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# Editorial

## From population goals to reproductive health autonomy: Reframing India's fertility transition

Rapid fertility decline is a defining demographic trend of our era, sparking both concerns and opportunities. While some warn that lower birth rates may hinder economic growth by shrinking the labour force and increasing the burden of elderly care[1,2], others see this shift as an opportunity to promote gender equality, reproductive autonomy, and broader human well-being[3]. In response to falling fertility, many governments have implemented pronatalist policies aimed at raising fertility to replacement levels[4]. Yet, amid this persistent global focus on numbers, a fundamental question is often overlooked: Are women truly free to make their own reproductive choices?

India's demographic transition reflects a broader global trend with growing concerns over declining fertility rates. As current discussions increasingly focus on how to boost fertility often by drawing on policies from developed countries, it is important to recall that 2025 marks 30 years since the International Conference on Population and Development (ICPD), a pivotal moment that initiated shifting the global family planning agenda from population control to a focus on rights, autonomy, and women's empowerment[5]. Yet, in practice, many countries, including India, have remained preoccupied with increasing modern contraception use and reducing fertility, falling short of the ICPD's vision to empower individuals and couples to make informed choices about whether, when, and how many children to have. This editorial examines the persistent disconnect between demographic targets and reproductive autonomy and calls for a renewed commitment to a truly rights-based approach in shaping future policies and programmes.

India has experienced a rapid and remarkable demographic transition over the past three decades. Driven by the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) in the 2000s and informed by strong national and sub-national population and health policies, the country has made significant strides in reducing fertility and mortality, as well as improving maternal health. The Total Fertility Rate (TFR), that is, the average number of children per woman in her lifetime, in India declined from around six in the mid-20$^{th}$ century to 3.4 in 1992-93. It reached the replacement level of 2.1 by 2019[6,7]. Likewise, the Maternal Mortality Ratio (MMR) fell from 437 per 100,000 live births in 1992-93 to 88 in 2020-2022[8], putting the country on track to meet the SDG target of an MMR below 70. Gain in female literacy (from 34% in 1990 to 69% in 2022)[9], rise in the use of modern contraception (from 36.5% in 1992-93 to 56.4% in 2019–21) along with a reduction in the unmet need for contraception (from 21% to 9.4%), further reflect this transition. These achievements, however, raise a caution that without recalibrating the programmes toward a person-centered approach, there is a risk that the family planning programme may become complacent, overlooking the broader goal of supporting individual choice and autonomy.

Despite major strides in women's health, critical gaps remain. This 'unfinished health agenda' stems from both geographic and sub-group disparities in progress and unintended consequences of development policies and programmes over the years. While the recent efforts are addressing these geographic inequalities at the State, district, and subdistrict levels through evidence-based planning down to the sub-district-level (block-level), the unintended demographic effects of past programmes may have received less attention. For instance, although the family planning programmes have successfully reduced unwanted fertility over the years, infertility, particularly secondary infertility, has persisted or worsened. The secondary infertility has nearly doubled in 30 years from its base level of 19 per cent in 1992-93, possibly contributing to India's recent fertility decline[10]. Beyond demographics, infertility has serious psychological effects on women, including

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heightened stress, anxiety, and depression, underscoring the need to address it as a core reproductive health issue[11].

India has made significant progress in achieving near-universal institutional childbirth, driven by improved access to public and private healthcare facilities and the country's reproductive health programme interventions. Concurrently, as the TFR continues to decline rapidly across many Indian states, the preference for two children remains widespread[12]. This has led to a growing discrepancy between the desired and actual number of children. While rising rates of secondary infertility partly explain this gap, broader unintended consequences of reproductive health interventions may also be contributing to declining fertility. A major concern in this context is the high rates of caesarean sections (C-sections), hysterectomies, and female sterilisation. Although C-section rates in the public sector generally remain within World Health Organization recommendations, rates in the private sector are often very high. In several states, C-section rates exceed 50 per cent in private facilities, while those in Telangana, Tamil Nadu, and West Bengal exceeded 80 per cent, raising concerns about the medical necessity of such interventions vis-à-vis profit motives. These trends warrant further in-depth research to distinguish between necessary and unnecessary C-section deliveries. Excessive reliance on C-section intervention not only undermines women's autonomy but also causes a risk of negative childbirth experiences psychologically, and heightens the risk of severe complications, including uterine rupture, severe haemorrhage requiring transfusion or hysterectomy, and injury to adjacent organs[13]. Moreover, the persistently high prevalence of hysterectomy in certain states and among specific occupational groups within some states, often motivated by the desire to avoid menstruation at work, may be associated with the widespread use of surgical interventions such as C-sections. This trend raises important concerns about women's health and the broader implications of such practices.

On the other hand, the success of the family planning programme is often assessed by increases in modern contraceptive use, and this narrow focus has led to a skewed method-mix in many countries. In India, for example, discussions in the late 1990s and the well-intended programme efforts to meet the goals set by the National Population Policy (2000) have unintentionally caused a disproportionate rise in female sterilization[14]. Evidence shows that states such as Andhra Pradesh and Telangana, with the steepest fertility decline, also experienced the highest or fastest increases in female sterilisation over the past three decades[15]. Although India's family planning programme is officially considered voluntary, the cultural practices shaped by the coercive norms of the early 2000s continue to exert a strong and pervasive influence[16]. Ironically, even the well-intentioned private health financing that supports maternal health and family planning care is partially contributing to the rise in unnecessary surgical procedures. A multi-country study covering 172 countries detected links between private health financing and excess C-sections[17]. In India, research has shown how the incentives have helped in increasing the female sterilization rates within the public sector over the years, and continuation of such practice within the private sector given the insurance coverage[18].

As India prepares for its next Census in 2027, available data indicates a growing share of women who remain unmarried beyond age 30, particularly in States like Sikkim, Nagaland, Manipur, Mizoram, Andhra Pradesh, and Goa. This trend highlights a non-linear, complex relationship between modern contraceptive prevalence and total fertility rates. Women employed in managerial, technical roles or even those doing manual or agricultural work are less likely to marry before age 30[19], and women in the labour force generally achieve lower fertility rates than others or to the desired family size, with some opting for medically unnecessary procedures, including C-sections and hysterectomies.

Beyond fertility issues, in India, women's health is increasingly influenced by rising multimorbidity within the reproductive age group. Non-communicable diseases, premature menopause, and cancer are becoming more common, with evidence indicating that 28 per cent of urban women experience more than one NCD by the age of 35[20,21]. These health challenges are further worsened by structural inequalities, including a still modest but growing female labour force participation rate of 41.7 per cent[22], and persistently high prevalence (31%) of domestic violence[23].

Countries grappling with low fertility typically pursued two types of policy responses: pronatalist approaches and/or broader structural reforms. Pronatalist approaches, adopted in countries like Russia, Poland, and Hungary, involve direct financial support, such as baby bonuses, tax breaks, or child allowances - but these have produced only modest and short-lived effects[24,25], often influencing birth timings rather than overall fertility. In contrast, broader structural policies that address deeper socio-economic and gender-related barriers, including flexible work arrangements,

subsidized childcare, and generous gender-equal parental leaves, implemented in countries such as Sweden, Denmark, Finland, and Norway, produced comparatively better outcomes than other pronatalist policies. Vietnam, a country demographically and economically similar to India, has moved swiftly beyond restrictive policies, such as its two-child rule, and implemented evidence-based structural reforms. These reforms include workplace flexibility, childcare support, tax incentives, and expanded maternity leave benefits, contributing to more stable fertility patterns.

As India advances toward becoming a developed nation, it has a pivotal opportunity to shape a rights-based model that centres women's autonomy within its development agenda. Realizing the SDGs by 2030 and sustaining the progress requires moving beyond the conventional framing of family planning as solely about increasing contraceptive use or changing method-mix. A truly effective family planning programme must be framed as a comprehensive commitment to meeting women's reproductive needs throughout their life course. This includes affirming every woman's right to decide whether to have children, when to have them, and how many to have, backed by inclusive policies that ensure full access to a range of contraceptive methods (and discontinuation of incentives for sterilization), quality and affordable infertility treatments, and childcare services. Unlike many developed countries that have responded to low fertility with pronatalist policies, India's priority should be building trust in its health system by ensuring respectful, non-invasive reproductive care and reducing unnecessary medical interventions. With several decades of successful demographic transition, India's mature family planning programme may now evolve to advance priorities of women's health and choices, focusing not on what can be offered to increase the uptake of services, but on what individuals truly want. This shift requires embedding women's rights and lived experiences at the core of programme planning and implementation. Evidence suggests that empowering women through this approach in family planning programmes leads to significant productivity gains and long-term economic benefits for society[26].

On this World Population Day 2025, as India navigates its path between demographic maturity and economic aspirations, progress must be measured not by how much fertility has declined but by how much women's reproductive health autonomy has risen. The true mark of development lies in protecting every woman's right to choose when, whether, and how to become a mother and in creating systems that support those choices without coercion or constraint.

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