The Promotion of Family Planning and Women's Rights in Indian Public Space:

An Ethnographic Exploration of Visual Data

by

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Dedication

To my parents and my siblings.

To P.D.N.

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Introduction

This paper examines the promotion of family planning and women's rights through visual materials in India from 1966-2010 to identify changes over time and their reflection of policy. It opens with background on the history of family planning policy and its development in India, including the response to the International Conference on Population and Development in Cairo in 1994. It then explores the theoretical underpinnings of mass communication and the public sphere. Finally, the paper discusses the project's methods, analysis, and conclusions.

Background

POPULATION EXPLOSION AND THE HISTORY OF FAMILY PLANNING IN INDIA

With the overconsumption of developed nations and overpopulation in developing countries, the world faces the looming crises of increasing demand and diminishing supply. The exponential growth of the global population, coupled with the inequitable distribution of resources, have led to the instability of energy and water sources, recurring cycles of famine and food insecurity, global warming, conflicts over borders and immigrants, and the poor health of young children throughout the developing world. India, comprising less than 2.5% of the world's land mass, is home to 17% of the world's people (Whitty 2010), inhabiting the extremes of poverty and wealth. Twenty-two percent of the world population growth from 2000-2005 took place in India, and though its land mass is 1/3 of China's[i], the UN has projected that India's population will surpass China's in 2030 (United Nations 2005:5). The competition for resources has adversely affected the health of India's population: 25% of the world's hungry poor lives in India, and 43% of the population under five are malnourished[ii].

India attempted to meet the challenges of population growth and the poor maternal and child health outcomes associated with them in 1952, when it became the first country to institute a family planning (FP) program. This first FP program, integrated into the existing Ministry of Health, was based on abstinence and the rhythm method (Black & Potts 1978). More results-oriented approaches quickly gained traction, and incentives for sterilization were first offered in Kerala (then Madras) in 1957 (Chadney 1987:221). Though incentives carry an element of coercion, they were an important innovation, given the centrality of cultural norms and values in making family planning decisions. Incentives manufactured a new value – in the form of money or prizes – that could serve as an alternative option to traditional choices, and they have been an important part of successful FP programs in other parts of the world, such as South Korea[1]. India currently provides cash incentives not only for sterilizations, but also for the birth of a girl child who is first or second in birth order and to mothers who are over 19 at the birth of their first child (Ministry of Health 2000).

The Department of Family Planning broke off from the Ministry of Health in 1966, reflecting a shift in regarding FP as an aspect of overall health to the means by which demographic goals could be achieved (Bose 1996). The new FP department quickly conceived a bold plan to lower fertility rates more rapidly – the contraceptive target system. The target system set quotas, or targets, for each contraceptive method, with the highest numbers for permanent sterilization and the next highest for intrauterine devices, or IUDs. National targets were divided among regional areas and broken down by time periods. The responsibility to fulfill targets was passed to state-level and even more local entities, down to the community

[1] Under the dictatorial presidency of Park Chung-Hee in the 1960s and '70s, South Korea, a country that had a similar agrarian profile and cultural value for both large families and sons, very effectively used incentive systems to decrease TFR from 6.0 to 1.08 by 2003.

health worker, with quotas set by year, month, and even by the day (Murthy et al. 2002:26). Each person who signed up for a new method of contraception was known as an acceptor. Those who brought in new acceptors were known as motivators, and they benefited with their own cut of the cash incentives.

Kerala, then at the forefront of innovations in family planning – and internationally renowned for its success – established mass vasectomy camps in 1971 (Chadney 1987:223). The efficiency of mass sterilizations caught on in other states, and though it was supported, it was not yet instituted by the central government. That same year, India legalized abortion with the Medical Termination of Pregnancy Act, though availability was mostly limited to more urban areas (Nidadavolu & Bracken 2006:161).

On 25 June 1975, Indira Gandhi declared emergency rule, constitutionally suspending the civil liberties of all Indians in order to implement her 20-point economic revitalization plan. Mrs. Gandhi's son, Sanjay, though lacking an official government role, decided to spearhead his own development plan, one aspect of which was family planning "for a prosperous future" (Tarlo 2003:28). Without attempting to change the existing contraceptive target system, under Sanjay's oversight the government intensified its efforts and raised its target numbers to such a degree as to necessitate local coercion in achieving the set targets. In public addresses, Sanjay underscored the importance of the family planning program to the success of the nation's industrial, economic, and agricultural development, and this national arc toward modernity became the official narrative of the Emergency (Tarlo 2003:29). According to this narrative, everyone, rich or poor, could contribute to India's modernization through sterilization.

The full-force Emergency-era sterilization campaign efforts resulted in a number of documented (and likely, many more undocumented) cases of coercion, harassment, and forced

compliance (Chadney 1987:226, Visaria & Visaria 1981:39, Tarlo 2003). Though there exists controversy over the degree to which the Emergency truly increased (versus falsified, under pressure) the number of contraception acceptors, it seems true that the number of sterilized couples increased from 14% before the Emergency to 21% in 1976-1977 (Gwatkin 1979:49). Unfortunately, the reactionary response to family planning after the Emergency led to fewer acceptors and thereby erased these gains in sterilization. The reality and reputation of the family planning program were important in effecting Mrs. Gandhi's loss of power in the elections of 1977.

The post-Emergency period was marked most significantly by the government's silence around FP, but the contraceptive target system remained the official approach to controlling population growth in India. In the 1990s, though, critics and community advocates within India became increasingly vocal about the failings of the contraceptive target system. Through its focus on sterilization, the target system directed itself at older women with many children and few remaining fertile years, thus leaving unattended the contraceptive needs of younger women with fewer children and more years of fertility and potential child-bearing ahead (Murthy et al. 2002:31). Louder critiques bemoaned the system's violation and disrespect for the rights of women (Ramachandran 1996).

CHANGING ATTITUDES IN INDIA'S POPULATION POLICY

The failings identified by these critiques may be traced back to the fact that historically, the advocates for family planning and the development of international population policy have not always been concerned with the causes and ramifications of population growth in local communities (Campbell 1998). In addition, the under-acknowledged importance, until recent

times, of women's health in conversations about pregnancy, let alone family planning, has had lasting effects in India. A lack of both community acceptability of contraception and decision-making power among young married women was found in communities with high rates of early marriage and early pregnancy in Maharashtra state (Sethuraman et al. 2007). The failed history of top-down governance in reproductive health may perhaps be best understood in light of its lack of community engagement – particularly women's engagement – and its inability to address local community-level factors such as acceptability, agency, and relevance in promoting family planning.

The beginnings of change in official international population policy emerged in 1994, when women's rights and feminist perspectives on health shaped the agenda at the United Nations' International Conference on Population and Development (ICPD) in Cairo. In this way ICPD represented a civil society movement not seen as part of any major international conference before or since 1994 (Ashford & Noble 1996). ICPD recognized the universal right to reproductive health, emphasized the empowerment of women and individual-centered care, and rejected the idea that permanent contraception should be the primary means of population control (United Nations 1995). ICPD popularized the idea that family planning should be user-friendly and comprehensive, and moreover, should honor the reproductive rights of women. Though it is reductionist and oversimplified to claim that ICPD marked the end of bad population policy and the beginning of good policy (Campbell & Bedford 2009: 3105), Cairo retains importance as a symbol and a turning point in international family planning policy.

The dramatic political shift in India's approach to family planning finally came about in the 1990s with the convergence of three factors. The first was the growing international pressure, as exhibited at ICPD, on population and development programs to protect human

rights. Next, experimental programs that focused on offering greater choice of family planning options in India and beyond were proving successful in reducing fertility (Murthy et al. 2002). And third, the recognition that meeting the large unmet need for contraception – estimated to be as much as 28% of women of reproductive age (Ministry of Health 2000) – would significantly decrease the country's fertility rate.

India officially eliminated its contraceptive target system in 1996. The central government changed its family planning policy to incorporate ICPD's tenets of 1) free choice of multiple contraceptive options, 2) gender equality and equity, 3) women's empowerment, and 4) elimination of violence against women (Murthy et al. 2002, Ministry of Health 2000). Thus the language of women's rights and empowerment became a part of official government rhetoric. The continuing decline in annual population growth rates over the years after ICPD has proven that choice and options – especially given both the improved safety and increased variety of longer-acting temporary intrauterine and implantable methods – can provide the right setting for effective family planning.

SIGNAGE AND MASS COMMUNICATION IN INDIA

This paper examines the visual manifestations of the post-ICPD shift in the focus of population policy (from demographics to women's rights) through the study of health promotion materials (e.g., signs and posters) for family planning and women's rights in India. It explores the following research question:

> How were the changes in the Indian government's population policy reflected in the images, language and rhetoric of materials promoting family planning and women's rights from 1966 to 2010?

Is it possible to see a change in the government's attempt to communicate with its citizens over time? Is there evidence of concomitant change in promotional materials that reflects the evolution of government policy? In other words, what associations can be identified between the materials produced and the time period from which they came?

India began its information campaigns for reproductive health in the late 1960s – pasting posters, passing leaflets, and using the radio to promote family planning and provide information about various contraceptive methods (Piotrow et al. 1997). In general, signage in India, especially urban India, is used by diverse segments of the population to communicate a wide variety of messages. In particular, communication through visual materials – such as signs, posters, and banners – is a common approach to health promotion. Visual health promotional materials are usually produced by Information and Education Cells (IEC) of the state or central government, then distributed to district level offices, which are charged with the dissemination of materials to local hospitals, NGOs, and *panchayat* (a rough equivalent to a village council) buildings (Nidadavolu & Bracken 2006:166). Bad roads, poor weather or lack of funds for transportation often result in the limited distribution of materials to easily accessible areas such as those on or near reliable roads (Nidadavolu & Bracken 2006:166).

Mass communication's ability to target both an individual and a community allows it to exert influence in both direct (personal) and indirect (ecological or environmental) ways, and effective public health media campaigns usually combine well-designed messages with far-reaching and frequent delivery (Abroms & Maibach 2008). From an anthropological perspective, the effectiveness of mass media communication also revolves around the social context – the "numerous other dialogues" that make such communication understandable and relevant to the public that views or hears it (Dewey 2009:135, Spitulnik 1996:161).

The last completed census of India in 2001 showed that literacy had risen from 18.33% in 1951 to 64.84% – an impressive gain, but still signifying a large illiterate population. The literacy rates differ significantly between the sexes; while 64.84% represents the average, only 48% of Indian women are literate[iii]. How has the Indian government communicated with citizens with such low literacy rates, particularly regarding such issues as family planning and women's rights, when illiterate women are a significant target of such messages? Radio, television, and other visual materials (such as posters and signs) in the public sphere become particularly important, given such circumstances.

The high rate of illiteracy among women is just one manifestation of the significant gender disparity extant in much of India, especially among the country's large rural population. As in much of South Asia, women are subjected to cultural subordination throughout a lifetime of discrimination, violence, and socioeconomic dependence on men (Fikree & Pasha 2004:823). Sex selective abortions, the neglect of girl children, high rates of maternal mortality, sexual and physical violence, dowry deaths, and poor access to health care all contribute to poorer maternal and child health outcomes and lower life expectancy indicators for Indian women (Fikree & Pasha 2004:824). These outcomes are rooted in the idea that women traditionally do not contribute "economic utility" to society (Fikree & Pasha 2004:825). Failing to provide income and, even worse, requiring the payment of dowry at their marriage, women are seen instead as an economic liability.

NEOLIBERALISM AND GOVERNMENTALITY IN THE PUBLIC SPHERE

In the West, the public sphere is central to discourse on most – if not all – topics, including women's health and family planning. The emergence of the public sphere in Europe

was a result of both its ability to facilitate the exchange and development of ideas as well as the need and desire for "the common" (Habermas 1989). The western concept of the public, of course, completes the private, and the two parts form a whole whether describing space, behavior, or conversational topics. Since Habermas, scholars from different fields have noted the inadequacy of the public-private dichotomy when applied outside the construct of western history and civilization.

The framework of the public sphere in India differs significantly from western constructs. Sudipta Kaviraj points out that public-private dichotomy suits the western tendency toward "universality of access," meaning that the line between private and public rests on the question of individual rights (Kaviraj 1997). This concept is less relevant, however, when used in traditional Indian societies, which delineate not by accessibility, but by belonging, understood through spheres of "restricted inclusivity" (Kaviraj 1997:90). These spheres are defined by religion, caste, geography, gender, family, age, and so on.

Perhaps a more helpful way to demarcate Indian space is the dichotomy of the Bengali *ghare/baire* (as used by Kaviraj) or Marathi *ghari/baher*, where *ghari* (*ghare*) means inside the house and *baher* (*baire*) means the outside (Kaviraj 1997:93). The home is ordered, governed by the norms of relationship and religion, and signified by family, altars to deities (and thus, the holy), purity, and safety. The outside, lawless and ungovernable, comprises everything else. While *ghari/baher* and private/public may be apparently similar, they are actually grounded in very different approaches – individual rights vs. restrictive inclusivity – to making sense of the world.

Within the public sphere, governmentality provides a frame for exploring population policy and development in India. Governmentality is defined by the processes by which a state

(or other "governing" bodies) governs people's conduct: by institutions and agencies; by "discourses, norms, and identities;" and by self-regulation (Foucault 1991, Ferguson & Gupta 2005). In the modern world, the welfare of the state's citizens is central to governmentality, as exemplified by public health efforts. Through the manufacture of discourses, norms, and identities, the state itself becomes the site of production of cultural symbols and social norms, evolving into more than just a "functional bureaucratic apparatus" (Ferguson & Gupta 2005). In this way, the state, too, is described by a multiplicity of ideological representations and interpretations. Visual materials that promote public health are part of the manufactured images and identities that the state uses to define – or redefine – its citizens, and in this way they are another tool used to govern conduct. The localization of such images of governance to one's hospital, village *panchayat*, and – through the scope of such images – to one's home and body (*ghari*) brings issues of individual agency and bio-politics face to face with governance.

The tensions between public and private, governance and agency, can be further explored through Habermas' definitions of what constitutes a public, particularly diffuse publics. The public sphere, Habermas contends, consists of three concomitant publics: "episodic publics" of individuals gathered informally, "arranged publics" that have come together at scheduled meetings, and "diffuse publics" comprising consumers of mass media (Habermas 1995). The diffuse publics are those who are targeted by and take in public health messages presented on signs, on television, and over the radio. Diffuse publics allow for the filtering of information from private to public – something that is primarily guarded by social and behavioral norms – to create a kind of "cultural consensus" (Dewey 2009:125).

Nancy Fraser claims that Habermas' assumptions of universal equality and of distaste for discussing private matters are problematic (Fraser 1992). From Fraser's feminist perspective,

Habermas' stark line between public and private actually comprises a large grey zone. The idea that public and private are clearly separated exemplifies the subordinating power of discourse where the public is speakable and the private is not.[2] For this reason, Dewey says, there emerge various parallel public spheres. The parallel public sphere, according to Dewey, provides a setting for the discourse of individuals not with the state, but with and within marginalized and/or devalued groups, usually following the exposure of inequality (Dewey 2009:125). Because of the way it concomitantly provides a space for discourse in these groups and reinforces norms of hierarchical power structures, the parallel public sphere is both "a consequence" and "an agent" of oppression (Dewey 2009:125). It is precisely this reality that may at once tempt an observer to celebrate the empowerment manifest as membership in a Habermasian diffuse public, despite the fact that the voice of this public can speak "only at certain times and in certain ways" (Dewey 2009:125).

The parallel public sphere, thus, often allows marginalized communities to be both internal (private) in their audience and external (public) in their dialogue (Dewey 2009:125), enabling individuals to speak the unspeakable and publicize the private. In India, in particular, it is only in the parallel public sphere that public conversations about female sexuality and violence against women take place and, as such, it becomes a place where individual women are able to find a way to circumvent and construct parallel norms of public space for women within India's sexist society (Dewey 2009:137).

The state, however, is far from marginalized; it is, in fact, an actor in the marginalization of subgroup communities in India's social hierarchies. Yet in promoting family planning and women's rights among the diffuse public sphere, the state enters the reserved domain of the

[2] The public discourse over domestic violence in the U.S., for example, has historically been linked to the appropriateness of publicizing the private (Dewey 2009:126).

marginalized parallel public sphere by broaching private and unspeakable topics of sex, reproduction, and violence. Thus, not only has the state attempted to enter this marginalized domain, it aims to enter the discussion of the unspeakable. Given Indian society's repressive attitude toward the exposure of the private, public communication around what might happen behind closed doors – including not only sex, but also domestic violence – must be thoughtfully constructed and carefully considered to remain relevant to and avoid alienation of the target audience for health promotion. Ideally, an effective promotion campaign can create a parallel public sphere in which women are able to access information that "address[es] desires and needs otherwise not open to discussion" (Dewey 2009:132). There has been some evidence that the facilitation of such "discussive spheres" in response to media campaigns can change behavior even more than just passively absorption of media messages (Abroms & Maibach 2008). In Nepal, for instance, women who heard messages of a family planning campaign in conversations with other women were more likely to use contraception than women who were only exposed to the campaign's messages and did not discuss them (Abroms & Maibach 2008).

More recently, the public discourse on empowerment has been used as a vehicle for redefining family planning and population policy. The globalization of India's economy and the liberalization of its state in the past few decades provide an interesting context for the changes inspired by ICPD and other women's health advocacy groups in India. The confluence of the neoliberal concept of "self-care" with the feminist movement's idea of women's empowerment during this time (Sharma 2006) lends important perspectives to developments in post-ICPD family planning policy. Perhaps the push for empowerment, resonant with those in support of women's rights, became a convenient tool for the neoliberal rollback state, which adopted a

hands-off approach to addressing its citizens' welfare and thus renouncing its role in governmentality. The subsequent "paradox of participation," in which the role of individual responsibility in family planning becomes an aspect of governance and population policy, is another perspective to consider given India's position as the world's largest democracy (Paley 2001). Paley describes how civil society measures can encourage neoliberal governments to avoid spreading already thin budgets by involving poor citizens in the provision of public services in the form of "empowerment programs" and "community participation" (Paley 2002:483). This approach effectively sidesteps the Foucauldian role of government to protect and provide for its citizens by placing those responsibilities in the hands of those same citizens under the auspices of empowerment.

The public sphere is the domain of governmentality, yet when it comes to matters of health and family planning, governance begins to creep across the line dividing public from private. In legalizing abortion and defining a minimum legal age of marriage, the laws of the public sphere have attempted to govern the practices of the private/*ghari*. The Indian state encounters a significant challenge in attempting to bridge the two realms.

Methods

Data collection and analysis for this project were grounded in visual ethnographic methods. The protocol included collection and visual analysis of public images and textual data through archival materials, capturing public images through fieldwork, and field observation.

The significance of an image as well as the context in which the image has meaning is best illuminated in the ethnographic tradition. Ethnography attempts to glean insight into the 'insider's' world, and to gain a sense of the ideas, understandings, and assumptions that come

with belonging to it. Thus, the goal of such study is not to uncover true and unbiased data, which may not exist anyway, but to "discover the correct manner of interpreting" the data (Hammersley & Atkinson 1997:131). Ethnography illuminates not just what is seen, but also a way of seeing, making it a particularly important element of this project.

SAMPLE

Three topics were selected for study for the visual ethnographic study of India from 1966 to 2010: family planning and contraception, population, and women's rights. Over two hundred signs, posters, banners, and other forms of promotional display were originally collected for this project through mostly web-based archival analysis and fieldwork in western Maharashtra. Brochures, images with unreliable or unverifiable translations, and those that did not specifically speak to the three topics listed above were excluded. The final data set consists of 137 images collected online or captured by digital camera. The images were organized by time periods relative to ICPD in1994. All data from the years preceding and including 1992 were grouped as "pre," for pre-ICPD. Data from the years 1993-1996 were grouped as "peri," and from 1997 through the present day as "post."

A total of twelve images did not have the year of production or publication listed, but comparison with other data by the same producer enabled informed estimation of the time period for eleven of the twelve.[3] These eleven undated images were grouped according to similarities in style and content of other materials. As illustrated in the following table, the pre group comprises 40 images and 4 additional likely candidates (total 44); peri includes 47, plus 1 likely candidate (total 48); and post consists of 38, plus 6 likely candidates (total 44).

[3] The last, a poster for condoms produced by VHAI (Volunteer Health Association of India), could reasonably be argued to belong to either the peri or post group, and is referred to in the following tables as (+1).

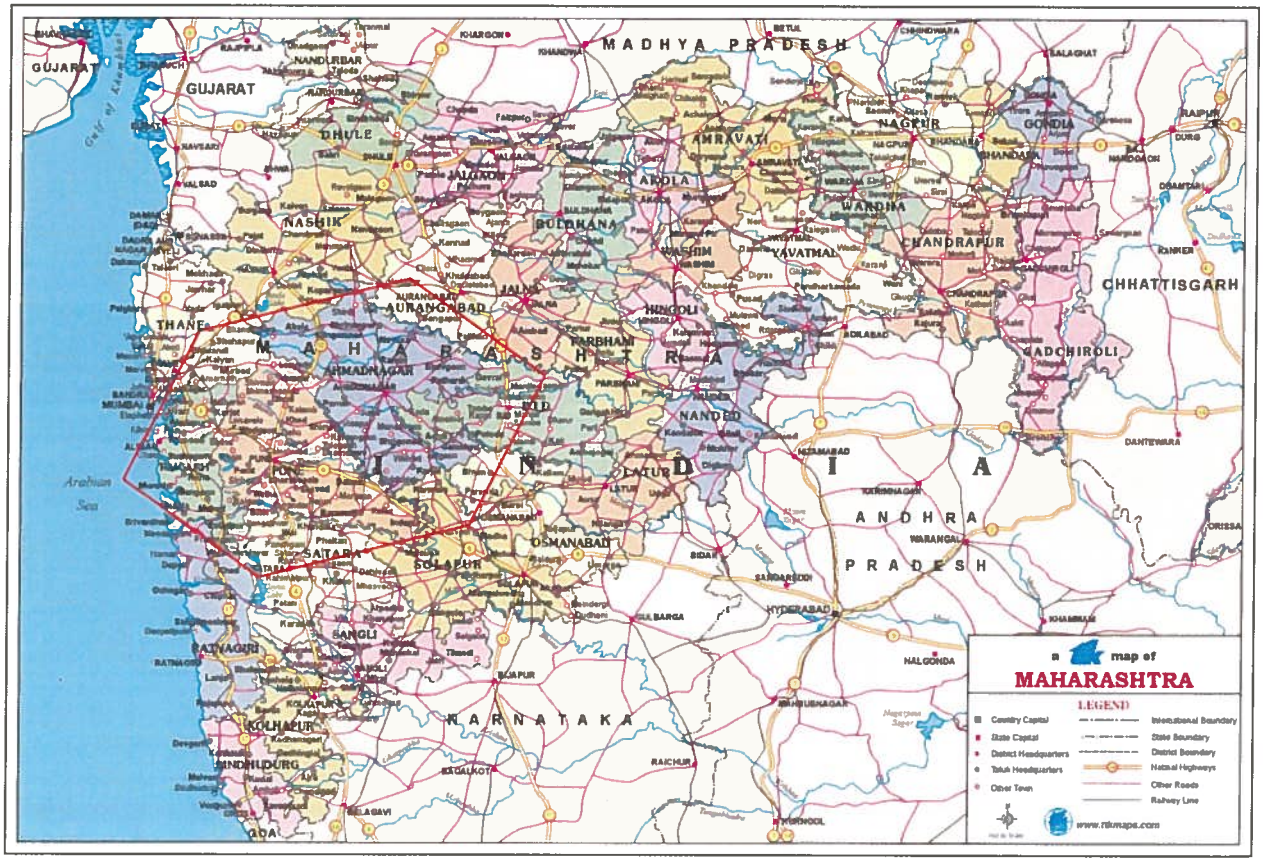
Time Period	Count	Likely	Total
Pre-ICPD *(Until 1992)*	40	4	44
Peri-ICPD *(1993-1996)*	47	1	48
Post-ICPD *(1997-2010)*	38	6	44
Total	125	14 (+1)	136 (+1)

TABLE 1. BREAKDOWN OF DATA BY PERIOD. (+1) = DATUM OF INDETERMINABLE PERIOD.

STUDY PROTOCOL

Fieldwork took place in various parts of western Maharashtra, in the large cities of Mumbai and Pune, as well as towns and small villages in Ahmednagar, Pune, and Solapur Districts. (The general outline of these areas are circled in red on the maps on the following page.) Maharashtra was chosen because of the researcher's previous experience in the state and some knowledge of Marathi, the official state language. Five trips were made in total; the first visit, 10 months in duration, took place in 2007 and return visits (varying in length from 3 weeks-3 months) were made semiannually since then. Fieldwork comprised ethnography, most intensive during 2007-08, and the observation and collection (by digital photography) of visual materials in the field. Field notes were made in a small field notebook throughout the day and reviewed in the evening. Notes recorded the details of locations and setting for collected data, including any interactions that took place, as well as striking events and observations throughout the day. The latter were most usually related to the treatment of and/or behaviors of women as they challenged or illustrated typical norms. Often these were rewritten as short vignettes and saved as electronic documents.

FIGURE 1. MAPS OF INDIA AND MAHARASHTRA: FIELDWORK SITES OUTLINED IN RED.



The primary source of data for this project was the online Media/Materials Clearinghouse (M/MC), "a leading international resource for health communication materials" affiliated with Johns Hopkins University Bloomberg School of Public Health (JHUBSPH) and Center for Communication Programs (http://www.m-mc.org/). Hard copies of all materials are housed in an office of the JHUBSPH at the Inner Harbor in Baltimore, MD, and were collected in-country by staff members. All materials in the database are part of the public domain and were obtained with permission to be displayed and shared on the worldwide web[4]. M/MC's website returned 425 matches for materials from India. Excluding brochures, pamphlets, and novelty items (like badges and stickers), signs and posters relating to women's rights, family planning, and population totaled 104 materials including both government- and NGO-produced materials. The remainder of the project data came from fieldwork, Emma Tarlo's *Unsettling Memories: Narratives of the Emergency in Delhi* (2003), and the websites of the Indian National Rural Health Mission (NRHM) and the advocacy organization We Can End Violence Against Women (WCEVAW).

Source	Pre	Peri	Post	Total
M/MC	40	48	15	103 (+1)
Fieldwork	0	0	14	14
NRHM website	0	0	6	6
Tarlo 2003	3	0	1	4
WCEVAW website	0	0	8	8
Filmfare magazine	1	0	0	1
Total	44	48	44	136 (+1)

TABLE 2. BREAKDOWN OF DATA BY SOURCE. (+1) = DATUM OF INDETERMINABLE PERIOD.

[4] Information about the M/MC database was gathered through a phone conversation with the current *ad hoc* manager (Sean Stewart, personal communication, 2/23/10 1:06 PM PST, 410 659 2652). Mr. Stewart also revealed that because of a loss of funding, the database has been in flux and without a librarian since 2007.

Analysis

Each image from each respective time period (pre-, peri-, and post-ICPD) served as its own unit of analysis, and was analyzed with consideration of the context and time period in which it was produced. The change in materials over time and clues to future directions were discerned by content analysis (Altheide 1996). Codes were built on text and language, image, color, people depicted, setting, values invoked, audience targeted, tone and affective elements, and other details, in addition to the overall gestalt of each image. Coding was performed and managed using Atlas.ti software. Ethnographic content analysis (ECA), which is guided by predefined categories while allowing the emergence of new ones, was used to analyze the data (Altheide 1996). ECA involves continuous comparison and interpretation with the goal of being able to place an image within the context in which it was produced (Altheide 1987). The general analytic process following the acquisition of data involved a cycle of category creation, data coding, and data analysis. Iterative coding was performed until each group was found to exhibit saturation of major themes and codes, justifying the sample size for each.

Data were categorized by time, topic, source, and producer. Though the vast majority of data were obtained from web-based sources, the real-time discovery of materials – or the lack of them – was instructive. Such materials are primarily found in and around hospitals, as well as at the *panchayat* (a rough equivalent to a village council) office in most towns. Fieldwork revealed that visual promotion may be more visible and widespread during epidemics (as during the H1N1 influenza epidemic of 2009) and during annual polio vaccination campaigns, but it is not uncommon to see weathered signs with various health messages at busy intersections, hand-painted on the wall of a small business shack, or even on the mud guards of trucks. Public and family health messages are also spread by television and radio commercials, potentially

reaching an audience beyond those who want or need to go to hospitals or their local *panchayat*.

Fourteen images collected in the field met the inclusion criteria for this project, but many more health-related materials were encountered and collected for context. AIDS, malaria, and tuberculosis (and H1N1 "swine" flu, during the summer of 2009) were the most common foci of non-study materials.

Results: Organizational Sources and Linguistic Background

The primary institutions that produced the visual materials on family planning and contraception, population development, and women's rights in India from 1966 to 2010 included governmental and non-governmental organizations. One hundred and five images were produced by the government at local or national levels, and the remainder by non-governmental organizations (NGOs), including not-for-profit advocacy groups and contraceptive manufacturers. Of those produced by contraceptive manufacturers, some images were closer to advertisement than health promotion.

By language, the public images produced were in six languages, including Hindi, English, Marathi, Gujarati, Bengali, and Tamil, with Hindi and English language images accounting for 80% of all data (see Table 3). English language materials were most common in the pre-ICPD period and Hindi language materials because most common in the peri- and post-ICPD periods. This may suggest an attempt to make these health promotion messages more accessible to less educated groups.

Language[5]	Pre	Peri	Post	Total
Bengali	2	1	0	3
English	18	9	14	41 (+1)
Gujarati	9	0	0	9
Hindi	12	38	17	67
Hindi (transliterated)	2	0	0	2
Marathi	0	0	12	12
Tamil	1	0	1	2
Total	44	48	44	136 (+1)

TABLE 3. BREAKDOWN OF DATA BY LANGUAGE AND TIME PERIOD. (+1) = DATUM OF INDETERMINABLE PERIOD.

Results: Changes over Time and Major Themes

From the early narrow-sighted focus on small families and sterilizations to the modern-day visibility of the rights of the girl child and contraceptive options, there has been a strong arc of evolution in this data set of visual communication materials from India in the past 45 years. Not only topically, but also in language and tone, these materials have become less instructive and less euphemistic about how couples should have families while becoming more specific and more challenging of social norms and attitudes around both family planning and women's rights over time. The remainder of this section will detail these changes first by decade and then by further examination of significant themes.

In the late 1960s, the Department of Family Planning, extricated from the auspices of the Ministry of Health, began its first media campaigns as it officially adopted the incentivized contraceptive target system as national FP policy (Piotrow et al. 1997). The images in Figure 2 below show some of the department's earliest efforts in promotional visual media. The content of the posters from this earliest period tend to be vague, pithy, and directive, with strong

[5] Translation was possible through the invaluable help of research assistant PD Nagtilak, as well as Sheela and Usha Maru, and Roona and Kal Ray.

recommendations on spacing children or limiting their number. Despite the nationalized policy of contraceptive targets, the posters make little attempt to "sell" these concepts nor to provide detail on how to achieve them. That said, in telling the public how to have children, neither do they contradict policy. It is interesting to note that though incentives were in place at this time (Chadney 1987), public promotion of these incentives through visual media is conspicuously absent from most of this early data.

FIGURE 2. LEFT: 1966 "TWO OR THREE KIDS ARE GOOD ENOUGH. CONSULT A DOCTOR." (BENGALI). RIGHT: 1970, THE NEXT CHILD NOT NOW. AND TWO OR THREE KIDS LATER, NO MORE." (HINDI).

In terms of design, the color yellow in these posters is attention-grabbing, and the prominent red triangles symbolize family planning. This design of these early posters is significant because the color combination, schematized faces, and especially, the inverted red triangle universally and unambiguously suggest FP to most observers, even today.

In the early 1970s, mass vasectomies and the legalization of abortion were the biggest developments in family planning (Chadney 1987, Nidadavolu & Bracken 2006), but neither was seen in the data from this time period. The content, design, and language of the posters became more sophisticated, and somewhat less directive, but generally, the message was the same: don't have too many children. The image in Figure 3 illustrates this, and also shows the promotion of condoms (*nirodh*) as contraception. (In recent times, condom promotion is more

visible as prophylaxis for HIV rather than contraception.) Again, the red triangle on yellow background is present.

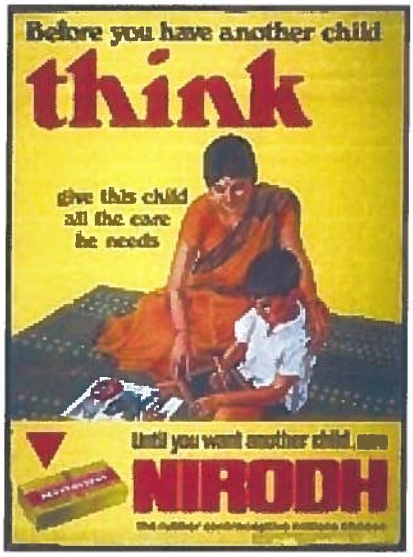


FIGURE 3. 1971, *NIRODH* = CONDOM.

With the Emergency of 1975-1976, the Ministry of Health and Family Planning formalized a national population policy that, among other measures, increased the legal minimum age of marriage for both sexes, increased sterilization incentives, and legalized compulsory sterilization (Gwatkin 1979:37-38). Beyond a notice for increased incentives, the limited visual data available for this period did not promote these measures. The absence of data from M/MC dated to the mid- to late 1970s is puzzling. Besides encouraging interesting speculation around Emergency-era propaganda, it presents a liability of this data set. Two examples of data, which present an ironically sanitized and inappropriately triumphant perspective on sterilization, from this time period are further examined in Figures 12 and 14, later in the paper.

Though Indira Gandhi reintroduced the small family message when she returned to power in 1980, the government of the post-Emergency decade until the era of ICPD generally kept silent on family planning after the disastrous efforts of the mid-1970s (Chadney 1987).

Nevertheless, the visual data from the 1980s show new developments in the promotion of family planning. Male and female sterilization became a topic of some posters, which also addressed the common concerns of virility, energy, and hospital time, albeit briefly. During this period, the first government-sponsored advertisement (as opposed to promotion) of condoms was seen in the data (Figure 4). No overt mention is made of family planning, though the red triangle is visible on a condom packet displayed in the poster. Though no obvious connection or context is described, freedom is invoked with the visual allusion to FP.

FIGURE 4. 1987.

While the images of earlier posters were not really placed in identifiable settings (as in Figures 2 and 3), during the 1980s, two common tropes of setting and context began to emerge. The first is the depiction of rural village scenes; this became one of the most consistent aspects of all the visual data in the following years. But while agrarian traditions are often alluded to in these images, they are rarely spoken to directly, with the exception of the common metaphor of spacing both plants and children. Figure 5[6] shows two such posters – the first, in English, explicitly connects "proper spacing" to "better, sturdier" growth while the

[6] Though the trope of rural settings was traced back to the 1980s, these examples from the 1990s are used for the sake of illustration.

second is more poetic. Both use "the law of nature" to convey what is "proper" in terms of raising and spacing children, even while the use of contraception might be considered by most people to be an artificial restraint on more natural tendencies and behaviors.

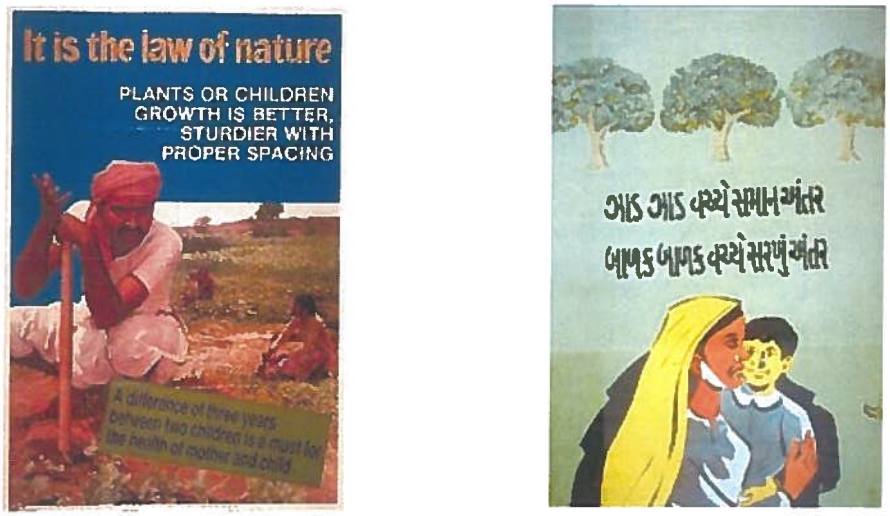


FIGURE 5. LEFT: 1992. RIGHT: 1990, "AS YOU KEEP SPACE BETWEEN TREES, KEEP SPACE BETWEEN CHILDREN." (GUJARATI)

In contrast to the posters in Figure 5, the second trope that emerged at this time rejected backwards rural life, emphasizing a new kind of citizen – modern, global, and progressive – and it linked these attributes to sterilization. These posters showed, instead of farmers, more urban men and women in clean doctor's offices for sterilizations (Figure 6).

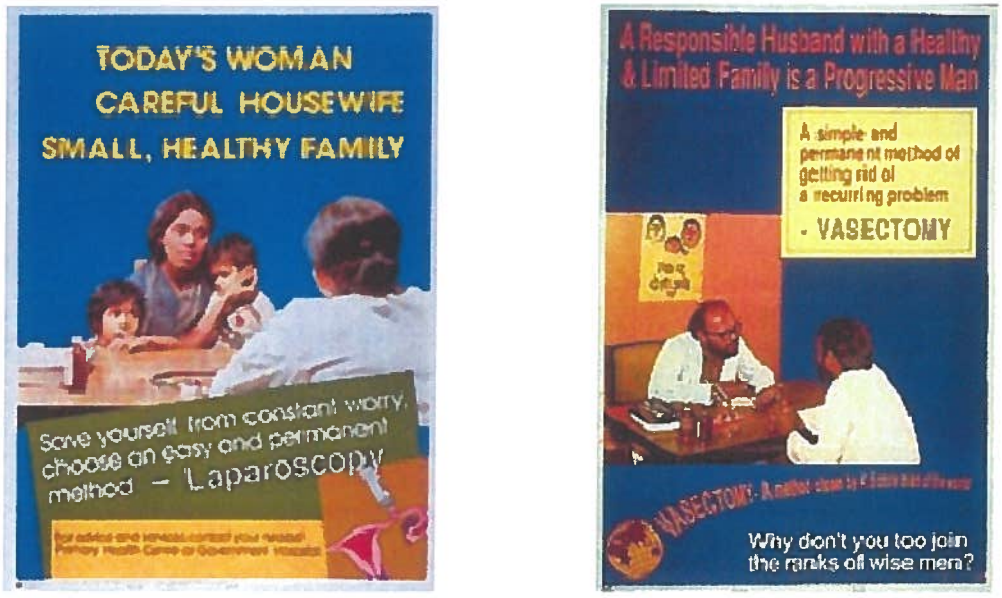


FIGURE 6. LEFT: 1988. RIGHT: 1992.

This new citizen was described as careful and responsible – a "progressive man" and a woman of today. Such citizens also had "small," or "limited," and healthy families. The sterilization procedures were advertised as simple or easy and permanent, and especially, desirable for "saving" one from "constant worry" or "getting rid of a recurring problem." The second poster in Figure 6 even asks, after noting that vasectomy is a method chosen by millions of men around the world, "why don't you too join the ranks of wise men?"

These examples, like others of the same and previous decade, used a degree of delicacy in addressing family planning issues. Even while promoting sterilization, they avoided any explicit explanation of the connection between sex and family size, at most only referencing men and women as husbands and housewives, thus implicating marriage and the societal expectations of it (i.e., children). The language of these and slightly earlier posters tended to be vague and euphemistic, for example, "Vasectomy enables you to lead a normal married life" and, "childbirth not by destiny but by decision."

Finally catching up with the actual national population policy of the Emergency-era, the first posters to mention a delayed age of marriage appeared in 1987 (Figure 7). This poster also illustrates the trend – increasingly common in the 1990s – of causally associating desirable family planning decisions with happiness and prosperity.

FIGURE 7. 1987, "MARRY LATE AND HAVE ONLY ONE CHILD FOR HAPPINESS AND PROSPERITY." (GUJURATI)

While often presented as an issue of girls' rights (to continued education, and later, to avoid the burdens of married life), delayed marriage age is an important strategy in decreasing total fertility rates (TFR), which accounts for its widespread use in FP promotion over the following decades, as well as the criminalization of underage marriage.

In the early 1990s, "small family, happy family" and minor variations on this phrase became the theme of most family planning promotional materials. Along with this came the common trope of large and small family comparisons (see Figure 8). Often contextualized in rural environments, large families were depicted in barren settings with ragged clothes and rundown homes, often looking miserable. Small families, usually with no more than two kids,

were shown with fertile fields and neat homes. Children were often shown studying or going to school; everyone is smiling and dressed nicely.

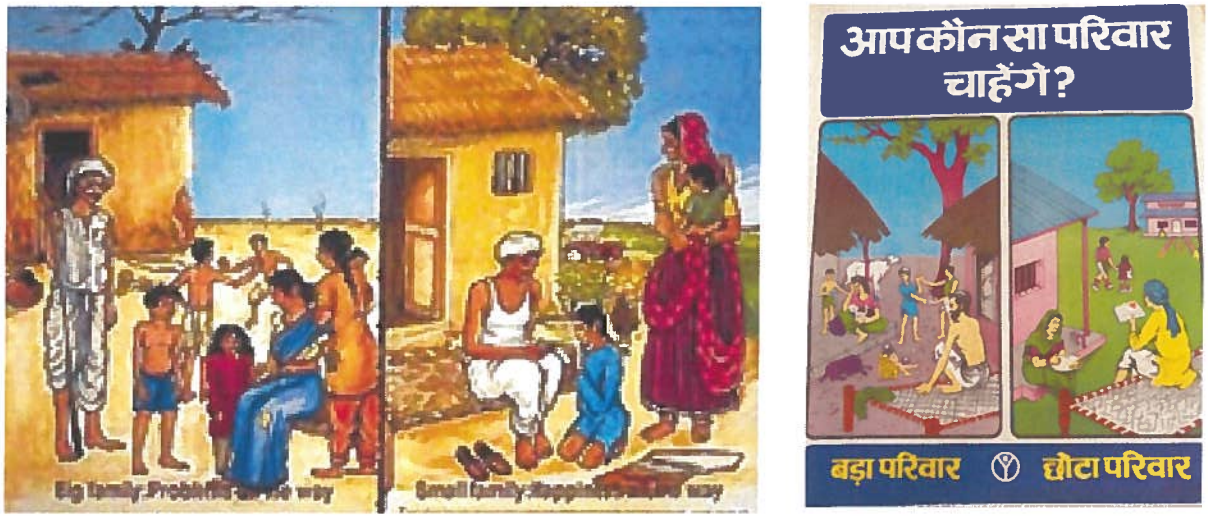


FIGURE 8. LEFT: 1992, "BIG FAMILY: PROBLEMS ON THE WAY. SMALL FAMILY: HAPPINESS ALL THE WAY." RIGHT: 1994, "WHICH FAMILY WOULD YOU PREFER? BIG FAMILY, SMALL FAMILY" (HINDI).

Though the approaches evolved over time, it is clear that the promotion of small families was the primary tactic of the pre-ICPD approach to FP promotion through visual media. The data of the peri-ICPD years began to show the first shifts in the way family planning was addressed in visual communication with the first posters explicitly addressing the cultural preference for sons and the devaluation and poor treatment of girl children (see Figure 9, left).

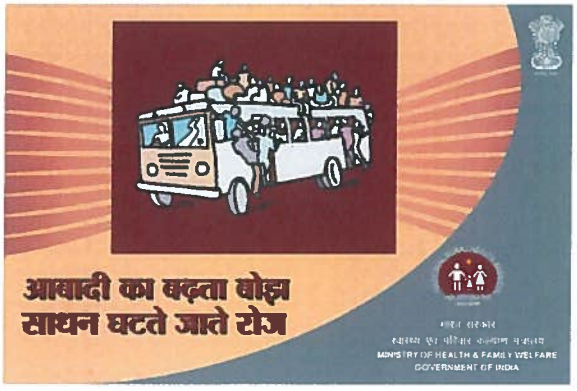
FIGURE 9. LEFT: 1993, "I AM YOUR DAUGHTER, NOT A BURDEN" (HINDI). MIDDLE: 1993, "WHY ONLY A BOY? ARE THESE NOT GIRLS?" (HINDI). RIGHT: 1993, ON THE JOURNEY OF LIFE, HUSBAND AND WIFE ARE EQUAL PARTNERS (HINDI).

Before this time, most posters promoting small families depicted families that magically produced one son and one daughter. From this point, posters began to show two or even only one daughter in a happy, healthy small family. Other posters asserted that the education and career opportunities for boys and girls were the same (see Figure 9, middle), often emphasizing the need for education as a reason to delay a girl's marriage. Around this time, there was also an increase in the materials that emphasized the importance of equality in the husband/wife relationship as well as in the responsibilities of the household. The poster in Figure 9, right, showed a husband and wife eating together, a scene which – for its rarity in more rural areas, even today – makes it especially powerful.

Unlike the dearth of data dating to the Emergency, the number of available data during the four peri-ICPD years constituted over one-third of the data set. Produced by the Ministry

of Health and Family Welfare[7] (MoHFW), these visual data illustrated an emerging paradigm shift in the central government's efforts to address family planning. The data of this period are rich and varied, however. Themes that emerged earlier – small happy family, delayed marriage age – but also new ideas, such as oral contraceptives, a variety of contraceptive options (in government-produced posters), as well as the rights of girls and women (see Figure 9), all populated the visual data from 1993-1996. This mixing of older and newer ideas in the posters is to be expected during these transitional years.

Along with the central government's family planning promotion, perhaps a surprising development from around this time was the role of NGOs in producing materials that directly addressed overpopulation. These images are often overwhelming, with crowded depictions of people amid too few resources, which often include food, housing, jobs, and transportation (see Figure 10).



[7] MoHFW was previously known as the Ministry of Health as well as the Ministry of Health and Family Planning. MoHFW is consistent with the current name of the department, but its use in reference to the data of this project includes previous naming and ultimately refers to the central government of India.

FIGURE 10. TOP LEFT: 1994, "AFTERWARD WHAT? GROWING POPULATION, GROWING DESTRUCTION. STOP THE GROWING POPULATION." (HINDI) RIGHT: 1994, "WHAT? NO JOBS!" (HINDI). BOTTOM LEFT: 2010, "THE POPULATION BURDEN SHRINKS OUR RESOURCES DAILY" (HINDI).

The post-ICPD data from the late 1990s to 2010 reveals a progression from the peri data, but little that is conceptually new or innovative among government-produced materials. Advertisements for all kinds of contraceptives and posters displaying three or more contraceptive options were common. In addition, contraception and reproductive health have been incorporated into posters that address other public health issues, such as childhood diarrhea and proper nutrition. Beyond the girl child, in very recent times, posters questioning violence against and mistreatment of women and their condonement by social norms have become more visible. The NGO known as WCEVAW (We Can End Violence Against Women) has launched a major campaign to challenge the cultural assumptions of male superiority and female mistreatment, using comic strip style posters and compelling images (see Figure 11, right). Figure 11, left, brings up the contradiction of a society that worships goddesses but abuses women, and also alludes to the irony in which women become the abusers of other women as they attain the status of mothers-in-law, finally reaching a position of power in their life cycle (Das Gupta 1996).

FIGURE 11. LEFT: 2010, "ON THE ONE HAND, WORSHIP OF THE GODDESS, BUT ON THE OTHER HAND, DISREGARD FOR WOMEN. ("GO, DIE" WRITTEN ON THE PUSHING HANDS.) HOW CAN IT BE THAT FROM WOMEN THERE COMES THE HUMILIATION OF WOMEN? WHAT IS A SON AND WHAT IS A DAUGHTER? IN JOBS AND RESPONSIBILITY THEY ARE THE SAME." (MARATHI). RIGHT: 2010, "IF THE CONDITION OF OUR GIRLS IS LIKE THIS, THEN...? (GIRL IS BURDENED BY "SOCIETY" AND "LIFE.") IT'S POSSIBLE, THE END OF VIOLENCE AGAINST WOMEN."(MARATHI).

MAJOR THEMES

There remain a few interesting points which could not be adequately addressed in the discussion of data by chronology. These include the role of men, the nationalistic influence, the evolution of the family planning logo, and the comparison of government and non-government materials. A discussion of each follows below.

Though men are far from being the primary target of the majority of materials in this data set, they have been targeted in a significant minority of posters in interesting ways. Figure 12 shows two early examples of this that reflected Indian society's partriarchal structure and power from the 1960s and 1970s. Both images here specifically targeted men, and interestingly, both invoked some form of power and its transfer to men (not, notably, women) through the use of contraception – condoms (*nirodh*) and vasectomy.

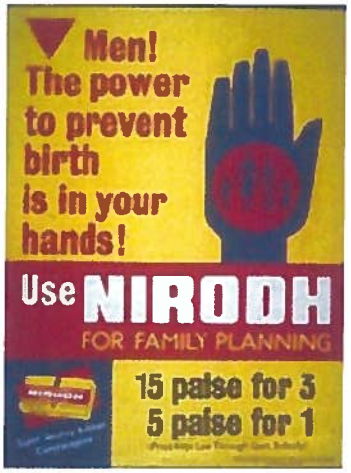
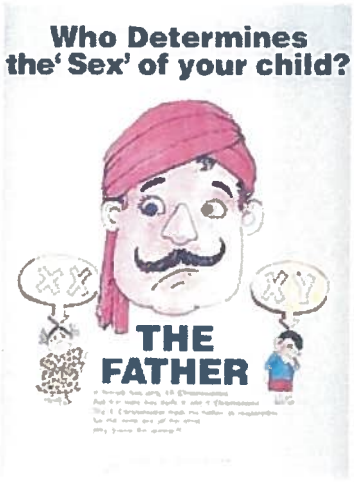


FIGURE12. LEFT: 1969. RIGHT: 1976 (EMERGENCY-ERA).

They both twisted traditional and more familiar meanings of certain concepts through their invocation in these images. On the left, power is associated with the prevention of birth rather than the production of offspring, which has been far more common an association with virility and masculine power, not just in India but in many cultures. On the right, vasectomy was portrayed as the key to a "normal married life," which, for many Indians, has been associated with family and fertility rather than sterilization. Notably, it is the man in this image who is "enabled," "free," and almost victorious in appearance, while the woman is shrouded. It would most likely be the woman, after all, who would feel fear as the true bearer of the literal and metaphorical burden of an "unwanted pregnancy." In both cases, prevention and agency, rather than production and fertility, were being defined as powerful and are also, effectively bypassing women, firmly placed in the hands of men.

More recent examples from the peri-ICPD period (Figure 13) focused on how paternal responsibility affects the composition and happiness of a family.



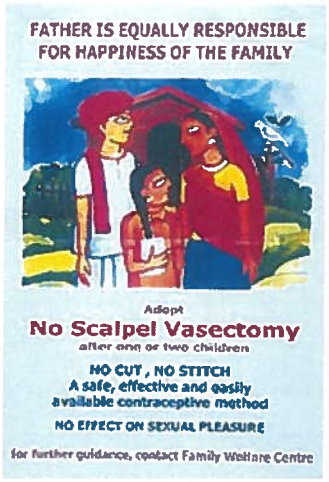


FIGURE 13. LEFT: 1996. RIGHT: 1994.

The first poster, by explaining the father's role in determining the sex of his children, attempted to shift the blame – and buffer the violence – endured by women in bearing daughters to the father. The second, again equating happiness with small families, reminded of the equal responsibility of fathers in ensuring this happiness.

Though not particularly common, an interesting observation from this data set was the connection made between family planning and national responsibility. In Figure 14, the first example from the 1970s epitomized the propagandist nationalism invoked in the name of the contraceptive targets during the Emergency era. The image is triumphant, bringing an ironic sense of victory to the sterilization of hundreds of thousands in the state of Uttar Pradesh. The second poster from 2010, promoting a World Population Day event in Bihar, declares a national commitment to a "stable population" in ensuring the health of the nation, oddly echoing the Emergency-era narrative of national development.

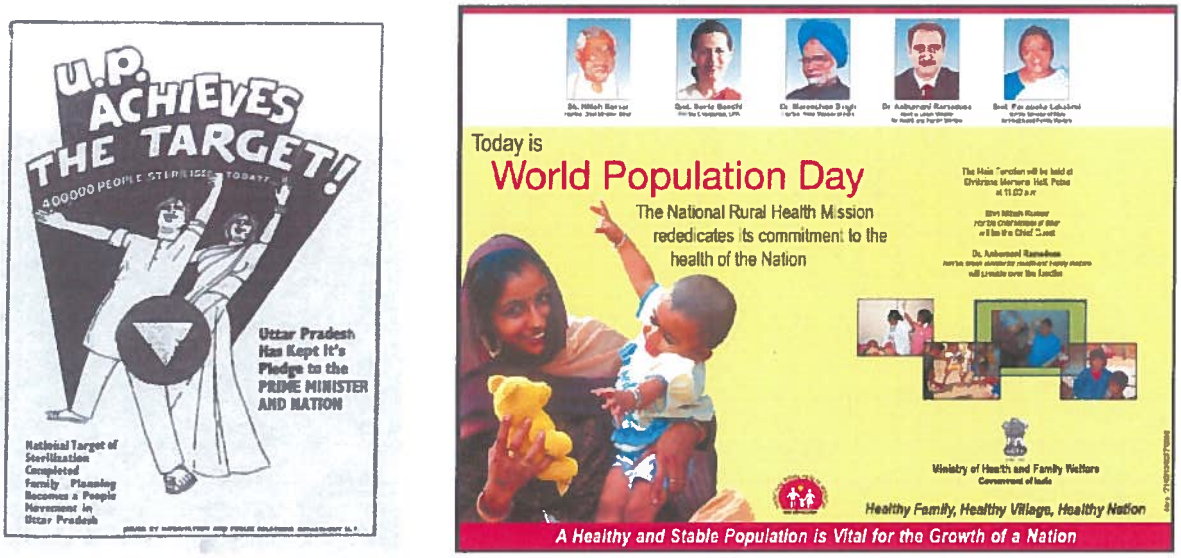


FIGURE 14. LEFT: 1976 (EMERGENCY-ERA). RIGHT: 2010.

Not only the content of messages and the means, but also the triangular logo of family planning has itself evolved significantly over the years, often mirroring changes in the posters (see Figure 15). From the solid inverted triangle, to one superimposed with an abstracted mother and son, to a vaguely outlined couple with a daughter, and finally a more clearly delineated single-daughter family, these changes signaled the Ministry of Health's efforts to promote small families, and especially those that might only include girl-children.

FIGURE 15. EVOLUTION OF THE MINISTRY OF HEALTH'S FAMILY PLANNING LOGO.

Though the available government-produced data far outnumbered those produced by NGOs, it seems unmistakable that NGOs often pioneered new messages and innovative ways to tell them. Notably, the first poster in the data set to emphasize choice in FP by displaying

multiple contraceptive options came from the 1980s, far earlier than MoHFW-produced materials, and was produced by the British-based reproductive health NGO Marie Stopes International. VHAI in the mid-90s and WCEVAW in recent times have both produced bold and challenging posters, a couple of which have been shown earlier, that affronted social norms. The government has often followed the lead of these NGOs in the production of their own materials – following suit with posters showing different methods of contraception, as well as their own recent version of VHAI's "Who Determines the Sex of your Child?" (see Figure 13, left). The ten to fifteen year lag in the government's production of the same materials as NGOs reflects the slow pace of national policy change and social acceptability.

Following are tables summarizing the data by topic and producer.

Topic	Number
Contraception	39 (+1)
Family Planning	74
Population	15
Women's/Girls' Rights	35
Male Role or Responsibility	15

TABLE 4. DATA BY TOPIC. FP AND CONTRACEPTION WERE CONSIDERED SEPARATELY GIVEN THAT PROMOTION OF CONTRACEPTION DID NOT ALWAYS INVOKE FAMILY PLANNING. (NOTE: CATEGORIES OVERLAPPED OFTEN.) (+1) = DATUM OF INDETERMINABLE PERIOD.

Producer	Pre	Peri	Post	Total
MoHFW	30	42	9	81
NRHM	0	0	9	9
State Gov't	11	0	0	11
Local Gov't	0	0	4	4
Literacy House	0	* 13	0	* 13
Oxfam	0	0	1	1
PKK	0	0	1	1
PHD	1	0	0	1
SIFPSA	0	* 1	0	* 1
UNDFW	0	0	2	2
UNFPA	0	1	0	1
VHAI	0	5	0	5 (+1)
DKT India	0	0	1	1
Marie Stopes	2	0	1	3
PSI	0	0	4	4
WCEVAW	0	0	12	12
Total	44	48	44	136 (+1)

TABLE 5. BREAKDOWN OF DATA BY PRODUCER. MOHFW = MINISTRY OF HEALTH AND FAMILY WELFARE (I.E., CENTRAL GOVERNMENT). MOHFW, NRHM, STATE AND LOCAL ARE ALL GOVERNMENT ENTITIES. DATA IN RED WERE PRODUCED BY GOVERNMENT-NGO PARTNERSHIPS AND WERE NOT RE-COUNTED IN THE TOTAL.

Discussion

Though India reduced its total fertility rate (TFR) from 6 in 1950 to 3 in 2007 (Registrar General of India 2009), not a single policy or event has managed to make a downward dent in the growth of its population (Whitty 20100. The global population demographic approach to lowering TFR has been three-pronged: 1) meeting the world's unmet demand for contraception, 2) reducing demand for large families, and 3) slowing population momentum (Muir 2009). The first, of course, is dependent on the provision and pricing of contraceptive options, and meeting this demand is expected to reduce future worldwide population growth

by 30% (Muir 2009). The latter two strategies require the production of fewer offspring, delaying marriage age, and increasing spacing between children. These, while effective ways to decrease TFR, tend to be more easily abstracted and more subject to the normative practices of particular cultures and societies. The Indian government focused almost exclusively, until the last fifteen years, on vague and pithy promotion of two-children families with three years of space between each birth rather than on the availability and accessibility of multiple options for varying contraceptive needs. Perhaps the hesitance to focus on the unmet contraceptive demands of 28% of Indian women (Ministry of Health 2000) undermined, to some degree, the potential change that might have been effected in promoting a menu of contraceptive options even before ICPD.

Historically, culturally, and religiously, the role and value of men and sons have been an important part of Indian families, and in agricultural areas, large families have also been a source of labor, investment, and pride (Fikree & Pasha 2004). It is particularly helpful in examining these visual data to recognize that the conceptualization of family planning and women's rights in India presents a radical challenge to existing social norms, and thus to the governmentality of the state and other agencies of governance. In addressing topics that are not only drawn within normative definitions, but are also traditionally of the realm of *ghari*, and thus governed by the rules of home and family, producers of public health messages and images must grapple with the balance between delicacy and clarity. The earliest family planning messages – never showing men interacting with women, and never using anything more than a reference to marriage to indicate the sexual act – reflected this hesitation to speak in anything but euphemistic associations and vague terms. These same social norms perhaps influenced the government's decision to promote two children and three years of spacing over the availability and options

for contraceptives during the pre- and peri-ICPD periods. While less so in more globalized urban areas, such norms continue to stifle public discussion and promotion of family planning in traditionally agrarian areas.

It has long been recognized that the more education a woman has, the older she will be both at marriage and at the birth of her first child. The UNFPA's 1990 *State of World Population* report found that in the developing world, if a girl receives seven or more years of schooling, on average, she will marry four years later and have 2.2 fewer children than one who receives less than seven years of school (Sadik 1990). A 2004 survey conducted in the northern states of Bihar and Jharkhand found that girls who married before age 18 were twice as likely to be beaten, slapped, or threatened by their husbands than girls who married later (ICRW 2005). Thus more schooling corresponds not only with more desirable socio-demographic characteristics, but also increased safety for women. Higher levels of education attained by mothers have also been shown to correlate with better infant and child health (Bicego & Boerma 1993). It is no surprise that, after 1990, a significant fraction of this data set combined the message of delayed marriage age with increased education of girls.

This association of formal education with smaller family size leaves no question about the imperative to prioritize the education of girls around the world, but information about, options for, and access to family planning methods have been the only prerequisites to their use and effectiveness even among illiterate and very poor women (Whitty 2010). Without taking away from the need to improve universal education, the real-time lag in the actualization of economic development and social change further underscores the present need to fund and support family planning programs that facilitate the widespread availability of contraceptives in an effort to meet the unmet demand until more reliable infrastructures are in place.

When examined through the lens of these visual media, it can be concluded that the confluence of India's history of family planning policy and the global pronouncements of ICPD paved the road for the issue of rights, particularly for girls and women, to enter the discussion of the formal public sphere. Particularly in India, ICPD represented an important global shift, given a track record of FP atrocities that left the government sensitive to shifts in the international consensus. Around the time of ICPD, India was gun-shy around the topic of FP and had not yet determined a way to publicly and actively promote FP values. Through reframing policy constructed around the empowerment and rights of girls and women, India was given a way to re-engage on the topic of family planning in the public sphere. This led to the production of materials focusing on the rights of the girl child, the importance of female education, and sundry contraceptive choices. The ability to challenge the social norms that violate women's rights through signs and posters was an important development given the task of the government to create new norms and cultural values in the promotion of both FP and women's rights.

The task of manufacturing new norms, values, and identities through health promotional materials is central to the enduring struggle for both family planning and women's rights in India. This has been illustrated in multiple ways – from the early patriarchal posters targeted toward men to the more recent signs that emphasize their responsibility to their families, from the depiction of small families with at least one son to those with only one daughter, and in the evolution of the family planning logo itself. The marketing of a new kind of progressive and modern citizen at the cusp of the 1980s and 1990s was a short-lived attempt, in addition to the still-visible small-family-happy-family trope, to establish new constructs for social value. Alongside these techniques was the ready invocation of responsibility, which was redefined in

the discourse of population development as an impetus for sterilization and other forms of contraception as well as something owed to one's daughter.

The recommended strategies for TFR reduction in India may be categorized by those requiring government responsibility – by meeting the unmet need for contraception – and those demanding the responsibility of citizens – by decreasing family size, raising marriage age, and spacing children. Earlier, this paper questioned the possibility that empowerment movements since the time of ICPD gave the state an exit route from meeting its responsibility to the welfare of its citizens. While there may be other ways to support or reject this claim, this analysis did not find evidence for this hypothesis. Rather the liberalization of the Indian state in the empowerment age of the 1990s corresponded to an increase in visual materials that promoted options in contraception and sought to make children acceptable, even when they were fewer in number and female in gender.

The composition of the public sphere itself was affected by the radical challenge brought by the transformation of family planning and women's rights in India. Through visual health promotion, a new value was bestowed on citizens. No longer a Malthusian burden, Indian citizens are now – all of them – pronounced worthy of investment, education, freedom from violence, and the absence of a sibling within three years of their own age. This traditionally middle class philosophy of freedom and opportunity, extended to all citizens – including girls and women – suggests that they have become not only valuable *per se*, but also potential contributors to society. Thus by promoting the rights of women and girls, the need for smaller families and the benefits of marrying later , the attempt to govern and regulate fertility through visual promotion has placed a rhetorically productive value on its citizens.

These population policy developments as reflected through the visual materials have also effected the localization of national and global priorities to the villages, hospitals, homes, and bodies of the citizens of the state. Given that, it is important to at least consider – though an actual conclusion may be foregone – the line between choice and coercion when examining the ideological materials that are meant to persuade. To what degree might a poorer and more marginalized woman actually have agency in deciding to undergo sterilization for the cash incentives she would gain? Is the incentive empowering or coercive? If the same decision is made by an educated, higher class woman, do the choices made by each woman truly reflect democracy or only the variations in power among women in India?

Limitations

The limitations of the data set obviously place important limitations on the findings in this paper. The absence of Emergency era materials in the M/MC database is the most significant example of these limitations. While the analysis and conclusions detailed above are accurate to the best of this researcher's ability, in describing this particular data set, the inadequacies of the data set itself affect the generalizability of these results.

While it may have been an interesting finding, it is important to note the possibility that the lack of concordance between policy and data (as detailed above) may actually reveal a limitation – namely a lack – of the data.

Because the dating of materials was dependent on when they were collected (whether by M/MC, this researcher, or other parties), it carries a degree of inherent inaccuracy. For example one poster focusing on the status and rights of women found in Solapur District Hospital in July 2010 also promoted a public awareness event about the same topic that was to

take place in August 2002. While, in this case, the eight year gap did not have an effect on its classification into the post group, such time lags in data collection may have played a role in the groupings of other data.

In addition, while the grouping of visual materials by time period was central to addressing the research question, and thus a vital part of data analysis, it is important to remember that the groupings were a construct of this researcher and not determined by explicit plans or programs of the MoHFW's Information and Education Cell (IEC). As a result, the groupings were made, to a small degree, with a nod toward convenience. Materials collected spanned the years 1966 to 2010, but the frequency of materials by year varied widely. As evidenced by the small range of the "peri" years, from 1993-1996, there was a preponderance of data available from this time period. Thirty-one images were from 1993 alone. Outside of the peri years, only 2010 (26 materials) and 1992 (13) had double-digit data counts. While they do not match the peri grouping in depth of data, the increased breadth of years comprising the pre and post periods has enabled the observation of repetition and saturation – the standard marker of a sufficient qualitative sample size – among the data's codes and themes.

As is true in any ethnographic study, the subjectivity of the researcher was both shaped and limited by her position as an outsider to the community being studied. Issues and interpretations deemed important, while largely validated by analysis of the data, were ultimately determined by the researcher. The constraints of time and resources precluded the conduction of focus groups and structured interviews in information gathering.

Though data collected through online sources originated from a large geographic area, fieldwork for both ethnography and data collection took place only in western Maharashtra. As

a result, not much regional variation of post-ICPD materials is likely to have been recognized through this study. Likewise, the possible variations in historical materials by language could not be determined due to the variations in availability of materials in different languages.

Conclusions and Implications

The Indian state faces the not insignificant challenge of encouraging behavioral and social change to family planning and gender equity through the address of private topics in the public sphere. Its approach over time has reflected this struggle, primarily, as illustrated by the visual data, through the tendency to address more publicly acceptable topics in less offensive ways. This has generally translated to vague, simplistic, and abstracted messages (suggesting delayed marriage age and fewer children) that give few real solutions or suggestions to family planning on an individual level. In speaking to this individual level, enlisting village health workers and investing more resources at the local level can facilitate widespread education to enable the development of new norms of small families and women's rights. Reaching schoolchildren in the promotion of gender equity also seems to be an important tactic in planting seeds for social change (Fikree & Pasha 2004:825). While public communication through visual materials alone may not be enough to effect change, government-produced visual materials provide an important, almost subconscious, backdrop in establishing new public norms. In addition, the media backdrop in conjunction with local interventions facilitates the creation of parallel "discussive spheres," which increase the potential impact of media messages.

The visual data over the past fifteen years have shown an increased prioritization of messages that promote contraception itself, and this trend should continue. Not only has meeting the unmet need for contraception proven to be an effective strategy in family planning

(Muir 2009), but also, as an individual-level decision – unlike ending domestic violence, having smaller families, and delaying the age of marriage – it does not require the renegotiation of cultural values. Focusing on meeting the unmet contraceptive need of 28% of India's women can make a significant impact, even as longer term goals and infrastructure building are pursued. The role and example of the village health worker and other local health entities in providing contraception also provides an effective entry to the horizontal promotion of and education around family planning and women's rights.

The leadership of NGOs in pushing for social change has led to innovation in both the subject matter and the approach to health promotion of FP and women's rights. Among the available visual data, WCEVAW, VHAI, and other organizations were often the first to address such sensitive topics as paternal responsibility and comprehensive definitions of violence against women. In following the lead of such NGOs it seems that the state has recognized the benefits of such innovations. Government-NGO partnerships that combine the potential reach and resources of the government with the specialization and knowledge of local NGOs could produce a beneficial relationship in promoting social change.

Usability testing of images with end users was not a part of this study. Future studies should, however, examine the responses of target audiences to these visual materials in an attempt to both evaluate past successes and identify useful tropes and tactics in future promotion of family planning and women's rights in India. In addition, studies that explore community attitudes toward FP and women's rights today, as well as variations in attitudes by age and demographics, will be useful in furthering development of effective state policy. Understanding these variations would promote the development of more effective messages, targeted to audiences of different regions, languages, religions, and economic backgrounds.

Village health workers themselves could be an insightful resource in such future study, given their relationships as primary care providers to their communities. Their role in providing such information could also be quickly translated into the planning of local interventions that aim to improve the acceptability of contraception, small families, and gender equity.

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