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The Ghost of Population Past:
How Population Control Persists in India

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The Ghost of Population Past:
How Population Control Persists in India

Executive Summary

The national total fertility rate (TFR) of India is 1.9, well below replacement fertility. In the absence of Bihar and Uttar Pradesh, the TFR stands at 1.6. This is comparable to Northern Europe (1.5) and the United States (1.6). The demographically mature Southern states, namely Andhra Pradesh (1.4), Telangana (1.5), Karnataka (1.5), Kerala (1.3) and Tamil Nadu (1.3), alongside states like West Bengal (1.3), Punjab (1.4), Goa (1.6), Himachal Pradesh (1.5), Sikkim (1.0), Maharashtra (1.4), and Delhi (1.2), have been below replacement fertility for over two decades now. With a median age of almost 35 years, these states are demographically closer to ageing economies like the United States (39), than to our national median age of 30 years.

The annual number of births in India peaked at roughly 29.3 million in 2001. It has reduced by one-fifth since then, to about 23.2 million births in 2023. At the current juncture, India is at the same level of births it had about fifty years ago in 1974.

Despite this, our public discourse on demographics is still haunted by our outdated anxiety over population explosion. Even though population control is less emphatic, the underlying effect persists within the National Family Planning Programme through a system of misplaced incentives. These incentives include: a 'compensation' to the acceptor who undergoes the procedure, a 'motivation' incentive to the Accredited Social Health Activist (ASHA) or individual who mobilised the acceptor, and a service payment to the provider. Furthermore, terminal methods, i.e. male and female sterilisations, pay far more in incentive payments to promote greater adoption, than the reversible methods, like IUCDs or injectables. This design exists even in low fertility states. Moreover, incentive payments to promote terminal-methods are enhanced in high-focus 'Mission Parivar Vikas' states to suppress fertility as per the Mission's objective. The incentives on terminal methods in these states are up to ten times those offered for reversible methods like IUCDs and injectable doses - which are the same across the country. Nationally, 80% of all fiscal allocation for incentives and compensations are towards sterilisations.

Let us look at the compensation structure of the ASHAs as an illustration. First, their income rises with the number of acceptors they motivate to undergo procedures. Second, the incentive payment to motivate people to adopt terminal methods, like sterilisations, have remained higher than reversible methods. Third, if the ASHA successfully motivates a couple to adopt a permanent limiting method after the birth of two children, she receives an additional premium incentive payment. As a result, an ASHA can make four times as much by counselling and motivating a couple to adopt a terminal method and counselling them to limit births, over reversible methods. This is a well-oiled incentive structure that implicitly promotes population control.

Bureaucratic inertia and cultural indoctrination have ensured that states have not fully grasped the consequences of suppressing fertility and maintaining the status quo, when, in fact, they are no longer relevant. This paradox is glaringly evident in states that are introducing measures to promote higher fertility, whilst maintaining the budget allocation to incentivise sterilisations. For instance, in August 2026, Tamil Nadu extended maternity leave for government employees to a year, for the birth of a third child. Concurrently, however, they have budgeted direct benefit transfers (DBTs) to incentivise 1.6 lakh female sterilisations in 2026-27. This is an explicit policy contradiction.

Despite being below replacement fertility, the legacy narrative around the need for population control persists. Alongside these transactional incentives sit population control rituals. On "World Population Day", our populace is educated on how important it is to control our population. States, districts, and health workers are actively rewarded for achieving family planning metrics. On "Vasectomy Fortnights", the frontline health workers are incentivised to mobilise and motivate clients to undergo vasectomies. Several states compound this architecture by still enforcing two-child norm restrictions

that bar citizens from government employment, local office, and access to welfare. All this culminate to perpetuate a narrative of the need to pursue population control, which is unwarranted.

We draw a critical structural parallel with the historical policy experience of the People's Republic of China to illustrate how and why a family-planning bureaucracy and its incentives can outlast the demographic conditions that justify them. China kept its coercive One-Child Policy apparatus running for more than two decades after fertility fell below replacement in 1991, and long after demographers highlighted the dangers of continuing the policy. The one-child policy continued because of a cultural indoctrination and Malthusian fear of population explosion, in addition to, a large bureaucratic system that both perpetuated and administered it. The apparatus built to implement the policy became the main force resisting its reform. As a result, China's policy reversal in 2016, came too late. Despite a three-child policy, since 2021, China's TFR has not recovered and, instead, declined to less than 1. Indeed, China's population will decline by 60-to-100 million per decade, on average, till 2100. That is the equivalent to losing the population of Germany, per decade.

Fortunately, some states are coming around to recognise this issue. Andhra Pradesh, for instance, achieved below replacement fertility more than two decades ago. Notably, its family planning policy relied overwhelmingly on promoting female sterilisations as the primary contraception method. Today 70 per cent of married women in Andhra Pradesh are sterilised – the highest in the nation. Even then, until 2024-26, Andhra Pradesh provided incentives for more sterilisations, per capita, than even a high fertility state like Uttar Pradesh. However, they have since altered their policy. They have not budgeted any incentives for sterilisations in 2026-27. The state has also scrapped its decades old law restricting individuals with more than two children from contesting local body elections. Under the Andhra Pradesh Population Management Programme (2026), the state has also proposed to provide hefty cash benefits for couples who have a second and third child. While the efficacy of such pro-natalist policies is questionable, it is a positive development that some states are aligning their population policy to their demographic reality.

Our collective fears of a population explosion, even in high-fertility states, are misplaced. We need to overcome our population control mindset and align our policy objectives with the new demographic reality. The historical experience of other countries shows that once fertility declines below a behavioural tipping point, and alters social norms, it is very difficult to reverse. The national TFR is going to decline naturally, regardless of state intervention. Hence, there is no need for us to suppress this any further and risk falling into a low-fertility trap sooner. Therefore, we recommend the following:

- ***End sterilisation-linked incentive payments:*** *Roll-back all direct benefit transfer payments, including acceptor payments, wage-loss compensations, and enhanced incentives to acceptors and service providers, related to sterilisations. These services can be provided without incentivising people or motivating others to adopt them. There is no economic rationale why these need to continue in the states that are now below replacement fertility.*
- ***Repeal motivational payments****: Eliminate all motivational incentive payments tied to terminal methods and the ASHA incentive related to limiting couples to two children.*
- ***Roll back population control rituals and rules:*** *Discontinue all family-planning related awards, World Population Day celebrations and Vasectomy Fortnight observances that call for population control. In addition, repeal two-child norm disqualifications across all states.*
- ***Redefine administrative mandates:*** *Adjust the scope of Mission Parivar Vikas to the new demographic reality in the states which are at or below replacement fertility. Remove all fertility-reduction, population control or 'stabilisation' language from our national and state policy frameworks and outputs.*

We would like to point out that we are not against family planning for reasons of health, child spacing or personal preference. The central argument of our paper is that population control is no longer relevant as an objective of state policy. Our family planning policies need to reflect the new demographic reality.

Acronyms

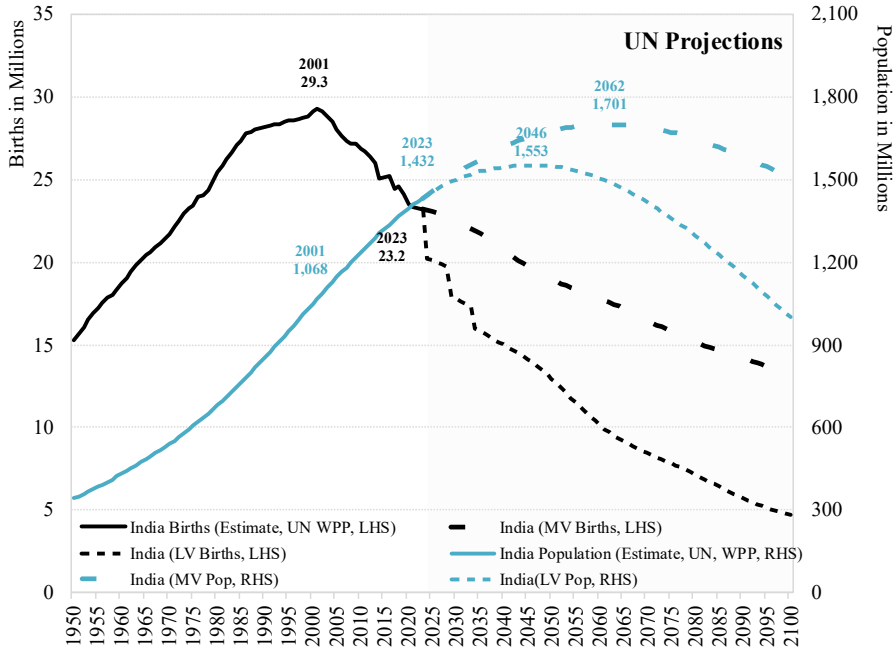
ANM	Auxiliary Nurse Midwife
ASFR	Age-Specific Fertility Rate
ASHA	Accredited Social Health Activist
BE	Budget Estimate
CCP	Chinese Communist Party
CHC	Community Health Centre
COT	Clinical Outreach Team
ECP	Emergency Contraceptive Pill
ELA	Expected Level of Achievement
ESB	Ensuring Spacing at Birth
FDS	Fixed Day Static services
FP	Family Planning
FP2030	Family Planning 2030
FP-LMIS	FP Logistics Management Information System
GHE	Government Health Expenditure
GSDP	Gross State Domestic Product
HDC	Home Delivery of Contraceptives
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JSY	Janani Suraksha Yojana
LEB	Life Expectancy at Birth
LLF	Late, Long, Few (campaign)
MoHFW	Ministry of Health and Family Welfare
MPA	Medroxyprogesterone Acetate (Antara)
MPV	Mission Parivar Vikas
NCERT	National Council of Educational Research and Training
NFHS	National Family Health Survey
NHA	National Health Accounts
NHM	National Health Mission
NHP	National Health Profile
NPP	National Population Policy
NRHM	National Rural Health Mission
NRR	Net Reproduction Rate
NSV	Non-Scalpel Vasectomy
OADR	Old-Age Dependency Ratio
OCP	One-Child Policy (China)
OCPs	Oral Contraceptive Pills
OVV	One-Vote Veto
PAIUCD	Post-Abortion Intrauterine Contraceptive Device
PFI	Population Foundation of India
PIP	Programme Implementation Plan
PPIUCD	Post-Partum Intrauterine Contraceptive Device
PPS	Post-Partum Sterilisation
RGI	Registrar General of India
RoP	Record of Proceedings
SBCC	Social and Behaviour Change Communication
SRS	Sample Registration System
TFR	Total Fertility Rate
TPP	Technical Group on Population Projections
UN	United Nations
UN WPP	UN World Population Prospects
UNFPA	United Nations Population Fund
UP	Uttar Pradesh
UT	Union Territory
WPD	World Population Day

I. The 'New' Demographic Reality

In Charles Dickens' *A Christmas Carol*, Ebenezer Scrooge is haunted by the *Ghost of Christmas Past,* who shows him how his choices have culminated in his lonely present. Similarly, our public discourse on demographics is haunted by our outdated anxiety over population explosion - *the Ghost of Our Population Past*.

Indians are not having too many babies. The annual number of births peaked at roughly 29.3 million in 2001. It has reduced by one-fifth to about 23.2 million by 2023 (UN WPP, 2024), even as the population has risen since. At the current juncture, India is at the same level of births it had fifty years ago in 1974 (see Figure 1). Our population is only growing because we are relatively young,[1] which is driving a growth momentum[2]. Moreover, healthcare access and living standards have improved. As a result, the infant mortality rate has fallen[3], and we are living longer.[4]

Figure 1: Births and Population Estimates for India, 1950-2023 (Projections up to 2100, MV = Medium Variant; LV= Low Variant)



Source: United Nations World Population Prospects (UN WPP), 2024.
Note: The black lines show absolute live births, based on the left-hand side (LHS) axis. The blue lines represent the total population estimates and projections, based on the right-hand side (RHS) axis. Data labels show the respective peaks in 2001 (for births) along with the peak population projected values under the medium and low variant projections, denoted as MV (medium variant) and LV (low variant), respectively. Estimates end in 2023 (data labels shown for 2023), and projections are for the period 2024-2100.

The single most important factor driving demographics is the total fertility rate (TFR), defined as the average number of children a woman would bear over her reproductive lifespan (conventionally, ages 15-to-49). **The national TFR was 1.9 in 2024**, based on the *Sample Registration System* (SRS, 2024), or 2.0, based on sixth round of *The National Family Health*

[1] The national median age is estimated at 30 years in 2026 according to the Report of the Technical Group on Population Projections (TGPP), titled 'Population Projections for India and States, 2011-2036', published in July 2020. See footnote 9.
[2] A larger cohort of a younger population may have lesser children, per se, but the absolute number of births continue to be greater than total mortalities. This will change within the next two decades as the population ages, mortalities rise, and as the share of the younger population declines.
[3] Infant mortality is down from 173 deaths in 1951 (per 1,000 births, Census 1951) to 24 (SRS, 2024).
[4] Life expectancy at birth (LEB) was 41 years in 1951 (Census), and is around 72 years today (SRS, 2024).

Survey (NFHS-6, 2023-24). A TFR of 2.1 is the globally accepted metric for replacement fertility[5]. **On both measures, India has been below replacement fertility since 2019** (Table 1).[6]

However, 2.1 is an approximation and is only the actual replacement rate when two conditions hold. First, when the sex ratio at birth is close to 105 boys per 100 girls (approximately 953 females to a 1000 males), and, second, when about 97 per cent of girls survive to the mean childbearing age. Since India witnessed decades of a skewed sex ratio at birth towards males, and a higher infant mortality rate, historically, the actual replacement rate has been higher, around 2.2 – 2.4, over the last two decades. In reality, India has been below its *true* replacement fertility since 2016 - for a decade (Table 1).[7]

Table 1: Total Fertility Rate (TFR) & Corresponding Replacement Fertility, 2000-2024

Year	SRS observed TFR	NFHS observed TFR (round)	Replacement TFR (computed)	At or below replacement?
1999/2000	3.2	2.9 (NFHS-2)	2.4	No
2001	3.1	-	2.4	No
2005	2.9	2.7 (NFHS-3)	2.4	No
2011	2.4	-	2.3	No
2016	2.3	2.2 (NFHS-4)	2.2	No, for SRS / Yes, for NFHS
2017	2.2	-	2.2	Yes
2018	2.2	-	2.2	Yes
2019	2.1	2.0 (NFHS-5)	2.2	Yes
2020	2.0		2.2	Yes
2021	2.0		2.2	Yes
2022	2.0	-	2.2	Yes
2024	1.9	2.0 (NFHS-6, prelim.)	2.2	Yes

Source: SRS vintages, NFHS surveys. See Annex 1 for the methodology behind the computed replacement TFR.

The national TFR conceals a stark and policy-relevant divergence across states. Five states: Bihar (2.9), Uttar Pradesh (2.6), Madhya Pradesh (2.4), Rajasthan (2.3) and Chhattisgarh (2.2) are above replacement, while Jharkhand (2.2) is at replacement fertility (Table 2 for SRS and Appendix Table 1 for the NFHS equivalent).

In the absence of Bihar and UP, India's national TFR is closer to 1.6. In the absence of the six 'high' fertility states, listed above, the national TFR drops even further to 1.4. This is comparable to Europe (1.4), lower than the United States (1.6), and only slightly above Japan (1.2) (Table 3).

[5] The replacement fertility is defined as the average number of children each woman needs to have for the next generational cohort to replace the previous. The underlying principle is simple: two people having two children for complete replacement, plus a buffer of 0.1 to account for infant mortality and a skewed sex ratio at birth. A TFR of 2.1 implies that if the trend continues, the population will eventually stabilise at an equilibrium level.

[6] Moving forward we will only refer to SRS, although the appendix includes comparable computations using NFHS. We recognize that some states and UTs have seen a slight uptick in the TFR from NFHS-5 to NFHS-6, which is not the case in SRS. We also recognize that there are TFR discrepancies for many states when comparing SRS and NFHS-6 values. We have opted for SRS because it helps provide a consistent time-series and comparable macro-level picture. However, the reader will observe that the arguments made here are valid when using NFHS-6 data too, especially since only Bihar and Meghalaya have above replacement fertility according to NFHS-6. We use NFHS-6 for TFR for North-Eastern states in some table to provide the reader with some reference.

[7] Annex 1 provides an explanation on the underlying computations.

Table 2: Observed Total Fertility Rate & Corresponding Replacement Fertility based on Sample Registration System data at different periods

State / UT	SRS 2001	SRS 2005	SRS 2011	SRS 2016	SRS 2020	SRS 2024	Replacement TFR 2024 (computed)	At/below own replacement since at least
Andhra Pradesh	2.3	2.0	1.8	1.7	1.5	1.4	2.1	2001
Assam	3.0	2.9	2.4	2.3	2.1	1.9	2.2	2020
Bihar	4.4	4.3	3.6	3.3	3.0	2.9	2.2	Above Replacement
Chhattisgarh	-	3.4	2.7	2.5	2.2	2.2	2.1	Above Replacement
Delhi	-	2.1	1.8	1.6	1.4	1.2	2.2	2005
Gujarat	2.9	2.8	2.4	2.2	2.0	1.7	2.2	2016
Haryana	3.1	2.8	2.3	2.3	2.0	1.9	2.2	2011
Himachal Pradesh	2.2	2.2	1.8	1.7	1.5	1.5	2.1	2001
Jammu & Kashmir	-	2.4	1.9	1.7	1.5	1.4	2.1	2011
Jharkhand	-	3.5	2.9	2.6	2.4	2.2	2.2	2024
Karnataka	2.4	2.2	1.9	1.8	1.6	1.5	2.1	2005
Kerala	1.8	1.7	1.8	1.8	1.5	1.3	2.1	2001
Madhya Pradesh	3.9	3.6	3.1	2.8	2.6	2.4	2.2	Above Replacement
Maharashtra	2.4	2.2	1.8	1.8	1.5	1.4	2.2	2005
Odisha	2.6	2.6	2.2	2.0	1.8	1.6	2.2	2011
Punjab	2.4	2.1	1.8	1.7	1.5	1.4	2.2	2005
Rajasthan	4.0	3.7	3.0	2.7	2.4	2.3	2.2	Above Replacement
Tamil Nadu	2.0	1.7	1.7	1.6	1.4	1.3	2.1	2001
Telangana	-	-	-	1.7	1.5	1.5	2.2	Before 2016
Uttar Pradesh	4.5	4.2	3.4	3.1	2.7	2.6	2.2	Above Replacement
Uttarakhand	-	2.5	2.1	1.9	1.8	1.7	2.2	2011
West Bengal	2.4	2.1	1.7	1.6	1.4	1.3	2.1	2005

Source: SRS vintages. See the equivalent table for NFHS data in Appendix Table 1. The TFRs are rounded off to one decimal point. See Annex 1 for the methodology behind the computed replacement TFR. TFR data for Chhattisgarh, Delhi, J&K, Jharkhand, Telangana and Uttarakhand are not available in earlier years. The "at/below own replacement" column is based on computations at different points of time (2001, 05, 11, 16, 20, 24) and are not to be interpreted as the exact year at which the state achieved its true replacement fertility. Each state's replacement level differs because sex ratio at birth and child survival differs by state.

States like Andhra Pradesh (1.4)[8], Himachal Pradesh (1.5), Karnataka (1.5), Kerala (1.3), Punjab (1.4), Maharashtra (1.4), Tamil Nadu (1.3), West Bengal (1.3), Goa (1.6), and Delhi (1.2) have been below replacement since 2005 (see Table 2 for SRS and Appendix Table 1 for the NFHS equivalent). Some even as far back as 2001. With a median age of 35, and a collective average TFR of 1.4, these states are demographically closer to ageing economies like China (40) and the United States (39) than to the national median (30).[9]

[8] And Telangana which has been below replacement fertility since its formation, using both SRS and NFHS evidence.

[9] We use the 2026 median age estimate from the National Commission on Population, Ministry of Health and Family Welfare (MoHFW). Report of the Technical Group on Population Projections (TGPP), titled *'Population Projections for India and States, 2011-2036'*, published in July 2020. The China and US median age are from the *UN World Population Prospects, 2024.*

Table 3: India's TFR compared with International Benchmarks

Region / State	TFR
India	**1.9**
Bihar	2.9
Uttar Pradesh	2.6
India excluding Bihar & Uttar Pradesh	**1.6**
Rajasthan	2.3
Madhya Pradesh	2.4
Jharkhand	2.2
Chhattisgarh	2.2
India excluding Bihar, UP, Rajasthan, MP, Jharkhand & Chhattisgarh	**1.4**
TFR in Select Aggregates and Countries (For Comparison)	
Europe	1.4
Eastern Europe	1.4
Northern Europe	1.5
Southern Europe	1.3
Western Europe	1.5
United States of America	1.6
East Asia	1.0
China	1.0
Japan	1.2
Republic of Korea	0.7

Source: SRS, 2024 (Statement 21) and UN WPP, 2024; Report of the Technical Group on Population Projections (TGPP), 2020 (Table 17). The calculations for TFR excluding states use the 2026 estimate for women of reproductive age (15-49) from the report of TGPP as the weights. The calculations do not change when using total population or share of the population as weights.

The national urban TFR has been below replacement for over two decades, long before the country reached replacement fertility (Table 4). As India urbanises rapidly, the TFR will only fall further, as has ubiquitously been the case globally. With rural TFR now below replacement too (Table 4), it's time for us to internalise a new demographic reality of a sub-replacement India.

Table 4: Urban Rural Divide across SRS and NFHS

Year	Total (SRS)	Rural (SRS)	Urban (SRS)	Total (NFHS)	Rural (NFHS)	Urban (NFHS)
SRS 2005 NFHS-3 (2005-06)	2.9	3.2	2.1	2.7	3.0	2.1
SRS 2016 NFHS-4 (2015-16)	2.3	2.5	1.8	2.2	2.4	1.7
SRS 2020 NFHS-5 (2019-21)	2.0	2.2	1.6	2.0	2.1	1.6
SRS 2024 NFHS-6 (2023-24)	1.9	2.1	1.5	2.0	2.1	1.6

Source: SRS and NFHS. Highlighted (green) cells show that they are below replacement fertility.

Our population growth is now driven entirely by longevity and population momentum, not fertility. There is going to be no population explosion moving forward. The national TFR is going to decline naturally, regardless of state intervention. There is no need for us to suppress this any further and risk falling into a low-fertility trap sooner.

The bureaucratic administration, health apparatus, and financial incentives, within the *National Family Planning Programme* that were created to reduce a TFR that stood well above

replacement for most of the twentieth and early twenty-first century haven't fully adjusted to the new reality, even as the objective has been achieved for a decade.

In this paper we evaluate the structural misalignment within India's *National Family Planning Programme*, where active, incentive-driven population control persists. This is discussed in Section III**.**

To provide the reader some context, we draw a critical structural parallel with the historical policy experience of the People's Republic of China to illustrate how and why a family-planning bureaucracy and its incentives can outlast the demographic conditions that justify them (Section II). China kept its coercive One-Child Policy apparatus running for more than two decades after fertility fell below replacement in 1991, and long after demographers highlighted the dangers of continuing the policy. As a result, the policy reversal came too late. India's current family planning structure has the same self-perpetuating logic.

We would like to clarify that we are not against family planning for reasons of health, child spacing or personal preference. We are not calling for the rollback of the provision of contraception in the country. This paper simply evaluates the complex architecture of legacy population control measures that states still pursue despite rapidly changing demographics. We argue that population control is no longer relevant as an objective of state policy.

II. The Chinese Warning: How A Bureaucratic Apparatus Outlived Its Rationale

The institutional mechanics behind China's historical population policy experience help understand why bureaucracies perpetuate a legacy population policy long after they are relevant.

II.A China's One-Child Policy and The Institutional Framework

China's *One-Child Policy* (OCP) was introduced in 1980 and continued till 2016. It was a stringent framework of birth limits designed to curb population growth and align demographic expansion with centrally planned economic goals.

The Chinese state established the National Family Planning Commission in 1981, creating a vertical administration that extended from the central government down to village-level cadres (Li, Meng, Miller, & Yang, 2025). Under OCP, couples were required to obtain official approval (permits) to have a child (Wang, Cai, & Gu, 2013; Jiang & Liu, 2016). Local family planning committees managed quotas in their communities. Citizens who complied with the policy received certificates that entitled them to financial bonuses, better housing, and preferential work assignments (Wang, Cai, & Gu, 2013). Those who had unauthorized children faced severe "social maintenance fees," (essentially fines) which could often exceed a family's annual income (Jiang & Liu, 2016). Other penalties included job loss, demotion, and the denial of state benefits for the unregistered child (Wang, Cai, & Gu, 2013). Enforcement involved the widespread promotion of contraceptives, as well as coercive methods like forced abortions and sterilisations overseen by local officials (Jiang & Liu, 2016).[10]

[10]The OCP was exempted at different instances. In the rural areas, in the initial years, where resistance was strongest, exemptions were made for two children (Gu et al., 2007), and couples whose first child was a daughter were permitted a second (Gu et al., 2007). As a result, the TFR never dropped exactly to one during the period.

While OCP is known around the world, what people know less about are two programmes in China that were a lot more effective in controlling TFR than the blanket restriction of the OCP, alone. First, and crucially, OCP was established after a decade of (lesser but equally dramatic) coercive fertility decline. During the 1970s, under the "late, long, few" (LLF) campaign, China's total fertility rate (TFR) fell by more than half, dropping from 5.8 in 1970 to 2.7 in 1979 (Wang, Cai, & Gu, 2013). Second, while the TFR fluctuated around 2.2-2.7 in the 1980s, fertility fell decisively below replacement once the policy was enforced far more strictly nationwide in 1991 through the "One Vote Veto" (OVV) system (Li, Meng, Miller, & Yang, 2025; Gu et al., 2007).

OVV was a bureaucratic evaluation system that tied local officials' career prospects directly to family-planning outcomes (Edin, 2003). If a local government official failed to meet population targets, it acted as a performance "veto" overriding all other achievements (Edin, 2003). The incentive this created was not merely to comply but to over-comply. Because a single missed quota could erase a career's worth of achievement, and because the quota was numeric, the rational response of a local cadre was to drive recorded births below the ceiling by whatever means were available (Li, Meng, Miller, & Yang, 2025). As a result, TFR fell almost instantly. China's censuses recorded a TFR of 2.1 in 1990, and 1.2 in both 2000 and 2010 (Jiang & Liu, 2016). Though there are some variations in the numbers based on sample surveys, the downward trend broadly remained the same.

II.B Why China Continued the Policy Long After Its Relevance

Despite the decline in TFR, the One Child Policy in China continued. What makes China's case a genuine warning is that the leadership was aware that the policy had the potential of adverse effects on the demographics. Chinese demographers submitted collective appeals to relax or re-examine the policy in April 2004, January 2009 and January 2015 (Wang, Gu, & Cai, 2016). Projections on accelerated ageing and a declining working-age population, that actually began shrinking in 2012, had been anticipated by the policy's own designers as early as the 1980 open letter that launched it (Central Committee of the CPC, 1980; Wang, Cai, & Gu, 2013, p. 120). Alternatives achieving the same demographic objective with far less coercion were offered by academics back in the 1980s and early 90s (Bongaarts and Greenhalgh 1985, and 1987; Vaupel and Zeng, 1991). None of these were heeded.

The official position for continuing was two-fold. First, the authorities genuinely believed that their own recorded data was not entirely reliable, and that they undercounted actual births. It is possible that there was some truth to this in the initial years. The fines and crackdown incentivised Chinese households to hide births (Wang, Cai, & Gu, 2013). The quotas and the consequences of missing them incentivised local cadres and officials to under-report births (Wang, Cai, & Gu, 2013).

As a result, the National *Population and Family Planning Commission* repudiated successive low readings, treating them as underestimates produced by under-counting and the deliberate concealment of births (Merli & Raftery, 2000; Cai, 2013). The pattern repeated with each cycle - a census or survey would return a very low TFR, the figure would be attributed to under-counting and adjusted upward by indirect estimation (Jiang & Liu, 2016). Each successive five-year plan continued to assume a TFR of about 1.8 when actual TFR was much lower (Jiang & Liu, 2016).

The second reason OCP continued can only be explained by an ingrained cultural indoctrination and *Malthusian* fear perpetuated and internalised by officials and the

bureaucracy alike (Jiang & Liu, 2016). Even in 2007, The National Population Development Strategy Report (2006-07) prescribed that the national fertility rate be kept around 1.8 for the next 30 years (National Population Development Strategy Research Group, 2007; Gu et al., 2007, see Figure 2). When finally coming around to recognise the problem, as late as 2012, China's Population Development Report projected that a one-child policy reversal, and a two-child policy imposition, would raise the annual births above 47 million for the first several years – at a time when annual births were closer to 15 million (Jiang & Liu, 2016).

The policy makers and administration truly believed that in the first few years, in the absence of a one-child limit, births would skyrocket. This fear and policy inertia rested on a population crisis that was itself a construction of official discourse - and, in turn, a product of that construction (Liu, De, & Xiong, 2014; Jiang & Liu, 2016).

Figure 2: Snapshots of News Articles from 2008 and 2012 Showing How Bureaucratic Inertia Perpetuated the One-Child Policy Well into The Later Years

Sources: Yardley (2008); The Wall Street Journal (2012); Wong (2012). Only the introductory excerpts of the articles are provided for the reader to get a general idea of the narrative and situation thirty years into introducing the One-Child Policy. These articles are not the authors' original work.

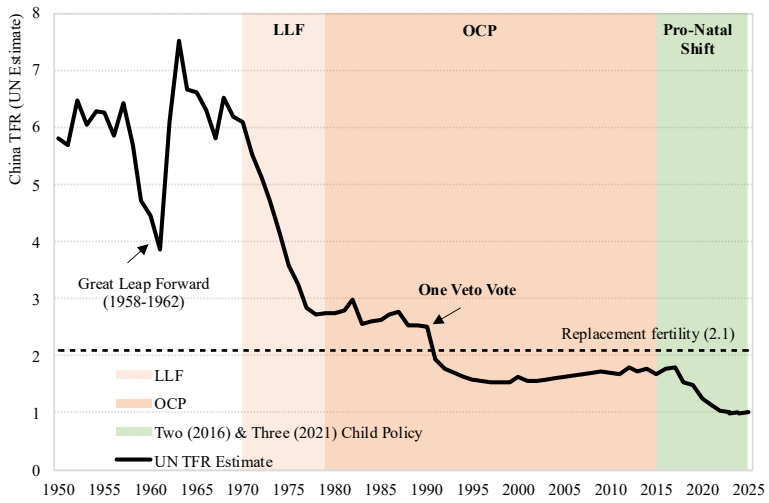
Further, the bureaucratic apparatus also had a direct stake in the policy's continuation. By the end of 2005, China had more than 80,000 population and family-planning institutions across nearly 40,000 towns, that staffed more than a million people (Fan, 2010 as cited in Jiang & Liu, 2016, p. 561). This made it one of the largest single-purpose bureaucracies on earth. The apparatus built to implement the policy became the main force resisting its reform, precisely

because its budgets, salaries and careers were tied to that policy's survival (Wang, Cai, & Gu, 2013; Jiang, Li, & Feldman, 2013).

II.C. The Population Explosion That Never Occurred: The Aftermath of Repealing OCP

China repealed its one-child policy in 2015 (effective 2016) and has since entirely pivoted from restricting births to actively promoting them. China now has a three-child policy (since 2021), and the central government now funds a nationwide universal childcare subsidy providing 3,600 yuan (approx. $500 USD) per year for every child under the age of three, regardless of birth order (Government of China, 2025). The local authorities are mandated to establish free or highly subsidized public preschool networks to lower early education costs, zero expenses for childbirth, and increasing maternity and paternity leave (Government of China, 2025). So far, there is no evidence that these have been able to revive fertility.

Figure 3: China TFR, Under Different Natalist Policies



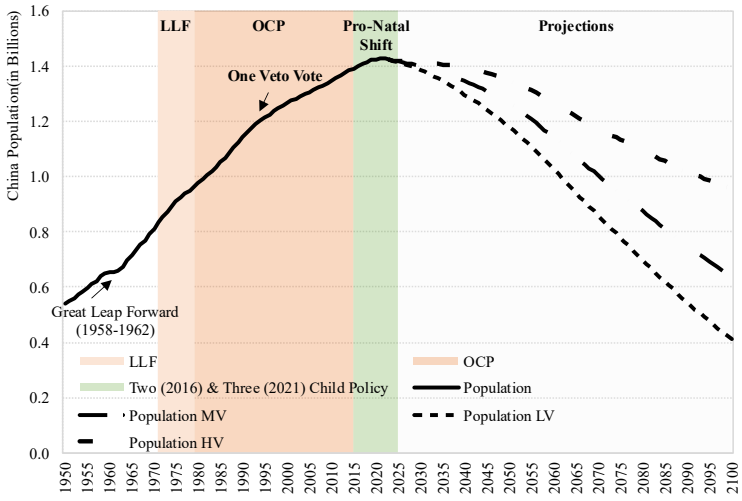
Source: UN WPP, 2024. 2024 and 2025 uses the medium variant which is broadly in line with the trend observed using data from the National Bureau of Statistics (NBS) of China. LLF: "late, long, few" campaign. OCP: One-Child Policy. The Pro-natal shift includes the period for the two and three child policy.

China's experience also shows how the fear of population explosion was misplaced. Despite a decade of easing restrictions, China's TFR has only fallen, ironically, more drastically than under OCP, to below 1.0 (UN WPP, 2024, Figure 3). Annual births rose only slightly in the first two years[11] and by the third year, births were down to the pre-2015 levels (15.2 million, in 2018, NBS China). In 2025, annual births came in as low as 7.9 million (NBS, China), and the population contracted for the fourth straight year (NBS, China).

This rapid decline in fertility has locked China into a highly unfavourable demographic structure. China's youth population (ages 0-14) has shrunk to just 15% of the total population, while the share of the elderly population (65 and older) has risen to over 15% (UN WPP, 2024). China's working age population has been declining since 2012 – which was the major motivation behind reversing the OCP in the first place (Wang, Gu, & Cai, 2016). China will lose between 60-to-100 million people, per decade, moving forward till 2100 (Figure 4).[12] That's the equivalent of losing the population of Germany, every decade.

[11] to around 17.5 million in 2016 and 2017 (NBS, China).
[12] The estimates are based on the medium and high variant projections using the UN WPP, 2024.

Figure 4: China Population Estimates & Long-term UN Projections



Source: UN WPP, 2024. HV, MV and LV are the high, medium and low variant projections, respectively. LLF: "late, long, few" campaign. OCP: One-Child Policy. The Pro-natal shift includes the period for the two and three child policy.

III. How Bureaucratic Inertia, Misplaced Incentives, & Indoctrination Keep Population Control Alive in India

China's experience is a cautionary tale for us to keep in mind when examining the current administrative paradox in India. Unlike China, India's family planning programme is entirely voluntary, rights-based and target-free. In April 1996, the Government of India abolished the centrally-set, method-specific contraceptive targets replacing them with a "Community Needs Assessment Approach" (Government of India, 1996) under which health workers were to assess and meet local demand rather than fill quotas from the top. The National Population Policy (2000) and Family Planning 2030 vision document affirm the government's commitment to voluntary and informed choice while delivering integrated reproductive healthcare. In addition, the 2016 Supreme Court judgement further ordered the phase-out of any coercive, target-driven, camp-based sterilisation model (Devika Biswas v. Union of India, 2016).

The Centre and States have since pivoted to a key deliverable and performance-based budgeting approach where states have flexibility to use funds and exercise discretion based on their own priorities (NIPFP, 2026).

In India, family planning is carried out within the *National Family Planning Programme*, which is a component of the broader National Health Mission (NHM)[13]. It operates under the *RMNCAH+N* (Reproductive, Maternal, Neonatal, Child, and Adolescent Health + Nutrition) framework of the National Health Mission.

There are various measures undertaken by states under the National Family Planning Programme (Table 5 provides a non-exhaustive summary of the measures). The reversible, spacing methods under the National Family Planning Programme include condoms, oral and emergency pills, Intrauterine Contraceptive Device (IUCD), the injectable *Antara*, and the weekly pill *Chhaya*. The terminal, limiting methods are female sterilisation (tubectomy) and

[13] The NHM is a Centrally Sponsored Scheme (CSS). As a CSS, the Centre provides financing towards allocated priorities and key deliverables agreed upon by both the Centre and States within the collaborative National Programme Coordination Committee (NPCC). The Central Government's direct budgetary contribution to the NHM (which includes much more than family planning and does not include the state share) was ₹37,000 crore (revised estimate), in 2025-26. Implementation is carried out by the State and Union Territory.

male sterilisation (non-scalpel vasectomy). A set of ASHA incentives covers home delivery of contraceptives and 'Ensuring Spacing at Birth' (ESB), which also includes incentives for promoting terminal methods as a way to limit births (Table 5). The effort is intensified in the high-fertility states through *Mission Parivar Vikas*, which adds demand-generation activities such as the *Nayi Pahal* newlywed contraception kits and *Saas-Bahu Sammelans*. (Table 5). The health administration and states adhere to strict centrally set guidelines ensuring that services and activities are conducted safely, professionally, and through informed choice and consent.

Table 5: Key Initiatives Under the National Family Planning Programme

Programme / measure	Description (in brief)
National Family Planning (FP) Programme	Voluntary, target-free; delivered via National Health Mission across all States/UTs as the overarching framework.
Mission Parivar Vikas (MPV)	Mission Parivar Vikas (2016) substantially increases access to contraceptives and family planning services in seven high focus states (146 high-focus districts) originally having a TFR or more than 3, namely Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh and Assam, and six other North Eastern States, namely, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura.
Expanded Basket of Choice	Contraceptive basket comprising of condoms, combined oral contraceptive pills, emergency pills, intrauterine contraceptive uterine devise (IUCD) and sterilisation procedures for males and females; injectable contraceptive (Antara programme) and Centchroman (Chhaya).
ANTARA (injectable depot medroxyprogesterone acetate or DMPA)	3-monthly injectable; free in public facilities. Reversible contraception.
Chhaya (Centchroman)	Weekly non-hormonal pill.
New methods (Family Planning 2030 vision rollout)	Implant & SC-DMPA being rolled out.
PPIUCD (Post-partum Intrauterine Contraceptive Device) and PAIUCD: (Post-abortion Intrauterine Contraceptive Device)	IUCD at post-delivery or post-abortion is a spacing or reversible method.
Female Sterilisations	Laparoscopic sterilization and Mini-lap Tubectomy can be carried at any time (Interval Sterilization); shortly after child-birth (Post-Partum Sterilization) or following a safe abortion (Post-Abortion Sterilization).
FDS (Fixed Day Static)	Fixed Day Static services are essentially fixed days where family planning operations are performed at a nearby or mobile health facility. The aim is to provide contraception services in places that otherwise lack medical facilities or technical expertise for delivery of these services.
NSV (Non-Scalpel Vasectomy)	Terminal (sterilisation) contraceptive method for males.
Sterilisation Compensation Scheme	Includes per-case wage-loss compensation for the acceptor, incentive payment to the motivator and service providers. These are enhanced in MPV states.
NFPIS (National Family Planning Indemnity Scheme)	Insurance for death/complication/failure following a procedure.
ASHA - HDC (Home Delivery of Contraceptives)	Accredited Social Health Activists (ASHAs) deliver family planning supplies directly to the doorstep of eligible couples, ensuring privacy and improving access to reproductive healthcare.
ASHA - ESB (Ensuring Spacing at Birth)	ASHAs counselling incentives for birth spacing. These provide incentive payments to ASHAs to encourage couples to wait at least two years after marriage before having their first child. (ESB-I); advising a gap of three years or more between the first and second child (ESB-II); to limit births to two children by motivating couples to adopt a terminal method within the child limit (ESB-III).
FP-LMIS (The Family Planning Logistics Management Information System)	It tracks, monitors, and manages the supply chain of contraceptive commodities and family planning products across health facilities down to the grassroots level (ASHA level).
SBCC (Social and Behaviour Change Communication) & IEC (Information, Education, and Communication) awareness media	Demand-generation campaigns. SBCC is a wholistic approach used to promote and sustain positive health, hygiene, and nutrition practices at the individual, community, and societal levels. IEC stands for Information, Education, and Communication. It is a strategy used to raise awareness and spread critical health messages to the public.
World Population Day & Vasectomy Fortnights	World Population Day and Vasectomy Fortnight are national and global health campaigns observed to promote family planning. World Population Day is marked on July 11, with an extended fortnight through July 24, while Vasectomy Fortnight (focused on male sterilization) are drives to promote vasectomies.

Programme / measure	Description (in brief)
Nayi Pahal Kit ('New Beginning' Kit) in MPV states	Distributed by ASHA workers to newly married couples. It includes contraceptives like condoms and pills, an emergency contraceptive pill, a pregnancy test kit, and basic hygiene items to encourage birth spacing and delay a first pregnancy.
Saas-Bahu & Pati Sammelan in MPV states	Community gatherings designed for mothers-in-law, daughters-in-law, and husbands. These meetings promote open talks on reproductive health, family size, and healthy birth spacing
SAARTHI (Awareness on Wheels) in MPV states	Mobile publicity van to spread awareness.

Source: Author's compilation; National Health Mission. The list is non-exhaustive and aims to provide the reader an idea of the various initiatives under Family Planning in India.

Apart from these initiatives, a further layer of communication campaigns along with World Population Day celebrations and Vasectomy Fortnight outreaches are meant to spread awareness and build public demand for family planning.

III.A. Misplaced Incentives & The Agency Problem

While the Family Planning Programme has abandoned direct targets and quotas, population control is sustained through an intricate system of misplaced incentives, called direct benefit transfer payments, that give every actor in the chain a stake in the activity being performed. A single sterilisation triggers three payments at once (Table 6):

- The acceptor - the person who undergoes the procedure - is paid a "compensation," framed as reimbursement for lost wages, following the procedure.
- The Accredited Social Health Activist (ASHA), any health worker or individual, who mobilised and motivated the acceptor is paid a per-case "motivation" incentive, for counselling and motivating the acceptor to avail the procedure.
- The provider - the surgeon, and behind them the team and facility - is paid a *service* or *honorarium compensation* for carrying it out.

The first issue is that the direct benefit transfers (DBTs) structure overwhelmingly incentivises terminal methods, like female sterilisations, as a means to promote family planning in the country. The logic behind sterilisations having higher 'compensation' rates than reversible methods are that these procedures have higher recovery times than IUCDs or injectable doses. Therefore, the acceptor is 'compensated' for lost wages for the additional days kept in recovery. This logic, however, fails when we look at the structure from a wider demographic lens, especially since it exists in low fertility states as well. Considering the declining fertility in most of the country, and even accounting for the social preference of women to undergo these procedures, it makes no sense for a government to continue to spend resources to incentivise adoption of such procedures, especially when they can simply offer these services without any incentivisation

Moreover, the terminal method payments are enhanced for the high focus[14] Mission Parivar Vikas (MPV) States[15]. The core objective was to reduce TFR from above 3 to replacement, in these states, hence this incentive structure is designed to do exactly that. This is why a female gets anywhere from five-to-ten times the compensation for a post-partum sterilisation in these

[14] High-focus states/UTs (that don't include Mission Parivar Vikas) are Odisha, Uttarakhand, Haryana, Gujarat, Himachal Pradesh, Sikkim, Lakshadweep and J&K.

[15] Mission Parivar Vikas is a targeted, scheme launched in 2016 under the National Health Mission to fast-track access to modern contraceptives in laggard districts of high focus states: Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Assam, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura.

states compared with one in the rest of the country. Even though the TFRs of MPV states have also reduced substantially since then, these incentive structures remain. Many MPV states are below replacement fertility.

Table 6: Family Planning Direct Benefit Transfers: Compensation & Incentive Payments, Under the National Health Mission

Component	High-focus states[1]	MPV states / districts[2]	Other high-focus states[3]	Non-high-focus states[4]
Female sterilisation - interval / minilap (per case) in public medical facilities				
Acceptor (DBT/ compensation)	₹1,400	₹2,000	₹600	(APL) ₹250-600 (BPL)
Motivator/ASHA (incentive)	₹200	₹300	₹150	₹150
Provider / team (aggregate incentive)	₹400	₹500	₹250	₹250
Total per case (acceptor + motivator + team)	₹2,000	₹2,800	₹1,000	₹650-1,000
Female sterilisation - postpartum (PPS) (per case)[5] in public medical facilities				
Acceptor (DBT/compensation)	₹2,200	₹3,000	₹600	No separate PPS. Same as above. ₹250-600
Motivator/ASHA (incentive)	₹300	₹400	₹150	₹150 (BP+SC/ST)
Provider / team (aggregate incentives)	₹500	₹600	₹250	No separate PPS. Same as above. ₹250
Total per case (acceptor + motivator + team)	₹3,000	₹4,000	₹1,000	₹650–1,000
Male sterilisation - NSV / vasectomy (per case) in public medical facilities				
Acceptor (DBT compensation)	₹2,000	₹3,000	₹1,100	₹1,100
Motivator/ASHA (incentive)	₹300	₹400	₹200	₹200
Provider / team (aggregate incentive)	₹400	₹600	₹400	₹400
Total per case	₹2,700	₹4,000	₹1,500	₹1,500
IUCD - PPIUCD / PAIUCD (per insertion)				
Acceptor (DBT compensation)	₹300	₹300	₹300	₹300
Motivator (ASHA incentive)	₹300 (₹150 until recently)	₹300 (₹150 until recently)	₹300 (₹150 until recently)	₹300 (₹150 until recently)
Service Provider (incentive)	₹150	₹150	₹150	₹150
Injectable contraceptive - Antara / MPA (per dose)				
Beneficiary (acceptor DBT)	₹100 per dose	₹100 per dose	₹100 per dose	₹100 per dose
Motivator (ASHA incentive)	1st, 2nd & 3rd dose ₹100 per dose 4th dose: ₹200 (prev. ₹100)	1st, 2nd & 3rd dose ₹100 per dose 4th dose: ₹200 (prev. ₹100)	1st, 2nd & 3rd dose ₹100 per dose 4th dose: ₹200 (prev. ₹100)	1st, 2nd & 3rd dose ₹100 per dose 4th dose: ₹200 (prev. ₹100)
Mission Parivar Vikas - demand generation (paid to ASHA; MPV states only)				
Nayi Pahel FP kit for newlyweds	—	₹200 / kit	—	—
Saas Bahu Sammelan	—	₹200 / event	—	—
Eligible-couple survey (block, max 4 rounds)	—	₹150 / round	—	—

Source: National Health Mission (NHM) Guidelines; Lalchandani et al. (2021); MoHFW Revised Family-Planning Compensation Scheme for Sterilisation & IUCD (public facilities); FY. Each of the rates are corroborated with the 2026-27 State NHM Records of Proceedings documents. These rates are for public facilities only. Private facilities have different rates.Note: Amounts in parentheses are the pre-revision rate. The states have been classified into four categories. 1: High-focus states include Odisha, Uttarakhand, Haryana and Gujarat. 2. MPV (Mission Parivar Vikas) district/states include: Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan and Assam, plus six North-Eastern states (Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Tripura). The MPV enhanced rates are extended to all districts of the state and, therefore, apply to the whole state – and not just to the applicable district. 3. The other high-focus states/UTs include: Sikkim, Lakshadweep, Jammu & Kashmir, and Himachal Pradesh, which use the non-high-focus rates. 4. Non-high-focus states are all remaining states/UTs in the country 5: Female postpartum sterilisation carries a different rate to regular sterilisations in high-focus and MPV states. The table here shows the regular tubectomy rate for the other high focus and non-high focus states. NSV = Non-Scalpel Vasectomy. APL = Above Poverty Line. BPL = Below Poverty Line.

Furthermore, the compensation structures of ASHAs are set up in such a way that their income rises with the number of acceptors they motivate to undergo procedures. Unlike

salaried government employees, they are honorary community health volunteers whose remuneration is structured around task-based incentives. This creates a significant agency problem. Consider the 'Ensuring Spacing at Birth' (ESB) scheme, designed to extend the inter-pregnancy interval. Under the ESB scheme, an ASHA is economically incentivized to counsel newly married couples and tightly monitor their reproductive timelines. The standard payout structure provides ₹500 to the ASHA for ensuring a spacing of two years after marriage before the birth of the first child (ESB-I in the Record of Proceeding documents). A further ₹500 is awarded for ensuring a spacing of three years between the birth of the first and second child (ESB-II in the Record of Proceeding documents). If the ASHA successfully motivates the couple to adopt a permanent limiting method (i.e. sterilisation) after the birth of two children (ESB-III in the Record of Proceeding documents), she receives the premium incentive of ₹1000 (Table 7). If the ASHA is also the motivator for the sterilisation, this incentive payment can be in addition to the payment for motivating the acceptor to avail the terminal method. Because a substantial portion of an ASHA's income depends on these transactional payouts, they face strong incentives to prioritize terminal methods over others – especially with the limiting births premium.

Table 7: ASHA incentives (in ₹ per-case/per-dose) by state groups

Activity	High-focus states[1]	MPV states / districts[2]	Other high-focus states[3]	Non-high-focus states[4]
Spacing & limiting methods				
Ensuring spacing of 2 years after marriage (ESB-I)	₹500	₹500	₹500	₹500
Ensuring spacing of 3 years after birth of 1st child (ESB-II)	₹500	₹500	₹500	₹500
Couple opts for permanent limiting method after 2 children (ESB-II)	₹1,000	₹1,000	₹1,000	₹1,000
Sterilisation - counselling, motivating & follow-up (per case)				
Tubectomy (female sterilisation)	₹200	₹300	₹150	₹150
Vasectomy / NSV (male sterilisation)	₹300	₹400	₹200	₹200
Female postpartum sterilisation[5]	₹300	₹400	₹150 (see footnote 5)	₹150 (see footnote 5)
IUCD - escorting / facilitating beneficiary (per case)				
PPIUCD insertion	₹300 (prev. ₹150)	₹300	₹300 (prev. ₹150)	₹300 (prev. ₹150)
PAIUCD insertion	₹300 (prev. ₹150)	₹300	₹300 (prev. ₹150)	₹300 (prev. ₹150)
Injectable contraceptive (Antara / MPA, per dose)				
1st, 2nd & 3rd dose	₹100	₹100	₹100	₹100
4th dose	₹200 (prev. ₹100)	₹200 (prev. ₹100)	₹200 (prev. ₹100)	₹200 (prev. ₹100)
Mission Parivar Vikas - demand generation (MPV districts only)				
Eligible-couple survey, block level (max 4 rounds)	-	₹150 / round	-	-
Nayi Pahel FP kit for newlyweds	-	₹200 / kit (prev. ₹100)	-	-
Saas Bahu Sammelan (max 4 rounds)	-	₹200 / event (prev. ₹100)	-	-

Source: NHM, "ASHA Incentives" (2025–26); Department-related Parliamentary Standing Committee on Health & Family Welfare – for the revision in ASHA incentives (170th Rajya Sabha report; page 181); The Lok Sabha Unstarred Question No. 1116, titled, "Revision of Incentive of ASHA Workers. Note: ASHA incentives are based on the NHM Guidelines (2025–26), Annexure I document titled, "ASHA incentives" available on the NHM website. We have also included the centrally revised rates as indicated in the Lok Sabha Unstarred Question No. 1116, titled, "Revision of Incentive of ASHA Workers", and the Department-related Parliamentary Standing Committee on Health & Family Welfare (170th Rajya Sabha report; page 181).These have been corroborated using the 2026-27 Record of Proceeding documents. The amounts in parentheses are the pre-revision rate. The states have been classified into four categories. 1: High-focus states include Odisha, Uttarakhand, Haryana and Gujarat. 2. MPV (Mission Parivar Vikas) district/states include: Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan and Assam, plus six North-Eastern states (Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Tripura). The MPV enhanced rates are extended to all districts of the state and, therefore, apply to the whole state – and not just to the applicable district. 3. The other high-focus states/UTs include: Sikkim, Lakshadweep, Jammu & Kashmir, and Himachal Pradesh, which receive the non-high-focus rates. 4. Non-high-focus states are all remaining states/UTs in the country 5: Female postpartum sterilisation carries a different rate to regular sterilisations in high-focus and MPV states. The table here shows the regular tubectomy rate for the other high focus and non-high focus states. NSV = Non-Scalpel Vasectomy.

This incentive structure for ASHAs persists even in states where the fertility rate has already fallen well below replacement. For instance, Gujarat, that has been below replacement fertility for a decade, has budgeted ₹12.4 crores towards ASHA incentives to motivate 1.2 lakh clients to adopt terminal methods, in 2026-27, alone. Even North-eastern states, which we collectively never associate with overpopulation, are adopting these incentives. States like West Bengal and Punjab that have been below replacement fertility for over two decades, or even Uttarakhand, that is facing the problem of '*Ghost Towns'* (Bhalla, 2024), due to low fertility and emigration, are also adopting these incentives (Table 8).

Table 8: Record of Proceeding allocations towards ASHA incentive ESB-III to motivate couples to opt for a limiting method after two children

State	2025-26		2026-27	
	ESB-III ASHA incentive allocation (in ₹ lakhs)	Number of People to Motivate	ESB-III ASHA incentive allocation (in ₹ lakhs)	Number of People to Motivate
Arunachal Pradesh (1.5)	N.d	N.d	0.91	91
Assam (1.9)	346	34,582	277	27,666
Bihar (2.9)	500	50,000	500	50,000
Chhattisgarh (2.2)	400	40,000	275	27,500
Gujarat (1.7)	1,137	1,13,650	1,238	1,23,800
Haryana (1.9)	307	30,740	250	25,000
Jharkhand (2.2)	500	50,000	320	32,000
Madhya Pradesh (2.4)	1,435	1,43,500	1,000	1,00,000
Manipur	2	200	2	200
Meghalaya (2.2)	6	600	7	700
Mizoram (1.6)	2	158	-	-
Odisha (1.6)	245	24,464	144	14,400
Punjab (1.4)	35	3,500	35	3,500
Rajasthan (2.3)	673	67,300	746	74,600
Tripura (1.7)	20	2,000	20	2,000
Uttar Pradesh (2.6)	907	90,696	N.d.	N.d.
Uttarakhand (1.7)	24	2,400	24	2,400
West Bengal (1.3)	10	1,000	10	1,000

Source: SRS, 2024; NFHS-6. Respective state RoPs, 2024-26 and 2026-27. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026. N.d: not disclosed. Calculations for Uttar Pradesh are not available for disaggregated activities in the 2024-26 cycle although a headline amount is allocated towards the incentive. Mizoram's 2026-27 RoPs was not available at the time of publication.

Moreover, in some states, like Kerala, until recently, ASHAs were required to achieve a minimum performance incentive of ₹500 to qualify for their full state honorarium payment of ₹12,000 for their recurring activities. If the total incentive earned in a month fell even slightly short of ₹500, the ASHAs honorarium was reduced by half to ₹6,000 (The News Minute, 2025). Naturally, the primary motivation of an ASHA would be to promote any procedure that provides a higher financial incentive to them.

Until recently, the ASHA incentive payments for reversible methods like IUCD and injectable contraceptives were half the motivation payment for terminal methods. Fortunately, these have recently been revised to be comparable (from ₹150 to ₹300) for the 2026-27 year. Despite that, with the 'Ensuring Spacing at Birth' limiting premium on top for counselling for a sterilisation, the ASHAs cumulative payment can be four times as much as a reversible method.

When the service provider, acceptors, and the ASHA are all incentivised for more sterilisations - the outcome is obvious. In other words, the one lever the central design pushes harder is the terminal one - a design that signals "*sterilise more*," specifically.

Lalchandani et al. (2021) show that financial incentives, for ASHAs, are a strong motivator for providing family planning related services. They also show that there is a tendency among them to promote methods which have greater financial incentives compared with ones with lesser amounts. Even amongst lower-income couples, and service providers such as doctors and nurses, financial incentives are shown to be important, although not the determinant to adopt or provide the service. Moreover, there is also evidence that family planning is heavily influenced by medical advice. A UNFPA study found that 14 per cent of Indian respondents limited their family size due to advice or pressure from health workers and medical specialists, which is nearly triple the global average of 5 per cent (UNFPA, 2025).

Even though population control is less emphatic within family planning policy now, the underlying effect persists through a well-oiled incentive structure that implicitly promotes population control. This needs to change considering the new demographic reality in India.

III.B. Bureaucratic Inertia in the budgeting process & state population policies

The continued focus on population control is also evident is the Record of Proceedings (RoP) of states. State governments prepare a Programme Implementation Plan (PIP) where they propose their family-planning activities, along with other activities, under the NHM. Sub-centres, districts and state population cells estimate the number of people they expect to avail procedures - which is termed as "Expected Level of Achievement" or ELA – based on, unmet needs, demographics and past trends in uptake of procedures. The Ministry of Health and Family Welfare, approves a state's PIP as a *Record of Proceeding* (Annex 3 for an illustrative document). The RoPs set state-level and district-by-district activities, key deliverables, conditionalities, and budgetary calculations for every family planning activity.

In principle, RoPs are meant to provide the districts and states an action plan on the activities they themselves have prioritised, based on a central template. The are reflective of the policy priorities of the state in the upcoming cycle. While the Expected Level of Achievement are not hard targets or criterion for a performance review, states are expected to meet their RoP key deliverables and conditionalities. The performance-based budgeting framework for NHM means that failure to do so can affect the fiscal releases in the succeeding cycle (NIPFP, 2026).

The immediate consequence of this process is that if a state government has historically carried out a primary form of contraception, for instance, in female sterilisations, they inherently expect the next cycle to have a similar uptake**.** The analysis of states RoPs show that they still budget significant number of resources on direct benefit transfers for terminal methods such as female sterilizations. Successive ROPs attempt to promote other forms of contraception too, but the majority of the fiscal allocations remain towards DBTs for sterilizations**. On average, about 80 per cent of all fiscal allocations for DBTs go towards terminal methods in India** (Table 9).

Table 9: Fiscal Allocations Per Activity (2025-26) By Contraception Option

States/UT	Female sterilisations allocation (in ₹ lakhs)	Male sterilisations allocation (in ₹ lakhs)	Terminal Methods (F+M, in ₹ lakhs)	Reversible Methods (IUCD+Antara, in ₹ lakhs)	Share of allocation towards Terminal %
Madhya Pradesh (2.4)	12,706.4	323.1	13,029.5	1,595.0	89.1%
Rajasthan (2.3)	11,192.2	224.0	11,416.2	1,485.3	88.5%
Kerala (1.3)	201.4	15.1	216.6	29.1	88.2%
Bihar (2.9)	14,415.8	198.8	14,614.5	2,197.4	86.9%
Telangana (1.5)	766.1	70.0	836.1	153.0	84.5%
Tamil Nadu (1.3)	1,779.9	35.0	1,814.9	353.5	83.7%
Gujarat (1.7)	5,034.0	68.9	5,102.9	1,061.9	82.8%
Andhra Pradesh (1.4)	1,250.6	131.0	1,381.6	299.3	82.2%
Chhattisgarh (2.2)	2,715.4	258.4	2,973.8	651.3	82.0%
Tripura (1.7)	159.1	3.4	162.4	37.7	81.2%
Karnataka (1.5)	1,128.0	78.9	1,206.9	349.1	77.6%
Mizoram (1.6)	77.8	0.0	77.8	24.1	76.4%
Jharkhand (2.2)	4,375.4	153.4	4,528.8	1,480.3	75.4%
Odisha (1.6)	2,090.4	63.1	2,153.5	756.2	74.0%
Goa (1.6) *	6.1	0.2	6.2	2.2	73.8%
Nagaland (2.0)	131.2	2.0	133.1	51.0	72.3%
Uttar Pradesh (2.6)	13,766.7	247.9	14,014.7	5,388.0	72.2%
Maharashtra (1.4)	1,798.2	223.5	2,021.7	834.3	70.8%
Haryana (1.9)	1,061.0	143.8	1,204.8	511.3	70.2%
Meghalaya (2.2)	178.9	0.6	179.5	87.3	67.3%
Uttarakhand (1.7)	355.5	30.9	386.3	197.9	66.1%
Punjab (1.4)	441.2	33.0	474.2	351.2	57.5%
Assam (1.9)	1,551.5	116.6	1,668.1	1,337.4	55.5%
Arunachal Pradesh (1.5)	60.0	4.6	64.7	54.7	54.2%
West Bengal (1.3)	1,497.4	11.7	1,509.1	1,379.5	52.2%
Jammu & Kashmir (1.4)	113.7	8.0	121.7	113.5	51.7%
Himachal Pradesh (1.5)	78.7	18.4	97.1	97.4	49.9%
Manipur	69.0	5.6	74.6	82.1	47.6%
Delhi (1.2)	142.8	14.8	157.6	302.7	34.2%
Sikkim (1.0) *	2.3	1.9	4.1	15.9	20.6%
National (1.9)	**79,146.3**	**2,486.5**	**81,632.9**	**21,279.3**	**79.3%**

Source: SRS, NFHS-6 (for fertility where SRS data is not used). Respective State RoPs 2024-26 documents & NHM Websites. Value shown for the fiscal year 2025-26. DBT is Direct Benefit Transfers. Note: The table shows family-planning budget allocation by activity sub-head, in ₹ lakhs. Terminal = female + male sterilisation; Reversible = IUCD + injectable (Antara). Not included are other temporary contraception options because of lack of standardisation in budget documents across states. Sorted by terminal share percentage. * Some of the state values like Goa and Sikkim are negligible in absolute terms and therefore their share is not worth consideration. The last available TFR data for Manipur is from NFHS-5 at 2.2, and therefore not indicated here. The male and female sterilisations headline allocation includes DBTs, equipment and other minor expenses. We have used the headline value due to lack of standardisation across the RoPs, however, DBTs are usually the majority share of the headline.

This administrative paradox is glaringly evident in some of the demographically mature southern states (Tamil Nadu, Karnataka, Telangana, and Andhra Pradesh). These states collectively budgeted DBTs to incentivise close to 4.3 lakh female sterilisations annually in the 2024-26 RoP cycle – almost twenty-five years after reaching sub-replacement fertility. Andhra Pradesh and Tamil Nadu - where nearly six in ten married women are already sterilised – budgeted for more female sterilisations per capita than Uttar Pradesh - a state with significantly higher fertility and a fraction of the sterilisation coverage (17 per cent of married women, according to NFHS-6, see Table 10).

The 'high focus' and ‘Mission Parivar Vikas’ states are pursuing similar volumes. Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh and Jharkhand together budgeted

DBTs for more than 15 lakh sterilisations annually (Table 10). Even there, states like Madhya Pradesh, where close to one-in-two married women are already sterilised, continued to budget for DBTs for another 3 lakh female sterilisations in 2026-27. Madhya Pradesh also budgeted additional incentive payments for ASHAs to motivate up to 1 lakh couples to opt for a terminal method (the ESB-III limiting premium discussed earlier), in the latest 2026-27 fiscal cycle (see Annex 3). Other states with comparable fertility rates are also allocating significant amounts towards sterilisations as a primary method. Regardless of the fertility rate and choice, terminal methods continue to be disproportionately favoured in structure for DBTs (see Table 9).

Table 10. Comparison of select State DBTs and number (2025-26 fiscal cycle) of female sterilisations incentivised

State (TFR)	Percentage of Married Women already sterilised (NFHS-6)	Number of annual female sterilisations budgeted for DBTs	Female sterilisations incentivised (DBTs) per million population	Female sterilisations fiscal allocation in 2025-26 (in ₹ crores)	Per-case DBT payment to female (cost as booked)
Uttar Pradesh (2.6)	17.0%	350,003	1,441	137.7	Rs 2,800-4,000
Bihar (2.9)	37.6%	400,000	3,024	144.2	Rs 2,800-4,000
Rajasthan (2.3)	37.2%	300,000	3,587	111.9	Rs 2,800-4,000
Madhya Pradesh (2.4)	47.8%	357,100	3,982	127.1	Rs 2,800-4,000
Chhattisgarh (2.2)	42.4%	75,000	2,403	27.2	Rs 2,800-4,000
Jharkhand (2.2)	32.9%	86,000	2,100	43.8	Rs 2,800-4,000
Tamil Nadu (1.3)	56.6%	155,000	1,999	17.8	Rs 650-1,000
Andhra Pradesh (1.4)	69.5%	125,000	2,327	12.5	Rs 650-1,000
Karnataka (1.5)	56.9%	85,000	1,233	11.3	Rs 650-1,000
Telangana (1.5)	62.5%	70,000	1,812	7.7	Rs 650-1,000

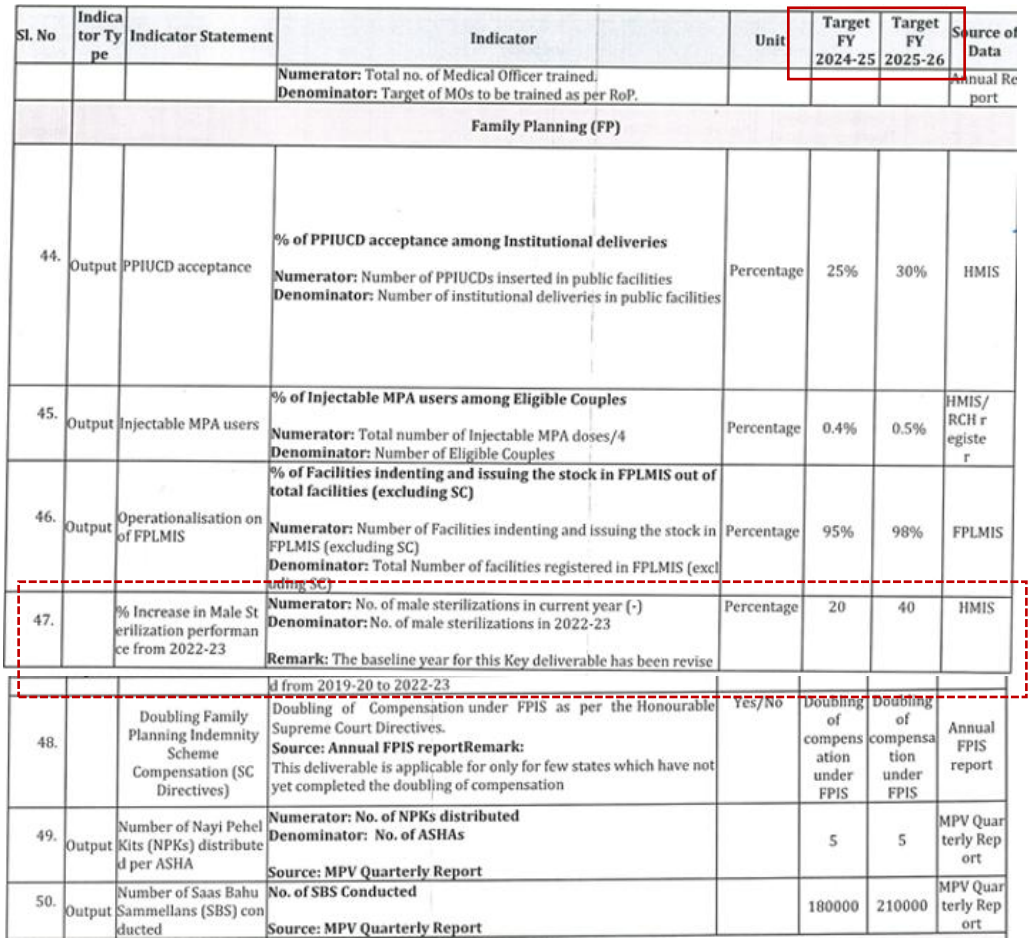
Source: SRS, NFHS-6, State RoPs 2024-26 Cycle documents & NHM Websites. Per-million rates computed using the Registrar General's Technical Group projected population for 2026. DBT is Direct Benefit Transfers. Per case DBT includes the range for tubectomy and post-partum shown in Table 6. The female sterilisations headline allocation includes DBTs, equipment and other activities. We have used the headline activity due to lack of standardisation across the RoPs, however, DBTs are usually the majority share of the headline activity.

Even if it is true that people themselves are increasingly choosing to opt for sterilisations, it makes no sense for the state to keep giving incentives for the same.

The Centre and States pivot by introducing new deliverables to ensure that the policy is adapting to changing needs. Across all states, the 2024-26 RoPs set a recurring target to "increase male sterilisation" by anywhere between 10-200 per cent - which is basically an increase of 0.2 to 1 per cent of the male population. Madhya Pradesh, for example, set a target to increase vasectomies by 20-40 per cent, annually, over this cycle, relative to the 2022-23 reference year (Figure 5a). The health argument behind increasing male sterilisations is that it eases the burden of family planning on women in these states. However, overall, any increase on this metric is essentially increasing the sterilisation rate among married couples.

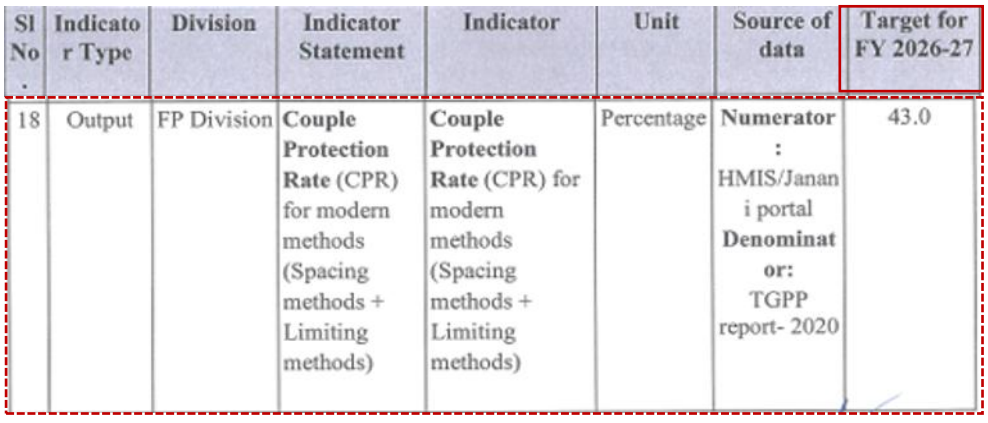
Fortunately, the key deliverables have been revised in the latest 2026-27 cycle. They pivot to a softer and singular "*Couple Protection Rate (CPR) for modern methods"* deliverable target (Figure 5b). This metric calculates what percentage of married couples have used modern contraception methods for both spacing and limiting births. While this is well-meaning, it will not be successful as a lasting change in practice if the state fiscal allocation for DBTs continue to be skewed towards terminal methods. By implication, any state can simply perform well on this metric by continuing to promote limiting methods. For instance, Madhya Pradesh continued to have the highest share of allocations for DBTs towards limiting methods in 2026-27 as well (95 per cent, see Table 12).

Figure 5a: Madhya Pradesh: Key Deliverables in the 2024-26 Record of Proceeding



Sl. No	Indicator Type	Indicator Statement	Indicator	Unit	Target FY 2024-25	Target FY 2025-26	Source of Data
			Numerator: Total no. of Medical Officer trained. **Denominator:** Target of MOs to be trained as per RoP.				Annual Report
	Family Planning (FP)						
44.	Output	PPIUCD acceptance	**% of PPIUCD acceptance among Institutional deliveries** **Numerator:** Number of PPIUCDs inserted in public facilities **Denominator:** Number of institutional deliveries in public facilities	Percentage	25%	30%	HMIS
45.	Output	Injectable MPA users	**% of Injectable MPA users among Eligible Couples** **Numerator:** Total number of Injectable MPA doses/4 **Denominator:** Number of Eligible Couples	Percentage	0.4%	0.5%	HMIS/ RCH register
46.	Output	Operationalisation on of FPLMIS	**% of Facilities indenting and issuing the stock in FPLMIS out of total facilities (excluding SC)** **Numerator:** Number of Facilities indenting and issuing the stock in FPLMIS (excluding SC) **Denominator:** Total Number of facilities registered in FPLMIS (excluding SC)	Percentage	95%	98%	FPLMIS
47.		% Increase in Male Sterilization performance from 2022-23	**Numerator:** No. of male sterilizations in current year (-) **Denominator:** No. of male sterilizations in 2022-23 **Remark:** The baseline year for this Key deliverable has been revised from 2019-20 to 2022-23	Percentage	20	40	HMIS
48.		Doubling Family Planning Indemnity Scheme Compensation (SC Directives)	Doubling of Compensation under FPIS as per the Honourable Supreme Court Directives. **Source: Annual FPIS reportRemark:** This deliverable is applicable for only for few states which have not yet completed the doubling of compensation	Yes/No	Doubling of compensation under FPIS	Doubling of compensation under FPIS	Annual FPIS report
49.	Output	Number of Nayi Pehel Kits (NPKs) distributed per ASHA	**Numerator: No. of NPKs distributed** **Denominator: No. of ASHAs** **Source: MPV Quarterly Report**		5	5	MPV Quarterly Report
50.	Output	Number of Saas Bahu Sammellans (SBS) conducted	**No. of SBS Conducted** **Source: MPV Quarterly Report**		180000	210000	MPV Quarterly Report

Figure 5b: Madhya Pradesh: Key Deliverable in the 2026-27 Record of Proceeding



Sl No.	Indicator Type	Division	Indicator Statement	Indicator	Unit	Source of data	Target for FY 2026-27
18	Output	FP Division	**Couple Protection Rate** (CPR) for modern methods (Spacing methods + Limiting methods)	**Couple Protection Rate** (CPR) for modern methods (Spacing methods + Limiting methods)	Percentage	**Numerator:** HMIS/Janani portal **Denominator:** TGPP report- 2020	43.0

Source: Madhya Pradesh RoP 2024-26 Cycle, pages 26-27. Madhya Pradesh RoP 2026-27 Cycle, page 22.
Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

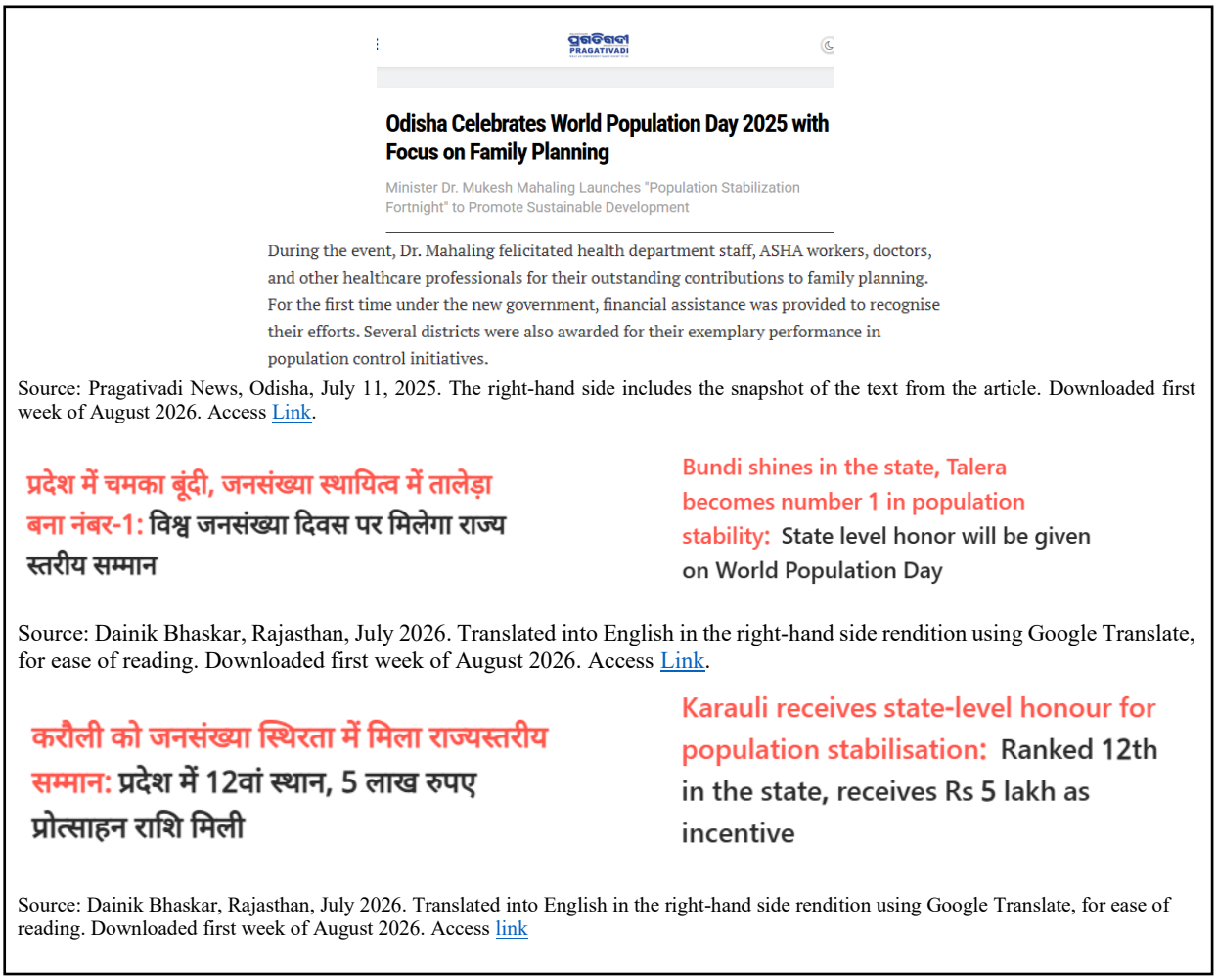
III.C. World Population Day Celebrations, Awards, and Vasectomy Fortnights

Our health apparatus has come a long way from the "*Hum Do humare Do*" (translates to *We two, Our two*), slogan. States now allocate significant fiscal efforts towards what are collectively known as Social and Behaviour Change Communication (SBCC) strategies. These work through schools, universities and rural outreach programs, and employ mobile vans and radio communication outreach, to educate people on the importance of family planning and

availability of different contraception methods. These are also meant to desensitise people to otherwise taboo topics related to family planning (Table 5). While the overall idea behind this kind of outreach is very good, there is a need to relook at the narrative around population 'stabilisation' in these outreach programs.

Moreover, what turns a practice into a ritual is recognition - rituals like "World Population Day" and "Vasectomy Fortnights". Our health infrastructure celebrates World Population Day on 11th July, by promoting how important it is to stabilise our population. From 27 June to 10 July frontline workers fan out to identify and register eligible couples. From 11 to 24 July follows the "*population stabilisation fortnight*," in which the registered clients are brought in for educational awareness, and in some instances, are provided contraception services, including male and female sterilisations (see example excerpts in Figure 6).

Figure 6: Snapshot illustrations of World Population Day Celebrations and Vasectomy Fortnights



ପ୍ରଗତିବାଦୀ
PRAGATIVADI

Odisha Celebrates World Population Day 2025 with Focus on Family Planning

Minister Dr. Mukesh Mahaling Launches "Population Stabilization Fortnight" to Promote Sustainable Development

During the event, Dr. Mahaling felicitated health department staff, ASHA workers, doctors, and other healthcare professionals for their outstanding contributions to family planning. For the first time under the new government, financial assistance was provided to recognise their efforts. Several districts were also awarded for their exemplary performance in population control initiatives.

Source: Pragativadi News, Odisha, July 11, 2025. The right-hand side includes the snapshot of the text from the article. Downloaded first week of August 2026. Access Link.

प्रदेश में चमका बूंदी, जनसंख्या स्थायित्व में तालेड़ा बना नंबर-1: विश्व जनसंख्या दिवस पर मिलेगा राज्य स्तरीय सम्मान

Bundi shines in the state, Talera becomes number 1 in population stability: State level honor will be given on World Population Day

Source: Dainik Bhaskar, Rajasthan, July 2026. Translated into English in the right-hand side rendition using Google Translate, for ease of reading. Downloaded first week of August 2026. Access Link.

करौली को जनसंख्या स्थिरता में मिला राज्यस्तरीय सम्मान: प्रदेश में 12वां स्थान, 5 लाख रुपए प्रोत्साहन राशि मिली

Karauli receives state-level honour for population stabilisation: Ranked 12th in the state, receives Rs 5 lakh as incentive

Source: Dainik Bhaskar, Rajasthan, July 2026. Translated into English in the right-hand side rendition using Google Translate, for ease of reading. Downloaded first week of August 2026. Access link

Municipal Corporation of Delhi
11 July ·

On #WorldPopulationDay 2026, the Health Department of MCD organised awareness programmes, pledge-taking activities and community outreach initiatives across various Maternal & Child Welfare (M&CW) Centres and Health Units.

The initiative focused on promoting awareness about population stabilisation, reproductive health, family welfare and informed healthcare choices.

Health officials, healthcare workers and beneficiaries actively participated, reaffirming their commitment towards building a healthier, empowered and sustainable society.

Lok Niwas Delhi Rekha Gupta CMO Delhi Pravesh Wahi

#MCD #MCDCares #WorldPopulationDay #MCDDelhi

Source: Facebook. The snapshot is a Facebook post from the official handle of the Municipal Corporation of Delhi, dated July 11, 2026. Downloaded first week of August 2026. Access Link.

Awareness events mark World Population Day in Coimbatore

Published - July 13, 2023 07:11 pm IST - IMBATOREVa

THE HINDU BUREAU

COrious awareness programmes were conducted as part of World Population Day in Coimbatore on Thursday. District Collector Kranthi Kumar Pati flagged off an awareness rally from the premises of the office of the Deputy Director of Health Services at Race Course. Around 150 nursing students from three private colleges took part in the rally in which they held placards to sensitise people about population explosion, family planning, etc. A pledge was administered to officials from various departments and students who took part in the event. The pledge stressed the need to focus on women and child welfare, education of girl children, prevention of child marriage and measures to control population. A seminar on World Population Day was held at the Masonic Medical Centre for Children at Race Course after the rally. Mr. Pati distributed prize and certificates to students who were declared winners in the essay and elocution competitions held to create awareness on World Population Day. Deputy Director of Health Services P. Aruna, Coimbatore Medical College Dean A. Nirmala, Deputy Director of Family Welfare M. Gowri and other senior officials were present.

Source: The Hindu (July 13 2023). Tamil Nadu. Includes an excerpt from the article detailing the events for the reader to get a brief idea. Downloaded first week of August 2026. Access Link.

Home / Haryana / Sirsa: Population Stabilisation Fortnight commences

Sirsa: Population Stabilisation Fortnight commences

OUR CORRESPONDENT
Updated At : 12:56 PM Jul 12, 2024 IST

The Haryana Government is organising its second Population Stability Fortnight aimed at promoting population control measures from July 11 to 24. In Sirsa, all government hospitals will host camps and offer vasectomies and tubectomies. Students from the Government ANM Training School organised an awareness rally, led by Sirsa Civil Surgeon Dr Mahendra Bhadu. The rally in JJ Colony told people about World Population Day. Volunteers distributed pamphlets through counsellors. Dr Bhadu talked about family planning options such as copper-T, condoms, pills, injectables, etc. He said these were readily available at government hospitals and health centres. He also said the government provided incentives on them to encourage family planning. ▣ Geographic Reference

World population day: Gujarat paves the way with fertility rate of 1.9

India has targeted the fertility rate of 2.1 by 2030 for the country. However, Gujarat has achieved it by 2020 itself, clocking at 1.9 overall, with 1.7 in urban and for rural Gujarat, it is two. The numbers were revealed in the National Family Health Survey-5 (NFHS).

The fertility rate refers to the number of children born for each woman. In the state, 2022-23 saw 6.64 lakh women opting for birth control devices. 3.08 lakh women opted for female sterilisation surgeries and 1,223 men opted for vasectomy, contributing to stabilising the population growth in the country.

Moreover, to promote population control, the state will celebrate population stability fortnight from July 11 to July 24.

Source (LHS): The Tribune (July 12, 2024). Haryana. Includes an excerpt from the article detailing the events for the reader to get a brief idea. Access Link. Source (RHS): Gujarat Samachar (July 11, 2023). Access Link. Downloaded first week of August 2026.

THE TIMES OF INDIA

Tamil Nadu gets award for best practices in family planning

Pushpa Narayan | TNN

Source: Times of India, Tamil Nadu (August 2, 2022). Downloaded first week of August 2026. Access Link. Note to the reader: these articles are meant to provide the reader an idea on how prevalent population stabilisation or control narratives are in the country. The articles are not the authors' original work.

Furthermore, our health and bureaucratic apparatus give awards for advocacy and to promote "healthy competition" (National Health Mission, Tamil Nadu). In 2025, on World Population Day, Odisha - a state with a total fertility rate of 1.6 - ran a "*Population Stabilisation Fortnight*". The state officials gave awards to healthcare and ASHA workers, and rewarded districts for their strong showing on population-control metrics (Rout, 2025). Similarly in 2025, Rajasthan ranked and awarded districts for their 'performance' in contraception distribution and adoption (Figure 6).

Meanwhile *Vasectomy Fortnight* is a national health campaign where the frontline workers mobilise and spread educational awareness to reduce taboo around vasectomies. The issue is that Regular Fixed Day Static (FDS) schedules - essentially, fixed days where family planning operations are performed on pre-announced regular days at a nearby health facility - are scaled up on these fortnights to carry out vasectomies (Figure 6).

III.D. Two-child norm and State Programme Restrictions

If incentives are the 'carrots', the two child norm disqualifications are the 'stick'. These compel couples to limit their families in order to be eligible for local elections, or employment with the government. They also include loss of access to select state sponsored welfare programme, in some cases. We provide a non-exhaustive list of such norms in Table 11.

Table 11: Prevailing Two-Child Norm Restrictions (including recently repealed norms)

State	Norm Restriction	Details	Status
Odisha (1993)	Two-child norm	Panchayat and Urban Local Bodies disqualification.	In force
Uttarakhand (2002)	Two-child norm	Panchayat disqualification.	In force
Maharashtra (2003)	Two-child norm	Local-body & state-service bar.	In force
Gujarat (2005)	Two-child norm	Local-body disqualification.	In force
Assam (2017)	Two-child norm & 2021 decision adding restrictions	Panchayat bar and state jobs/benefits restriction introduced in 2017 and phased in 2021 in full. Relaxed in 2025 for Scheduled Tribes (ST), Scheduled Castes (SC), tea garden communities, Morans, and Mataks to be allowed up to three children and remain eligible for government employment and local elections.	In force
Andhra Pradesh (1994)	Two-child norm - repealed	Panchayat bar removed Nov 2024. Pro-natalist shift through the new Population Management Programme (2026).	Repealed in Nov 2024
Telangana (1994 under unified Andhra)	Two-child norm - repealed	Panchayat bar abolished.	Repealed in Jan 2026
Madhya Pradesh (2000)	Two-child norm - rolled back	Panchayat norm repealed in 2005; civil-service rule recently rolled back.	Rolled back (June 2026)
Rajasthan (1992)	Two-child norm - repealed	Panchayat bar removed.	Repealed (Mar 2026)
Haryana (1994) / Himachal (2000)/ Chhattisgarh (2000)	Two-child norm - rescinded	Norm rescinded.	Rescinded Haryana (2005) Himachal (2005) Chhattisgarh (2005)

Source: Author compilation based on web research, government websites and regulations. As of first week of July, 2026. This list is a non-exhaustive one.

Fortunately, many of these have been repealed in recent years. Andhra Pradesh repealed its two-child restrictions in November 2024 (Government of Andhra Pradesh, 2024; Sudhir, 2024), followed shortly by Telangana in January 2026 (Government of Telangana, 2026; Akashvani News, 2026). Rajasthan similarly passed amendment bills to repeal its two child norm provisions of the Panchayati Raj Act in March 2026 (Government of Rajasthan, 2026). Madhya Pradesh has withdrawn its two-child norm restrictions for government service in June 2026 (Deccan Chronicle, 2026).

Meanwhile, such restrictions still continue in many states, while many new ones continue to be proposed. As recently as 2021, Uttar Pradesh proposed incentivizing a two-child policy with housing subsidies, tax rebates, enhanced pensions, and free healthcare. Non-compliance carried penalties, including restricted food rations and disqualification from welfare programs, public employment, and local elections. (Uttar Pradesh State Law Commission, 2021). This bill was not passed.

However, Assam passed a bill with a similar restriction (Government of Assam, 2021) where the state announced that people with more than two children will not be able to avail benefits under specific schemes, or be eligible for local elections and government jobs (Government of Assam, 2021).

It's not just the states that tend to do this. In the past seven years, there have been at least five private member bills introduced in the Lok Sabha and Rajya Sabha calling for a national restriction to limit births to two,[16] though none of them were passed in the Parliament.

The economic argument against these norms is simple. Most Indians have ideal family sizes that are already at or less than two (NFHS-5)[17] and TFR is already below replacement in many of these states. Furthermore, as female literacy and household incomes rise, TFR will only drop further. Modern Indian couples are already radically redefining their family aspirations. The mean age of fertility, that is when a woman has her first child, has increased to 28.4 years, from 21.2, in 2011 (SRS, 2024). Moreover, the gap between the actual and wanted fertility is narrowing (NFHS-5). In fact, as a recent UNFPA demographic survey shows, modern urban cohorts are often having fewer children than they desire (UNFPA, 2026).

Overall, there is a need to have a complete relook at the family planning policy of the government. At this stage of our demographic transition, there is no case for deterrent norms and practices to suppress fertility further.

IV. Why is it Important to Have This Discussion?

The most common response to rolling back population control measures is that in the absence of it the population will explode. No country's population has ever exploded at this stage of their demographic transition. We provide China's example to assuage this exact fear.

Furthermore, the historical record of demographically mature countries in North America, Europe, and East Asia confirm a central premise: **it is structurally harder to increase a declining fertility rate than to suppress it. No country has managed to reverse a declining**

[16] The Population Regulation Bill, 2019 (Rajya Sabha); The Population Control Bill, 2019 (Lok Sabha); The Constitution (Amendment) Bill, 2020 (Rajya Sabha); The Population Control Bill, 2021 (Rajya Sabha Proposal); The Population Control Bill, 2021 (Lok Sabha Proposal)

[17] Older evidence from NFHS-5 showed that the perception of an ideal family size has changed over time. Women with no schooling considered 2.5 children to be ideal, compared with 1.8 children for literate women. Perceived ideal family sizes also shrink as household wealth increases, dropping from an average of 2.4 children among women in the poorest quintile to just 2.0 among the wealthiest.

TFR and their long-term aging. Pro-natalist policies, like cash grants for more children, childcare benefits, tax breaks and extended parental leave, etc, have not shown to work anywhere around the world. Nor are we advocating for them. In most cases, ageing economies have only managed a deceleration in the decline in TFR through sustained immigration.

Public discourse and policy papers ubiquitously use the *United Nations' World Population Prospects* (UN WPP) (default) medium variant projections to show that the population will continue to grow till 2062. We show in Annex 2 that this is a fundamentally misleading trajectory. The national TFR has consistently undershot every UN medium-variant projection across successive vintages since 2012. In fact, it has tracked much closer to the pessimistic low variant, which will be the likely baseline moving forward. Under the low variant baseline, the population is projected to peak at 1.55 billion in 2046, sixteen years ahead of the default medium variant projection with 150 million lesser people.

Demographics have a tendency of catching up sooner than we think. Not too long ago the UN predicted our population to touch two billion (UN WPP, 2004). That's unlikely to happen even by their latest projections (UN WPP, 2024). Nor are we arguing that a TFR below 2.1 is a '*magic number*' that has triggered this fertility resistance. However, once a country's fertility falls below a behavioural tipping point (some estimates put this at 1.5, for instance, according to Lutz, Skirbekk, and Testa, 2006), and stays there for an extended period to alter social norms, as it has already in most of the country, we risk falling into a *low-fertility trap*. Many of our own states, like Sikkim and Andhra Pradesh, are now facing this predicament. If it can happen in parts of the country, it will happen nationally too.

Bureaucratic inertia and cultural indoctrination maintaining the status quo can risk long-lasting effects. We saw this in the example of China. This is entirely possible for us too. Andhra Pradesh is a native example for us to keep in mind. The state achieved below replacement fertility more than two decades ago. Notably, its family planning policy relied overwhelmingly on promoting female sterilisations as the primary contraception method. Today, seven-in-ten married women in Andhra Pradesh are sterilised – the highest in the nation (NFHS-6, see Appendix Table 2). The sterilisation rates in Andhra are well above what can be explained by personal or health choice, indicating some sort of a social, government or provider-imposed bias. Even until last year, their 2024-26 RoP shows that the state budgeted to incentivise 1.25 lakh female sterilisation, annually.

Fortunately, the state government is now attempting to reverse this demographic shift. By admission of the state itself:

"

*...**Recalibrating Incentive Structures**: The current incentive system under the National Health Mission (NHM) has inadvertently reinforced sterilization predominance by providing significantly higher incentives for providers and ASHA workers for sterilisation compared to spacing methods. All incentives for sterilisation shall be eliminated and replaced by incentives for adoption of spacing techniques.*

"

[**Andhra Pradesh Population Management, 2026**, Chapter 4, *Pillar I Matrutva: Transforming Reproductive and Fertility Care, Section B Diversifying the Contraceptive Method Mix*, **page 19***]*

Andhra Pradesh's latest 2026-27 RoP shows that no fiscal resources have been budgeted towards DBTs to incentivise both male and female sterilisations (see Table 12). As mentioned earlier, the state has dropped its two-child norm restriction. Moreover, under the newly proposed *Andhra Pradesh Population Management Programme (2026)*, the state has firmly

transitioned to pro-natalist. The new population policy proposes a one-time direct cash incentive of ₹25,000 for a second child, and onwards, and a monthly stipend of ₹1,000 for the third child's first five years. It also proposes full government coverage of educational expenses, and lifetime health insurance to any household with three or more children.

Table 12: Fiscal Allocations Per Activity (2026-27) By Contraception Option

States/UT	Female sterilisation allocation (in ₹ lakhs)	Male sterilisation allocation (in ₹ lakhs)	Terminal Methods (F+M, in ₹ lakhs)	Reversible Methods (IUCD+Antara, in ₹ lakhs)	Share of allocation towards Terminal %
Madhya Pradesh (2.4)	9,518.5	98.0	9,616.5	410.0	95.9%
Nagaland (2.0)	133.6	2.0	135.5	6.8	95.2%
Tripura (1.7)	219.7	1.0	220.7	14.0	94.0%
Gujarat (1.7)	5,184.7	71.7	5,256.4	511.3	91.1%
Bihar (2.9)	12,222.8	195.1	12,417.9	1,295.5	90.6%
Rajasthan (2.3)	9,400.0	142.6	9,542.6	1,007.7	90.4%
Kerala (1.3)	86.6	5.7	92.3	9.9	90.3%
Jammu & Kashmir (1.4)	190.8	4.2	195.0	26.8	87.9%
Uttarakhand (1.7)	371.1	7.9	379.0	52.2	87.9%
Chhattisgarh (2.2)	1,853.0	206.5	2,059.5	340.0	85.8%
Arunachal Pradesh (1.5)	54.7	0.4	55.0	9.4	85.5%
Meghalaya (2.2)	130.5	0.4	130.9	27.9	82.4%
Haryana (1.9)	1,061.0	143.8	1,204.8	271.0	81.6%
Odisha (1.6)	1,683.2	64.8	1,748.0	397.7	81.5%
Jharkhand (2.2)	4,241.8	146.4	4,388.2	1,114.5	79.7%
Uttar Pradesh (2.6)	9,834.9	170.4	10,005.3	2,561.2	79.6%
Manipur	30.7	3.3	33.9	9.6	77.9%
Himachal Pradesh (1.5)	70.2	5.1	75.3	24.4	75.5%
Karnataka (1.5)	467.0	13.0	480.0	160.0	75.0%
Tamil Nadu (1.3)	1,714.9	44.8	1,759.7	601.3	74.5%
Goa (1.6)	5.6	0.2	5.7	2.2	72.5%
Maharashtra (1.4)	891.6	103.4	995.0	466.1	68.1%
Punjab (1.4)	264.3	33.0	297.3	144.5	67.3%
Delhi (1.2)	149.0	11.3	160.3	150.7	51.5%
West Bengal (1.3)	1,065.0	9.0	1,074.0	1,337.0	44.5%
Telangana (1.5)	25.0	15.0	40.0	113.0	26.1%
Sikkim (1.0)	0.2	0.2	0.5	7.2	6.0%
Andhra Pradesh (1.4)	0.0	0.0	0.0	100.0	0.0%
National (1.9)	**61,978.6**	**1,525.6**	**63,504.2**	**11,841.0**	**84.3%**

Source: SRS, NFHS-6 (where SRS data is not used). Respective State RoPs 2026-27 cycle documents & NHM Websites. Value shown for the fiscal year 2025-26. DBT is Direct Benefit Transfers.Note: Family-planning budget allocation by method sub-head, in ₹ lakhs. Terminal = female + male sterilisation; Reversible = IUCD + injectable (Antara). Not included are other temporary contraception options because of lack of standardisation in budget documents across states. Sorted by terminal share percentage. Some of the state values like Andhra Pradesh, Telangana, Kerala, Goa and Sikkim are negligible in absolute terms and therefore their share is not worth consideration. The last available TFR data for Manipur is from NFHS-5 at 2.2, and therefore not indicated here. The male and female sterilisations headline allocation includes DBTs, equipment and other minor expenses. We have used the headline value due to lack of standardisation across the RoPs, however, DBTs are usually the majority share of the headline.

Andhra's example also shows how much harder it is to get people to have more children, than to suppress fertility. Until 2024-26, the state was annually allocating only ₹12 crores for the DBTs related to 1.25 lakh female sterilisations. The latest proposed incentives to promote a similar number of second and third child births is estimated to cost them close to ₹1,000 crores annually (Andhra Population Management, 2026, page 40).

The small family norm is now a social default in the state. Even with the proposed pro-natal shift, by admission of the latest Population Management policy, it will take at least five to ten years for the share of sterilisation among married women to fall to 50 per cent (AP Population Management, 2026, page 20). The share of the population in the state aged 0-14 is projected to decline to less than 16 per cent by 2036, while the share of the population aged 60 years and above is projected to increase to 19 per cent by 2036 (Report of the TGPP, 2020). This is the exact unwarranted demographic structure China is in now.

Even today, policy contradictions exist in various other states. For instance, in August 2026, Tamil Nadu announced expanded maternity leave up to a year for women government employees having a third child, replacing the earlier 12-week provision, to promote greater births. Concurrently, the state has budgeted DBTs to incentivise 1.6 lakh female sterilisations in 2026-27 (see Annex 3 and Table 12).

The best policy moving forward is to allow TFR to follow its natural course. The national TFR is going to decline, regardless of state intervention. Therefore, there is no need for us to suppress this any further and risk falling into a low-fertility trap sooner.

V. Conclusion and Recommendations

This paper attempted to highlight some of the explicit contradictions within the family planning programme and the new demographic reality. Many legacy population control elements and restrictions remain, explicitly or subtly, within our policy and bureaucratic apparatus. The default of the system still remains tuned towards encouraging lower fertility and the mistaken perception that India faces a population explosion problem. Our collective fears of a population explosion, even in high-fertility states, are misplaced. We need to change our population control mindset and align our policy objectives with the new demographic reality.

Fortunately, things are changing. Many states have reversed course on their two-child norm restrictions. Further, the latest available RoP for the 2026-27 cycle[18] show that many states have reduced the fiscal allocation towards DBTs for terminal methods (see Table 12), and for the ESB-III limiting incentive (see Table 8) in absolute terms. The services are still provided but the overall allocation for incentives have reduced. While this is a positive change, it isn't enough. Despite the reduction in absolute levels, the share of the DBTs still lean disproportionately towards terminal methods (see Table 12).

Within the national school curriculum, the current framing now treats population as human capital and an economic asset rather than a burden. The Class 8 economics chapter "*People as Resource*" is built explicitly to "explain the population as an asset for the economy rather than a liability," (NCERT, 2023). More importantly, it talks about the issues related to falling fertility and aging population for the first time.

[18]Not all Record of Proceeding Documents were available for 2026-27 at the time of writing.

We must not repeat China's policy errors. The first step is to collectively internalise the new demographic reality. Second, we need to look beyond the sheer size of our population. Absolute numbers should not drive public discourse - underlying fertility trends should.

Given this background, we recommend the following:

- **End sterilisation-linked incentive payments:** Roll-back all direct benefit transfer payments, including acceptor payments, wage-loss compensations, and enhanced incentives to acceptors and service providers, related to sterilisations. These services can be provided without incentivising people or motivating others to adopt them. There is no economic rationale on why these need to continue in the states that are now below replacement fertility.

- **Repeal specific motivational payments**: Eliminate all motivational payments tied to terminal methods and the ASHA incentive related to limiting couples to two children.

- **Roll back population control rituals and rules:** Discontinue all family-planning related awards, World Population Day celebrations and Vasectomy Fortnight observances that call for population control. In addition, repeal two-child norm disqualifications uniformly across all states.

- **Redefine administrative mandates:** Adjust the scope of Mission Parivar Vikas to the new demographic reality in the states which are at or below replacement fertility. Remove all fertility-reduction, population control or 'stabilisation' language from our national and state policy frameworks and outputs.

We would like to point out that we are not against family planning for reasons of health, child spacing or personal preference. We are not calling for the rollback of the provision of contraception in the country. The central argument of our paper is that population control is no longer relevant as an objective of state policy. Our family planning policies need to reflect the new demographic reality.

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Appendix Figures & Tables Accompanying The Main Paper

Appendix Table 1: Total Fertility Rate & Corresponding Replacement Fertility, National Family Health Survey

State / UT	NFHS-2, 1998-99	NFHS-3, 2005–06	NFHS-4, 2015–16	NFHS-5, 2019-21	NFHS-6, 2023-24	Below since
Andhra Pradesh	2.3	1.8	1.8	1.7	1.8	NFHS-2 (1999)
Arunachal Pradesh	2.5	3.0	2.1	1.8	1.5	NFHS-4 (2016)
Assam	2.3	2.4	2.2	1.9	1.6	NFHS-4 (2016)
Bihar	3.7	4.0	3.4	3.0	2.7	Above Replacement
Chhattisgarh	2.8	2.6	2.2	1.8	1.9	NFHS-4 (2016)
Goa	1.8	1.8	1.7	1.3	1.6	NFHS-2 (1999)
Gujarat	2.7	2.4	2.0	1.9	1.9	NFHS-4 (2016)
Haryana	2.9	2.7	2.1	1.9	2.0	NFHS-4 (2016)
Himachal Pradesh	2.1	1.9	1.9	1.7	1.8	NFHS-2 (1999)
Jharkhand	2.8	3.3	2.6	2.3	2.2	At Replacement
Karnataka	2.1	2.1	1.8	1.7	1.8	NFHS-2 (1999)
Kerala	2.0	1.9	1.6	1.8	1.8	NFHS-2 (1999)
Madhya Pradesh	3.4	3.1	2.3	2.0	2.1	NFHS-5 (2020)
Maharashtra	2.5	2.1	1.9	1.7	1.8	NFHS-3 (2006)
Manipur	3.0	2.8	2.6	2.2	-	N/A possibly at replacement
Meghalaya	4.6	3.8	3.0	2.9	2.2	Above (marginal)
Mizoram	2.9	2.9	2.3	1.9	1.6	NFHS-5 (2020)
Nagaland	3.8	3.7	2.7	1.7	2.0	NFHS-5 (2020)
Odisha	2.5	2.4	2.1	1.8	1.7	NFHS-4 (2016)
Punjab	2.2	2.0	1.6	1.6	1.6	NFHS-2 (1999)
Rajasthan	3.8	3.2	2.4	2.0	2.1	NFHS-5 (2020)
Sikkim	2.8	2.0	1.2	1.1	1.0	NFHS-3 (2006)
Tamil Nadu	2.2	1.8	1.7	1.8	1.7	NFHS-2 (1999)
Telangana	-	-	1.8	1.8	1.9	NFHS-4 (2016)
Tripura	1.9	2.2	1.7	1.7	1.7	NFHS-2 (1999)
Uttar Pradesh	4.1	3.8	2.7	2.4	2.2	At Replacement
Uttarakhand	2.6	2.6	2.1	1.9	1.9	NFHS-4 (2016)
West Bengal	2.3	2.3	1.8	1.6	1.6	NFHS-2 (1999)
Andaman & Nicobar	-	-	1.4	1.3	0.9	NFHS-4 (2016)
Chandigarh	-	-	1.6	1.4	1.8	NFHS-4 (2016)
Dadra & Nagar Haveli and Daman & Diu	-	-	2.1	1.8	1.7	NFHS-4 (2016)
Delhi	2.4	2.1	1.8	1.6	1.6	NFHS-2 (1999)
Jammu & Kashmir	2.7	2.4	2.0	1.4	1.8	NFHS-4 (2016)
Ladakh	-	-	-	1.3	1.6	NFHS-5 (2020)
Lakshadweep	-	-	1.8	1.4	2.2	Above Replacement
Puducherry	-	-	1.7	1.5	1.6	NFHS-4 (2016)

Source: National Family Health Survey (NFHS). The below since column compares relative to the true replacement fertility.

Appendix Table 2: Contraceptive Method-Mix by State/UT (NFHS-6, 2023-24) per cent of married couples aged 15-49

State / UT	Any method (%)	O/w Any modern Method (%)	O/W Female sterilisation (%)	Male sterilisation (%)	Traditional (%)
Andhra Pradesh	74.7	73.1	69.5	0.8	1.6
Arunachal Pradesh	65.3	47.9	21.1	0.1	17.4
Assam	71	53.4	7.7	0.3	17.6
Bihar	59.3	44.7	37.6	0.2	14.6
Chhattisgarh	64.1	53.9	42.4	1.4	10.2
Goa	72.8	39	23.4	0.1	33.8
Gujarat	74	51.6	33.9	0.2	22.4
Haryana	74.5	53.1	28.5	0.9	21.4
Himachal Pradesh	76.1	58.3	32.2	2.3	17.8
Jharkhand	63.7	44.7	32.9	0.4	19
Karnataka	64.8	63.2	56.9	0	1.6
Kerala	66.9	54.6	42.3	0.2	12.3
Madhya Pradesh	76.4	62.1	47.8	0.9	14.3
Maharashtra	73.7	66.7	49	1.1	7
Meghalaya	42.1	30.2	7.1	0.1	11.9
Mizoram	64.2	61	29.1	0	3.2
Nagaland	73.6	47.8	11	0.1	25.8
Odisha	66.2	40.8	26.1	0.3	25.4
Punjab	69.5	48.1	21.7	0.6	21.4
Rajasthan	74.4	57.1	37.2	0.4	17.3
Sikkim	76	42.2	11.7	1.8	33.8
Tamil Nadu	68.5	65.1	56.6	0.1	3.4
Telangana	68.8	67.6	62.5	3.6	1.2
Tripura	71	40	11.6	0.1	31
Uttar Pradesh	62.4	33.2	17.0	0.1	29.1
Uttarakhand	71.1	50.4	23.6	0.8	20.7
West Bengal	79.8	54.9	27.5	0.2	24.9
Andaman and Nicobar Islands	78.3	66.3	41.5	0	12
Chandigarh	70.9	48.1	16.7	0.3	22.8
Dadra & Nagar Haveli and Daman & Diu	67.2	50.1	36.2	0.2	17.1
Jammu and Kashmir	61.2	39.4	17.9	0.3	21.8
Ladakh	66.4	57.1	13.5	0.1	9.3
Lakshadweep	53.7	23.8	12.5	0.1	29.9
NCT of Delhi	67.4	51.2	14.7	0.4	16.2
Puducherry	67.9	62.9	53	0.9	5

Source: NFHS-6. *Any method* is the sum of *modern* and *traditional* methods. Male and female sterilisations are a sub-component of modern methods, which includes other reversible contraception methods.

Annex 1: How the True Replacement Level is Computed

The standard method in the demographic literature (Preston, Heuveline, & Guillot, 2001; Espenshade, Guzman, & Westoff, 2003) computes the *Net Reproduction Rate* (NRR) directly from the age-specific fertility schedule and a female life table, rather than approximating survival at a single mean age (point approximation method). The Net Reproduction Rate is the sum of the births in each five-year group from 15-19 to 45-49, weighted by the fraction that are female and by the probability that a daughter survives from birth to that age:

$$NRR = f \times \Sigma_a \, (ASFR_a / 1000 \times 5) \times p_a \quad (1)$$

where f is the fraction of live births that are female, $ASFR_a$ is the *age-specific fertility rate* of age group a, and p_a is the probability that a newborn girl survives to the midpoint of age group a. The replacement-level TFR is then the observed TFR divided by the NRR. Equivalently,

$$1 / (f \times \bar{S}) \quad (2)$$

where $\bar{S} = \Sigma_a \, \varphi_a \cdot p_a$ is the female survivorship weighted by the shape of the fertility schedule (φ_a being each group's share of total fertility). This uses the whole age schedule and the whole survivorship curve.

There is a second, equivalent form that is useful when a data source already publishes the Net Reproduction Rate. Since NRR = TFR × f × S, dividing the observed TFR by the observed NRR cancels the f × S term and returns the same result:

$$Replacement\ TFR = observed\ TFR / NRR. \quad (3)$$

The fraction female f comes from the sex ratio at birth. The fertility schedule $ASFR_a$ is published by the SRS by five-year age group. The survivorship p_a is built from two official SRS quantities - the probability of survival to age five (the complement of under-five mortality) and the adult survival rate (the probability of surviving from age 15 to age 60) - with survival across the reproductive ages interpolated using a standard age pattern of adult mortality calibrated exactly to the SRS adult survival rate. The replacement level is insensitive to the interpolation (by less than 0.01 of a child), because female mortality across the childbearing ages is low and smooth.

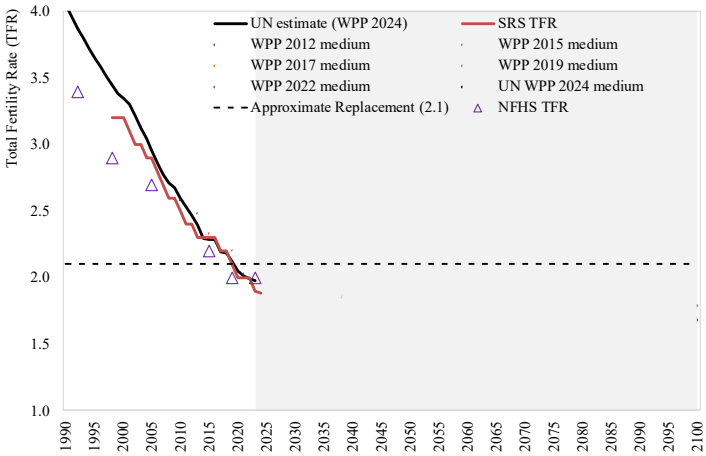
We use SRS to calculate replacement fertility and corroborate the value using the UN World Population Prospects (2024). Since these are reference benchmarks, we do not believe that one or two decimal places distinctions require excessive consideration for public discourse and policy consideration. However, the length of time when a nation and state have been below replacement without policy reconsideration is more important.

Annex 2: The Default UN Projections Provide a Misleading Trajectory

India Will Track Closer to the UN Low-variant.

Public discourse almost always uses the *United Nations' World Population Prospects* (UN WPP) (default) medium variant projections to forecast the trajectory for India. These default UN projections provide a misleading trajectory. India has consistently undershot every UN medium-variant TFR projection since 2012 (see Figure A.2.1). In fact, India tracks much closer to the UN's pessimistic *low-variant* projections (see Figure A.2.2).[19] For example, the 2012 UN medium variant had India's TFR easing only gradually, reaching 2.1 around 2033 (between 2030-35). India reached 2.1 in 2019, at least, fourteen years ahead of the projection. Meanwhile, the 2012 low variant projected TFR at 1.8 around 2024, only 0.1 less than the 1.9 observed under the SRS.

Figure A.2.1: Total Fertility Rate Estimates & Projections Under the Medium Variant



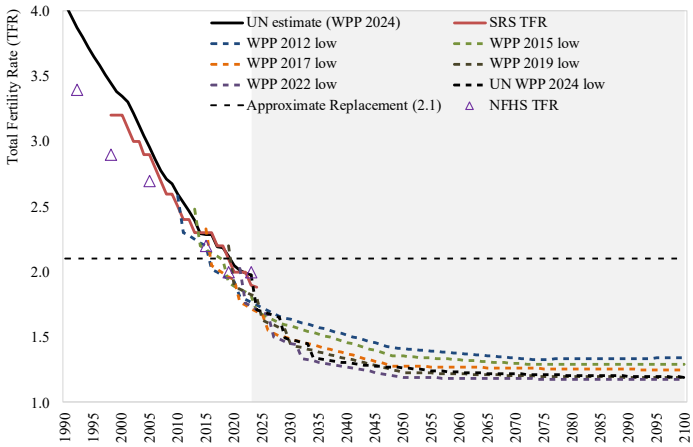
Source: Sample Registration System (SRS, 1998-2024); National Family Health Surveys (NFHS, 1-6); Census of India, UN WPP, 2024. Estimates till 2023. Projections from 2024. NFHS-6 estimates are preliminary. The chart compares the UN TFR estimations and successive UN World Population Prospects (WPP) medium variant projections with national TFR estimates under SRS, NFHS and the Census. The chart shows that national TFR has always undershot UN medium variant projections.

The national TFR will continue to undershoot the UN medium variant and track closer to the low variant. This can be corroborated by examining the model assumptions. The medium variant optimistically assumes a slow TFR decline to 1.8 by 2040 and 1.7 by 2100. However, most of India has already fallen below this threshold much sooner than projected. Moreover, the remaining 'high' fertility states are already exhibiting a similar, albeit delayed, decline. Conversely, the low variant projects a drop to 1.3 by 2040 and 1.2 by 2100. Given that much of the country has already achieved these sub-replacement levels, the low variant serves as a far more plausible baseline for our demographic future.

Under the low variant baseline, the population is projected to peak at 1.55 billion in 2046, after which it will begin to contract. This is sixteen years ahead of the default medium variant projection with 150 million lesser people.

[19] The low variant projections induce a drop of 0.3 relative to the medium variant immediately, an additional 0.1 drop in 5 years, followed by another 0.1 drop in 5 years, after which it follows the trajectory of the medium variant.

Figure A.2.2: Total Fertility Rate Estimates & Projections Under the Low Variant



Source: Sample Registration System (SRS, 1998-2024); National Family Health Surveys (NFHS, 1-6); Census of India, UN WPP, 2024. Estimates till 2023. Projections from 2024. NFHS-6 estimates are taken from the fact sheets which are preliminary. NFHS-6 estimates are preliminary. The chart compares the UN TFR estimations and successive UN World Population Prospects (WPP) low variant projections with national TFR estimates under SRS, NFHS and the Census. The chart shows that national TFR has tracked closer to the UN low variant projections.

Annex 3: What A Record of Proceeding (RoP) Document Looks Like

This Annex provides illustrative examples of a Non-High Focus State (Tamil Nadu) and High-focus State (Madhya Pradesh) 2024-26 and 2026-27 RoP Document for Activities Related to Family Planning. These are reproduced here through snapshots for the reader to get an idea of what a Record of Proceeding document looks like and the respective family planning related activities and allocations.

I. Tamil Nadu

Tamil Nadu National Health Mission, Record of Proceeding, 2024-26, Document Outlining Family Planning Related Key Deliverables, Approved Fiscal Allocations & Family Planning Associated Annexure Documents.

Tamil Nadu National Health Mission, Record of Proceeding, Key Deliverables 2024-26 (1/3):

Sl No.	Indicator Type	Indicator Statement	Indicator	Unit	Target 2024-25	Target 2025-26	Source of data
Family Planning (FP)							
44	Output	PPIUCD acceptance	**Percentage of PPIUCD acceptance among Institutional deliveries** **Numerator:** Number of PPIUCDsinserted in public facilities **Denominator:** Number of institutional deliveries in public facilities	Percentage	67%	67%	HMIS
45		Injectable MPAusers	**Percentage of Injectable MPA users among Eligible Couples** **Numerator:** Total number of Injectable MPA doses/4 **Denominator:** Number of Eligible Couples	Percentage	0.20%	0.20%	HMIS/ RCH register
46		Operationalizationof FPLMIS	**Percentage of Facilities indenting andissuing the stock in FPLMIS out oftotal facilities (including Sub Centres)** **Numerator:** Number of Facilitiesindenting and issuing the stock inFPLMIS (including Sub Centres)	Percentage	90%	95%	FPLMIS

Tamil Nadu National Health Mission, Record of Proceeding, Key Deliverables 2024-26 (2/3):

Sl No.	Indicator Type	Indicator Statement	Indicator	Unit	Target 2024-25	Target 2025-26	Source of data
			Denominator: Total Number of Facilities registered in FPLMIS (including Sub Centres) Remark: This key deliverable *has been revised to include Sub Centres*				
47	Output	% Increase in Male Sterilization performance from 2022-23	**Numerator:** No. of male sterilizations in current year (-) **Denominator:** No. of male sterilizations in 2022-23 **Remark:** The baseline year forthis Key deliverable has been revised from 2019-20 to 2022-23 **Existing additional Key ROP deliverables for selected States/UT's**	Percentage	10%	20%	HMIS
48		Doubling FamilyPlanning Indemnity Scheme Compensation (SCDirectives)	**Doubling of Compensation under FPIS as per theHonorable Supreme Court Directives.** **Source: Annual FPIS report** **Remark:** This deliverable is applicable for only for few states which have not yet completed the doubling of compensation	Yes/No	NA	NA	Annual FPIS report
49	Output	Number of Nayi Pahel Kits (NPK)	**Numerator:** No. of NPKs distributed	Number	NA	NA	MPV Quarterly Report

Tamil Nadu National Health Mission, Record of Proceeding, Key Deliverables 2024-26 (3/3)

Sl No.	Indicator Type	Indicator Statement	Indicator	Unit	Target 2024-25	Target 2025-26	Source of data
		distributed per ASHA	**Denominator:** No. of ASHAs **Source: MPV Quarterly Report Remark:** This deliverable is applicable only to 13 MPV States and few other states.				
50		Number of Sass Bahu Sammela Conducted	**No. of SBS Conducted** **Source: MPV Quarterly ReportRemark** This deliverable is applicable only to 13 MPV States and few other states.	Number	NA	NA	MPV Quarterly Report

Source: Tamil Nadu RoP 2024-26 Cycle, page 25-27. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2024-26, Amounts Approved By Activities Related to Family Planning (1/3):

FMR Code	Program/ Theme	Sl. No.	Scheme/ Activity	Amount Proposed (Rs In Lakhs) FY 2024-25	Amount Proposed (Rs In Lakhs) FY 2025-26	Amount Approved (Rs In Lakhs) FY 2024-25	Amount Approved (Rs In Lakhs) FY 2025-26	Remarks of NPCC/ Ministry
RCH. 6	Family Planning	42	Sterilization - Female	1779.87	1779.87	1,779.87	1,779.87	**Approved Rs. 1779.87 lakh for FY 2024-25. Approved Rs. 1779.87 lakh for FY 2025-26. Details as under for 2024-25 & 2025-26: 1) Rs.1600 Lakh under DBT:** i) Rs. 1450 lakh for 1,45,000 sterilization cases@ Rs. 1000/Case in Public Facilities. ii) Rs. 150 lakh for 10,000 cases @ Rs. 1500/case in Private Facilities **2) Rs. 65 Lakh under Capacity Building incl Training:** i) Rs 34.10 lakh for Laparoscopic sterilization training for doctors (2 MO, SN, and OT assistant), 12 days, 70 Batches - 4 Participants/Batch @48720 lakh per Batch. ii) Rs 30.90 lakh for Minilap Training of doctors, 12 days, 80 Batches - 4 Participants/Batch@ 38620/batch. **3) Approved Rs. 114.85 lakh under OOC:** 4 FDS per block for total 388 blocks in an year. totaling 1552 Fixed-Day Services (FDS) @ Rs.7400/- per FDS.
		43	Sterilization - Male	35.00	35.00	35.00	35.00	**Approved Rs. 35 lakh for FY 2024-25. Approved Rs. 35 lakh for FY 2025-26. Details as under:** 1.Rs. 15 lakh under DBT for 1000 sterilizations @Rs.1500/ sterilization. 2.Rs 20 lakh under OOC for 400 FDS @ Rs 5000/FDS.
		44	IUCD Insertion (PPIUCD and PAIUCD)	340.97	340.97	340.97	340.97	**Approved Rs. 340..97 lakh for FY 2024-25. Approved Rs. 340.97 lakh for FY 2025-26. Details as under for 2024-25 & 2025-26: 1.Rs. 250.26 lakhs under DBT:** (i) Rs. 249 lakh as incentive for PPIUCD insertion @ Rs.300/- for 83,000 beneficiaries. (ii) Rs. 1.26 lakh as Incentive for PAIUCD insertion @ Rs.300/- for

Tamil Nadu National Health Mission, Record of Proceeding, 2024-26, Amounts Approved By Activities Related to Family Planning (2/3):

FMR Code	Program/ Theme	Sl. No.	Scheme/ Activity	Amount Proposed (Rs In Lakhs)		Amount Approved (Rs In Lakhs)		Remarks of NPCC/ Ministry
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								420 beneficiaries. **2. Rs. 23.06 lakh under equipment:** i) Rs18.50 lakh for 500 IUCD kit@ Rs.3700/- kit. ii) Rs 4.56 lakh for 570 PPIUCD forceps @ Rs 800/forceps. **3) Rs. 55.65 lakh under ASHA Incentive:** i)Rs 55.65 lakh for 37100 cases for accompanying PPIUCD/PAIUCD beneficiaries @ Rs.150/ insertion; **4) Approved Rs. 12 lakh under Capacity building:** i) Rs 6.2 lakh, Integrated IUCD Training of MOs, 20 batches, 10 participants /batch, for 5 days @ Rs.31000/batch. ii) Rs 5.8 lakh, for Integrated training of SNs, ANMs, 5 days training, 20 batches, 10 participants/batch, @ Rs.29000/batch.
		45	**ANTARA**	**12.56**	**12.56**	**12.56**	**12.56**	**Approved Rs. 12.56 lakh for FY 2024-25.** **Approved Rs. 12.56 lakh for FY 2025-26.** **Details as under for 2024-25 & 2025-26:** 1) Rs 12.56 lakh under Capacity building incl of Training: i) Rs 6.38 lakh for 1-day training of MOs @ Rs 25,500/batch, 25 batches, maximum 30 participants /batch. ii) Rs 6.19 lakh for training of SNs, 25 batches, 1-day training, maximum 30 participants/batch@ Rs.24750/batch.
		46	**MPV(Mission Parivar Vikas)**	**0.00**	**0.00**	**0.00**	**0.00**	NA
		47	**Family Planning Indemnity Scheme**	**119.62**	**119.62**	**119.62**	**119.62**	**Approved Rs. 119.62 lakh for FY 2024-25.** **Approved Rs. 119.62 lakh for FY 2025-26.** **Details as under for 2024-25 & 2025-26:** Rs. 119.62 lakh under DBT for Family Planning Indemnity Scheme.
		48	**FPLMIS**	**3.00**	**3.00**	**3.00**	**3.00**	**Approved Rs. 3 lakh for FY** 2024-25. **Approved Rs. 3 lakh for FY 2025-26.** **Details as under for 2024-25 & 2025-26:** Rs 3 lakh under Capacity building incl of Training for doctors and Staff nurse / Frontline workers, 20 batches @ Rs 15,000/batch.
		49	**World Population Day and Vasectomy Fortnight**	**31.00**	**31.00**	**31.00**	**31.00**	**Approved Rs. 31 lakh for FY 2024-25.** **Approved Rs. 31 lakh for FY 2025-26.** **Details as Under** 1. Rs. 31 lakh under IEC & promotional activities: (i) Rs. 15.50 lakh for IEC & Promotional activities for World Population Day celebration @Rs.35526/ for 38 districts & 1 state-level inauguration @ Rs 2 lakh. (ii) Rs. 15.50 lakh for IEC & Promotional activities for Vasectomy fortnight celebration @Rs.40789/ for 38 district.

Tamil Nadu National Health Mission, Record of Proceeding, 2024-26, Amounts Approved By Activities Related to Family Planning (3/3):

FMR Code	Program/ Theme	Sl. No.	Scheme/ Activity	Amount Proposed (Rs In Lakhs)		Amount Approved (Rs In Lakhs)		Remarks of NPCC/ Ministry
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
		50	**Other Family Planning Components**	194.10	194.10	194.10	194.10	**Approved Rs. 194.1 lakh for FY 2024-25.** **Approved Rs. 194.1 lakh for FY 2025-26.** **Details as under for 2024-25 & 2025-26:** **Activity 1:** Rs 5.01 lakh under Planning & ME: a) Rs 1.59 lakh for SQAC meeting for one Death Panel committee @ Rs.27,000/meeting; b) 6 FP subcommittee meeting @ Rs.12000/meeting; c) 1 Claim clearance meeting @ Rs.24,000/ meeting; d) 1 Court cases @ Rs.36,000/meeting. e) Rs 3.42 lakh for DQAC meeting for 38 districts @ Rs 9000/meeting. **Activity 2:** Rs 6.93 lakh under Capacity building incl of Training: i) Rs 4.62 lakh for Training of MOs, 3 days training, 12 batches, 20 participants /batch @ Rs 38,500/batch. ii) Rs 2.31 lakh for training of Staff Nurses/LHV/ANM, 1 day training, 10 batches, 30 participants /batch, @ Rs Rs.23,100/batch. **Activity 3:** Rs 182.16 lakh under IEC & printing i)Rs 14.80 lakh for 185 LED display board for Implant for 4 districts @ Rs 8000/board. ii)Rs 36.48 lakh for 3040 Wall paintings @ Rs 1200 per unit. iii)Rs 38.50 lakh for 770 Street drama (2 street drama/block) iv) Rs 31.92 lakh for FW awareness programme to reduce teenage marriage & teenage pregnancies@912 meeting, @ Rs 35/participant for 100 participants v)Rs 2.64 lakh for 1500 Antara register@ Rs 176/register vi)Rs4.96 lakh for 2000 Contraceptive Stock registers@ Rs 248/register vii) Rs 3.21 lakh for 1295 RMNCH registers. viii) Rs 21.60 lakh for 8713 home Delivery of Contraceptive registers. ix) Rs 6.20 lakh for 2500 IUCD/PPIUCD/PAIUCd registers @ Rs 248/register (248*2500=6.20 lakh) x)Rs 3.72 lakh for 1500 IUCD follow up register. xi) Rs 7.93 lakh for 3200 Sterilization register. Rs 1.58 lakh for 2,50,000 Sterilization Consent forms xii)Rs 2.40 lakh for 4 lakh IUCD consent forms. xiii)Rs 1.50 lakh for 2,50,000 sterilization certificate. xiv)Rs1.96 lakh for 280000 Medical record & checklist forms. xv)Rs 0.07 lakh for 9500 monthly welfare report form for private facilities xvi)Rs 0.42lakh for 60,000 monthly welfare report form for public facilities xvii)Rs 0.26 lakh 37000 monthly welfare report form for HSCs xviii)Rs0.01 lakh 1900 Sample verification of family welfare acceptor report forms xix)Rs 0.01 lakh for 960 indemnities claim form xx)Rs 0.28 lakh for 40,000 sample verification field visit form xxi) Rs 0.26 lakh for 37000 Address list for sterilization register forms. xxii)Rs 0.41 lakh for 58,000 Address list for PPPICD/PAIUCD acceptor forms xxiii) Rs 1.08 lakh for 43000 IUCD card.

Source: Tamil Nadu RoP 2024-26 Cycle, pages 86-89. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27, Document Outlining Family Planning Related Key Deliverables, Approved Fiscal Allocations & Family Planning Associated Annexure Documents.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27 Key Deliverable:

Sl No.	Indicator Type	Division	Indicator Statement	Indicator	Unit	Source of data	Target for FY 2026-27
18	Output	FP Division	Couple Protection Rate (CPR) for modern methods (Spacing methods + Limiting methods)	Couple Protection Rate (CPR) for modern methods (Spacing methods + Limiting methods) Numerator: Estimated Number of Couples protected by modern contraceptives	Percentage	Numerator: HMIS/Janani portal Denominator: TGPP report-2020	27 %

Source: Tamil Nadu RoP 2026-27 Cycle, page 20. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27, Amounts Approved By Activity Related to Family Planning:

FMR Code	S.No	Scheme/ Activity	Amount Proposed (In Lakhs)	Amount Approved (In Lakhs)	GoI Remarks for RoP
RCH.6	42	Sterilization - Female	1,714.85	1,714.85	**Approved Rs 1714.85 Lakh** as per the details as under: (i) Rs. 1600.00 lakh for 1.6 lakh sterilizations in public facilities @ Rs. 1000/- per case (ii)Rs. 114.85 lakh for 1552 FDS (1 FDS per quarter in 388 blocks) @ Rs. 7,400/- per FDS.
	43	Sterilization - Male	44.82	44.82	**Approved Rs 44.82 Lakh** as per the details as under: (i)DBT: Rs. 15.00 lakh for 1000 sterilizations @ Rs. 1500 per case. (ii) OOC: Rs. 29.82 lakh for 403 FDS (388 FDS in blocks & 15 in Chennai zone) @ Rs. 7,400/- per FDS.
	44	IUCD Insertion (PPIUCD and PAIUCD)	601.26	601.26	**Approved Rs 601.26 Lakh** as per the details as under: DBT: Rs. 601.26 lakh (i) Rs. 600.00 Lakh for 2,00,000 PPIUCD beneficiaries @ Rs 300/- per insertion ii) Rs. 1.26 Lakh for 420 PAIUCD beneficiaries @ Rs 300/-per insertion.
	45	ANTARA	0.00	0.00	-
	46	MPV (Mission Parivar Vikas)	0.00	0.00	-
	47	Family Planning Indemnity Scheme	118.74	118.74	**Approved Rs 118.74 Lakh** under Family Planning Indemnity Scheme (FPIS)
	48	FPLMIS	-	-	

FMR Code	S.No	Scheme/ Activity	Amount Proposed (In Lakhs)	Amount Approved (In Lakhs)	GoI Remarks for RoP
	49	World Population Day and Vasectomy Fortnight	0.00	0.00	-
	50	Other Family Planning Components	5.56	5.56	Approved Rs 5.56 lakh as per the details as under: Surveillance: Rs 5.56 Lakh (i) Rs 0.28 Lakh for 1 Death Panel Committee meeting (Death Audit). (ii) Rs 4.56 lakh for Quarterly DQAC/DISC meetings @ Rs 12,000/- per district (38 districts). (This is PM Activity. Expenditure for PM activities to be booked under sl no 194) (iii) Rs 0.72 Lakh for 6 FP Sub Committee meeting @ Rs 12,000/-per meeting.
	51	State specific Initiatives and Innovations			

Source: Tamil Nadu RoP 2026-27 Cycle, page 68-69. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27, Capacity Building Allocations for Family Planning:

Capacity Building (Details of trainings proposed under Sl. No. 201)					
S. No.	Programme/ Theme	Proposed Training/Activity	Amout Proposed(In Lakhs)	Amount Approved(In Lakhs)	GoI Remarks
19	Family Planning	Laparoscopic Training to MO	12.62	12.62	Ongoing activity: Approved Rs 12.62 lakh for laparoscopic training for FY 2026-27 Total No. of Batch: 20 Participants: maximum 4 participants per batch Duration: 12 days/batch Unit Cost: Rs 63,140/- per batch
20	Family Planning	Minilap Training MO - Refresher	5.52	5.52	Approved Rs 5.52 Lakh for Minilap Refresher Training Total No. of Batch: 26 Participants: 4 per batch Duration: 3 days/batch Unit Cost: Rs 21,230/- per batch
21	Family Planning	IUCD & Antara Training	19.23	19.23	Ongoing activity: Approved Rs 19.23 lakh for Integrated IUCD & Antara training of MOs for FY 2026-27 Total No. of batch: 38 Participants: Maximum 10 participants /batch Duration: 5 days/batch Cost: Rs 50,600/-per batch
22	Family Planning	IUCD & Antara Training	19.23	19.23	Ongoing Activity: Approved Rs. 19.23 Lakh for Integrated IUCD-Antara Training of SN/LHV/ANM for FY 2026-27 Total No. of batch: 38 Participants: Maximum 10 participants /batch Days: 5 days/batch Cost: Rs 50,600/-per batch

Source: Tamil Nadu RoP 2026-27 Cycle, page 113. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27, ASHA Incentives for Family Planning

Annexure 7.2: ASHA Incentives (Details of proposal under Sl. No. 202)					
10	Family Planning	Family Planning Escorting or facilitating beneficiary to the health facility for the PPICUD insertion	55.65	55.65	Ongoing activity: **Approved Rs. 55.65 lakh** under ASHA incentive for PPIUCD/PAIUCD – 37,100 PPIUCD/PAIUCD insertions, @ Rs 150 per ASHA for FY 2026–27.
11	Family Planning	Family Planning - Counselling and escorting beneficiary for ANTARA injection	63.60	63.60	Ongoing Activity: **Approved Rs. 63.6 lakh** under ASHA incentive for Antara for 63,600 Antara doses @ ₹100 per dose for FY 2026–27.

Source: Tamil Nadu RoP 2026-27 Cycle, page 125. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Tamil Nadu National Health Mission, Record of Proceeding, 2026-27, Information, Education and Communication Campaigns & Printing

Annexure 7.4 - IEC & Printing (Details of proposal under Sl. No. 204)					
S. No	**Programme/ Theme**	**Activity Proposed**	**Amount Proposed (In Lakhs)**	**Amount Approved (In Lakhs)**	**GoI Remarks**
		World Population Day' celebration for State and District level activities	15.50	15.50	Ongoing activity: **Approved Rs 15.50 Lakh** under IEC for FY 2026-27: (i) Rs 2 lakh for IEC & Promotional activities during WPD for State level. (ii) Rs 13.49 lakh for IEC & Promotional activities during WPD for District level @ Rs 29347/- per unit (for 46 Health unit districts).
		Vasectomy Fortnight celebration at District level activities	15.50	15.50	Ongoing activity: **Approved Rs 15.50 lakh** for Vasectomy Fortnight district activities @ Rs 40,789 per district for 38 districts for FY 2026–27.
6	Family Welfare	Printing and IEC for Family Welfare including CAC Services:	78.47	76.73	Ongoing activity: **Approved Rs. 76.73 lakh** as following activities: (a) Printing: Rs 35.90 lakh (i) Rs. 4.99 lakh – 2,49,950 Sterilization consent forms @ Rs. 2/ per Form (ii) Rs. 14.99 lakh – 2,49,950 Medical record & sterilization checklists @ Rs. 6/-per checklist (iii) Rs. 0.037 lakh – 3,750 Sterilization certificates @ Rs. 1/-per certificate (iv) Rs. 0.019 lakh – 950 Indemnity claim forms @ Rs. 2/- per form (v) Rs. 2.70 lakh – Post-Operative instruction cards @ Rs. 1/-per card (vi) Rs. 0.25 lakh – 25,050 Client exit interview forms @ Rs. 1/- per form (vii) Rs. 0.75 lakh – 25,070 MPA client cards @ Rs. 3/-per card (viii) Rs. 7.44 lakh – 2,48,050 IUCD cards @ Rs. 3/-per card (ix) Rs. 0.073 lakh – 2,450 Implant cards @ Rs. 3/-per card

Annexure 7.4 - IEC & Printing (Details of proposal under Sl. No. 204)					
S. No	Programme/ Theme	Activity Proposed	Amount Proposed (In Lakhs)	Amount Approved (In Lakhs)	GoI Remarks
					x) Rs. 1.32 lakh – 530 Sterilization registers @ Rs. 250/-per register xi) Rs. 1.80 lakh – 720 IUCD/PPIUCD/PAIUCD insertion & follow-up registers @ Rs. 250/-per register xii)Rs. 0.26 lakh – 107 RMNCHA+N counselling registers @ Rs. 250/-per register xiii)Rs. 1.25 lakh – 500 Antara registers @ Rs. 250/-per register xiv) Rs. 0.027 lakh – 11 Implant registers @ Rs. 250/-per register (b) Rs. 31.92 lakh for awareness on teenage pregnancy among college students in five districts with high teenage fertility rates (c) Rs 3.00 lakh for Trade Fair activities. Ongoing Activity: For FY 2026-27, Rs 5.9 Lakhs is approved for Medical Termination of Pregnancy Act Forms/Formats Printing. (CAC Printing Details: 1. RMP Opinion Form I: Quantity 1,00,000 forms @ Rs. 1/- per form ; 2. Form C/Consent Form : Quantity 1,05,000 forms @ Rs. 1/- per form ; 3. Form II: Quantity 72000 forms @ Rs. 1/- per form; 4. RMP Opinion Form (between 20-24 weeks) – Form E: Quantity 5000 forms @ Rs. 1/- per form ; 5. Form – III MTP Register: Quantity 960 forms @ Rs. 250/- per booklet; 6. MMA Client Card: Quantity 33,825 forms @ Rs. 2/- per form; 7. Form D: Quantity 350 forms @ Rs. 1/- per form)
Sub total			455.49	453.75	

Source: Tamil Nadu RoP 2026-27 Cycle, page 134-135. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026

II. Madhya Pradesh: Example of a high-focus MPV State.

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26, Document Outlining Family Planning Related Key Deliverables, Approved Fiscal Allocations & Family Planning Associated Annexure Documents.

Madhya Pradesh, National Health Mission, Record of Proceeding, Key Deliverables 2024-26:

Sl. No	Indicator Type	Indicator Statement	Indicator	Unit	Target FY 2024-25	Target FY 2025-26	Source of Data
			Numerator: Total no. of Medical Officer trained. **Denominator:** Target of MOs to be trained as per RoP.				Annual Report
	Family Planning (FP)						
44.	Output	PPIUCD acceptance	**% of PPIUCD acceptance among Institutional deliveries** **Numerator:** Number of PPIUCDs inserted in public facilities **Denominator:** Number of institutional deliveries in public facilities	Percentage	25%	30%	HMIS
45.	Output	Injectable MPA users	**% of Injectable MPA users among Eligible Couples** **Numerator:** Total number of Injectable MPA doses/4 **Denominator:** Number of Eligible Couples	Percentage	0.4%	0.5%	HMIS/ RCH register
46.	Output	Operationalisation on of FPLMIS	**% of Facilities indenting and issuing the stock in FPLMIS out of total facilities (excluding SC)** **Numerator:** Number of Facilities indenting and issuing the stock in FPLMIS (excluding SC) **Denominator:** Total Number of facilities registered in FPLMIS (excluding SC)	Percentage	95%	98%	FPLMIS
47.		% Increase in Male Sterilization performance from 2022-23	**Numerator:** No. of male sterilizations in current year (-) **Denominator:** No. of male sterilizations in 2022-23 **Remark:** The baseline year for this Key deliverable has been revised from 2019-20 to 2022-23	Percentage	20	40	HMIS
48.		Doubling Family Planning Indemnity Scheme Compensation (SC Directives)	Doubling of Compensation under FPIS as per the Honourable Supreme Court Directives. **Source: Annual FPIS reportRemark:** This deliverable is applicable for only for few states which have not yet completed the doubling of compensation	Yes/No	Doubling of compensation under FPIS	Doubling of compensation under FPIS	Annual FPIS report
49.	Output	Number of Nayi Pehel Kits (NPKs) distributed per ASHA	**Numerator: No. of NPKs distributed** **Denominator: No. of ASHAs** **Source: MPV Quarterly Report**		5	5	MPV Quarterly Report
50.	Output	Number of Saas Bahu Sammellans (SBS) conducted	**No. of SBS Conducted** **Source: MPV Quarterly Report**		180000	210000	MPV Quarterly Report

Source: Madhya Pradesh RoP 2024-26 Cycle, pages 26-27. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Pertaining to Family Planning (1/6):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
RCH.6	Family Planning	42	Sterilization - Female	11900.11	12706.35	11,900.11	12,706.35	Approved Rs. 11900.11 Lakhs for FY 2024-25 and Rs. 12706.35 Lakhs for FY 2025-26 as follows: For FY 2024-25:

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Related to Family Planning (2/6):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								1.Rs.11288.8 lakhs under DBT: a)Rs 7478.8 lakhs for 267100 interval sterlization cases in public sector @ 2800/case b) Rs 1200 lakhs for 30,000 PPS cases in public sector @ 4000/case c) Rs 280 lakhs for 8000 interval sterlization in private sector @ 3500/case . d) Rs 80 lakhs for 2000 PPS cases in private sector @Rs 4000/case e) Rs 2250 lakhs for 50000 sterlization cases through Clinical Outreach Team -COT @4500/case 2.Rs. 11.35 Lakhs under Capacity Building for: (a) Rs 3.24 lakhs for 12 days training of doctors on laproscope sterlization for 5 batches @Rs 64860 /Batch @ 2 participants/batch (b) Rs 1.62 lakhs for 3days refresher training of doctors on laproscope sterlization for 5 batches @Rs 32430 /Batch @ 4 participants/batch c) Rs 6.49 lakhs for 12 days Minilap training of doctors for 10 batches @Rs 64860 /Batch @ 2 participants/batch 3. Rs. 399.96 lakhs Under Other Operational Cost for: a) Rs 309.96 lakhs for conducting 5166 Female sterlization FDS

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								@6000/FDS. b) Rs 90 lakhs for drop back of clients of 3000 FDS @Rs 3000 per FDS 4. Rs 200 lakhs under IEC and printing for : a) Rs 200 lakhs for printing of 400000 copies of Sterilization essential documents (Consent form, Medical record checklist, Sterilization certificate, post operative dischage card) @Rs 50/copy **For FY 2025-26:** 1. Rs.12015.00 lakhs under DBT : a)Rs 7478.8 lakhs for 267100 interval sterlization cases in public sector @ 2800/case b) Rs 1200 lakhs for 30,000 PPS cases in public sector @ 4000/case c) Rs 280 lakhs for 8000 interval sterlization in private sector @ 3500/case . d) Rs 80 lakhs for 2000 PPS cases in private sector @Rs 4000/case e) Rs 2250 lakhs for 50000 sterlization cases through Clinical Outreach Team -COT @4500/case 2.Rs. 11.35 Lakhs under Capacity Building for : (a) Rs 3.24 lakhs for 12 days training of doctors on laproscope

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Pertaining to Family Planning (3/6):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								sterlization for 5 batches @Rs 64860 /Batch @ 2 participants/batch (b) Rs 1.62 lakhs for 3days refresher training of doctors on laproscope sterlization for 5 batches @Rs 32430 /Batch @ 4 participants/batch c) Rs 6.49 lakhs for 12 days Minilap training of doctors for 10 batches @Rs 64860 /Batch @ 2 participants/batch 3. Rs.390.00 lakhs Under Other Operational Cost for a) Rs 309.96 lakhs for conducting 6500 Female sterlization FDS @6000/FDS. b) Rs 90 lakhs for drop back of clients of 3000 FDS @Rs 3000 per FDS 4. Rs 200 lakhs under IEC and printing for : 400000 copies of Sterilization essential documents (Consent form, Medical record checklist, Sterilization certificate, post operative dischage card) @Rs 50/copy
		43	Sterilization - Male	297.10	323.10	297.10	323.10	**Approved Rs. 297.10 Lakhs for FY 2024-25 and Rs. 323.10 Lakhs for FY 2025-26 as follows:** **For FY 2024-25:** 1. Rs.269.50 lakhs under DBT: a) Rs244 lakhs for 6100 cases in public sector @Rs 4000/case b) Rs 10.5 lakhs for 300 cases private sector @Rs 3500/case

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								c) Rs 15 lakhs for 300 sterilization by Clinical Outreach Team @Rs 5000/case 2. Rs 1.35 lakhs under Capacity building for 5 days NSV training for 5 batches @Rs 27025/Batch @5 participants/batch 3. Rs 26.25 lakhs under other operationg cost -OOC to conduct 525 Male sterlization FDS @5000/FDS **For FY 2025-26:** 1. Rs.295.5 lakhs under DBT: a) Rs244 lakhs for 6100 cases in public sector @Rs 4000/case b) Rs 10.5 lakhs for 300 cases private sector @Rs 3500/case c) Rs 15 lakhs for 300 sterilization by Clinical Outreach Team @Rs 5000/case 2. Rs 1.35 lakhs under Capacity building for 5 days NSV training for 5 batches @Rs 27025/Batch @5 participants/batch 3. Rs 26.25 lakhs under other operationg cost -OOC to conduct 525 Male sterlization FDS @5000/FDS
		44	IUCD Insertion (PPIUCD and PAIUCD)	1137.17	1314.50	1,137.17	1,314.50	**Approved Rs. 1137.17 Lakhs for FY 2024-25 and Rs. 1314.50 Lakhs for FY 2025-26 as follows:** **For FY 2024-25:** 1. Rs 645 lakhs under DBT for: a)Rs 600 lakhs for 200,000 PPIUCD cases @Rs 300/PAIUCD case . (Rs 675 lakhs approved for 2.25 lakh PPIUCD cases for FY 2025-26)

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Pertaining to Family Planning (4/6):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								b)Rs 45 lakhs for Compensation to beneficiary for 15,000 PAIUCD cases @Rs 300/PAIUCD case 2. Rs 38.76 lakhs under equipments: a)Rs 30.60 lakhs for procurement of 1020 IUCD kits @Rs 3000/Kit b)Rs 8.16 lakhs for procurement of 1020 PPIUCD forceps @Rs 800 /forceps 3.Rs. 90.90 lakhs under Capcity Building for 5 days training on Integrated IUCD for CHO and ANM for 102 batches @Rs 89125/Batch @ 10 participants per batch. 4. Rs 307.50 lakhs under ASHA incentives for: a) Rs 300 lakhs is approved for incentives for accompanying the client for PPIUCD insertions for 200000 insertions @Rs 150/insertion /ASHA. b)Rs 7.50 lakhs is approved for incentives for accompanying the client for PAUCD insertions for 5000 PAIUCD insertions @Rs 150/insertion/ASHA 5. Rs 55 lakhs under IEC and printing for: a)Rs 40 lakhs for printing of 500,000 copies IUCD cards @Rs 8.0/card b)Rs 15 lakhs for printing of 2500 IUCD registers service delivery and follow-up register @Rs 300/register **For FY 2025-26:** 1. Rs 720.00 lakhs under DBT for : a) Rs 675 lakhs for 2.25 lakh PPIUCD cases@Rs 300/PAIUCD

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								case . b)Rs 45 lakhs for Compensation to beneficiary for 15,000 PAIUCD cases @Rs 300/PAIUCD case 2. Rs 58.14 lakh approved for 1530 IUCD Kits & 1530 PPIUCD forceps for: a) Rs 30.60 lakhs for procurement of 1020 IUCD kits @Rs 3000/Kit . b)Rs 8.16 lakhs for procurement of 1020 PPIUCD forceps @Rs 800 /forceps 3.Rs 136.36 lakhs under Capcity Building for 5 days training on Integrated IUCD for CHO and ANM for 153 batches @Rs 89125/Batch @ 10 participants per batch 4.Rs 307.50 lakhs under ASHA incentives for : a) Rs 337.5 lakhs is approved for incentives for accompanying the client for PPIUCD insertions for 200000 insertions @Rs 150/insertion /ASHA b)Rs 7.50 lakhs is approved for incentives for accompanying the client for PAUCD insertions for 5000 PAIUCD insertions @Rs 150/insertion/ASHA 5. Rs 55 lakhs under IEC and printing for a)Rs 40 lakhs for printing of 500,000 copies IUCD cards @Rs 8.0/card b)Rs 15 lakhs for printing of 2500 IUCD registers service delivery and follow-up register @Rs 300/register
		45	ANTARA	260.47	280.47	260.47	280.47	**Approved Rs. 260.47 Lakhs for FY 2024-25 and Rs. 280.47 Lakhs for FY 2025-26 as follows:** **For FY 2024-25:**

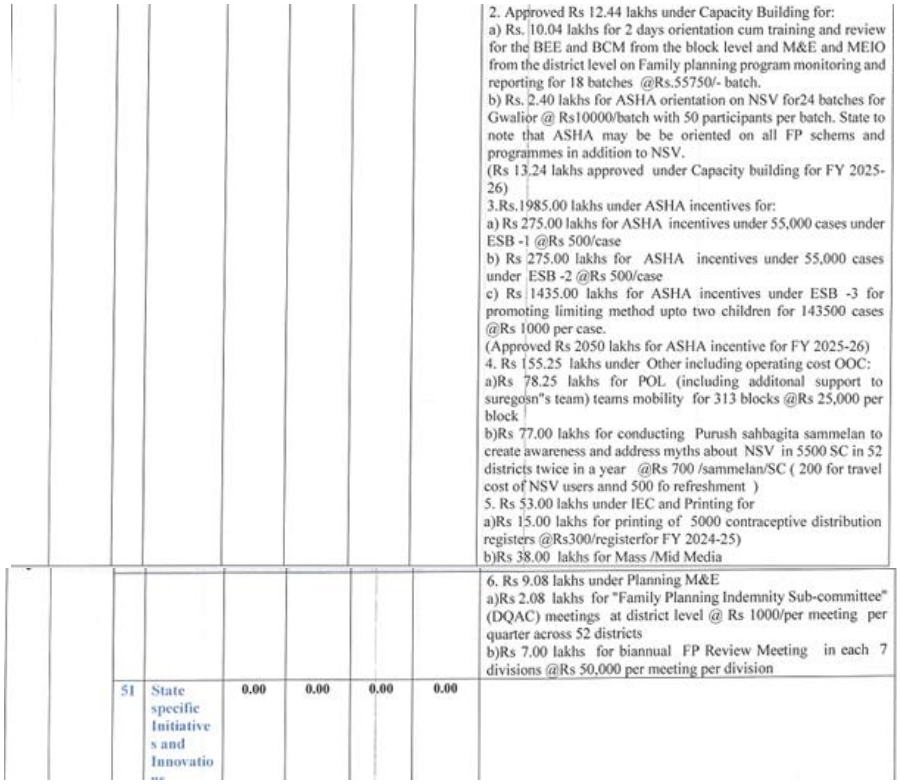
Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Related to Family Planning (5/6):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								1. Rs 100 lakhs under DBT to clients for 100,000 Injectable MPA doses @Rs 100/dose. 2.Rs 44.47 lakhs Under Capacity Building for : a) Rs 8.72 lakhs for one day training of Medical Officers on Injectable MPA Antara prog. For 52 batches @Rs 16775 /Batch. State to follow RCH norms for the training. Batch size should be around 25-30 participants as per the GoI norms. b) Rs 35.76 lakhs for one day training of CHO,ANM and SN for 104 batches @ Rs 34375 /batch .State to follow RCH training normsand the batch size should not exceed 30 participants 3.100 lakhs Under ASHA incentives for accompanying the client for Injectable MPA. for 100,000 doses @Rs 100/dose /ASHA 4. Rs 16 lakhs under IEC and Printing for printing 200,000 copies of MPA cards @Rs 8.0/card **For FY 2025-26:** 1. Rs 120 lakhs under DBT to clients for 1.2 lakhs Injectable MPA doses @Rs 100/dose. 2. Rs 44.47 lakhs Under Capacity Building for : a) Rs 8.72 lakhs for one day training of Medical Officers on Injectable MPA Antara prog. For 52 batches @Rs 16775 /Batch. State to follow RCH norms for the training. Batch size should be around 25-30 participants as per the GoI norms. b)Rs 35.76 lakhs for one day training of CHO,ANM and SN for 104 batches @ Rs 34375 /batch .State to follow RCH training normsand the batch size should not exceed 30 participants
FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								3. Rs.120 lakhs Under ASHA incentives for accompanying the client for Injectable MPA. for 1.2 lakh doses @Rs 100/dose /ASHA 4. Rs 16 lakhs under IEC and Printing for printing 200,000 copies of MPA cards @Rs 8.0/card
		46	MPV(Mission Parivar Vikas)	2448.22	2708.62	2,448.22	2,708.62	**Approved Rs. 2448.22 Lakhs for FY 2024-25 and Rs. 2708.62 Lakhs for FY 2025-26 as follows:** 1. Rs 804 lakhs under Drugs and Supplies procurement for procurement of 300000 Naye pahel kit @Rs 268 /kit. (Approved Rs 884.4 lakhs for 3.3 lakh Nayi Pehel Kits fo FY 2025-26) 2. Rs 690 .00 lakhs under ASHA incentive for: a) Rs 300 lakhs for ASHA incentives for distribution of 3 lakh Naye Pahel Kits @Rs 100/ASHA/Kit. b) Rs 180 lakhs for ASHA incentives fororganizing Sas Bahu Sammelan for 1.8 lakh SBS @Rs 100/SBS c) Rs 210 lakhs for ASHA incentives for updating EC couple register (70000 ASHAs * twice a year*150 per ASHA/ six month) (Approved Rs 720 lakhs as ASHA incentive for FY 2025-26) 3. Rs 917.72 lakhs under Other operating cost OOC for: a) Rs 900 lakhs for conducting 1.8 lakh Sas Bahu Sammelans in 52 districts @Rs 500/Sammelan as per the agreement with the

Madhya Pradesh, National Health Mission, Record of Proceeding, 2024-26 Amounts Approved By Activity Related to Family Planning (6/6):

								state.(Rs 1050 lakh approved for SBS for FY 2025-26) b) Rs 12.52 lakhs for Advocacy meetings in 313 blocks on quarterly basis@Rs 1000/meeting/quarter c) Rs 5.20 lakhs for DHO mobility cost @ Rs 5,000/district /campaign for 52 districts for 2 campaign. 4.Rs 36.50 lakhs under IEC & printing for: a) Rs 5.20 lakhs for MPV camapigns @ Rs 10,000/district for 52 districts for 2 campaign. b)Rs 31.3 lakhs for MPV campaigns @Rs 5000/block/campiagn for 313 blocks for 2 campaigns
		47	Family Planning Indemnity Scheme	196.50	196.50	196.25	196.50	**Approved Rs. 196.25 Lakhs each for FY 2024-25 and FY 2025-26, respectively, as proposed by the state under DBT for FPIS.**
		48	FPLMIS	142.36	126.64	142.36	126.64	**Approved Rs. 142.36 Lakhs for FY 2024-25 and Rs. 126.64 Lakhs for FY 2025-26 as follows:** 1. Rs 21.96 lakhs under Capacity Building for : a) Rs 6.24 lakhs for one day review cum refresher training of Store Incharge, BEE, BCM on FPLMIS in all districts @ Rs 12000/district .State to note that batch size should not exceed 30 b) Rs. 15.72 lakhs for one day trainings of ASHA supervisors on FPLMIS in 131 batches @ Rs 12000/batch for FY 2024-25.State to note that batch size should not exceed 30

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed		Amount Approved		GoI Remarks
				FY 2024-25	FY 2025-26	FY 2024-25	FY 2025-26	
								2. Rs 120.40 lakhs under Others including operating costs(OOC) as per the tender details submitted by state a)Rs 64.86 lakhs for transportation of FP commodities from state warehouse to divisional warehouses b)Rs 39.37 lakhs for transportation of FP commodities from divisional to district and block
		49	World Population Day and Vasectomy fortnight	46.90	46.90	46.90	46.90	**Approved Rs. 46.90 Lakhs each for FY 2024-25 and FY 2025-26, respectively, as follows:** 1. Rs 41.70 lakhs under IEC and Printing for: a) Rs 20.85 lakhs for IEC and promotional activities for WPD @ 10000/- per district for 52 districts and @ 5000/- per block for 313 blocks) b) Rs 20.85 lakhs for IEC and promotional activities for Vaectomy fortnight @ 10000/- per district for 52 districts and @ 5000/- per block for 313 blocks 2. Rs 5.20 lakhs under Planning M&E for: a)Rs 2.60 lakhs for mobility cost to monitor WPD activities for 52 districts by FP Nodal officers (DHO 2) @ 5000 per district during WPD x 52 districts b)Rs 2.60 lakhs is for mobility cost to monitor vasectomy fortnight by FP Nodal officers (DHO 2) @ 5000 per district for 52 districts
		50	Other Family Planning Components	2240.77	2265.57	2,214.77	2,265.57	**Approved Rs. 2214.77 Lakhs for FY 2024-25 and Rs. 2265.57 Lakhs for FY 2025-26 as follows:** 1. Rs 26.00 lakhs not approved under Equipments for procurement of 52 laptops @Rs. 50,000/laptop.



							2. Approved Rs 12.44 lakhs under Capacity Building for: a) Rs. 10.04 lakhs for 2 days orientation cum training and review for the BEE and BCM from the block level and M&E and MEIO from the district level on Family planning program monitoring and reporting for 18 batches @Rs.55750/- batch. b) Rs. 2.40 lakhs for ASHA orientation on NSV for24 batches for Gwalior @ Rs10000/batch with 50 participants per batch. State to note that ASHA may be be oriented on all FP schems and programmes in addition to NSV. (Rs 13.24 lakhs approved under Capacity building for FY 2025-26) 3.Rs.1985.00 lakhs under ASHA incentives for: a) Rs 275.00 lakhs for ASHA incentives under 55,000 cases under ESB -1 @Rs 500/case b) Rs 275.00 lakhs for ASHA incentives under 55,000 cases under ESB -2 @Rs 500/case c) Rs 1435.00 lakhs for ASHA incentives under ESB -3 for promoting limiting method upto two children for 143500 cases @Rs 1000 per case. (Approved Rs 2050 lakhs for ASHA incentive for FY 2025-26) 4. Rs 155.25 lakhs under Other including operating cost OOC: a)Rs 78.25 lakhs for POL (including additonal support to suregosn"s team) teams mobility for 313 blocks @Rs 25,000 per block b)Rs 77.00 lakhs for conducting Purush sahbagita sammelan to create awareness and address myths about NSV in 5500 SC in 52 districts twice in a year @Rs 700 /sammelan/SC (200 for travel cost of NSV users annd 500 fo refreshment) 5. Rs 53.00 lakhs under IEC and Printing for a)Rs 15.00 lakhs for printing of 5000 contraceptive distribution registers @Rs300/registerfor FY 2024-25) b)Rs 38.00 lakhs for Mass /Mid Media
							6. Rs 9.08 lakhs under Planning M&E a)Rs 2.08 lakhs for "Family Planning Indemnity Sub-committee" (DQAC) meetings at district level @ Rs 1000/per meeting per quarter across 52 districts b)Rs 7.00 lakhs for biannual FP Review Meeting in each 7 divisions @Rs 50,000 per meeting per division
	51	State specific Initiatives and Innovatio	0.00	0.00	0.00	0.00	

Source: Madhya Pradesh RoP 2024-26 Cycle, page 140-152. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27, Document Outlining Family Planning Related Key Deliverables, Approved Fiscal Allocations & Family Planning Associated Annexure Documents.

Madhya Pradesh National Health Mission, Record of Proceeding, Key Deliverable 2026-27:

Sl No.	Indicator Type	Division	Indicator Statement	Indicator	Unit	Source of data	Target for FY 2026-27
18	Output	FP Division	**Couple Protection Rate** (CPR) for modern methods (Spacing methods + Limiting methods)	**Couple Protection Rate** (CPR) for modern methods (Spacing methods + Limiting methods)	Percentage	**Numerator :** HMIS/Janani portal **Denominator:** TGPP report- 2020	43.0

Source: Madhya Pradesh RoP 2026-27 Cycle, page 22. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27 Amounts Approved By Activity Pertaining To Family Planning (1/3):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed by State/UT for FY 2026-27 (Rs. in Lakhs)	Total Amount Approved for FY 2026-27 (Rs. in Lakhs)	GoI Remarks
RCH. 6	Family Planning	42	Sterilization - Female	9,518.45	9,518.45	**Rs. 9,518.45 Lakhs approved for under Sterilization - Female for FY 26-27** as follows: **DBT: Rs. 9,085.00 Lakh approved for:** a) Rs.5,880 Lakhs for 2,10,000 interval sterilization cases in public sector @ 2800/case b) Rs. 1,200 Lakhs for 30,000 PPS cases in public sector @ 4000/case c) Rs. 350 Lakhs for 10,000 interval sterilization in private

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27 Amounts Approved By Activity Pertaining To Family Planning (2/3):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed by State/UT for FY 2026-27 (Rs. in Lakhs)	Total Amount Approved for FY 2026-27 (Rs. in Lakhs)	GoI Remarks
						sector @ 3500/case. d) Rs. 80 Lakhs for 2,000 PPS cases in private sector @Rs 4000/case e) Rs. 1,575 Lakhs for 35,000 sterilization cases through Clinical Outreach Team -COT @4500/case **Equipment: Rs. 0.60 Lakh approved for:** a) Rs. 0.60 Lakh for Procurement of 20 minilap kit @ Rs. 3000/ Kit **Others including operating costs (OOC): Rs. 432.85 Lakh approved for:** a) Rs. 312 Lakhs for conducting 5,200 Female sterilization FDS for@6000/FDS. b) Rs. 15 Lakhs for Drop back of clients of 500 FDS @Rs 3,000 per FDS c) Rs. 78.25 Lakhs for POL (including additional support to surgeon's team) teams' mobility for 313 blocks @Rs 25,000 per block d) Rs. 27.6 lakhs for maintenance of 120 Laproscopes Rs. 23,000/ laproscope
		43	Sterilization - Male	98.00	98.00	**Rs. 98 Lakhs approved under Sterilization - Male for FY 2026-27** as follows: **DBT: Rs. 92.5 Lakh** approved for: a) Rs. 84 Lakhs for 2100 cases in public sector @Rs 4000/case b) Rs. 3.5 Lakhs for 100 cases private sector @Rs 3500/case c) Rs. 5 Lakhs for 100 sterilizations by Clinical Outreach Team @Rs 5000/case **Equipment: Rs. 0.50 Lakh** approved for: a) Rs. 0.50 Lakh for Procurement of 25 NSV kit @ Rs. 2000/ kit **Others including operating costs (OOC): Rs. 5 Lakhs** approved for: a) Rs. 5 Lakhs under other operating cost to Conduct 100 Male sterilization FDS @5,000/ FDS
		44	IUCD Insertion (PPIUCD and PAIUCD)	345.00	345.00	**Rs. 345.00 Lakhs approved under IUCD Insertion for FY 2026-27** as follows: **DBT: Rs. 345.00 Lakhs** approved for: a) Rs. 330 Lakhs for 1,10,000 PPIUCD cases @Rs 300 per case b) Rs. 15 lakhs for 5,000

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27 Amounts Approved By Activity Pertaining To Family Planning (3/3):

FMR Code	Programme/ Theme	S. No.	Scheme/ Activity	Amount Proposed by State/UT for FY 2026-27 (Rs. in Lakhs)	Total Amount Approved for FY 2026-27 (Rs. in Lakhs)	GoI Remarks
						PAIUCD cases @Rs 300 per case.
		45	ANTARA	65.00	65.00	**Rs. 65.00 Lakhs under ANTARA for FY 2026-27** as follows: **DBT:** Rs 65.00 lakhs under DBT to clients for 65,000 Injectable MPA doses @Rs 100/dose.
		46	MPV (Mission Parivar Vikas)	1,056.68	1,056.68	**Rs. 1056.68 Lakhs approved under MPV (Mission Parivar Vikas) for FY2026-27** as follows: **Drugs and Supplies: Rs. 364.48 Lakhs** approved for the procurement of 1,36,000 Naye pahel kit @Rs 268 /Kit **Others including operating costs (OOC): Rs. 692.20 Lakhs** approved for: a) Rs. 680 lakhs for conducting 1.36 lakh Sas Bahu Sammelans @Rs 500/Sammelan as 2 Sammelans/ASHA b) Rs 7 lakhs for conducting Purush sahbagita sammelan to create awareness and address myths about NSV in a year @Rs 700/sammelan/AAM (200 for travel cost of NSV users and 500 for refreshment) for 1,000 sammelan. c) Rs 5.20 lakhs for DHO mobility cost @ Rs 5,000/district /campaign for 52 districts for 2 Campaign.
		47	Family Planning Indemnity Scheme	330.00	330.00	**Rs. 330 Lakhs approved under FPIS for FY 2026-27** as follows: **DBT:** a) Rs. 165.30 lakh for Projected - 551 Sterilization Failure Claims in Current year (2026-27) @Rs 30,000 b) Rs. 164.70 lakh for Cumulative Pendency of previous year for 549 Sterilization Failure Claims @Rs 30,000
		48	FPLMIS	65.00	65.00	**Rs. 65.00 lakhs approved under FPLMIS for FY 2026-27** as follows: **Others including operating costs (OOC): Rs 65.00 lakhs** approved for transportation of FP commodities from State warehouse to divisional warehouses
		49	World Population Day and Vasectomy Fortnight	0.00	0.00	NA

Source: Madhya Pradesh RoP 2026-27 Cycle, page 92-97. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Annexure Capacity Building (Details of S.No.201)

Amount in Rs. (Lakhs)

S. N.	Training	Pool	Programme/ Theme	Proposed Training/ Activity	Total Budget Proposed in Lakh Rs.	Total Amount Approved for FY 2026-27	GoI Remarks
51	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	Laparoscopic refersher training	1.62	1.62	**Rs. 1.62 Lakhs approved** for No.of Batches : 5 No.of Days: 3 No. of Participants/Batch: 4 Amount/Batch : Rs. 32,430.00
52	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	FPLMIS Refresher	0.00	0.00	**approved :** Virtual Training planned for refresher course of FPLMIS
53	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	IUCD training of Para Medical Staff (CHO, NO & ANM)	16.75	16.75	**Rs. 16.75 Lakhs approved** for: No.of Batches : 52 No.of Days : 5 No. of Participants/Batch: 10 Amount/Batch : 32,230.00
54	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	Antara training	0.00	0.00	**Activity is approved.** NIL Budget
55	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	Antara training	0.00	0.00	**Activity is approved.** NIL Budget

S. N.	Training	Pool	Programme/ Theme	Proposed Training/ Activity	Total Budget Proposed in Lakh Rs.	Total Amount Approved for FY 2026-27	GoI Remarks
56	A. Integrated Training of Core Cadres(Induction +Team Based+Refresher)	RCH	Family Planning	Antara training	0.00	0.00	**Activity is approved.** NIL Budget
57	B. Specific Packages	RCH	Family Planning	Laparoscopic sterilization	3.24	3.24	**Rs. 3.24 Lakhs approved** for: No.of Batches : 5 No.of Days : 12 No. of Participants/Batch: 2 Amount/Batch : Rs. 64,860
58	B. Specific Packages	RCH	Family Planning	NSVT Training	1.35	1.35	**Rs. 1.35 Lakhs approved** for: No.of Batches : 5 No.of Days : 5 No. of Participants/Batch: 2 Amount/Batch : Rs. 27,025
59	B. Specific Packages	RCH	Family Planning	Minilap Training	3.24	3.24	**Rs. 3.24 Lakhs approved** for: No.of Batches : 5 No.of Days : 12 No. of Participants/Batch: 2 Amount/Batch : Rs. 64,860

Source: Madhya Pradesh RoP 2026-27 Cycle, page 185-187. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27 ASHA Incentives for Family Planning

Annexure - ASHA Incentives (Details of proposal under Sl. No. 202)						
S. No	Programme/ Theme	Old Sl. No.	Activity Proposed	Budget Proposed (Rs. in Lakhs)	Total Amount Approved for FY 2026-27 (Rs. in Lakhs)	GoI Remarks
14	FP	44	ASHA PPIUCD incentive for accompanying the client for PPIUCD insertion (@ Rs.	255.00	255.00	**Rs. 255 Lakhs approved** for ASHA incentives : Accompanying Clients for PPIUCD insertion 85,000 Insertions @ Rs. 300/Insertion

Annexure - ASHA Incentives (Details of proposal under Sl. No. 202)						
S. No	Programme/ Theme	Old Sl. No.	Activity Proposed	Budget Proposed (Rs. in Lakhs)	Total Amount Approved for FY 2026-27 (Rs. in Lakhs)	GoI Remarks
			300/ASHA/insertion)			
15	FP	44	ASHA PAIUCD incentive for accompanying the client for PAIUCD insertion (@ Rs. 300/ASHA/insertion)	15.00	15.00	**Rs. 15 Lakhs approved** for ASHA incentives : Accompanying Clients for PAIUCD insertion 5,000 Insertions @ Rs. 300/Insertion
16	FP	45	ASHA incentive for accompanying the client for Injectable MPA (Antara Prog) administration	54.00	54.00	**Rs. 54 Lakhs approved** for ASHA incentives : Accompanying Client for Injectable MPA(ANTARA Programme) 54,000 doses @Rs100/dose(1-3 dose) @ Rs. 200/Dose(4th Dose)
17	FP	46.1	ASHA Incentives under Saas Bahu Sammellan	190.40	190.40	**Rs. 190.40 Lakhs approved** for ASHA incentives :SBS - 95,200 Sammellan@ Rs. 200/Sammellan
18	FP	46.2	ASHA Incentives under Nayi Pehl Kit	193.20	193.20	**Rs. 193.20 Lakhs approved** for ASHA incentives: 96,600 Nayi Pahel Kits Distribution Rs. 200/ ASHA/Kit.
19	FP	46.3	ASHA incentive	207.00	207.00	**Rs. 207.00 Lakhs approved** for ASHA:
			for updation of EC survey before each MPV campaign			69,000 @Rs. 150 per ASHA per EC Survey (twice a year)
20	FP	50	ASHA incentive under ESB scheme for promoting spacing of births	550.00	550.00	**Rs 550.00 Lakhs approved** for ASHA Incentive : ESB-1(Delaying) & ESB -2 (Spacing) 1,10,000 Case @Rs. 500/-
21	FP	50	ASHA Incentive under ESB scheme for promoting adoption of limiting method up to two children	1,000.00	1,000.00	**Rs. 1000 Lakhs approved** for ASHA Incentive: ESB-3(Limiting) 1,00,000 cases @Rs. 1,000 per case. Avg. No. of Cases : 1 Lakh

Source: Madhya Pradesh RoP 2026-27 Cycle, page 229-231. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.

Madhya Pradesh National Health Mission, Record of Proceeding, 2026-27 Information, Education & Communication Campaigns, & Printing Allocations

Annexure - IEC & Printing (Details of proposal under Sl. No. 204)

Amount in Rs. (Lakhs)

S. No	Programme / Theme	Activity Proposed	Budget Proposed	Total Amount Approved for FY 2026-27	GoI Remarks
RCH.6	Family Planning (FP)	IEC Activities for Family Planning	170.41	170.41	**Rs. 170.41 Lakhs approved** as follows: a) Rs.100 Lakh for Sterilization Essential documents – 2,00,000@ Rs. 50/Copy b) Rs. 4 Lakh for MPA Cards – 50,000 @ Rs. 8.00 per Card c) Rs. 12 Lakh for IUCD Cards – 1.5 Lakh@ Rs.8.00 per Card d) Rs. 4.50 Lakh for IUCD Register – 1,500@ Rs.300/Register e) Rs. 3 Lakh for Contraceptive Distribution Register – 1,000@ Rs.300/Register d) WPD & Vasectomy Fortnight celebration: Rs. 26.06 Lakh i) Rs 10.43 lakhs for IEC and promotional activities for WPD ii) Rs 10.43 lakhs for IEC and promotional activities for Vasectomy Fortnight (Ongoing Activity) iii) Rs 2.60 lakhs for M&E WPD activities for 52 districts by FP Nodal officers (DHO 2) @Rs. 5,000 per district during WPD iv) Rs 2.60 lakhs is for mobility cost to monitor vasectomy fortnight for 52 districts by FP Nodal officers (DHO 2) Rs. 5000 per district for 52 districts e) MPV Campaign: Rs. 20.85 Lakh District : 52 District – 2 Campaign/ District@Rs.5,000/District (Rs. 5.20 lakhs) Blocks : 313 blocks - 2 Campaigns@Rs.2,500/ Block (Rs. 15.65 lakhs)

Source: Madhya Pradesh RoP 2026-27 Cycle, page 245-46. Note: Snapshot of selected features for illustration purposes only. Not the author's original work. Documents available under State PIP and RoPs of the NHM website. Downloaded, first week of August, 2026.