WOMEN'S COLLECTIVE FORUM

Confederation of Indian Industry

INDIA'S PROGRESS ACHIEVEMENTS & OPPORTUNITIES IN FAMILY PLANNING

Better Family Planning Outcomes Supporting India's Progress and Development

POPULATION COUNCIL INSTITUTE
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Gates Foundation

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Foreword

Every family planning decision impacts not only individuals but also households, communities, and the nation's demographic profile. Ensuring equitable access to contraception empowers women to pursue education, participate in the workforce, and make informed decisions about their futures. Promoting shared responsibility in family planning enables greater gender equality at home and in society.

India has placed reproductive health at the centre of its development priorities. Over the decades, declining fertility rates, safer deliveries, and expanded contraceptive choices have contributed to improved health outcomes and increased opportunities. Programmes across successive governments, emphasizing access to affordable contraception and respectful counselling, have demonstrated that supporting individual choice benefits families and strengthens the nation.

Nevertheless, gaps remain. Several districts continue to face barriers to service access, adolescents often lack appropriate guidance, and the burden of contraception falls primarily on women. Male participation in family planning is limited, and not all families receive counselling on the range of available, safe modern methods. Addressing these issues requires clear, resolute action that honours both individual rights and collective responsibility.

This report, developed in collaboration by the Women's Collective Forum (WCF), Confederation of Indian Industry (CII), and the Population Council Institute, New Delhi, affirms that family planning is a fundamental human right and a crucial aspect of economic and social development. It advocates for rights-based, youth-friendly, and gender-responsive approaches that align with the FP2030 vision and India's constitutional commitment to personal liberty. The report also recognizes the intrinsic links between reproductive health, maternal health, child nutrition, education, and overall quality of life. This work provides policymakers, programme leaders, and community representatives with a comprehensive view of progress achieved and the challenges that remain.

Family planning is not a peripheral aspect of public health but a strategic investment in India's future. The policy and programme choices made today regarding access, quality, and equity will shape the wellbeing of future generations and the prosperity of the nation.

Smriti Z. Irani

Chairperson, Alliance for Global Good
Gender Equity and Equality and
Advisor, Women's Collective Forum

Foreword

Family planning has been one of India's most enduring public health commitments. From launching the world's first national programme in 1952 to our present-day FP2030 commitments, it has shaped the nation's demographic trajectory, improved survival outcomes, and expanded opportunities for women and families. The decline in fertility rates, the rise in contraceptive use, and the widening of method choices are notable milestones.

Yet, the journey is not complete. Inequities in access and quality persist across states, communities, and socio-economic groups. The contraceptive method mix remains skewed with limited male participation, and too many young people continue to face barriers to information and services. These gaps must be addressed, and we must move beyond a narrow focus on population control toward a rights-based framework that puts choice, dignity, and equity at the centre.

Developed collaboratively by the Women's Collective Forum, Population Council Institute, and Confederation of Indian Industry (CII), this report offers a comprehensive, evidence-based analysis of India's family planning landscape. It highlights the country's progress while identifying critical challenges and opportunities that warrant focused attention. The report emphasizes the importance of a rights-based, equitable approach that places choice, dignity, and autonomy at the centre of family planning initiatives.

This paper is intended as both a call to action and a practical guide for policymakers, program implementers, and stakeholders across sectors. It affirms that advancing family planning is not solely a health objective but a vital driver of women's empowerment, economic growth, and the realization of India's demographic dividend.

I commend the collective efforts of all contributors whose expertise and dedication have enriched this work. I urge all stakeholders to engage fully with the insights and recommendations provided here, recognizing that sustained, collaborative action is essential to shaping a future where reproductive autonomy is guaranteed for all.

Dr. Naresh Trehan

Chairman, CII Steering Group on Health and CII Healthcare Council
Chairman and Managing Director, Medanta – Medicity

Foreword

It is with great pleasure that I introduce this White Paper on India's Progress, Achievements, and Opportunities in Family Planning, developed by the Population Council Institute under the guidance of the Steering Group on Health and Healthcare Council of the Confederation of Indian Industry (CII). The white paper examines India's Family Planning journey, offering evidence-based insights into its impact on health and development while outlining key challenges, inequities, and actionable steps toward universal reproductive health access.

Family planning has been a cornerstone of India's public health agenda for more than seven decades, delivering profound demographic, health, and economic benefits. Reduced fertility rates, improvements in maternal and child health, and greater opportunities for women's education and participation in the workforce stand as enduring achievements. Yet, as this White Paper makes clear, challenges remain. Inequities in access and quality, geographic disparities, limited male engagement, and method skewness must be addressed to ensure that family planning continues to drive inclusive growth, gender equality, and sustainable development.

This White Paper consolidates evidence, expert perspectives, and forward-looking recommendations to inform policymakers, programme leaders, and industry stakeholders. It calls for a rights-based and system-wide approach that expands contraceptive choices, meaningfully engages men and youth, harnesses technology, and positions family planning within broader national priorities such as human capital development, and economic empowerment.

I am confident that this White Paper will serve as a valuable resource for decision makers at both national and state levels. Its findings and recommendations will, I hope, inspire robust and inclusive policies that advance India's family planning goals. On behalf of the Population Council Institute, I extend deep appreciation to CII's Health and Healthcare Council and all partners whose expertise and commitment have shaped this important effort.

Dr. Sowmya Ramesh

Executive Director
Population Council Institute

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ABBREVIATIONS

ANC	Antenatal Care
ART	Assisted Reproductive Technologies
COT	Community Outreach Team
FLWs	Frontline Healthcare Workers
FP	Family Planning
FPLMIS	Family Planning Logistics Management Information
GBV	Gender-Based Violence
GoI	Government of India
HWCs	Health and Wellness Centers
ICPD	International Conference on Population and Development
ICF	International Coaching Federation
IPPF	International Professional Practices Framework
IIPS	International Institute for Population Sciences
IUCDs	Intrauterine Contraceptive Devices
IUD	Intrauterine Device
LARCs	Long-Acting Reversible Contraceptives
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
mHealth	Mobile Health
MII	Method Information Index
MoHFW	Ministry of Health and Family Welfare
MPV	Mission Parivar Vikas
NFHS	National Family Health Survey
NFPIS	National Family Planning Indemnity Scheme
NHM	National Health Mission
NHP	National Health Policy
NITI	National Institution for Transforming India
NPP	National Population Policy
NRHM	National Rural Health Mission
PNCs	Postnatal Care Services
QoC	Quality of Care
RMNCH+A	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
RTIs	Reproductive Tract Infections
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Introduction

Repositioning Family Planning as a Driver of Equity, Resilience, and Development:

India stands at a pivotal moment in its family planning (FP) journey. While fertility rates have declined and contraceptive use has expanded, significant gaps persist—by geography, gender, age, and socio-economic status. The current FP approach, still shadowed by legacy population control models, must evolve into a comprehensive, rights-based system that delivers choice, dignity, and health equity.

Objective of the Paper

To analyse the evolving landscape of family planning in India through a critical lens, examining its demographic, economic, and gendered implications; to interrogate structural and systemic barriers that shape access and outcomes; and to identify evidence-informed policy and programmatic interventions that advance reproductive autonomy, health equity, and inclusive sustainable development through continued investments and efforts.

Key Findings

1. Uneven Fertility Decline: While India has seen a national decline in fertility, significant disparities persist across regions and population groups, reflecting gaps in access and quality of FP services.
2. Health Improvements with Equity Gaps: FP use is linked to lower maternal and child mortality, yet these health gains are uneven, particularly among marginalized communities.
3. Economic Gains through Reproductive Autonomy: FP access enables women to delay childbirth, increasing participation in education and the workforce, which contributes to household income, economic growth, and reduced poverty.
4. Empowerment and Gender Dynamics: FP enhances women's agency over reproductive decisions, with broader effects on autonomy, employment, and intra-household power, and in some contexts, reduces gender-based violence.
5. Policy Shift, Implementation Gaps: Despite transitioning to a rights-based FP framework, implementation still reflects legacy practices such as a focus on female sterilization and limited male involvement.
6. Intergenerational Impact: Smaller, better-spaced families support improved investments in children's health and education, strengthening human capital and breaking cycles of poverty.

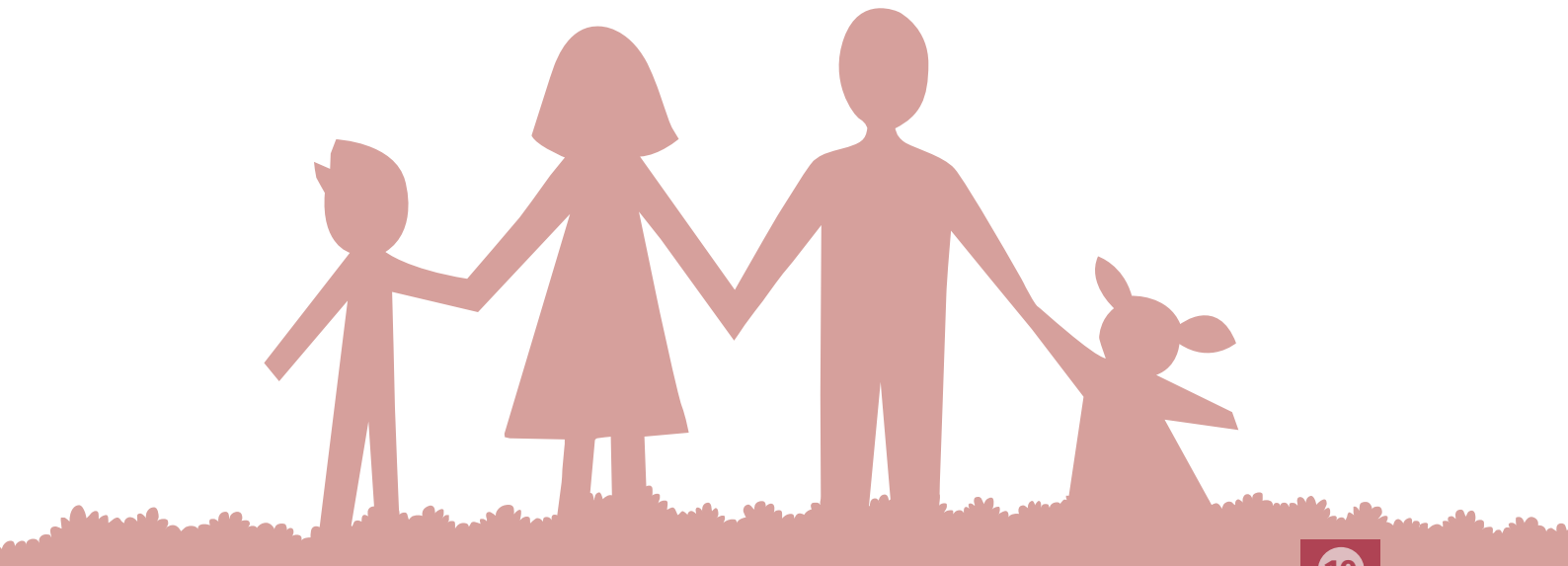
7. Structural Barriers: Systemic issues—including weak service integration, inadequate counselling, and gender-insensitive delivery—continue to limit the transformative potential of FP programs.

Key Recommendations

1. Reframe FP as a Rights and Health Issue: Ensure equitable, voluntary access to contraceptive choices, especially for marginalized and underserved populations.
2. Modernize the Method Mix: Expand access to long-acting reversible and male-controlled methods, backed by quality counselling and informed consent.
3. Engage Men and Adolescents: Design and scale interventions that position men as responsible partners and address youth with tailored, stigma-free services.
4. Leverage Digital Tools: Strengthen last-mile delivery through tech-enabled systems—FPLMIS, telehealth, AI chatbots—to improve access, monitoring, and user experience.
5. Localize and Integrate Delivery: Prioritize high-need geographies with context-specific strategies and integrate FP within primary healthcare and climate-resilient development plans.
6. Strengthen Accountability: Institutionalize real-time data systems, grievance redressal platforms, and performance-linked incentives to ensure quality, transparency, and responsiveness.

Key Actionable Points

India's family planning programme has reached a pivotal stage: demographic progress is visible, but inequities, quality gaps, and entrenched social norms continue to constrain impact. To consolidate gains and accelerate progress toward FP2030 and SDG 3.7, policy and programme responses must move from broad commitments to concrete, measurable actions.

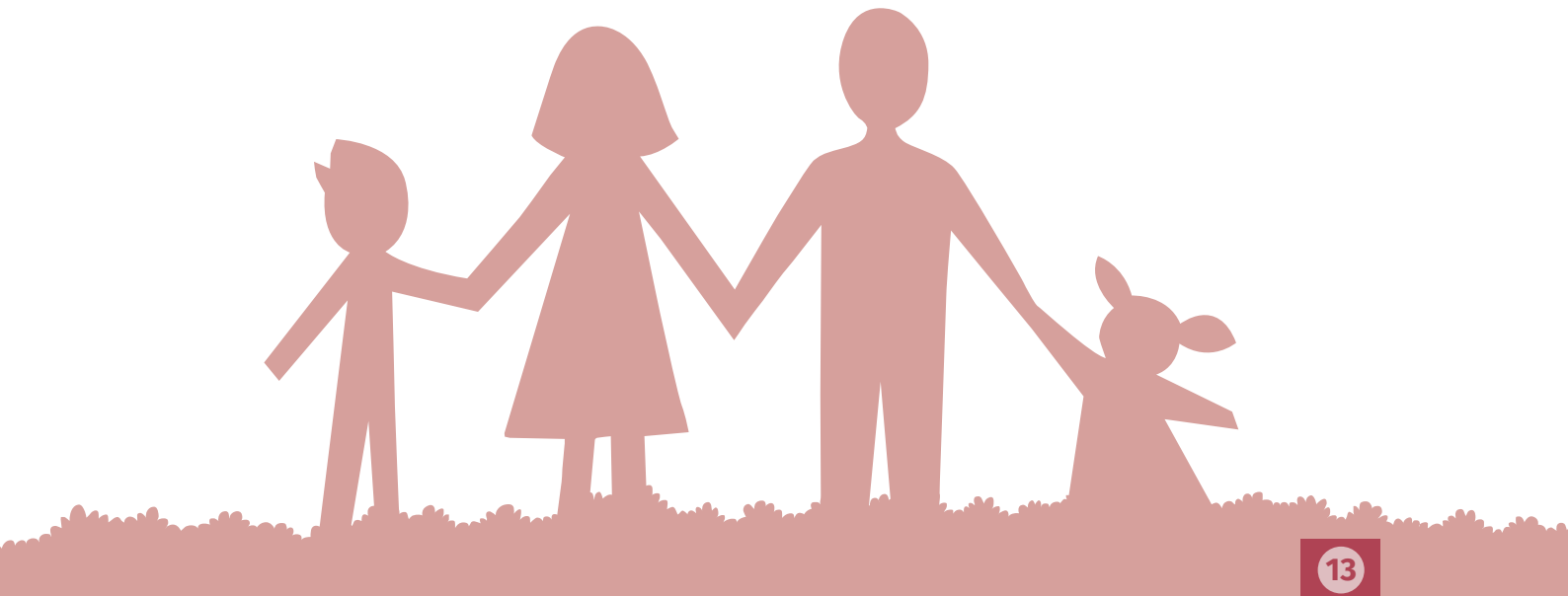


Key Action Area	Key Partners	Action Steps
Rights-Based FP Services	Civil society organisations, Women's rights groups, Academic & training institutes	• Revise national and state FP policies to embed reproductive rights and client autonomy (SDG 3.7; Fp2030). • Guarantee access to a full contraceptive method-mix and unbiased information (Ministry of Health & Family Welfare, 2017). • Remove structural and social barriers for adolescents, rural women, and marginalised groups. • Allocate dedicated funding for demand-generation (IEC, community engagement) and rights-training for providers (UNFPA, 2021).
Fertility Care via Public–Private Partnerships	ICMR, Private fertility clinics & ART specialists, FOGSI, Public hospitals	• Integrate fertility support (preconception counselling, early screening) into Urban Health and Sub-district centres in low-TFR states. • Establish PPP models for subsidised ART and infertility care for low-income clients. • Leverage private expertise to train public providers, develop referral networks, and co-manage complex cases (Das Gupta, 2011).
Digital Tools for Youth & Underserved	Health-tech startups, NGOs Adolescent health platforms, Education departments	• Develop AI-powered chatbots, mHealth apps, and mobile platforms for confidential SRH information. • Integrate solutions into DIKSHA, e-Sanjeevani, and state portals for credibility. • Ensure multilingual, voice-enabled, and mobile-first design to reach low-literacy and non-smartphone populations (Bloom et al., 2009).

Male Engagement & Community-Driven Outreach	Community-based organisations, ASHAs & male health workers, SHGs, Local NGOs	• Launch campaigns to reframe FP as shared responsibility. • Recruit and train male peer educators in local settings (tea shops, youth mandals, workplaces). • Establish male-friendly FP service points at PHCs/CHCs. • Embed spousal communication modules in community events to improve joint decision-making (UN Women, 2022).
Community-Led Accountability & Monitoring	VHSNCs, SHGs, Local NGOs, ASHAs/ANMs, Digital monitoring apps	• Formalise community committees to oversee FP service delivery. • Use simple tools (Excel) or digital dashboards to track uptake, quality, stock availability, and satisfaction. • Deploy WhatsApp- or app-based reporting for real-time alerts on stock-outs or service gaps. • Recognise high-performing blocks/VHSNCs to incentivise rights-based, responsive FP programming (Canning & Schultz, 2012).
Media & Strategic Communication	Media agencies, Content creators, Digital influencers, Development partners	• Co-create culturally resonant campaigns challenging taboos around contraception and consent. • Use short films, reels, podcasts, and regional dramas with local dialects and role models. • Engage vernacular influencers and grassroots creators to counter misinformation. • Integrate FP messaging in TV, radio, and geo-targeted digital ads in low-coverage districts (Sindig & Steven, 2009).

Conclusion

Transforming India's FP landscape requires embedding reproductive autonomy at the center of policy and practice. By grounding programs in rights, equity, and system-wide accountability, India can not only meet its reproductive health goals but also accelerate progress across gender, health, and economic dimensions.



Introduction

Overview of Family Planning (FP) in India

India's family planning programme has evolved over seven decades into a core component of national health policy. As the first country to launch a national FP programme in 1952, India established a blueprint for reproductive autonomy. Early efforts focused on expanding clinic-based contraceptive services, while the 1994 International Conference on Population and Development (ICPD) reoriented policy toward rights-based, client-centred care (UNFPA, 1994). Mission Parivar Vikas (2016 onwards) further targeted high-fertility districts, elevating FP within the National Health Mission (MoHFW, 2017).

Family planning now anchors India's wider development agenda, linking health and gender equality goals. It advances SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality). Initiatives such as Mission Parivar Vikas and the integration of family planning into the Ayushman Bharat health-care platform demonstrate the Government of India's commitment to embedding these services within universal health coverage (MoHFW, 2017; NITI Aayog, 2022). By ensuring access to a comprehensive range of contraceptive methods and counselling, family planning programmes contribute directly to reductions in maternal and infant mortality, promote women's agency in reproductive decision-making, and support broader economic productivity through improved health outcomes (WHO, 2017; Guttmacher Institute, 2023).

Fertility has declined sharply, reflecting the impact of sustained policy interventions. India's total fertility rate fell from 5.7 in 1966 to 2.0 in 2020, a shift that aligns with the country's demographic transition and the long-term reach of family planning programmes (IIPS & ICF, 2021; MoHFW, 2013). These gains have been significant, but inequities in access and uptake continue to constrain the full realisation of the demographic dividend.

India has achieved a steady decline in fertility, with most states now approaching replacement-level rates. Yet, the persistence of geographical disparities remains evident. Several districts still experience high fertility, with approximately 15 districts in India with a TFR> 3.5. Furthermore, disparities in access to FP across various socio-economic groups persist, with 149 districts (out of 707) having a mCPR <45%. The gap between met and unmet contraceptive needs is particularly pronounced in the northeastern states. Addressing these inequities will be essential for ensuring the success of FP programs and achieving sustainable demographic and health outcomes across the country.

To capitalise on its demographic progress, India must pivot from broad-based expansion to targeted equity-driven strategies. This requires strengthening service quality, engaging men, and tailoring outreach to underserved districts. Only by bridging these gaps can India secure sustainable health outcomes and fully harness its demographic dividend.

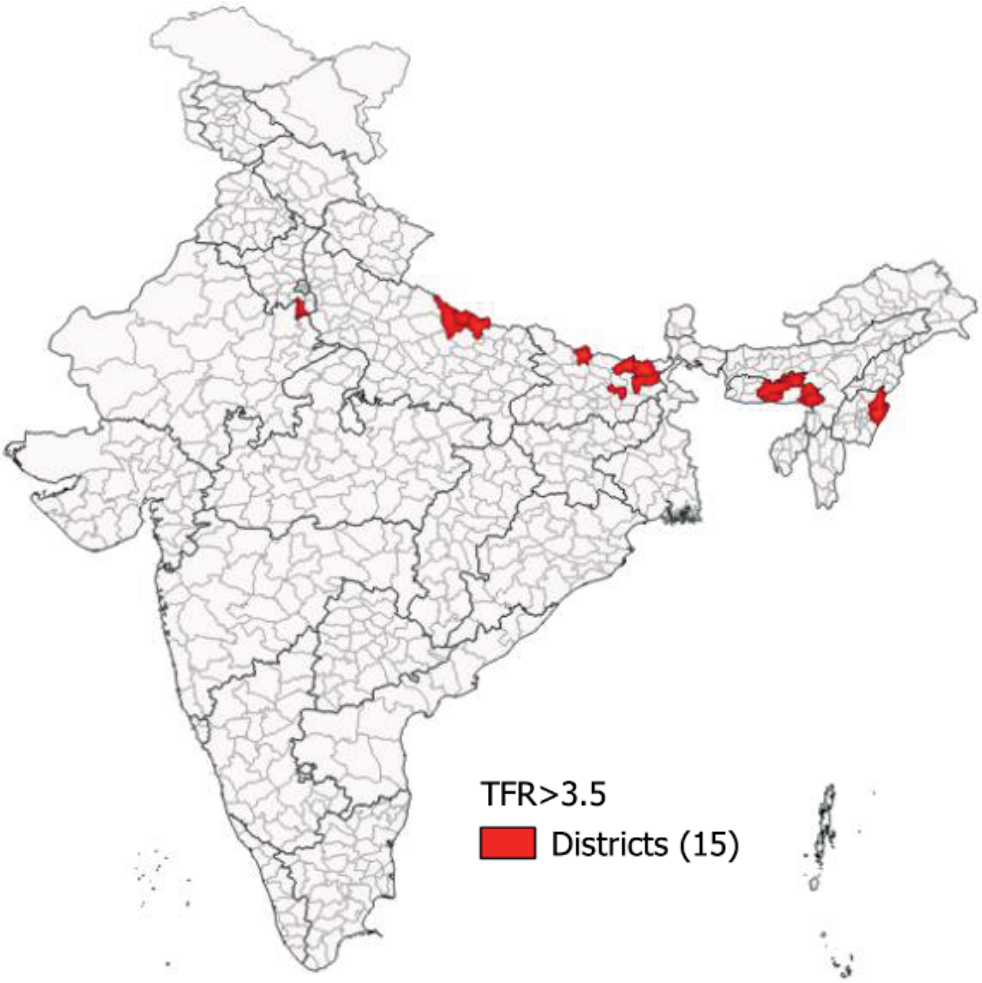


Figure 1. Indian districts with high TFR (Annexure 1)
Indian districts with TFR> 3.5
Source: NFHS-5 (2019-21)

Key Policy Shifts

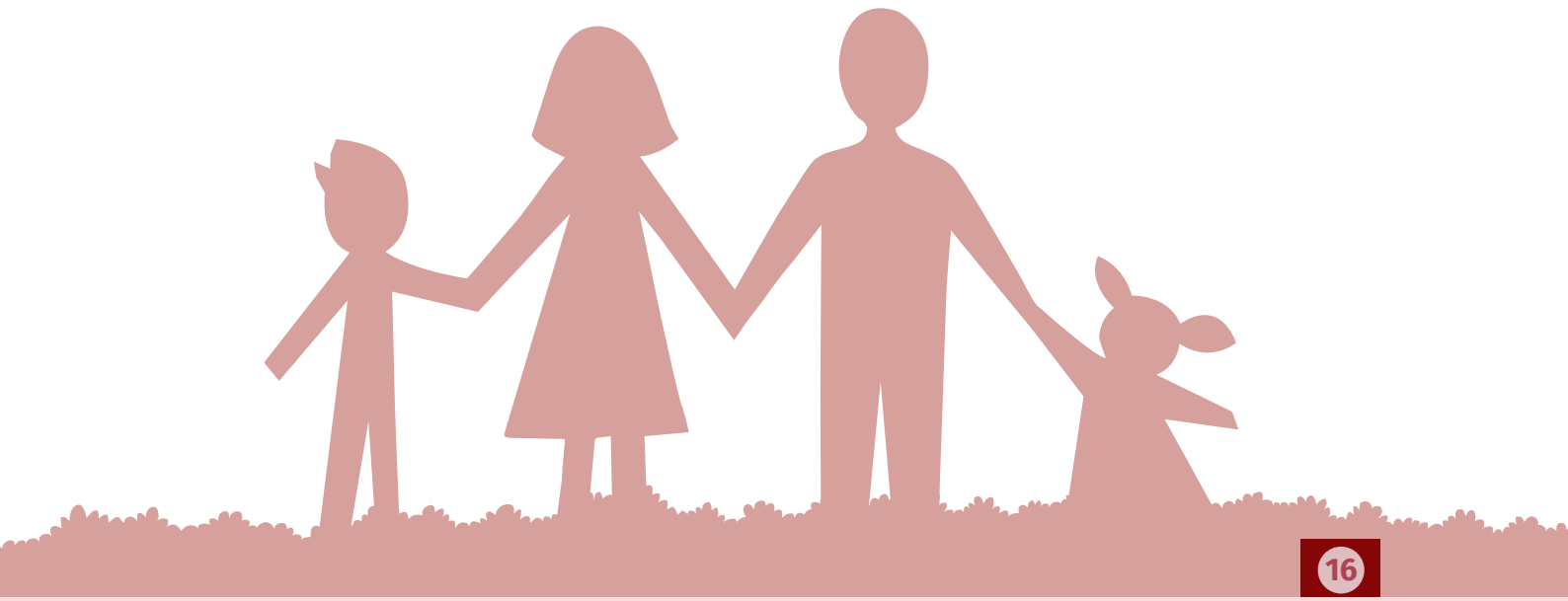
- **Rights-Based Framework (1994):** Adoption of the ICPD's reproductive rights paradigm moved FP beyond demographic targets to quality of care and informed choice (Gu, 2021).
- **District-Level Targeting (2016):** Mission Parivar Vikas introduced performance-linked incentives and intensified demand-generation in 146 high-priority districts (MoHFW, 2017).
- **Universal Health Coverage Integration (2018–):** Under Ayushman Bharat, FP services were embedded within primary health centres and Health and Wellness Centres to strengthen referral linkages and community outreach (NITI Aayog, 2022).

Outcomes

- **Demographic Transition:** TFR decline to near-replacement levels nationally, with concomitant reductions in maternal mortality (MMR from 167 in 2011–13 to 103 in 2017–19) and infant mortality (IIPS & ICF, 2021).
- **Economic and Social Gains:** Delayed first birth and wider birth spacing have expanded women's participation in education and the labour force, contributing to the nascent demographic dividend (IPPF, 2012; Finlay, 2021).
- **Cost-Effectiveness:** FP interventions remain among the most cost-effective health measures, saving healthcare expenditures by preventing unintended pregnancies and associated complications (IPPF, 2012).

Despite overall success, significant challenges remain:

1. Uneven Access: Over 149 districts report modern contraceptive prevalence rates below 45%, with the North-East and select tribal regions disproportionately affected (IIPS & ICF, 2021).
2. Unmet Contraceptive Need: Approximately 12% of married women report unmet need, with adolescents and marginalized communities bearing the highest burden (IIPS & ICF, 2021).
3. Gender Dynamics: Male engagement in FP remains low, and patriarchal norms continue to restrict women's autonomy in certain states (Muttreja & Singh, 2018).
4. Quality and Continuity of Care: Stock-outs, inadequate counselling, and gaps in post-abortion care persist, undermining client trust and programme efficacy (Singh et al., 2021).



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India's FP2030 Vision and Commitments

India's renewed commitment to the FP2030 global partnership signals a bold and inclusive agenda for advancing reproductive rights, improving health outcomes, and accelerating gender equity. Anchored within the Universal Health Coverage (UHC) framework and the goals of the National Health Mission (NHM), India's FP2030 vision emphasises equity, access, choice, and accountability. The focus is not only on expanding the reach of family planning services, but also on transforming how communities—especially youth, marginalised populations, and underserved geographies—engage with and benefit from these services.

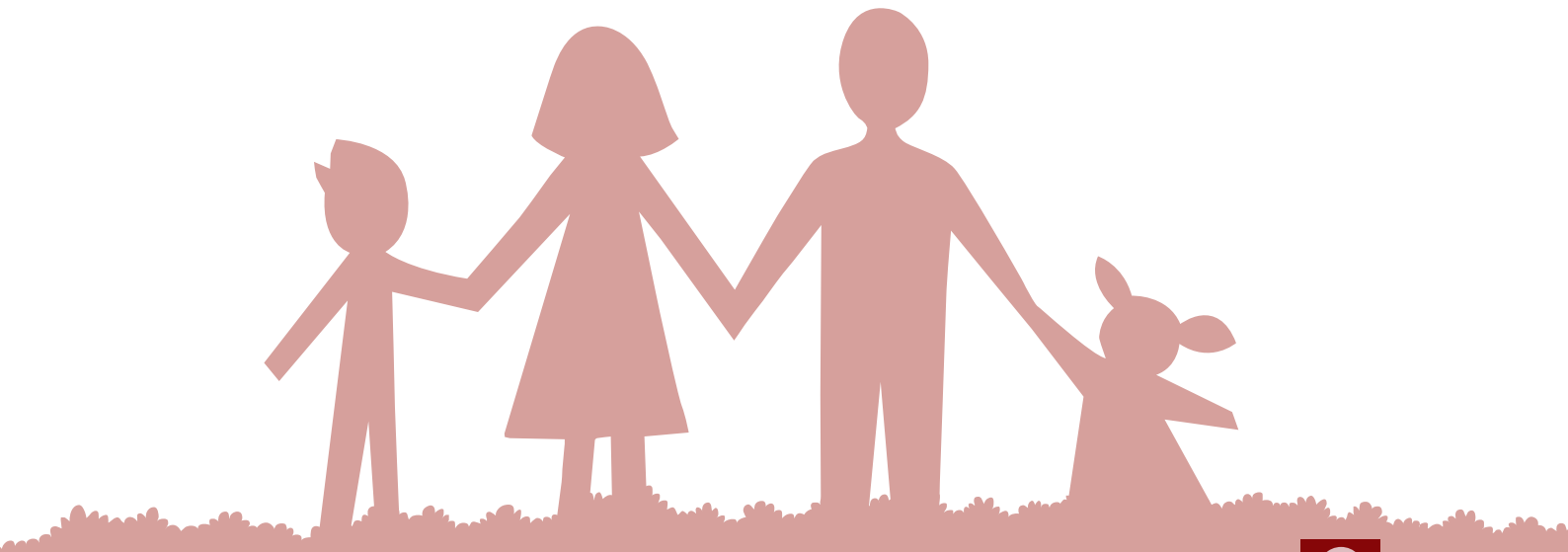
The following commitments reflect India's strategic roadmap to ensure that family planning becomes a core driver of sustainable development and population stabilisation by 2030.

FP2030 Vision Statement

"By the end of 2030, provide access to high-quality, comprehensive family planning services to all people of reproductive age—including those from marginalised groups—by ensuring equitable, affordable, and appropriate contraceptive choices and information through improved health systems and community engagement within India's UHC framework."

FP2030 Commitments (to be achieved by 2030)

1. Expand contraceptive choice and reach – introduce new methods and ensure equitable availability across urban and rural areas.
2. Ensure healthy timing and spacing of pregnancies – improve demand generation, uptake, and quality for postpartum contraception.
3. Scale up Mission Parivar Vikas – deliver a full-service package in all 146 high-priority districts, including hardest-to-reach rural and urban communities.
4. Intensify social and behaviour change (SBC) activities – strengthen access to information and services for all women, couples, and especially young people.
5. Mobilise civil society – engage and equip NGOs and community groups to raise awareness, generate demand, and provide services where needed.



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Rationale of the white paper

The rapid deceleration of India's fertility rate to near-replacement level 2.0 by 2020 (IIPS & ICF, 2021), coincides with a temporary surge in its working-age population of 15-64 years with their share increasing to 67.2 percent in 2020, up from 58.0 percent in 1990. In this context, sustained improvements in family planning are critical to safeguarding reproductive autonomy, consolidating maternal and neonatal health gains, and alleviating long-term pressures on health-care infrastructure (Gu, 2021). Moreover, by enabling women to complete their education and participate fully in the labour force, access to comprehensive contraceptive services underpins the realisation of India's demographic dividend and contributes materially to economic growth (The Lancet Global Health, 2023).

This white paper provides:

A. a concise historiography of India's national family planning programme, from its inception in 1952 through the adoption of a rights-based framework in 1994, district-level targeting under Mission Parivar Vikas, and integration within universal health coverage initiatives.

B. an evidence-based assessment of persistent inequities in service availability, method mix, counselling quality, male participation, and regional uptake.

C. Finally, it proposes a set of targeted, actionable interventions across policy formulation, financing mechanisms, service delivery models, and community engagement strategies, with the objective of achieving universal reproductive health coverage by 2030.

The Confederation of Indian Industry (CII), the Women's Collective Forum (WCF), and the Population Council Institute bring together complementary strengths in empirical research, private-sector expertise, and strategic engagement. By combining rigorous data analysis, industry insights, and collaborative investment frameworks, this partnership aims to inform policy deliberations, foster public–private synergies and mobilise resources to ensure that India's family planning programme delivers equitable, high-quality services adapted to contemporary socioeconomic challenges.

This paper is designed to inform policy choices and investment decisions at a critical demographic juncture. By framing family planning as both a public health priority and an economic lever, it calls for coordinated action to ensure India captures the full potential of its demographic dividend.

Methodology

This white paper outlines India's progress in FP programs, the current status, and highlights the ongoing need for sustained attention to meet both national and global FP goals. For developing this white paper, we adopted the following process:

- Stakeholder Consultations (experts from the thematic area)
- Collation of evidence from reports and data available in public domain
- Literature review

Collation of evidence

To highlight the progress of FP in India, data from multiple NFHS reports and factsheets were used. In instances where estimates were not directly available in the reports, data analysis was to derive estimates. All evidence pertains to currently married women aged 15-49 years.

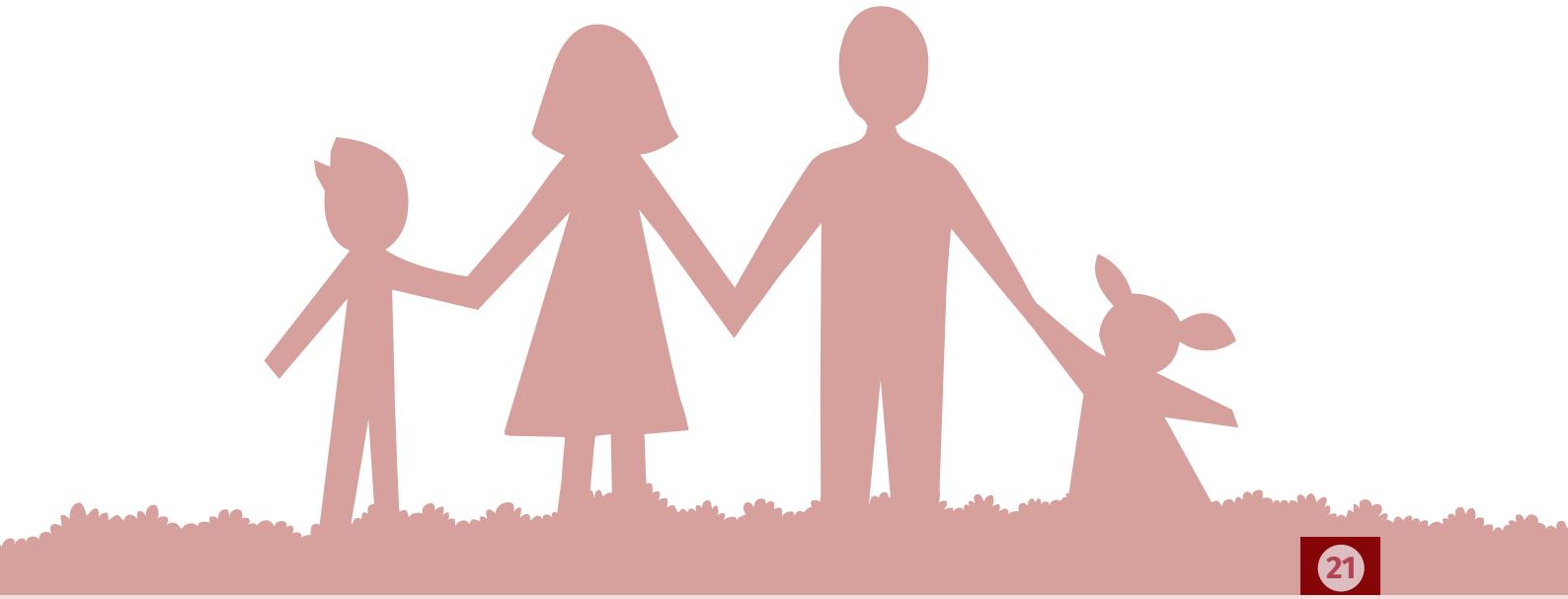
Review of Literature

A review of literature was conducted using a systematic approach to identify relevant studies on FP interventions from various databases. The search terms included "family planning interventions," "contraceptive uptake," "maternal and child health," and "reproductive health programs." Studies with well-defined methodologies, robust statistical analyses, and clearly reported outcomes were selected.

To ensure the review reflected contemporary evidence, studies published within the last ten years were prioritized. Additionally, only studies directly related to FP interventions and their impact were included to maintain relevance. Eligible study designs encompassed systematic reviews, randomized controlled trials (RCTs), cohort studies, and qualitative research. The review primarily focused on studies examining women of reproductive age, couples, and community-based FP programs. Furthermore, research conducted in India or comparable low- and middle-income countries (LMICs) was given precedence. Studies published more than 10 years ago were excluded unless they provided foundational insights essential to the discourse. The selected studies were synthesized using a thematic approach to extract relevant insights.

Consultation meeting with FP experts

In order to get guidance about the future of FP programming, consultation meetings were organized with family planning experts of different sectors such as academia/researchers, program implementers, program managers from government, and donor organizations who are investing on FP in India and states supporting the government. One-to-one consultative meeting was also conducted following structured guidelines with few experts to gather a comprehensive understanding of the country's achievements, existing inequities, and actionable recommendations.



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Achievements of Family Planning in India

India has achieved replacement-level fertility for the first time. The recent National Family Health Survey 2019-21 brought several noteworthy milestones in India's demographic and reproductive health landscape. For the first time in the country's history, the TFR dropped below the replacement level, reaching 2.0 nationwide, with most states presenting a similar estimate. Additionally, modern contraceptive prevalence surpassed the 50% milestone, with 56% of currently married women aged 15–49 years using a modern method. The unmet need for contraception declined significantly, entering single-digit figures, marking a crucial advancement in reproductive health services.

The method mix is becoming more balanced and client choice is improving. Female sterilisation's share of modern contraceptive use declined to approximately 65%, down from 90% two decades ago. Furthermore, informed choice in contraceptive use improved, reaching 50%, while health workers' outreach for FP services expanded over the past five years. Lastly, the demand for FP satisfied through modern methods increased to 75 percent, aligning with one of the key FP2020 targets (IIPS and ICF, 2021).

	1992-93	1998-99	2005-06	2015-16	2019-21
Total fertility rate	3.39	2.27	2.68	2.18	1.99
Current use of any method (%)	40.6	48.2	56.3	53.5	66.7
Modern contraceptive prevalence rate (%)	36.3	42.8	48.5	47.8	56.4
Unmet need for contraception (%)	19.5	15.8	12.8	12.9	9.4
Share of sterilization to total modern method use (%)	75.2	79.9	76.9	75.3	67.2
Demand for FP satisfied with modern method (%)	60.4	66.9	70.2	72.0	74.1
Informed choice* (%)			27.9	53.9	69.4

Table 1: Progress in key family planning indicator in India, 1992-2021

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History of Family Planning Programs in India

India's current achievements in family planning are rooted in seven decades of sustained government effort. At the time of independence in 1947, India had a population of 340 million, with a TFR of approximately 6, which persisted through the 1940s to the early 1960s (Spear, 2025). Faced with rapid population growth and limited resources, the government concluded that unchecked fertility would hinder India's nation-building efforts. Thus, India became the first country to formally launch a national FP program, integrating it into its First Five-Year Plan in 1951–52 (Kongawad and Boodeppa, 2014). Over the decades, FP programs in India have evolved through several phases of policy transformation, adapting to the changing demographic and socio-political landscape. Today, with a population of 1.45 billion and a TFR of 2.0—just below the replacement level—the FP program remains a critical component of India's public health strategy (Tripathi et al., 2023; United Nations, 2024).

In its initial phase (1951-52), the FP program adopted the clinic-based approach. FP clinics provided contraceptives such as condoms, diaphragm, jellies, and male vasectomy services, focusing on the urban population (Srinivasan, 2014). However, the 1961 census data highlighted the need for a more assertive approach to stabilise the population size, leading to the introduction of the low-intensity health department-operated, incentive-based, target-oriented, time-bound, and sterilization-focused (HITTS) approach in 1962. This strategy incentivized male vasectomies and intrauterine device (IUD) insertions for women. To expand coverage, the clinic-based model was replaced by an extension approach, wherein health workers conducted door-to-door outreach to promote contraceptive adoption. This phase also saw the establishment of a dedicated Family Planning Division within the government, fully funded by the central administration (Srinivasan, 1995).

By the 1970s, FP efforts intensified further, with large-scale vasectomy camps organized across the country. In Kerala alone, approximately 60,000 vasectomies were conducted within a single week in 1970. Government departments were mobilized to persuade the public to participate in these camps. However, during the Emergency (1975–77), the ruling government implemented an aggressive and coercive FP policy under the National Population Policy of 1976. State officials were directed to meet sterilization quotas or face punitive action, leading to a surge in vasectomies, with estimated 8.26 million male sterilizations done between 1976 and 1977. This approach, however, fostered deep public mistrust in FP programs. In response, the new government elected in 1977 abolished coercive measures, shifting the focus toward education, awareness, and voluntary FP adoption, encouraging the public to adopt modern and reversible methods of contraception. The policy framework emphasized informed choice, while an alternative strategy sought to curb population growth by raising the legal age of marriage for men and women.

The 1980s marked a paradigm shift in FP trends, with female sterilization overtaking male sterilization as the predominant method, particularly following the birth of a third child. Since then, female sterilization has remained the most widely used contraceptive method in India. In subsequent years, policy emphasis gradually transitioned from sterilization-centric strategies to broader reproductive health initiatives, incorporating child spacing and child survival as integral components.

The 1990s embedded a rights-based framework. Against the backdrop of decentralisation, economic liberalization, and globalization, India's FP landscape evolved. The landmark International Conference on Population and Development (ICPD) in 1994 further reinforced the need for a rights-based approach to FP. Women's voices played a critical role in reshaping FP policies, leading to the adoption of the Reproductive Health Approach in 1997. Under this model, FP services expanded to include contraception, child immunization, and comprehensive reproductive healthcare for women, including the treatment of sexually transmitted and reproductive tract infections (STIs/RTIs), adolescent health education, and screenings for uterine and cervical cancers. However, despite the broadening scope of services, financial allocations did not increase proportionally to meet the expanded mandate.

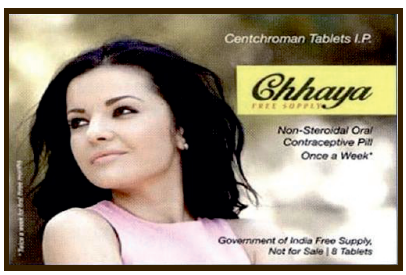
The 2000s integrated FP into health system reforms. The early 2000s ushered in a new era of FP governance with the introduction of the National Population Policy 2000 (NPP 2000) and the National Health Policy 2002 (NHP 2002). This period also saw the launch of the National Rural Health Mission (NRHM) in 2005, which aimed to improve rural healthcare delivery, including FP services (Srinivasan, 2014). In 2012, the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategy was introduced, replacing the vertical approach with an integrated framework encompassing reproductive and maternal health, child survival, and adolescent well-being.

Currently, India's FP program operates under the guidance of the National Health Policy 2017. Since 2016, India has transitioned its family planning landscape by broadening the basket of contraceptive options, focusing on areas with high fertility rates, improving service delivery systems, getting communities involved, and using data-driven tools to keep track of progress.

This is in line with its commitment to the Sustainable Development Goals (SDGs), especially Goal 3.7, which calls for universal access to sexual and reproductive healthcare services. The FP2020 cooperation, now extended to FP2030, together with the National Population Policy, governs these programs.

Expanded contraceptive options have widened access and choice. The basket of contraceptives beyond the traditional methods includes injectables Antara (Medroxyprogesterone Acetate) and the weekly oral pill Chhaya. These methods were integrated with provider training via public sector facilities (NFHS 5). 2.4 million doses of Antara and 757.9 million strips of Chhaya had been distributed as of 2023 (MoHFW, 2023).

Mission Parivar Vikas targets high-fertility districts with innovative outreach. In 2016, the government also launched a high-priority initiative, Mission Parivar Vikas (MPV) to accelerate the access to FP services in 146 high-fertility districts across the seven EAG states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh). The initiatives such as



"Nayi Pehel" kits for newlyweds, and "Saas–Bahu Sammelans" to foster inter-generational dialogue on FP were introduced.

Service delivery and logistics systems have been strengthened. To improve service delivery and care quality, public health facilities expanded their Fixed Day Static (FDS) services, focused more on clinical quality standards, adopted National Standards for Family Planning Services. To ensure consistent availability of contraceptives, the government has rolled out the Family Planning–Logistics Management Information System (FP-LMIS).

Recent strategies place renewed emphasis on reversible and male methods. While family planning programmes have historically focused on women, recent strategies have placed renewed emphasis on reversible methods (PPIUCD, injectables, pills, condoms) and male sterilization techniques like non-scalpel vasectomy (NSV)—backed by media campaigns and provider incentives

India has met FP2020 goals and now focuses on FP2030 targets. By 2020, India successfully achieved its FP2020 commitments—and has now shifted its focus toward the FP2030 targets, reinforcing its commitment to universal access to reproductive health and contraceptive services (MoHFW, 2022).

Fund Allocation and Utilization

Family Planning remains a stated priority under the National Health Mission, but expenditure trends are difficult to track consistently. Analysing expenditure and utilisation trends over time has presented a methodological challenge. Variations across data sources, including Union Budget documents, Ministry of Health and Family Welfare (MoHFW) reports, and evaluations of national health policies and programmes are common, often due to evolving reporting formats, reclassification of budget heads, and shifts in programmatic focus.

The budget allocated for family planning under the NHM is detailed in the following table:

Year	Fund allocated (cr)
2015-16	2420.2
2016-17	2673.6
2017-18	2943.1
2018-19	15.5% of the total Reproductive Child Health Flexi-Pool budget (12.7% -FP activities, 0.6% - FP training, 2.2% - program management)
2019-20 onwards	NA

Table 2: Budget allocated to FP in India (Under NHM)
Note: Data not available in public domain for all the years

India's FP budget is structured to cover service delivery, training, and programme management, supporting a wide range of interventions. The allocations support a broad spectrum of interventions, including Mission Parivar Vikas (MPV), postpartum intrauterine contraceptive device (PPIUCD) services, expanded contraceptive options, and redesigned packaging to enhance acceptability and uptake. The budget also funds critical schemes such as compensation for sterilisation acceptors, the Community Outreach Team (COT) scheme, doorstep delivery of contraceptives, ASHA incentives for promoting spacing methods, and provision of pregnancy testing kits.

Funds are also directed toward systems strengthening and quality assurance. Funds are directed toward systems strengthening through the Family Planning Logistics Management Information System (FP-LMIS), quality assurance mechanisms, the National Family Planning Indemnity Scheme (NFPIS), deployment of RMNCH+A counsellors in high-load facilities, and nationwide information, education, and communication (IEC) campaigns. While these interventions are comprehensive, effective implementation pivots on a coherent rollout strategy, well-defined targets, and robust accountability mechanisms.

Budget trends show volatility, with gains offset by persistent gaps. FP expenditure experienced a 67% surge in 2016–17, following a steep 54% cut in allocations between 2013–14 and 2015–16 (Population Foundation of India [PFI], 2018). However, this increase has not fully bridged the funding gap, and emerging trends are cause for concern. Like the IEC budget, critical demand generation has been declining consistently, from ₹40 crore in 2022–23 to ₹36.56 crore in 2023–24 (Ministry of Health and Family Welfare [MoHFW], 2023).

Persistent unmet need highlights structural challenges in access and choice. The unmet need for family planning remains at 9.4%, as per NFHS-5 (IIPS & ICF, 2021). This figure points to enduring challenges, including limited access in rural areas, narrow method mix, and suboptimal community awareness.

Future investment must focus on equity and effectiveness. Looking ahead to India's FP2030 targets, prioritising investments in behaviour change communication, expanding contraceptive choices, and improving rural service delivery is essential to ensure that all individuals and couples can exercise informed reproductive choices.

The economic payoff of adequate FP funding is significant. Projections indicate that without adequate FP investment, India could witness an additional 149 million people by 2031; 69 million of whom would be from just four states: Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh (PFI, 2018). Conversely, scaling up FP services could increase per capita income by 13% and raise per capita GDP growth by 0.4 percentage points between 2016 and 2031, underscoring FP's centrality to demographic moderation and economic advancement (PFI, 2018). This highlights the crucial role of FP in shaping both population growth and economic progress.

5

Challenges of the FP program in India

National progress masks uneven and persistent gaps. India has made significant progress in improving key FP indicators; however, substantial challenges remain in ensuring universal access to SRH services, as articulated under Sustainable Development Goal (SDG) Target 3.7. Achieving this target requires addressing geographic and socioeconomic disparities in FP program coverage and overcoming barriers related to access and utilization of contraceptive services. While national-level progress in FP is evident, specific areas outlined below require focused programmatic interventions to align with SDG commitments.

1. Method Skewness

India's contraceptive method mix is highly unbalanced, dominated by female sterilisation. It accounts for 66% of modern method use nationally and up to 80% in states such as Bihar (IIPS and ICF, 2021). The continued overreliance on female sterilization suggests a limited range of contraceptive choices, which may not adequately meet the evolving FP needs of Indian women. Strengthening the availability and accessibility of modern spacing methods is imperative to ensure a balanced and comprehensive FP strategy. However, the official FP service delivery system, which remains the backbone of FP efforts in India, faces critical organizational and administrative challenges in this regard (Chaurasia, 2020).

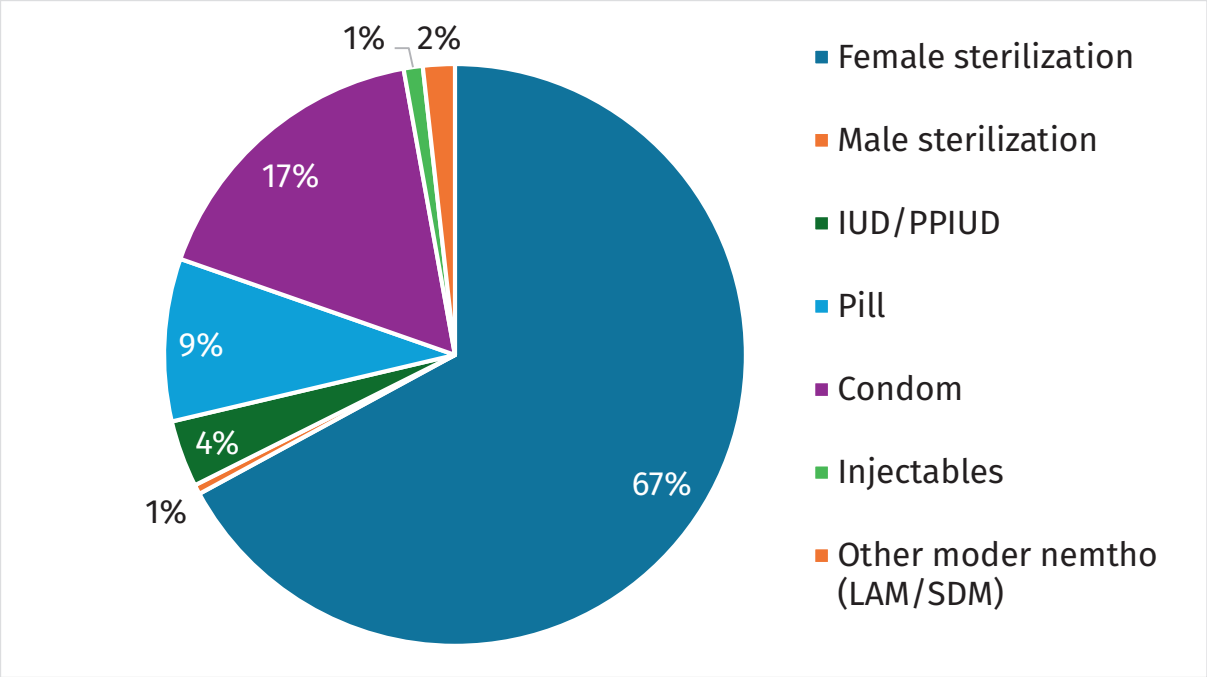


Figure 3. Contraceptive method-mix (share of modern methods to total modern method use) in India, 2019-21

2. Quality of Care

Despite increased contraceptive coverage, the quality of FP services, as measured by the Method Information Index (MII), remains low. Recent data indicates that 50% of users of sterilization, intrauterine contraceptive devices (IUCDs), and pills were adequately informed about side effects, management of side effects, and alternative contraceptive methods (IIPS and ICF, 2021). The quality of information provision varies across states, with MII as low as 35% in Bihar and as high as 74% in Tamil Nadu. Enhancing provider-client interactions and ensuring comprehensive counseling can significantly strengthen informed choice and continuity of contraceptive use. Focusing on service quality is essential for the Ministry of Health and Family Welfare's transition from a 'population control-centric' to a 'reproductive rights-based' approach to FP in India.

3. Geographic Variation in Service Delivery and Uptake

While national FP indicators have improved, stark inequalities persist at the state and district levels. The mCPR is below 30% in states such as Manipur (18%), Meghalaya (23%), and Mizoram (30%), whereas it exceeds 65% in states like Madhya Pradesh (66%), Tamil Nadu (66%), Telangana (67%), Karnataka (68%), and Andhra Pradesh (71%) (IIPS and ICF, 2021). Additionally, 134 districts report an mCPR below 45%, reflecting regional disparities influenced by socioeconomic conditions, health system readiness, and service availability. Lower contraceptive use is particularly evident in northern and northeastern states, where education levels and healthcare access are comparatively low. Addressing these disparities necessitates geographically targeted interventions focusing on demand generation, service provision, and health system strengthening.

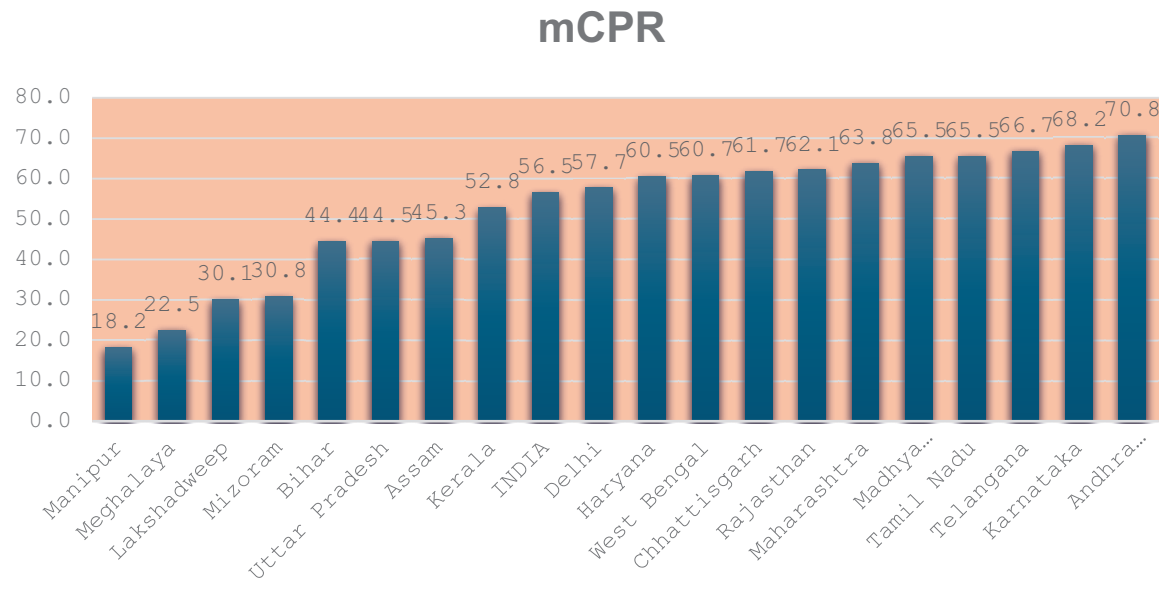


Figure 4. Modern contraceptive prevalence rate across states of India, 2019-21

4. Socioeconomic and Demographic Variation in Service Uptake

Contraceptive use in India varies significantly based on socioeconomic and demographic factors. The mCPR is 51% among women in the poorest wealth quintile, compared to 59% among the richest (IIPS and ICF, 2021). Similarly, first-time mothers (women with one child) have an mCPR of only 38%, whereas women who have completed their families (four or more children) report a prevalence of 62%. Addressing these disparities is crucial to ensuring universal access to FP services and meeting the contraceptive needs of all individuals, regardless of socioeconomic or demographic background.

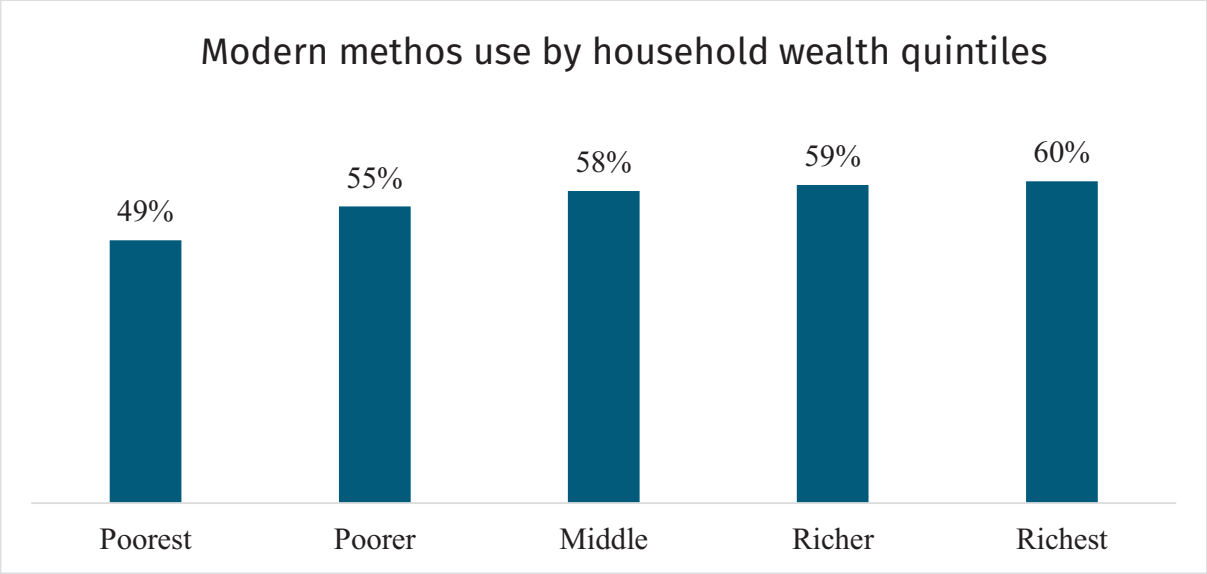


Figure 5. Modern contraceptive prevalence rate across states of India, 2019-21

5. Unmet Need Among Adolescents and Young Women

Although India's overall unmet need for contraception has declined to single digits, it remains disproportionately high among adolescents and young women. The unmet need is 18% among married women aged 15–19 years and 20–24 years, compared to 9% among all married women aged 15–49 years (IIPS and ICF, 2021). This gap has contributed to persistently high levels of teenage pregnancy, with 10% of adolescents (aged 15–19 years) already mothers or pregnant at the time of survey. States such as Tripura, West Bengal, Andhra Pradesh, Jharkhand, Assam, Bihar, and Arunachal Pradesh report teenage pregnancy rates exceeding 10%. At the district level, over 118 districts, primarily in Bihar, West Bengal, Assam, Maharashtra, Jharkhand, Andhra Pradesh, and Tripura, face similar challenges. Addressing the FP needs of adolescents through tailored programs and improved contraceptive access is critical for reducing teenage pregnancy rates and improving reproductive health outcomes.

6. Coverage of Family Planning Programs

Despite improvements in FP outcome indicators over the past decade, program coverage is still insufficient and shows considerable variation across states. Health worker outreach to non-users of contraception remains low, with only 24% of women reporting having ever been counseled by a health worker on FP during 2019–21, reflecting an increase of just 5 percentage points in five years (IIPS and ICF, 2021). Exposure to FP messages through media is also limited, with only 35% of women reporting having seen FP-related content in newspapers or magazines, and 56% having seen FP messages on wall paintings or hoardings. Strengthening FP program outreach and communication efforts is essential to improving awareness and uptake.

7. Male Involvement in Family Planning

Low male participation perpetuates the burden on women. Despite its critical role in reproductive health, FP programs in India have historically overlooked male engagement, reinforcing the belief that pregnancy and child-rearing are solely women's responsibilities. Evidence suggests that community-based programs emphasizing behavior change and gender-equity approaches can improve maternal health indicators. Studies have identified several determinants of male participation, including education, socioeconomic status, stereotypes, and the lack of male-friendly healthcare services (Mishra et al., 2014; Subramanian, Simon & Daniel, 2018; Shakya et al., 2018; Muttreja & Singh, 2018). Increasing male engagement in FP discussions through community volunteers, male peer educators, workplace-based education, and policy reforms can foster a more inclusive approach (Angusubalakshmi et al., 2023). According to NFHS 2019–21, while modern contraceptive use among married men has increased by four percentage points since 2015–16, a vast majority (76%) remain non-users. Among couples in the high-fertility age group (20–29 years), women's share in the modern contraceptive method mix is more than double that of men's. Despite a preference for spacing methods, modern contraceptive use remains low at 42% within this cohort (PFI, 2022).

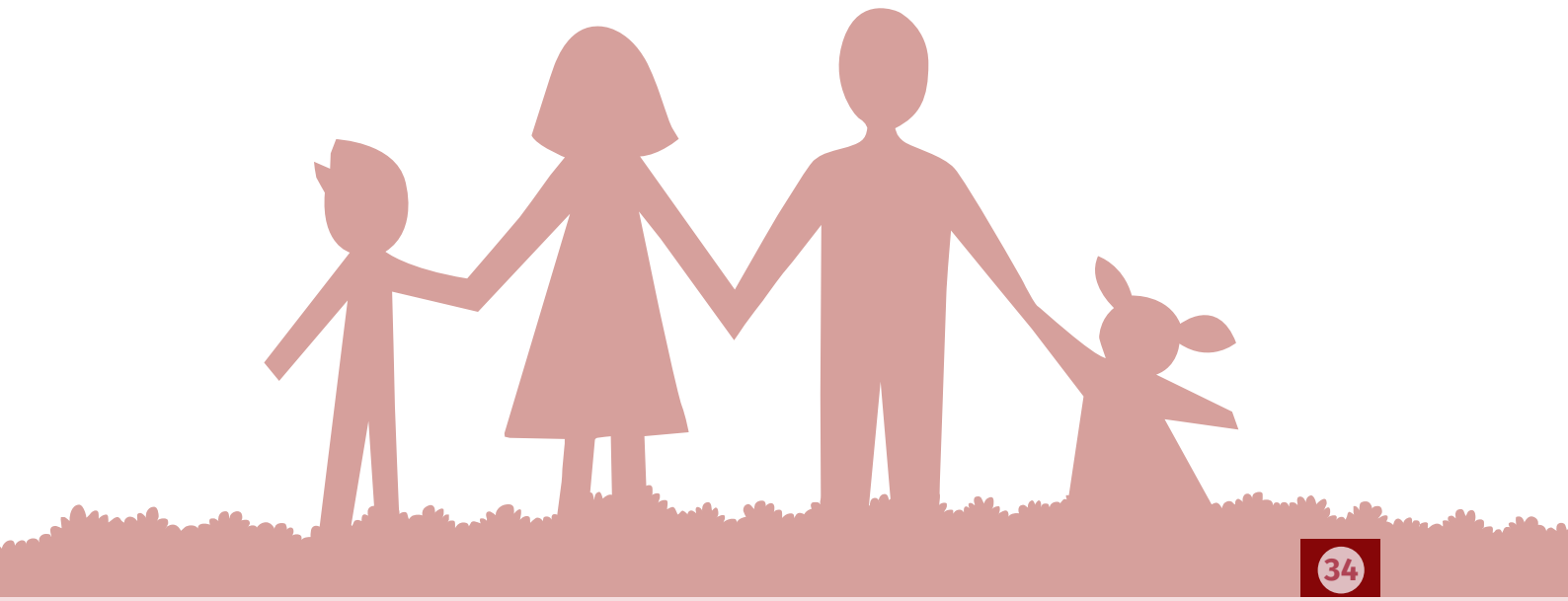
8. Socio-Cultural Factors in Family Planning

Norms, stigma, and provider bias continue to constrain access. In certain communities, religious doctrine discourages contraceptive use or sterilization (Shradha et al., 2021). Additionally, social stigma and biases among healthcare providers deter individuals from accessing FP services, exacerbating reproductive health risks (Muttreja and Singh, 2018; Baxter et al., 2011). Gender norms also influence contraceptive choices, with some women preferring female doctors for FP consultations, a factor that affects service uptake (Roberts and Noyes, 2009). Addressing these sociocultural barriers through targeted community engagement and gender-sensitive FP services is crucial for enhancing contraceptive use.

Persistent inequities demand targeted reforms. Contraceptive use remains lower among economically disadvantaged groups, marginalized communities such as scheduled castes, scheduled tribes, individuals with lower literacy levels, and those residing in rural areas (Yadav & Dhillon, 2015; Sharma & Singh, 2022). Addressing these

inequities requires strengthening community healthcare networks, particularly frontline workers, to improve FP awareness and access. Ensuring quality of care (QoC) through diverse contraceptive choices, comprehensive counseling, accurate information, and follow-up services can help bridge the unmet need for FP (Achyut et al., 2015; Muttreja & Singh, 2018).

India's progress in family planning is real, but unfinished. Achieving the SDG targets requires intensified efforts to address method skewness, enhance service quality, bridge geographic and socioeconomic disparities, and promote equitable access to FP services. Strengthening program coverage, increasing male participation, and mitigating social and religious barriers are essential to ensuring universal FP access and advancing reproductive rights. By implementing targeted interventions, India can accelerate progress toward its SDG commitments and foster a more inclusive and effective FP program.



6

Broader Impact of Family Planning

Family planning is not only about fertility rates—it is a driver of empowerment, equality, and sustainable development. While TFR is an important demographic indicator, FP focuses on providing comprehensive reproductive health care, empowering individuals and communities, promoting gender equality, improving economic opportunities, and ensuring sustainable development. A few such indicators are outlined below:

A. Impact of Family Planning Programs on Women Empowerment and Gender Equality

Family planning strengthens women's autonomy and reproductive rights. Family planning programmes strengthen women's control over childbearing, enabling informed decisions on the number and timing of pregnancies (Upadhyay et al., 2014).

1. This autonomy reduces health risks particularly for adolescents and high parity mothers and supports educational and career pursuits by preventing closely spaced births (World Health Organization, 2018; Shukla et al., 2020).
2. In India, integrated antenatal and postnatal FP counselling increases postpartum contraceptive uptake by 25–40%, directly enhancing women's capacity to plan their lives (Achyut et al., 2015; Bansal et al., 2021).
3. Access to contraception correlates with higher female labour-force participation and financial independence. Duflo (2012) reports that women with reproductive health services are up to 15% more likely to be employed.
4. In India, modern contraceptive users, 63.8% of sterilised women are more likely to engage in market activities than non-users (Dhak et al., 2021).
5. Moreover, reductions in maternal mortality from 254 to 103 deaths per 100,000 live births improve women's overall well-being and their ability to contribute economically (Registrar General of India, 2021).

Involving men in FP shifts norms and builds gender equality. Male-inclusive programmes promote shared responsibility in reproductive health.UN Women (2022) finds that male-inclusive programmes increase shared decision-making and couple-based contraceptive use by 20%, fostering more equitable partnerships and better health outcomes.

B. Impact of Family Planning on Maternal and Child Health

Family planning directly reduces maternal and neonatal morbidity and mortality by preventing unintended and high-risk pregnancies.

1. Ahmed et al. (2012) estimate that global contraceptive use averted over 230,000 maternal deaths between 2008 and 2012 by lowering exposure to complications such as pre-eclampsia and postpartum hemorrhage.
2. In contexts marked by adolescent or high-parity pregnancies, targeted FP interventions diminish risks associated with closely spaced births (Yadav & Dhillon, 2015; Dehingia, 2020; Askew et al., 2024).

3. Moreover, spacing births at least 24 months apart can halve infant mortality rates (World Health Organization, 2018).
4. Shukla et al. (2020) demonstrate that adequate interpregnancy intervals reduce preterm births and low birth weight by up to 30%.
5. In Ethiopia, women who received FP counselling during antenatal care (ANC) were 1.8 times more likely to adopt modern contraception postpartum, leading to healthier birth intervals and improved neonatal outcomes (Pfitzer et al., 2024).
6. In India, integration of FP counselling within ANC and postnatal services similarly increases postpartum method uptake, with studies reporting a 25–40% higher adoption rate among counseled women (Achyut et al., 2015; Bansal et al., 2021; Dev et al., 2019).

Shifting focus from fertility rates to health trajectories strengthens SDG progress. Beyond aggregate fertility indicators, FP directly contributes to Sustainable Development Goal 3.1 by reducing maternal mortality ratios and improving neonatal survival. The evidence highlights FP not only as a demographic tool but as a critical health intervention.

C. Impact of Family Planning on Education

Delaying childbearing improves educational attainment and future earnings. In India, unintended and early pregnancies disproportionately disrupt girls' schooling, perpetuating cycles of poverty and gender inequity (UNFPA, 2021). By enabling women to delay first births and space subsequent pregnancies by at least 24 months as recommended by the World Health Organization (2018), FP reduces school drop-out rates and supports continuous academic progression.

Empirical evidence from low- and middle-income countries demonstrates that each year of delayed childbearing increases the likelihood of completing secondary education by 12–15% (Klein et al., 2020), a gain that translates directly into enhanced lifetime earnings and labour-force participation (Canning & Schultz, 2012).

Family planning strengthens women's education and household prosperity. Beyond individual benefits, FP yields measurable intergenerational effects. Global evidence suggests access to modern contraception post-marriage was associated with an average 1.5-year increase in women's educational duration in Tehran (Erfani & McQuillan, 2015). Similar studies in Bangladesh and Ghana reveal that FP programmes correlate with improved household incomes, greater female asset ownership, and higher school enrolment rates—particularly among daughters of FP beneficiaries (Gribble & Voss, 2009; Canning & Schultz, 2012).

D. Impact of FP on Economic Empowerment and Poverty Reduction

1. Breaking the Cycle of Intergenerational Poverty

Research indicates that families with the ability to control childbearing invest more in each child's education and well-being, significantly enhancing upward mobility. FP ensures that parents can allocate resources effectively, improving children's health and education outcomes (Goli S et al. 2023, Canning D et al. 2012, Chairil, A. et al. 2024, Mari Bhat, P. N. 2002, Finlay J.E. et al. 2018). When women remain in the workforce, household incomes rise, enhancing purchasing power for education and healthcare. Improved education strengthens human capital, increasing productivity and lifting families out of poverty (T. Paul Schultz et al. 2007, Sapana S et al. 2019, Shareen Joshi T. et al. 2012).

2. Economic Contributions and GDP Growth

Countries with robust FP services have witnessed significant contributions of women to GDP growth, innovation, and productivity. Investment in FP yields substantial economic returns, particularly in developing nations like India. Evidence suggests FP investments in India from 1991 to 2016 resulted in significant economic benefits, with projections indicating even greater returns by 2061 (Goli, Rana, & James, 2023). However, extremely low fertility rates could diminish these gains, underscoring the need for a balanced approach (Canning, Karra, & Wilde, 2012). Strengthening FP services and addressing unmet reproductive health needs will maximize economic benefits.

3. Expanding Autonomy and Control

The ability to control reproduction has wide-ranging implications for women's autonomy and decision-making. FP equips women to pursue professional and personal goals that require long-term planning and investment. Studies show that women who exercise reproductive control are more likely to engage in sectors demanding continuous participation—such as education, business, and civil services—thereby increasing their contribution to the economy (Francavilla et al., 2011; Finlay, Özaltin, & Canning, 2018).

4. Clarifying the fertility–growth debate.

The relationship between fertility and economic growth remains contested but consequential. Perspectives on this issue have evolved—from acknowledging strong effects to questioning their significance, and back to recognizing their substantial impact (Sindig Steven W. 2009, Das Gupta Monica 2011). FP, encompassing information, services, and contraceptives, empowers individuals and couples to determine the number and spacing of their children. Its benefits extend beyond individual well-being, yet the economic impact of fertility changes often unfolds over extended periods.

5. Increased Workforce Participation

Childbearing responsibilities fall disproportionately on women, limiting education and career opportunities. Research extensively documents the link between fertility and female labour force participation (Francavilla et al. 2011, Bloom, D.E. et al. 2009, Sapana Singh et al. 2019). When women control their reproductive choices, they can pursue education and career aspirations more effectively. Contraceptive access allows them to delay childbearing, acquire skills, gain experience, and advance professionally—opportunities often constrained by early parenthood.

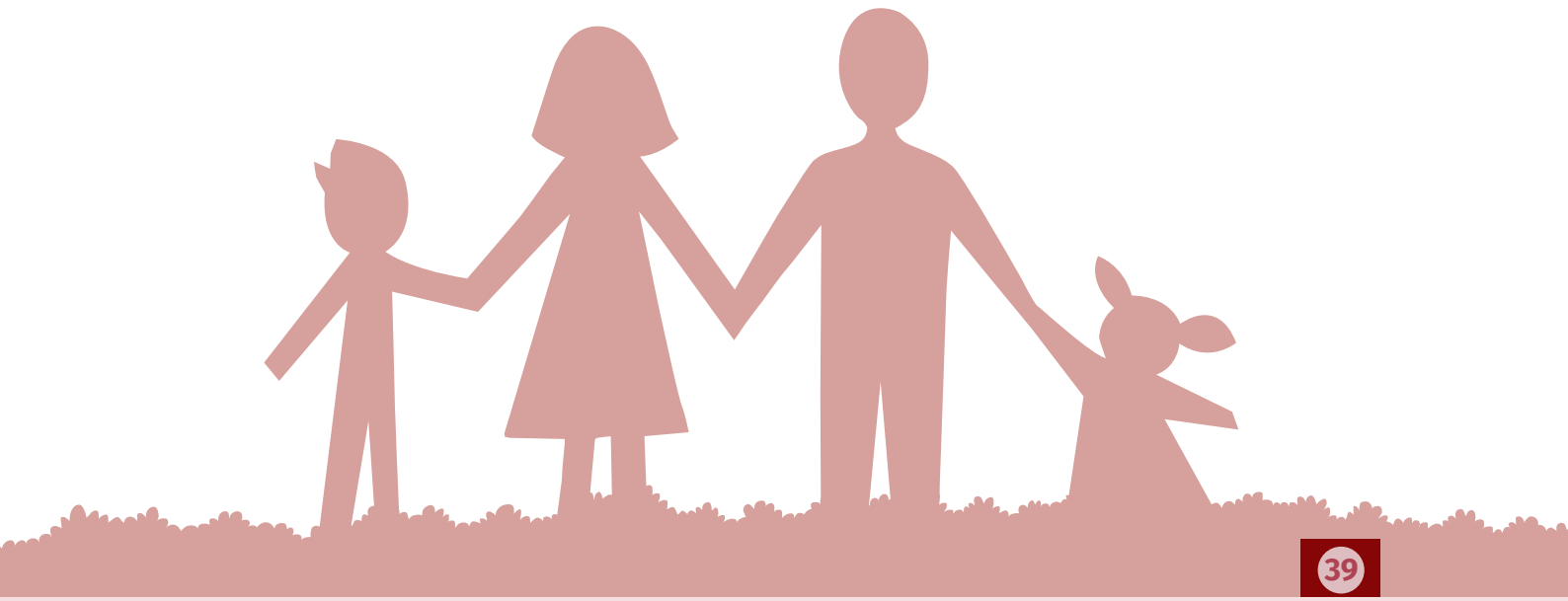
6. Reducing the Gender Gap in Employment

Improved access to FP services contributes to narrowing the gender gap in paid work. By allowing women to plan pregnancies and avoid workforce dropouts, FP supports continuous labour force participation (Joshi & Schultz, 2012). This directly improves women's income potential, enhances gender parity in employment, and reduces structural inequalities within the labour market (Schultz, 2007; Singh et al., 2019).

7. Entrepreneurship and Economic Independence

Beyond formal employment, FP empowers women to engage in entrepreneurial activities. With fewer child-rearing responsibilities, women can invest time and capital in business ventures. This leads to job creation, diversification of the economy, and increased local development (Chairil, Maharani, & Utami, 2024). In low-income contexts, female entrepreneurs also contribute to inclusive growth and innovation.

Family planning is not just a health service—it is an economic strategy. By enabling reproductive control, FP facilitates greater workforce participation, educational attainment, and financial independence. These changes benefit not only women but also contribute to broader economic growth and poverty reduction. In developing economies like India, investing in FP serves as a strategic approach to alleviating poverty, enhancing educational outcomes, and driving sustainable economic progress.



7 Recommendations

Strengthening India's family planning programme requires a shift in orientation, financing, and accountability. The analysis above highlights both achievements and persistent challenges: a skewed method mix, uneven service quality, geographic and socioeconomic disparities, and low male engagement. At the same time, evidence demonstrates FP's transformative impact on women's empowerment, education, health, and economic growth. To sustain progress and achieve SDG 3.7, India must reframe FP as a rights-based empowerment strategy, not just a demographic tool. This demands stronger governance, inclusive service design, innovative financing, and community-led accountability.

A.Governance and Accountability

1. Emphasis on Rights-Based Approach

Transition from a "population control-centric" model toward a "reproductive rights-based" paradigm. India's FP strategy must prioritise equity, autonomy, and informed choice (UNFPA, 1994). This shift entails removing structural and social barriers such as stigma, provider bias, and supply-chain gaps that disproportionately affect adolescents, rural women, and marginalised groups (MoHFW, 2017).

Rights-based care requires broad method choice and clear accountability. A rights-based approach necessitates that all individuals have access to a comprehensive method mix spanning modern to traditional contraceptives accompanied by unbiased, culturally sensitive counselling (WHO, 2018). Managers should embed clear performance indicators for choice availability, counselling quality, and client satisfaction into State Health Plans, with dedicated budget lines for demand-generation activities (community engagement, IEC) and provider training on rights and ethics.

Complacency risks undermining progress as fertility declines. As India advances through its demographic transition, declining fertility rates risk engendering programme complacency. Sustained investment in both urban and underserved rural settings is essential to uphold reproductive autonomy and protect gains in gender equity (FP2030, 2021). Reframing FP as an empowerment tool, rather than a demographic lever, aligns India's National Health Mission with SDG 3.7 and international human-rights commitments, ensuring services remain responsive, inclusive, and ethically grounded.

2. Evaluation of Family Planning Programs

Robust monitoring and user feedback must guide future design. To ensure the continued success of FP initiatives, robust evaluation mechanisms must be implemented. The following key questions need to be considered:

A. What contraceptive methods are individuals interested in, and why?

B. Are they willing to adopt these methods?

C. Are they satisfied with how and where the method was provided?

D. What outcomes follow after adopting a method?

E. Are adequate follow-up services available?

Evaluation should address barriers and improve inclusivity. Overall, the stakeholders highlighted that FP is a crucial component of reproductive health in India, and its success hinges on accessibility, informed decision-making, and gender equity. Addressing existing barriers, expanding adolescent education, engaging men in FP, and leveraging technology can significantly enhance program effectiveness. By ensuring that FP services are rights-based and inclusive, India can continue to make strides toward improved reproductive health outcomes for all individuals and communities.

3. Expanding Family Planning to Include Comprehensive Fertility Care

Comprehensive fertility care and planned parenthood must be integrated. A holistic approach to reproductive health must acknowledge that FP is not only about contraception but also about supporting individuals and couples in achieving their desired family size, including infertility treatment, and assisted reproductive technologies (ART).

Infertility and ART must be included in the FP agenda. Assisted Reproductive Technologies (ART) encompass clinical and laboratory procedures such as in-vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and controlled ovarian stimulation which are designed to assist individuals and couples in achieving pregnancy when natural conception is impaired (WHO, 2021). However, In India, ART uptake remains limited due to high out-of-pocket costs, regulatory variability, and geographic inequities, particularly in low–total fertility rate (TFR) states such as Sikkim and Andhra Pradesh and other Southern states (ICMR, 2018). Integrating fertility care within FP programs particularly for low-income and marginalized populations ensures that reproductive autonomy extends beyond preventing unintended pregnancies to enabling planned parenthood.

Policy and financing levers can strengthen access to fertility care.

A. Embedding infertility screening and basic fertility diagnostics and pre-conception counselling within public FP packages,

B. Establish public–private partnerships (PPP) in FP and fertility treatments, including ART for low-income and marginalised groups under ICMR accreditation (ICMR, 2018).

C. Dedicated funding for subsidised ART cycles, provider training, and quality-assurance audits will ensure affordability and safety.

D. Disaggregated monitoring of ART uptake by region and socioeconomic status will guide targeted resource allocation and measure impact on fertility trends.

4. Performance-based financing model

Performance-based models can drive uptake and accountability. Building on the success of incentive-based models in India's maternal and child health programs, a performance-based financing (PBF) approach can be piloted to improve uptake of spacing methods in high-need geographies. Under the National Health Mission, incentives for ASHAs and ANMs have shown measurable impact on service coverage (MoHFW, 2019).

Key design elements ensure equity and measurable results. A PBF model in family planning should include:

A. Link frontline incentives to uptake of modern spacing methods (e.g., IUCDs, injectables);

B. Use digital tools for real-time monitoring and verification.

C. Include equity-based bonuses for reaching underserved groups.

D. Focus on measurable outcomes such as reduced unmet need.

Evidence underscores PBF's potential in FP. Global evidence supports PBF as an effective tool to improve service delivery (WHO, 2019) and piloting it for FP can strengthen accountability and accelerate contraceptive access.

5. Institutionalizing Accountability and Community-Led Monitoring

Community-led monitoring can rebalance FP delivery. To enhance method choice and reduce sterilization reliance, the community-led monitoring mechanisms and expand the role of frontline workers must be institutionalised. Training Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) to counsel and deliver reversible methods such as injectables and implants can shift the focus toward voluntary, rights-based care, especially among younger populations.

Community-based distribution models can extend reach. Mobile outreach clinics and community-based distribution through local NGOs and Self-Help Groups (SHGs) can ensure broader reach in underserved geographies (FP2020, 2019). Piloting strengthened roles for Village Health Sanitation and Nutrition Committees (VHSNCs) to distribute contraceptives and provide community education, prioritizing long-acting reversible contraceptives (LARCs) such as IUDs and implants can foster accountability, increase method satisfaction, and reduce coercive practices.

B. Health Systems and Service Delivery

1. Expanding the FP Method Mix and Ensuring User-Centred Care

User-centred care requires diversifying beyond female sterilisation. The family planning landscape and options remains largely centric around females and female sterilization, reflecting entrenched programmatic priorities and sociocultural norms. The dominance of female sterilization limits autonomy, especially for younger populations and those seeking reversible options. A diversified method mix is essential for ensuring user-centred, rights-based care that supports reproductive intentions across the life course.

Global experience shows diversification improves equity and satisfaction. Brazil reduced its reliance on female sterilization from 60% in 1986 to 30% by 2019 through integrating FP into postpartum care, expanding access to reversible methods, and improving service delivery quality (Queiroz, 2023). Bangladesh, Ethiopia, and Rwanda have significantly increased uptake of long-acting reversible contraceptives (LARCs) such as IUDs and implants, improving method balance and user satisfaction (Cleland, 2022; PRB, 2019). Similarly, Panama achieved a more equitable distribution of contraceptive use by enhancing access to a full method mix.

India must embed postpartum FP and normalise reversible methods. India can adopt a similar trajectory by embedding postpartum FP services and counselling related, investing in provider capacity for LARC delivery, and normalizing reversible methods through behaviour change campaigns and demand generation, particularly among youth and underserved communities.

2. Addressing Geographic and Socioeconomic Inequities in Service Delivery

Geographic and socioeconomic disparities require targeted, equity-driven strategies. Despite national-level progress, significant disparities in family planning (FP) access and utilization persist across states, districts, and socio-economic groups in India. FP services often take a clinical, one-size-fits-all approach, with insufficient attention to socio-cultural contexts, spousal dynamics, and individual preferences. Many facilities lack private counselling spaces, limiting the quality of patient-centred, informed choice.

Targeted, equity-driven interventions can close gaps. To address these inequities, a targeted, equity-driven approach is essential—one that focuses on regions with low mCPR, high unmet need, and adolescent pregnancy. This calls for:

A. Context-specific strategies aligned with local health system capacities, literacy levels, and cultural norms.

B. Strengthened community-based interventions, especially through ASHAs and local NGOs.

C. Tailored demand-generation campaigns to reach marginalized groups.

D. Improved provider training and facility infrastructure to ensure respectful, confidential, and user-centred care.

Investments in equity will ensure no one is left behind. Investing in these approaches will improve contraceptive uptake and ensure that no one is left behind in India's FP journey.

3. Strengthening Health Systems for Equitable Family Planning Service Delivery

Integration and accountability are critical for equitable delivery. The performance of FP programs is also limited by Health system challenges including shortages of human resources, supply chain inefficiencies, and weak accountability mechanisms.

Primary healthcare can improve last-mile access. Additionally, integrating FP into India's primary healthcare system more effectively, including within Ayushman Bharat's HWCs, can enhance last-mile delivery and continuity of care.

System strengthening requires capacity, supply chains, and accountability. This includes:

A. Strengthening HR capacity through task-shifting and upskilling;

B. Ensuring uninterrupted contraceptive supply chains;

C. Embedding accountability through real-time data systems and community oversight.

Such integration will improve service quality, enhance last-mile access, and ensure continuity of care—especially for underserved populations.

C. Data and Digital Innovations

1. Harnessing Technology for Equitable Access and Program Efficiency

Harnessing technology can expand access and improve programme efficiency. Implement digital health solutions in remote and underserved areas such as teleconsultation, mHealth, and AI-driven chatbot solutions, improve awareness, provide real-time information, education, counselling, reminders, and connections to services, enhancing awareness and uptake, and facilitate access to contraceptive services without geographical constraints.

Digital supply-chain systems are critical for uninterrupted service delivery. A notable example is India's Family Planning Logistics Management Information System (FPLMIS), developed by MoHFW, which streamlines supply chain management through real-time data on stock levels, demand forecasting, and distribution. Scaling up FPLMIS and integrating it with broader health information systems can prevent stockouts and enhance last-mile delivery. It is a critical innovation in ensuring

uninterrupted contraceptive supply. Using real-time data analytics optimizes inventory management, minimizes stockouts, forecast demand, and enhances the efficiency of FP service delivery to the last mile. Implementing FP-LMIS is part of India's commitment to strengthening supply chains within its National Family Planning Programme. Expanding its use and interoperability with other health data systems can further strengthen program reach and impact.

Building a tech-enabled FP ecosystem requires investment in infrastructure and skills. To fully harness these tools, investments in digital infrastructure, capacity-building, and interoperability are essential especially in low-resource settings. A data-driven, tech-enabled FP ecosystem is key to delivering client-centric, responsive, and resilient reproductive health services.

D. Social Norms and Engagement

1. Increasing Male Engagement to Shift Social Norms and Expand Shared Responsibility

Male engagement is critical to shift norms and expand shared responsibility. Improving family planning (FP) outcomes requires shifting from a female-centric model to one that positions men as equal partners in reproductive health. This involves promoting shared responsibility, increasing male contraceptive uptake, and fostering a culture where men actively support women's reproductive choices (Hardee, Croce-Galis, & Gay, 2017).

FP messag ing and services rarely target men. Reframing FP in terms of economic security, family well-being, and responsible fatherhood can drive greater male engagement (Sternberg & Hubley, 2004). Innovations in male contraceptive products and the deployment of male health workers and counsellors can further enhance outreach and normalize participation (Kabagenyi et al., 2014).

Community-based interventions must challenge gendered expectations and scale male-friendly service delivery points. Targeted campaigns can address misinformation, dismantle stigma, and ensure that FP decisions are collaborative—not solely a woman's burden (Shattuck et al., 2011).

2. Promote Youth-Centred Approaches to Family Planning

Youth remains on the margins of India's FP discourse despite high unmet need. Ensuring that young people have access to stigma-free, youth-friendly FP services is essential. The ongoing unmet need for contraception among adolescents and young women highlights the urgent requirement for comprehensive, rights-based sexuality education that equips youth with the knowledge and agency they need.

Limited sex education leaves adolescents without tools for informed choice. Adolescents and youth remain on the periphery of India's FP discourse, despite high unmet need. Most rely on limited, often inadequate, sex education with few safe

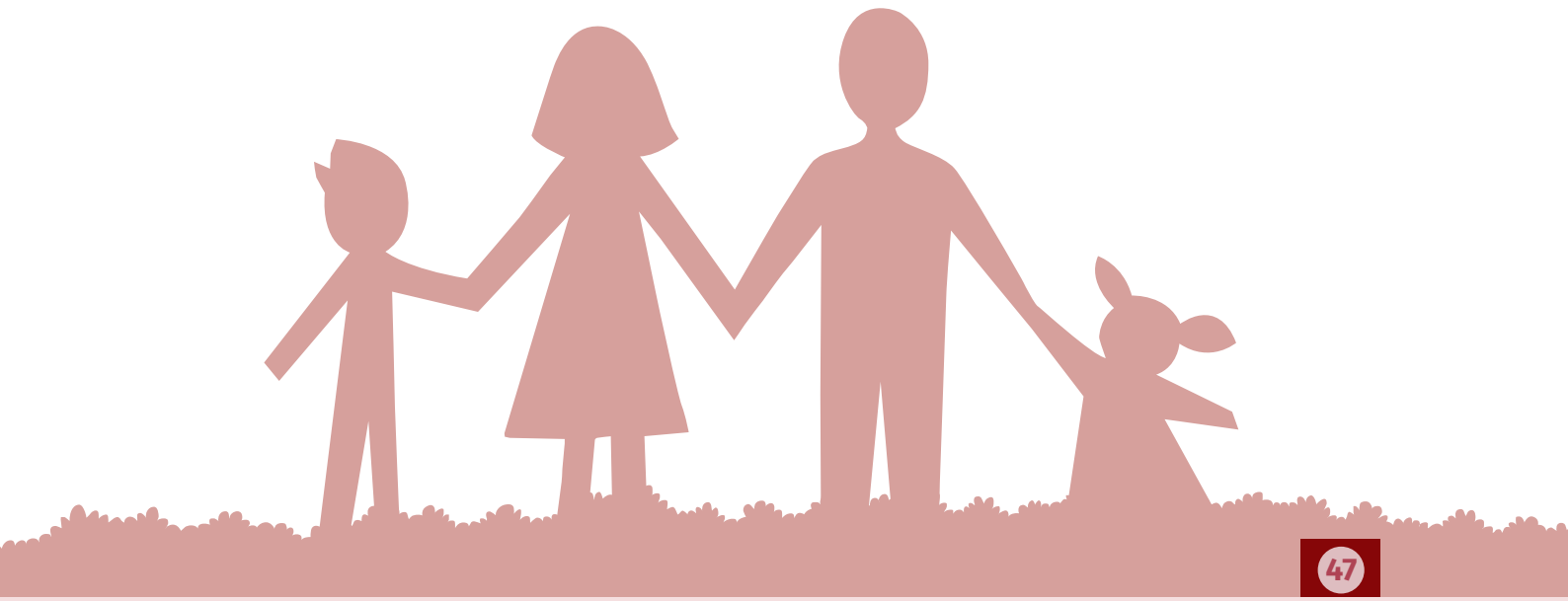
spaces for informed discussion (Jejeebhoy et al., 2014). Ensuring access to stigma-free, youth-friendly services, paired with comprehensive sexuality education (CSE), can delay early marriage, prevent unintended pregnancies, and promote informed, sustained contraceptive use (Chandra-Mouli et al., 2015).

Digital tools can bridge information and access gaps. Digital tools like AI-powered chatbots[1] offer confidential, culturally relevant guidance in local languages, countering misinformation and linking young people to appropriate services (Population Foundation of India, 2022).

Youth-friendly services and peer networks must be strengthened. Scaling adolescent-friendly clinics, investing in trained counselors, integrating CSE into school curricula, and supporting youth-led advocacy and peer networks are essential steps to drive meaningful engagement (Patton et al., 2016; UNESCO, 2018).

3. Advancing Gender-Transformative Approaches in FP

Gender-transformative FP must challenge norms, not just involve men. A gender-transformative FP strategy must go beyond increasing male involvement to actively challenge harmful social norms, engage communities in shifting perceptions, and promote bodily autonomy as a fundamental right. FP programs should also integrate gender-based violence (GBV) screening and response mechanisms, ensuring that women and girls facing violence have access to FP services within a broader rights-based framework.



F. Strategic Communication

1. Leveraging Media and Strategic Communication to Combat Misinformation and Stigma

Media and communication are powerful tools to reshape perceptions. Public perception of family planning (FP) is heavily influenced by cultural norms, misinformation, and entrenched stigma. Mass media can reshape these perceptions: national-level data show that exposure to FP messaging via television correlates with a 14% increase in the use of reversible modern contraception, and significantly higher odds of contraceptive discussion and adoption among married women (Ghosh et al., 2021). A meta-analysis across low- and middle-income countries confirms that media campaigns positively affect FP behaviors producing statistically significant improvements for both women (d= 0.19) and men (d = 0.16) (PCI, 2018).

Evidence suggests, media must be a strategic partner in FP advocacy. Leveraging partnerships with journalists, digital influencers, and entertainment creators enables evidence-based storytelling that is accurate, culturally resonant, and inclusive. Especially effective are entertainment-education models, which engage audiences emotionally and intellectually while promoting norm change (Ghosh et al., 2021; PCI, 2018)

Holistic messaging must reinforce rights, equity, and informed choice. Media campaigns should extend beyond promoting contraception—they must reinforce reproductive rights, gender equity, and informed choice. Such a holistic messaging strategy can reshape social norms, combat misinformation, and spark sustained demand across diverse communities.

Strategic Priority	Recommendations
Rights-Based FP Services	• Revise FP policies to embed reproductive autonomy and equity (UNFPA, 1994; MoHFW, 2017). • Ensure full method mix with unbiased, culturally sensitive counselling (WHO, 2018). • Allocate budgets for IEC, community engagement, and provider rights-training (FP2030, 2021).
Health System & Supply-Chain Strengthening	• Scale FP-LMIS for real-time inventory and demand forecasting (MoHFW, 2022). • Train ASHAs/ANMs in injectables, implants, and LARCs (Registrar General of India, 2021). • Pilot performance-based incentives for spacing methods uptake (Schultz et al., 2007).

Health System & Supply-Chain Strengthening	• Scale FP-LMIS for real-time inventory and demand forecasting (MoHFW, 2022). • Train ASHAs/ANMs in injectables, implants, and LARCs (Registrar General of India, 2021). • Pilot performance-based incentives for spacing methods uptake (Schultz et al., 2007).
Comprehensive Fertility Care Integration	• Add preconception counselling, infertility screening, and ART to public FP packages (Das Gupta, 2011). • Develop PPP models for subsidised ART and referral networks (Goli et al., 2023).
Male Engagement & Gender Transformation	• Launch norm-shifting campaigns framing FP as shared responsibility (UN Women, 2022). • Recruit male peer educators and establish male-friendly FP points at PHCs/CHCs (UN Women, 2022).
Youth-Centred, Inclusive Approaches	• Integrate comprehensive sexuality education in school curricula (UNFPA, 2021). • Scale confidential digital consultations and adolescent-friendly clinic hours (Klein, Frost, & Singh, 2020). • Support youth-led advocacy and peer networks (UNFPA, 2021).
Address Geographic & Socioeconomic Disparities	• Tailor interventions in low-mCPR districts via community outreach and SHG engagement (IIPS & ICF, 2021). • Disaggregate FP indicators by region, income, and caste to guide resource allocation (FP2030, 2021).
Diversify Method Mix & User-Centred Care	• Introduce LARCs and male methods, drawing lessons from Brazil and Rwanda (Queiroz, 2023; Cleland, 2022). • Institutionalise mystery-client audits and client-feedback loops (Cleland, 2022).
Strategic Communication & Media Partnerships	• Co-create culturally resonant campaigns with regional media and influencers (Sindig & Steven, 2009). • Use geo-targeted ads in low-uptake areas to counter misinformation (Sindig & Steven, 2009).
FP in Broader Development & Climate Resilience	• Align FP with education, women's economic empowerment, and climate adaptation plans (Finlay et al., 2018). • Engage VHSNCs in accountability tied to SDG 3.7 metrics (FP2030, 2021).

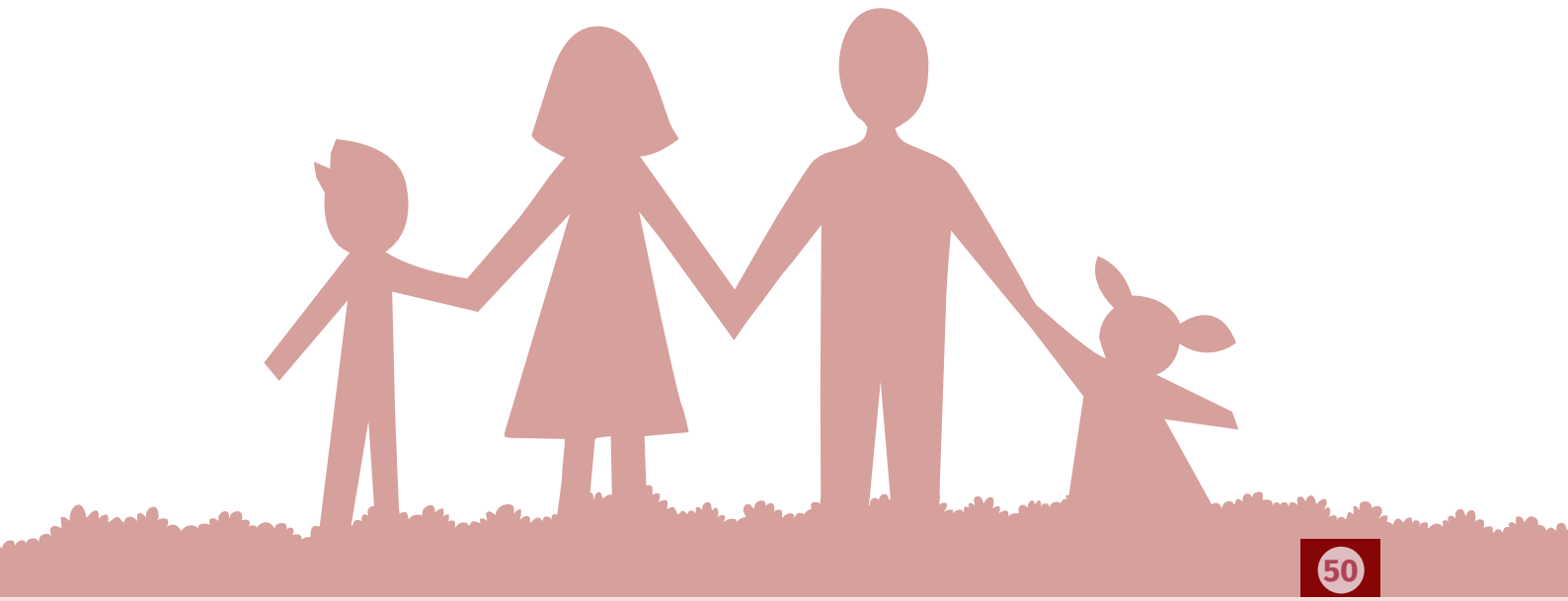
Conclusion

India must reframe family planning as rights, not control. Improving family planning (FP) outcomes in India demands a decisive policy shift, from population control narratives to positioning FP as a core pillar of reproductive rights, primary healthcare, and social equity. For policymakers, this means embedding FP within the Universal Health Coverage (UHC) agenda, ensuring availability of a full contraceptive basket, and integrating FP services across health and social protection schemes. It also requires addressing regional disparities, supporting adolescent and youth-friendly services, and proactively engaging men to rebalance gender dynamics in reproductive decision-making.

A rights-based FP system delivers measurable development gains. This shift will yield measurable development gains: reduced maternal and child mortality, improved school retention and workforce participation for women, and enhanced household economic resilience. With a large demographic cohort entering reproductive age, India stands at a critical juncture to leverage this potential through inclusive, well-resourced, and responsive FP systems.

Policy action must focus on investment, behaviour change, and accountability. Policy action must prioritize sustained public investment, community-led behavior change initiatives, and interoperability of digital systems to improve last-mile service delivery. Crucially, robust accountability mechanisms such as real-time data transparency, community feedback systems, and performance-linked monitoring must be institutionalized to track progress and course-correct in real time.

India's FP leadership must rest on equity and replicability. By championing equity and scale in FP programs, India can lead not through exceptionalism, but through a replicable, rights-based approach that supports health, gender, and development goals—delivering real impact where it's needed most.



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ANNEXURES

Annexure – I

State/Union Territory	Total Wanted Fertility Rate	Total Fertility Rate
India	1.6	2.0
North		
Chandigarh	1.2	1.4
Delhi	1.3	1.6
Haryana	1.5	1.9
Himachal Pradesh	1.4	1.7
Jammu & Kashmir	1.3	1.4
Ladakh	1.1	1.3
Punjab	1.3	1.6
Rajasthan	1.6	2.0
Uttarakhand		1.8
Central	1.5	
Chhattisgarh	1.6	1.8
Madhya Pradesh	1.6	2.0
Uttar Pradesh	1.8	2.3
East		
Bihar	2.2	3.0
Jharkhand	1.9	2.3
Odisha	1.5	1.8
West Bengal	1.4	1.6
Northeast		
Arunachal Pradesh	1.5	1.8
Assam	1.6	1.9
Manipur	2.0	2.2
Meghalaya	2.7	2.9

Mizoram	1.8	1.9
Nagaland	1.6	1.7
Sikkim	0.9	1.0
Tripura	1.5	1.7
West		
Dadra & Nagar Haveli and Daman & Diu	1.6	1.8
Goa	1.2	1.3
Gujarat	1.5	1.9
Maharashtra	1.4	1.7
South		
Andaman & Nicobar Islands	1.1	1.3
Andhra Pradesh	1.6	1.7
Karnataka	1.4	1.7
Kerala	1.7	1.8
Lakshadweep	1.2	1.4
Puducherry	1.3	1.5
Tamil Nadu	1.6	1.8
Telangana	1.6	1.7

Note of Caution:

The use of digital tools such as apps and chatbots should be approached with caution, with particular attention to data privacy and security to safeguard sensitive user information.

Disclaimer:

Although several individual interventions are mentioned, the paper does not endorse or recommend any specific one for adoption or scaling

Notes

Confederation of Indian Industry

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the development of India, partnering Industry, Government and civil society through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organisation, with around 9,700 members from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 365,000 enterprises from 318 national and regional sectoral industry bodies.

For more than 130 years, CII has been engaged in shaping India's development journey and works proactively on transforming Indian Industry's engagement in national development. CII charts change by working closely with the Government on policy issues, interfacing with thought leaders, and enhancing efficiency, competitiveness, and business opportunities for industry through a range of specialised services and strategic global linkages. It also provides a platform for consensus-building and networking on key issues.

Through its dedicated Centres of Excellence and Industry competitiveness initiatives, promotion of innovation and technology adoption, and partnerships for sustainability, CII plays a transformative part in shaping the future of the nation. Extending its agenda beyond business, CII assists industry to identify and execute corporate citizenship programmes across diverse domains, including affirmative action, livelihoods, diversity management, skill development, empowerment of women, and sustainable development, to name a few.

For 2025-26, CII has identified "Accelerating Competitiveness: Globalisation, Inclusivity, Sustainability, Trust" as its theme, prioritising five key pillars. During the year, CII will align its initiatives to drive strategic action aimed at enhancing India's competitiveness by promoting global engagement, inclusive growth, sustainable practices, and a foundation of trust.

With 70 offices, including 12 Centres of Excellence, in India, and 9 overseas offices in Australia, Egypt, Germany, Indonesia, Singapore, UAE, UK, and USA, as well as institutional partnerships with about 250 counterpart organisations in almost 100 countries, CII serves as a reference point for Indian industry and the international business community.

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About The Women's Collective Forum (WCF)

The Women's Collective Forum (WCF) is a pan-sectoral platform focused on equity-led systems transformation through scalable, institutionally grounded models.

Its enterprise initiative, SPARK – The 100K Collective, addresses the "missing middle" of women-led businesses—enterprises that are already established but remain excluded from formal finance, markets, digital systems, and regulatory frameworks. Through bootcamps in 300 locations, SPARK will work with 100,000 women entrepreneurs to strengthen their capacity to engage with capital, platforms, and institutions, ensuring that systems become navigable for those already building.

Beyond enterprise, WCF collaborates with leading health, technology, and management institutions to advance maternal health protocols, disease elimination, and the integration of new health technologies. In law and governance, WCF supports implementation of India's evolving criminal law frameworks with a focus on survivor-centricity and institutional accountability.

WCF also convenes cross-sectoral dialogues to highlight India's leadership in frugal innovation and systems change, engaging with global leaders and national platforms to translate research into policy and practice.

Across all these areas, WCF's model is consistent: build partnerships that connect evidence to institutions, and design approaches that can scale to strengthen systems for equity.

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INDIA'S PROGRESS ACHIEVEMENTS

&

OPPORTUNITIES IN FAMILY PLANNING

Better Family Planning Outcomes
Supporting India's Progress and Development