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Gender Disparities in India's Sterilisation Policy and Practice: Ethical Concerns and Human Rights Violations

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In the post-independence era, India's rapidly growing population became a major concern due to its potential to hinder economic development, strain resources, and exacerbate poverty. Government's view sterilisation as a long-term, cost-effective form of contraception, helping to reduce birth rates and improve family planning outcomes. In India rising population also posed challenges for healthcare, education, housing, and employment, affecting overall social and economic progress also aimed at improving maternal and child health by preventing unintended pregnancies. In some cases, sterilisation was promoted as part of broader economic and social development strategies, though it must be implemented ethically to avoid coercion. From the 1950s onward, the Indian government prioritised population control through various family planning programs. In many parts of India, male child preference has historically influenced the practice of sterilisation, particularly female sterilisation. Due to societal and cultural norms, having a male child is often seen as necessary for continuing the family lineage and performing religious rites. As a result, couples may opt for sterilisation only after having at least one male child, delaying sterilisation if they have daughters. Thus, reflecting deep-rooted cultural and social biases that affect family planning and reproductive health decisions male child preference has contributed to a gender imbalance, with women often undergoing repeated pregnancies until a male child is born before considering permanent sterilisation.

Men's sterilisation achieved through a procedure called vasectomy and women's sterilisation tubal ligation raises significant questions about human rights, autonomy, and health offering control over their reproductive lives yet its history and implementation in many regions highlight complex issues regarding consent, bodily autonomy, and reproductive justice. A key aspect of reproductive rights is the ability to make informed decisions about one's body, understanding the procedure, its risks, benefits, and alternatives. In some countries, humans have faced pressure to undergo sterilisation due to socio-economic incentives or pressure from healthcare providers, government programs, or even partners pushing them toward decisions they may not freely choose.

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Methods for Birth Control.

Ancient Indian society emphasised the importance of having children, especially sons, for religious and cultural reasons, such as performing ancestral rites. Therefore, concepts of permanent sterilisation or contraception were not prominently practised or promoted in ancient India. In ancient Indian society, natural methods of birth control were mentioned in classical texts like the Ayurveda and Kama Sutra, focusing on herbal remedies, timing, and physical techniques. Generally used herbal contraceptives were certain plants and herbs, like neem and ginger, believed to have contraceptive properties, Coitus Interruptus (Withdrawal Method) method used to prevent sperm from entering the uterus and timing based on menstrual cycle wherein couples avoid intercourse during the fertile window based on the woman's menstrual cycle. These methods were non-invasive and based on natural practices, though their effectiveness was variable.

In ancient India, sterilisation as a formal policy or medical practice similar to one practised in modern times did not exist as population control measures were not a focus of ancient Indian society. Texts like the Manu smriti and Ayurveda focus more on family roles, fertility, and natural methods for birth control. Family planning or limiting births is not explicitly encouraged or mentioned, as large families were often seen as a blessing in ancient India. Modern notions of contraception or birth control are absent in the Hindu texts.

Different short term and long term prevention methods are used by males and females to control the conception. Hormonal Methods using pills containing hormones (estrogen and progestin) that prevent ovulation, birth control patch through a patch worn on the skin that releases hormones to prevent pregnancy and birth control ring using flexible ring inserted into the vagina monthly, which releases hormones, birth control shot via an injection of progestin given every three months to prevent ovulation and a small rod implanted under the skin of the arm that releases hormones and lasts up to 3–5 years. Barrier methods such as condoms and diaphragm and cervical cap and spermicide are used at different times to avoid or kill the sperm from approaching the uterus. **I**ntrauterine devices (IUDs) like Copper IUD, a T-shaped device placed in the uterus that releases copper that is toxic to sperm used to prevent pregnancy for 10 years and Hormonal IUD, a T-shaped device that releases progestin and can prevent pregnancy for 3–7 years. Permanent Methods of Tubal Ligation is a surgical procedure in which a woman's fallopian tubes are tied, cut, or sealed to prevent eggs from reaching the uterus. and Vasectomy a surgical procedure that cuts or seals a man's vas deferens to prevent sperm from mixing with semen. Natural methods are environment friendly and cost effective method of

birth control, such as fertility awareness, withdrawal, and abstinence during fertile days, offer several unique benefits compared to other methods as unlike hormonal methods, natural methods do not alter the body's natural hormonal balance, avoiding side effects like weight gain, mood changes, or blood clot risks. Emergency contraception methods used after unprotected sex provide more liberty to the partners such as Morning-After Pill to be taken within 72 hours after unprotected sex, delaying ovulation. and Copper IUD as Emergency Contraception can be inserted within five days of sex.

Sterilisation Policy and Gender Construction.

Article 14 of the Constitution of India guarantees equality to all. In India women are burdened with the responsibility to get operated for controlling the birth of babies, whereas men avoid undergoing vasectomy. This is a clear violation of the fundamental right of equality guaranteed to all under the constitution. Policies of the government are also aimed at female sterilisation. To make the situation worse many times the women suffer several health complications due to these surgeries. As revealed by several rounds of reports of National Family Health Survey (NFHS), Annual Health Survey (AHS), United Nations Population Fund (UNFPA) and India's National Health Policy (NHP) Reports Consistently represented the largest share of contraceptive methods, with 36% of married women using sterilisation compared to 0.3% for male sterilisation. NFHS data reveals an overwhelming gender gap, showing that female sterilisation accounts for over 75% of all sterilisations. This data reinforces findings from the NFHS, showing regional variations but a consistently high reliance on female sterilisation due to perceived higher acceptance rates, government incentives, and the influence of legacy programs as the primary method partly due to socio-cultural factors and healthcare accessibility issues.

The significant gap between the rates of tubal ligation (female sterilisation) and vasectomy (male sterilisation). Tubal ligation is far more common, accounting for nearly 95% of sterilisations, while vasectomy represents only a small fraction. This disparity is largely due to cultural factors, where family planning is seen as the woman's responsibility. Misconceptions about vasectomy affecting masculinity, combined with societal expectations, contribute to the much lower uptake of vasectomy despite its simplicity and safety compared to female sterilisation. The data indicating over 3.3 million sterilisations in India in the fiscal year 2018-19, with the majority being female sterilisations, comes from health surveys and reports conducted by the Indian government, including the National Family Health Survey (NFHS)

and other reproductive health-related studies. These surveys provide detailed insights into family planning methods and their usage in India. In recent years, sterilisation has remained a significant method of contraception but male sterilisation (vasectomy) is far less common, making up a very small percentage of the total. As of 2015–2016, approximately 4.5 million women underwent sterilisation annually[3]. Article 15 provides for the prohibition of discrimination based on sex. Low-income group women are incentivized or pressurised to undergo sterilisation so that government officials can complete their targets. Article 15(3) also requires affirmative action to be taken for the benefit of women, this shows there is a constitutional mandate to promote a safe reproductive Programme for women, which would ensure women are protected from harm and have safe family planning measures at their disposal. In *Population Foundation of India v. Union of India* court stressed on the need to have supportive and gender sensitive family planning measures.

Although the government has made efforts to promote male sterilisation in recent years, the uptake remains low, with cultural resistance persisting. This imbalance in promotion continues to place the family planning burden disproportionately on women.

Violations of Bodily Autonomy and Sterilisation

Eugenics[4] as a set of beliefs and practices aimed at "improving" the genetic quality of human populations, often by promoting reproduction among people considered to have "desirable" traits and discouraging reproduction among those deemed to have "undesirable" traits developed in the late 19th and early 20th centuries, heavily influenced by concepts in genetics and evolutionary theory and applied in ways that justified discrimination, forced sterilisation[5] and other harmful practices. Eugenics-based policies often performed under state laws permitted or even mandated sterilisation of people deemed "unfit," including those with mental disabilities, psychiatric illnesses, criminal histories, or certain racial backgrounds.

After World War-II, eugenics was widely condemned as pseudoscientific and morally abhorrent, that harms human rights and dignity as its ideas resurface around discussions of genetics and upgradation of population health, has a history of touching peak in the early 20th century, notably in the United States and Europe, and influenced Nazi ideology, which

[3] The National Health Mission Report, available at : https://nhm.gov.in/New_Updates_2018/Monitoring/CRM/11th_CRM_Report_Web.pdf.
[4] Eugenics, defined as prohibiting marriage and breeding between “defective stock.”
[5] *Buck* v. *Bell*, 274 U.S. 200 (1927).

implemented eugenic policies on a massive, destructive scale during the Holocaust. Eugenics, a social philosophy and an ideology, aimed to shape the coming generations of humans by advocating for selective reproduction practices led to misguided policies that sought to "improve" populations but instead violated individual, cultural, ethnic and human rights.

During the second wave feminism spanned between 1960's to the 1980's, feminists focused on reproductive rights and autonomy, intersected significantly with issues of forced sterilisation, particularly affecting women of colour, low-income women, and women with disabilities raising awareness of forced and coerced sterilisations, which were often carried out on marginalised women without their full consent or knowledge[6].Women, particularly belonging to vulnerable communities, were sterilised without full knowledge or consent without adequate explanation or choice under the undue pressure of medical providers or social services providers as condition for entitlement for receiving welfare benefits. Feminist activists advocated for legal reforms and held protests against policies that enabled or incentivized coerced sterilisations. Lawsuits[7] were filed against hospitals, social service agencies, and government bodies to hold them accountable and push for stronger protections. As second-wave feminists fought for abortion rights and access to birth control, they argued that true reproductive freedom included the right to have children, as well as the right to avoid unwanted sterilisations. This led to the recognition of reproductive justice, which encompasses the right to have children, not have children, and parents in safe and supportive environments by bringing on global spotlight, leading to stricter consent laws and greater scrutiny.

Sterilisation and the right to bodily autonomy are deeply interconnected in the context of reproductive rights and medical ethics. Bodily autonomy refers to an individual's right to make decisions about their own body, free from coercion or external pressures. Sterilisation, being a permanent form of contraception, should be entirely voluntary and based on informed consent. Historically, forced or coerced sterilisation programs violated bodily autonomy, particularly affecting marginalised communities. Certain groups (such as poor, disabled, or marginalised communities) are disproportionately targeted for sterilisation programs. People are sterilised without their consent or through manipulation. Individuals must be fully informed about the procedure, including its permanence, risks, and alternatives and should be a voluntary decision, without external coercion, incentives that unduly influence, or pressure from family,

[6] U.S. General Accounting Office (GAO)1976.
[7] *Madrigal* v. *Quilligan*, No. CV 75-2057 JGD (C.D. Cal. 1978).

community, or the government. Individuals must have the freedom to change their minds before the procedure is performed.

Sterilisation Policy and Incentives

Government family planning programs have historically promoted female sterilisation as the primary form of contraception, often through mass sterilisation camps reinforcing the notion that contraception is primarily the woman's responsibility. The history of sterilisation in India illustrates the tensions between public health goals and individual rights, highlighting the importance of ethical standards, informed consent, and reproductive choice in family planning programs. The sterilisation drive during the Emergency remains a dark chapter in India's family planning history. While aimed at controlling population growth, the coercive methods and human rights abuses associated with the campaign had long-lasting negative consequences, both politically and socially. The political fallout of the campaign was significant, contributing to the downfall of the Congress government in 1977 and shaping India's future approach to reproductive health policies, which have since emphasised voluntarism and reproductive rights. *Haryana Panchayati Raj Act, 1994,*Section 175(1)(q) aimed at promoting family planning and population control, indirectly influencing personal reproductive choices sets the rules that disqualifies individuals with more than two children from holding certain public offices as a criterion for candidates contesting elections for positions within Panchayati Raj Institutions (PRIs), such as Gram Panchayats. However, the ruling sparked debate as it indirectly pressured individuals to undergo sterilisation or limit family size, especially impacting those in rural and economically disadvantaged communities, Supreme Court upheld the law, arguing that population control measures were necessary to manage limited resources. In India, government employees who opt for sterilisation or vasectomy are sometimes given incentives as part of the family planning policy. These incentives can vary by state but generally include benefits like additional paid leave, priority for certain benefits or promotions, or cash rewards. For example, some government schemes offer a 7 to 21-day special leave for male employees undergoing vasectomy. These incentives aim to promote family planning among public servants, making them role models for the broader population, while ensuring the procedure remains voluntary and ethical. Individuals and healthcare workers are often provided financial incentives for undergoing or facilitating sterilisation procedures, particularly as part of the country's family planning programs. The incentives vary by state and region but typically include monetary compensation to individuals who undergo sterilisation (tubal ligation for women or vasectomy for men) getting cash incentives ranging from ₹500 to ₹1,400 ($7 to $20) as a form of

compensation for lost wages or travel expenses. Healthcare providers or workers who perform the procedures or help mobilise patients for sterilisation may also receive monetary incentives designed to encourage voluntary sterilisation, particularly in rural and economically disadvantaged areas. However, these programs must ensure informed consent to avoid coercion.

Several incidents of botched sterilisations have occurred, resulting in deaths and severe health complications as in 2014, a sterilisation camp in Chhattisgarh led to the deaths of 13 women and serious illness for many others due to unhygienic conditions, substandard drugs, and inadequate postoperative care including poor surgical conditions, unsanitary equipment, and overcrowded settings resulting in infection and death, raising concerns about the quality and ethics of sterilisation services. The Supreme Court of India has emphasised the importance of informed consent and post-operative care and issued guidelines mandating that sterilisation should be voluntary, and no one should be coerced[8]. The Court called for better monitoring of family planning programs and accountability mechanisms to protect individuals from unsafe practices aimed to protect human rights within India's family planning program. Despite these guidelines, implementation remains inconsistent across regions.The Supreme Court underscoring the responsibility of the state to ensure safe and ethical conditions in sterilisation programs conducted by the government to provided strict guidelines for sterilisation procedures, emphasising voluntary consent, hygienic conditions, and appropriate post-operative care and ordered the government to create standard operating procedures and ensure medical standards in sterilisation camps via a writ filed by the non-profit organisation Similar situation was brought to notice of court in *Rajasthan State Human Rights Commission* v. *State of Rajasthan* (2012) with regard to mass sterilisation camps in Rajasthan. In *Poonam Verma* v. *State of Haryana*[9] relates to cases of medical negligence where the importance of qualified medical practitioners and accountability in healthcare was emphasised.

Human Rights and Ethics in Sterilisation

Human rights advocates have consistently raised concerns over the ethics of sterilisation practices in India, particularly the coercive elements and the focus on marginalised populations. They argue that the focus on sterilisation disregards the rights and health of individuals, especially women from low-income backgrounds who often do not have the resources to make

[8] *Devika Biswas v. Union of India & Others*, W.P. (C) No. 95 of 2012, Supreme Court of India (2016).
[9] AIR 1996 SC 339.

fully informed healthcare decisions.International human rights frameworks, such as the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), emphasise the importance of consent and freedom from coercive family planning practices. Eliminating coercive sterilisation would align India with these international standards, improving its global standing on human rights. June 2011, *the International Federation of Gynecology and Obstetrics* (FIGO) issued updated guidelines on female contraceptive sterilisation, with a strong emphasis on the necessity of informed consent[10].Sterilisation policy is directly related to human rights, gender equality and right to health. Several international frameworks provide protection and ensure the procedure is safe and voluntary and non-discriminatory. Article 25 of the *Universal Declaration of Human Rights, 1948* provides for the right to health and an adequate standard of living. This means that people who want to undergo sterilisation should have access to hygienic and safe conditions for it, this e means healthcare infrastructure should be developed to that standard. However, in many countries, particularly in India it is observed that poor and marginalised people, especially women are made to undergo sterilisation in unsafe and unhygienic conditions. This amounts to violation of their right to health and dignity.

Whenever any country needs to control population, they undertake discriminatory practices of targeting specific demographics, such as low-income communities, women and ethnic minorities in the name of "population control", wherein they are 'chosen' for the sterilisation Programme. UDHR asserts equality and provides protection against discrimination.[11]. Similarly, *International Covenant on Civil and Political Rights, 1966* provides protection against forced or pressurised sterilisation, as it is considered as an inhuman practice and violation of bodily integrity.[12] In 1970's India's policy of forced sterilisation was highly condemned by the international community for the violation of these principles. Decisions regarding family matters like reproduction and family planning are personal matters and are part of the right to privacy of an individual. Involuntary sterilisation breaches this right to privacy and autonomy.[13.] *International Covenant on Economic, Social and Cultural Rights, 1966* also guarantees right to health & reproductive choices and non-discriminatory access to

[10] Female Contraceptive Sterilisation - FIGO Guidelines ,*available at* :http://www.wunrn.org/news/2011/06_11/06_27/062711_female.htm
[11] Universal Declaration of Human Rights, 1948, art. 2.
[12] International Covenant on Civil and Political Rights (ICCPR), 1966, art. 7 &9. It prohibits torture and cruel treatment, explicitly mentioning that no one should be subjected to medical or scientific experimentation without their free consent.
[13] *Ibid*, art. 17.

health services[14]. *Convention on the Elimination of All Forms of Discrimination Against Women, 1979* provides that women must have reproductive autonomy[15], which means the right to decide the number of children they want to have , the spacing between the children and also they should be allowed to make informed choices. Forced sterilisation even amounts to violence against women as it is based on stereotypes of women's role in the society.

Although forced sterilisation is widely seen among women, even people with disabilities[16] (mental or physical) are subjected to the same. *Convention on the Rights of Persons with Disabilities,2006* provides protection against such discrimination[17].Often girls as young as 12 years are forcibly sterilised, this is a gross violation of their human rights guaranteed under *Convention on the Rights of the Child, 1989*[18]. Even the *World Health Organisation* has emphasised on informed choice, wherein the individual should knows that this procedure is permanent.The *"Eliminating Forced, Coercive, and Otherwise Involuntary Sterilisation" statement, issued on 3 May 2014*, was a collaborative effort led by the World Health Organization (WHO) and supported by a range of international human rights and health organisations. The statement addresses the widespread issue of non-consensual sterilisation practices globally and provides guidelines for governments and healthcare providers to prevent such violations[19].

Barriers to Voluntary Sterilisation.

Although India is a secular country with diverse religious practices, certain religious groups and communities may be less supportive of sterilisation as a form of family planning, some religious and traditional beliefs discourage permanent contraception, emphasising the sanctity of procreation.Societal norms, healthcare policies, and personal circumstances pose Barriers to voluntary sterilisation. Many countries or healthcare providers enforce age or parity requirements (having a certain number of children) before allowing sterilisation. Younger individuals or those without children may face significant hurdles in accessing sterilisation, as providers may fear future regret.Cultural expectations about childbearing, especially for

[14] International Covenant on Economic, Social and Cultural Rights, 1966, *arts.* 12 &2. It provides for Right to Health and Reproductive choice and non-discriminatory access to health services.
[15] Convention on the Elimination of All Forms of Discrimination Against Women, 1979, art. 16.
[16] UN General Assembly, Convention on the Rights of Persons with Disabilities, 24 January 2007, A/RES/61/106.
[17] Convention on the Rights of Persons with Disabilities, 2006, art. 23 & 25.
[18] Convention on the Rights of the Child, 1989, art. 24 &2.
[19] *Available at*: https://www.who.int/data/data-collection-tools/world-health-survey-plus.

women, often pressure people to remain open to the possibility of having more children. Women, in particular, may face judgement or stigma for choosing sterilisation, as it may be seen as going against traditional gender roles. Vasectomy rates are significantly lower in India compared to tubal ligation for women[20].Cultural expectations around masculinity often make men reluctant to undergo sterilisation. For men, there may be resistance to sterilisation due to societal expectations around Stereotypes relating to masculinity and virility, man's strength, libido, which can lead to stigmatisation of vasectomy as a sign of weakness, leading to hesitation .Individuals themselves may worry about regret, especially when faced with societal messages that imply they may change their minds later in life. Women who undergo tubal ligation sometimes face myths about decreased health, loss of vitality, or other negative consequences, which can lead to hesitation and reluctance. In some areas, there are required waiting periods after requesting sterilisation, intended to prevent impulsive decisions but which can also delay access. Some healthcare providers may be reluctant to perform sterilisations, either due to personal beliefs, institutional policies, or concerns about potential legal or ethical issues. Some individuals may avoid sterilisation due to fears or misunderstandings about the procedure's permanence, risks, or side effects. Misinformation can come from cultural beliefs, inadequate counselling, or even outdated information from healthcare providers. Without comprehensive reproductive health education, individuals may not fully understand sterilisation as a contraceptive option or may be unaware of their rights regarding sterilisation. Sterilisation can be costly, and in many places, insurance may not cover the procedure, making it unaffordable. Even when covered, high co-pays or deductibles can be prohibitive. In rural or low-income areas, access to sterilisation may be limited due to a shortage of trained providers, facilities, or resources.

In India, there exists a huge disparity/ imbalance in male and female sterilisation. The data from the NFHS-5 report shows that the percentage of women undergoing sterilisation is 37.9%, whereas for men it is only 0.3%. [21]. There is a clear-cut gender disparity between percentage of male and female sterilisation, which can be seen even from the state wise data.

[20] Biswas B, Kumar A, Agarwal N. Predictors of Male Sterilisation among Eligible, Modern Method of Family Planning Users in India: Evidence from a Nationwide Survey. Indian Journal of Community Health. 2020. April 1;32(2)
[21] National Family Health Survey (NFHS-5), Ministry of Health and Family Welfare.

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State	Female Sterilisation (%)	Male Sterilisation (%)
Andhra Pradesh	69.6	0.4
Andaman & Nicobar Islands	39.2	0.2
Assam	9	0.1
Bihar	34.8	0.1
Dadra & Nagar Haveli	41.6	0.2
Goa	29.9	0.0
Gujrat	35.9	0.2
Himachal Pradesh	37.7	3.3
Jammu & Kashmir	21.1	0.3
Karnataka	58.9	0.0
Kerala	46.6	0.1
Maharashtra	49.1	0.4

National Family Health Survey (NFHS-5), Ministry of Health and Family Welfare.

This data clearly indicates that the percentage of female sterilisation is much higher than that of males and male sterilisation barely crosses one percentage in the majority of states and Union territories in India. This is a reflection of discrimination against women where they are not informed about the procedure and made to undergo sterilisation by family members.

Cultural expectations play a significant role in influencing attitudes and decisions around sterilisation in India, impacting both women's and men's often shaping family planning norms, gender roles, and the balance of contraceptive responsibilities, leading to unique challenges in the voluntary use of sterilisation as a contraceptive method. The longstanding expectation that women are primarily responsible for family planning and contraception is reflected in the high rates of female sterilisation, commonly used contraceptive method in the country. Women are often pressured or encouraged to undergo sterilisation after they have had their desired number of children.Sterilisation sometimes is seen as rejecting the cultural reverence for fertility, leading to social disapproval and Fertility is often celebrated and valued within Indian culture, particularly in rural or traditional settings.

In many communities, especially in rural areas, there is a strong cultural preference for larger families or having male children. Couples may delay sterilisation in hopes of having more

children or specifically a son, which can lead to a higher total fertility rate before opting for permanent contraception. Some individuals may feel pressured by family members or partners to avoid sterilisation or, conversely, may be pressured to undergo it when they don't want to. Such coercion undermines autonomy and can interfere with voluntary decision-making. In some cases, there are pressures from governments or institutions, especially when incentives are provided or when policies encourage sterilisation as a method of population control, particularly affecting marginalised groups. Healthcare providers sometimes discourage sterilisation, especially for younger individuals or those without children, out of concern for future regret. This can lead providers to hesitate in approving the procedure, especially for those who are not considered "ideal candidates" by traditional standards.

CONCLUSION

Sterilisation is often taken up as a policy measure to control population growth, particularly in countries facing rapid population expansion that could strain resources, healthcare, and infrastructure. Governments view sterilisation as a long-term, cost-effective form of contraception, helping to reduce birth rates and improve family planning outcomes. It is also aimed at improving maternal and child health by preventing unintended pregnancies. In some cases, sterilisation is promoted as part of broader economic and social development strategies, though it must be implemented ethically to avoid coercion. Governments and organisations promoting sterilisation as part of family planning must prioritise the protection of bodily autonomy to ensure reproductive rights. Modern legal frameworks and human rights standards emphasise the importance of voluntary sterilisation, ensuring that individuals can freely choose whether or not to undergo the procedure without coercion, misinformation, or pressure from authorities and ensure informed consent to avoid coercion.

Over the years, India has attempted to diversify its family planning options to include more non-surgical contraceptive methods. However, female sterilisation remains the most widely used contraceptive method, partly due to socio-cultural factors and partly due to persistent governmental focus on sterilisation as a solution to population growth[22].The judgement of *Justice K.S. Puttaswamy (Retd.) and Another v. Union of India and Others,* (2017) recognized reproductive choices and bodily autonomy as essential aspects of privacy, thus reinforcing the principle that decisions related to sterilisation should be voluntary and protected from state

[22] International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-4), 2015–16: India.

coercion. The Supreme Court held that the right to health includes access to essential health services, including safe reproductive care demanding accountable healthcare services, including sterilisation practices. As society increasingly embraces a gender-inclusive approach to reproductive rights, normalising sterilisation as a shared option for men and women becomes essential. Vasectomy can empower men by offering a permanent contraception choice while underscoring reproductive responsibility as a shared endeavour. Many people are unaware of the range of contraceptive options available or may not have access to alternatives. This lack of awareness leads to sterilisation being viewed as the primary or only method of long-term contraception, especially in rural areas. Emphasising a more diverse set of contraceptive options (like IUDs, contraceptive injections, and oral contraceptives) can give women more choices. With limited sex education and reproductive health information in many parts of India, people often make family planning decisions based on incomplete knowledge, cultural norms, or family expectations rather than personal choice.

Government family planning programs have historically promoted female sterilisation as the primary form of contraception, often through mass sterilisation camps reinforcing the notion that contraception is primarily the woman's responsibility. In India, a shift in cultural narratives around sterilisation requires a multi-faceted approach, including increased education on reproductive health, stigmatisation of male sterilisation, and a more balanced approach to contraceptive responsibility between men and women. Family planning policies should promote voluntary, long-term, and short-term contraceptives based on women's preferences and individual circumstances, rather than prioritising sterilisation. Healthcare providers should offer non-directive counselling that genuinely respects a woman's reproductive wishes and providers need training on ethical, non-coercive communication that respects patient autonomy, allowing women to make voluntary, well-informed decisions. Laws to create accountability requires documented informed consent, independent verification processes, and penalties for coercion, especially within public health programs. Establishing third-party monitoring for sterilisation programs and involving civil society organisations can help ensure transparency and accountability. Regular audits and feedback mechanisms can prevent abuses and provide women with channels to report any coercive practices.

Eliminating coercive female sterilisation practices in India is crucial for upholding women's reproductive rights, promoting gender equality, and fostering ethical healthcare. Coercive practices not only undermine women's autonomy but also have lasting social, health, and psychological impacts. Historically, India's population policies have included sterilisation targets and financial incentives, primarily targeting poor, marginalised women pressuring

women to undergo sterilisation without full consent or due consideration in need of a Shift to a rights-based, target-free approach to family planning that could help eliminate coercion. The state is also duty bound under DPSP to ensure protection, provide adequate healthcare facilities and prevent exploitation. [23] good health care facilities and the duty of the state to raise standards of public health directly impacts the family planning practices. If the state does its duty diligently their population can be controlled in a much better way without impacting the health, safety and rights of all involved in the process. It is also our fundamental duty to renounce practices that are derogatory to the dignity of the women.[24] It puts duty on the citizen and collectively on the society to respect women's autonomy over her body and discourage practices that hinder her reproductive choices. In *Venkatesh & Ors. v. State of Tamil Nadu (2013)*, emphasised that coercion in sterilisation practices violates women's dignity, further reinforced by citizens' duty to promote equitable and dignified healthcare. Having a holistic approach towards reproductive healthcare, wherein a person can have access to safe, non-coercive family planning choices the states should abstain from making coercive sterilisation policies and those indulging in it should be made accountable for it. The UN general assembly adopted a resolution in 2018 to assure universal access to reproductive healthcare and ending coercive sterilisation. This resolution is meant to ensure that the sterilisation process is carried out ethically, without discrimination, in a hygienic way, which. Would ensure the right to human dignity and autonomy. The "Eliminating Forced, Coercive, and Otherwise Involuntary Sterilisation" statement, issued on 3 May 2014, statement remains a pivotal document in the international push for ethical and rights-based practices in reproductive health, aiming to protect individuals from forced sterilisation and ensure that all family planning services are consensual and respectful of personal autonomy.

Human Rights Law Network (HRLN), highlighting the appalling conditions in sterilisation camps, including unsterile environments, lack of informed consent, and poor post-operative care[25]. Demanding state accountability and justice for the victims of negligent and irresponsible sterilisation procedures with the widespread media coverage and subsequent investigation led the government to compensate the affected families and enforce stricter standards for sterilisation camps nationwide.

[23] The Constitution of India, art. 38,39(e) and 47.
[24] *ibid,* art. 51A (e).
[25] *Ramakant Rai v. Union of India & Others*, W.P. (C) No. 209 of 2003

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California's program offers financial compensation and an official apology, acknowledging the suffering endured by survivors to survivors of the state's eugenics program (1909-1979) and involuntary sterilisations in California's prisons that continued into till 2010's to compensate survivors of state-sponsored sterilisation is a landmark initiative aimed at providing reparations to individuals who were forcibly sterilised under state policies. India does not yet have a formal compensation program for survivors of state-sponsored sterilisations, but there have been calls for reparations and improved accountability. In November 2014, at a government-run sterilisation camp in Bilaspur district, Chhattisgarh, a series of botched sterilisation procedures resulted in the deaths of 13 women, following the tragedy, the Chhattisgarh state government announced a one-time financial compensation of ₹4 lakh (approximately $5,000 at the time) for each of the deceased women's families following incidents where individuals, primarily women, were subjected to coercive or unsafe sterilisation procedures under government-led family planning initiatives.