as these raise questions on the quality of care in government-funded agencies and the reliability of services. In addressing concerns such as this, the manual scheme aims to address the seamless operation of quality services. This manual is the attempt towards setting a template for quality services. Within the document, quality of sterilization services is highlighted as a major goal and area for change. As part of the introduction, the objective of the scheme is to create a framework of compensation for sterilization services, as well as compensation for any issues related to sterilization, such as failure to properly sterilize or death (Government of India, 2013).

Comparative Section

Now that the groundwork of the historical context and current legislation has been introduced, this section will compare and analyze the differences and similarities between Indian and Chinese family planning legislation. Both countries are recognized globally as heavily involved in family planning as a means to address population growth (Liu, 2013; V. & Kumar, 2013). While it is true that both countries have similarities in the social implications of their family planning policies, each country implemented policy through different means and on separate timelines. Geographical proximity does not equate sameness and this section will explore the unique nature of both countries, while acknowledging similarities present.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is important within this comparative piece. Article 16e states that women have, "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." This right is essential to the concept of family planning and quintessential in western qualms towards measures taken by both India and China, specifically the restriction of reproductive rights.

Historical Context

India was the first to have a singular event that sparked concern regarding population growth, being the Bengal famine of 1943 (Kaur, 2014). While not chronologically on the same path, China had two similar events that sparked that concern, the Great Leap Forward (1958-60) and the Cultural Revolution (1966-76). These events both paved the groundwork for family

planning in the 1950s and 1960s (Feng et al., 2012; Liu, 2014). In both scenarios, each country was experiencing population growth. India was experiencing an economic boom, while China was in economic turmoil. In this case, both countries were experiencing different economic environments, yet both populations suffered as a result and highlighted the need for national legislation. Both events were directly followed by political change to protect citizens by addressing the economy and how the economy impacts the individual experience. For the Chinese, there were not enough social services and the economy was failing (Bu & Fee, 2012). For Indians, the economy had grown too much without proper safeguards to protect the rural population from starvation due to growing food costs (Kaur, 2014). Even with the differences in how these events presented themselves, the impact similarly incited change to the system and change that would involve an increased role in government in addressing growing countries.

Chronologically, both countries have similarities in their progression towards family planning legislation. India's family planning policy of 1952 does predate China's Birth Planning Committee in 1961, showing that India was the first of the two countries to take governmental action (Chaurasia & Singh, n.d.; Liao, 2013). This difference in the timeline of government involvement may be due to India's willingness to take legislative action. In comparison, it is evident that China, while having impressive political power, has historically taken more time in the planning and implementation of policies (Liao, 2013). This difference in turn is a factor in the implementation of policy and the long-term success of programs. India's sheer quantity of legislation and willingness to produce legislation ties into the historical and present issue within India to implement legislation systemically across India (Chaurasia & Singh, n.d.). China does

not share this issue and once policy, even an open letter, is stated, the results are present and immediate.

When analyzing the two underlying views connected to reproductive autonomy and government role, India and China differ. From the 1950s onward, China has grown into the role of a government with a high level of control over reproduction and a similarly high government influence (Lin & Milhaupt, 2013). In comparison, India was the first to create a family planning program in the 1950s (Chaurasia & Singh, n.d.). What differs between the two countries is the viewpoint between the 1960s and up to the 1990s. Unlike China's steady development towards the view stated previously, India has moved back and forth between these two viewpoints. For one example, there was a relaxation of family planning government involvement before and after the Emergency Period in India, but that Emergency Period highlights a moment of government control far more severe than China at the same time of 1975-77. In this way, China's influence regarding family planning is more controlled and steady (Liu, 2013; Liu, 2014; Lundgren et al., 2012).

The 1970s were a period in which both countries mirrored each other in the restriction of rights for the welfare of the country as a whole. Like China, who had begun to implement two-child quotas on family size in the years leading up to 1979, India had begun mandating state quotas of sterilizations, IUDs, and other contraceptive measures (Chaurasia & Singh, n.d.; Liu, 2013; Whyte et al., 2015). This also marked a period in which India became similar to China in their focus on national well-being. While after 1979, the fertility reduction policy decentralized the role of family planning to individual states in China, they were still monitored heavily at the national level (Howden & Zhou, 2015). This means that both countries shifted

towards a monitoring system with an increased role from the national government. That said, ramifications for not meeting goals were less severe for India, and Chinese states proved more effective in meeting goals.

This ability to meet goals relates to two factors: feasibility of the goals and the culturally-driven relationship between the public and their government. China chose goals that, while extreme, were feasible for states to accomplish. In this way, China has reached for extreme measures, but with the understanding that extreme measures can be met. Unlike China, India chose goals that were not feasible and instead presented numbers that the national government would have liked to have seen (Feng et al., 2012; Lundgren et al., 2012). There is that difference between what the government hopes to achieve, and what a government is able to achieve within a specific time-frame.

For comparative purposes, there are two main historical points that mark a sudden shift in the previous relationship in government towards population-related action. The Emergency (1975-77) in India and the open letter (1979) in China are the most significant points of shift in the way each country addressed family planning. Both of these measures lacked transparency and influence of public opinion (Feng et al., 2012; Liao, 2013; Williams, 2014). These moments mark points in history where both India and China utilized political power that undermined reproductive freedom. From simply looking at the time span, it is clear that Chinese legislative reach over individual family planning autonomy was more extensive than in India. China's policy was only recently changed to a two-child framework in 2013-2014 (Whyte et al., 2015). India's Emergency period lasted less than two years, but the impact of that period is still felt by the

Indian population (Williams, 2014). So both family planning policies have left imprints on the communities it reached, but to varying extents due to success in implementation.

When addressing an issue such as population growth, there are a variety of philosophies that can be adopted, including Marxism and Realism. Both countries are grounded in Marxism, in the sense that both recognized their actions as economically driven and determined, as well as influenced by class struggle, experienced by both China and India. China experienced it during development of the open letter as political concerns dictated the necessity for the fertility reduction policy be read as an open letter instead of written into law. Similarly, political distress and conflict between the Indian population and Indira Gandhi led to the declaration of martial law (Liu, 2014).

A Realist perspective in this context is built on the premise that universal moral principles do not exist and action must be created through understanding the context. This can be seen in both countries because of the understanding of population as linked to economic growth and the importance of economic stability over individual rights (Liu, 2013; Zheng et al., 2013). The focus on the good of the whole over the rights of the individual is culturally grounded in both India and China and has influenced the historical progression of family planning (Liu, 2014).

Unlike a western mind-frame, India and China have cultural norms based on the prevailing understanding that the good of the country is more important than individual rights, but to varying degrees (Saggurti et al., 2013). These variations are seen by the backlash or lack of backlash to events that imposed on reproductive autonomy, including sterilization, abortion

and contraceptives. By analyzing the Emergency Period and open letter periods, it is apparent that the respective populations reacted differently. There was little to no backlash to the open letter in China, while India's Emergency period redefined the gender who now undergoes sterilization. The Indian population lashed out in response to the corruption present leading up to the Emergency, and during the period as well. There were riots and visual evidence of public discontent (Feng et al., 2012; Williams, 2014).

The Indian population has been more willing to speak out against their government, perhaps due to more political freedom for free speech. India has a history of having many national and state registered parties, which China only has the Communist Party of China. Free speech extends not only to the political arena, but also media. Indian media is not screened to the extent of China and flow of information, especially news, is more readily available. China on the other hand has a higher role in the assessment of media outlets and ensuring the cohesive nature of the country and its beliefs (Xie, 2013; Yadav & Patil, 2014).

The Current Legislation

The historical context conceptualizes the unique natures of both countries in addressing family planning. For India and China, differences center on government transparency. China has not been forthcoming with their fertility reduction policy and available legislation was not available until 2001 with the Population and Family Planning Law of the People's Republic of China (Order of the President No. 63). India is on the other side of the spectrum with dozens of schemes related to family planning and vast amounts of policies available to the public (Simmons, 2010). The difference is found not only in quantity, but implementation of said

policies. China adopted and effectively implemented the fertility reduction policy as a singular sweeping movement to address population growth. India has a multitude of schemes that are publicly available, but lack uniform implementation across the nation. Comparatively, India's reduction in fertility has not been as extreme in comparison to China.

One reason that explains this difference in success is again acknowledging the power of government over provinces and states. China has more control over their provinces and it is government officials who are directly assessed on success or failure to meet quotas, while India has incorporated agencies and organizations in addition to government officials, to meet requirements. In addition to those accountable, the manner of implementation differs. Chinese policy operates in an absolute manner, where there are severe ramifications to parents who do not comply with family planning policy. This includes pay cuts, substantial fines, as well as a benefit system (Howden & Zhou, 2015). India does not have a punishment system, but has incorporated a benefit aspect within schemes, similar to China (Samal & Dehury, 2015).

After analyzing the legislative texts, there are clear contrasts in the make-up and layout of legislation. The one Chinese law is structured and specific regarding the implementation, regulation, reward, services and legal ramifications under this act. Important to note is that the text is a law, while the majority of Indian texts are either schemes or packets. These documents build on one another and adapt dynamically, while China's text remains stagnant. This dynamic nature of family planning complicates the assessment of how schemes are interacting with communities and populations. Additionally, guidelines are located separately from schemes and locating these documents can prove difficult. In an aim towards transparency, Indian legislation is more difficult to analyze, compared to the singular document relevant in China (Ministry of

Health & Family Welfare, September 2007; August 2011; January 2014; May 2014; January 2015 & December 2015).

In conclusion, legislation within these two countries is different and impacted the countries differently by varying governmental influences that guided implementation. China managed to take an open letter and spread a 'one-child' framework across the entirety of China while India created dozens of schemes and laws that encompass family planning, but have failed to adequately address the issue of population growth.

Implications of Family Planning

As noted in the introduction, CEDAW, Article 16e, outlines the right of women in the spacing and number of their children. The International Federation of Social Workers (IFSW) states in the preamble that they recognize the social work career as dedicated to the achievement of social justice and the continual stride towards the improvement of the quality of life of all people. In this sense, the restriction of reproductive autonomy violates section 16e of CEDAW as well as social work commitment to social justice, outlined by IFSW. Even with these violations, it is necessary to maintain cultural humility and understanding of the historical progression and reasoning behind severe family planning methods.

Even though both countries implemented extreme family planning measures in the same continent and regional location on the globe, the outcomes varied. Through analyzing simple effectiveness, China was vastly more effective in their goal of decreasing the rate of population growth among citizens. From the previous text, there are two simplistic ways of looking at curbing population growth. One is birth planning and the other is birth limitation.

India has focused their funds and trajectory towards primarily birth limitation. This has been accomplished through sterilization, IUDs, and sex-selective abortions (Government of India, 2013). That said, birth planning has been attempted through the dispersal of contraceptive methods and funds spent towards education and access to care for married couples. China has implemented similar methods and the fertility reduction policy is essentially a 'poster child' of birth limitation. Unlike India, China has also implemented a successful birth planning scheme within the fertility reduction policy that has educated married couples and been successful in encouraging later marriages and childbirth (Population, 2001). The process has in many ways changed from China restricting the number of children allocated to each family to empowering families to educate and push resources towards one child for optimum results. This does not mean that ethical violations do not still occur and there are still women whom either feel pressured towards abortion or choose not to register their child. In both of these situations, the Chinese government has violated CEDAW by restricting a woman's right to choose the make-up and spacing of her children or the child's right to citizenship, which is lost if the child is not registered.

The implications of population have already spurred Chinese response since 2013. In November of 2013, China officially relaxed the fertility reduction policy ("China's one child policy change", 2013; Whyte et al., 2015). This relaxation made it so that parents who previously could only have one child were then able to have two in the case of one of the parents being an only child. This change was made for two reasons. One is the growing gender imbalance and subsequent growing bachelor generation. The other is the fact that current fertility rates in China are not meeting replacement level and the population may begin to

decline and create economic instability. Even after the implementation of the fertility reduction policy in 1979, decisions continue to propagate from economic implications. In October of 2015, the policy was officially abolished and replaced by a two-child policy (Liu, 2015 October).

The Chinese change to a two-child policy sounds initially positive for improving sex-selection and gender equality. The reality of the situation is that the one-child policy increased the cost of children and it remains to be seen if Chinese families will be able to financially support a second child or want to split earnings between two children instead of one. In comparison, India has continued to establish schemes with the goal of creating positive change, but a reality of failure of implementation.

Conclusion

Family planning in this paper's context is state or national efforts to provide services related to fertility, reproduction and maternal and child health with the intent to lower overall population growth. China and India are two countries that have received global recognition for family planning policies and subsequent implementation in specific cases. Extreme measures were taken during times when the respective governments registered real and present threats to their respective countries, economy and well-being of citizens.

Comparatively, these two countries are exceedingly different in their history, government, legislation and the interconnectedness to gender. These countries also share some cultural norms, legislative agendas and gender-related issues. Family planning in these two distinct countries share social issues including gender equality, gender disparity, sex-

selection and the overarching issue of reproductive autonomy. Both scenarios are complicated and in many of the issues discussed throughout the paper, there is no clear ethical right or wrong. Acknowledging that complexity is the first step towards conceptualizing solutions appropriate to the cultural setting.

This analysis highlights the fact that solutions are not a 'one size fits all.' The fertility reduction policy is unique to China and it is the unique dynamics of China that allowed a policy so severe to have the effect that it did. In India, it is stereotypes surrounding female sex workers that made a sex education scheme negatively stereotype female condoms. In essence, it is only through understanding the holistic complexities of family planning in the context of individual countries that family planning can be understood as a tool that can both deprive and empower reproductive freedom and economic prosperity.

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