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EDITORIAL

Policies to reverse low fertility in India: Need for an ethics perspective

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One of the measures of change in a country's population is the Total Fertility Rate (TFR), or the average number of children a woman is expected to have during her reproductive years. A TFR of 2.1 is considered the replacement level, where the population renews itself without growing or shrinking. India's TFR has declined from 5.2 in 1971 to 1.9 in 2024 [1]. The decline is far greater in some states, going as low as 1.4 in Andhra Pradesh (AP), and 1.3 in Kerala, Tamil Nadu and West Bengal [1], with the lowest at 1.0 in Sikkim, in 2023-24 [2].

Political and religious leaders from all sections have expressed concern over the expected shrinking population size implied by fertility levels going below replacement levels. Some have even urged women to have at least three children [3, 4]. In 2024, the then Tamil Nadu Chief Minister spoke of a "changing mindset favouring more children instead of small families" [5]. Missing in all these declarations and calls are the voices of women, whose choices are determined by their experiences and the pressures they experience due to these numbers.

For the political leadership of the southern states such as Tamil Nadu and Andhra Pradesh, the reason for wanting to arrest the declining TFR arises partly from the process of delimitation that is constitutionally mandated. Delimitation aims to ensure that political representation in Parliament is proportionate to population size [6]. After every Census conducted in India, the number of representatives in Parliament has to be revised to ensure that, across parliamentary constituencies, the number of persons a Member of Parliament represents is more or less equal. Currently, the number of parliamentary seats has been frozen at the level of the population size of the 1971 Census. Any recalibration will disadvantage the states that have reached a below replacement fertility level. States in India which have implemented fertility reduction policies effectively are the ones facing below replacement level fertility and, as a consequence, have low population growth rates. The population in other states, where these fertility reduction policies have not been as effective, has grown at a higher rate. This means, over time, states with a higher population growth rate will have more representatives in Parliament than states which have low population growth rates. This is why states like Tamil Nadu and Kerala view the delimitation process, which will diminish their representation in Parliament, as punishment for their efforts at reducing fertility.

Population control policies in India

In most Indian states, this reduction in fertility rates was achieved by the disproportionate use of female sterilisation, or tubectomy, among all the available contraceptive choices under the Indian Family Welfare Programme. This shift happened partly as a reaction to the Emergency period (1975-77) when there was substantial and coercive use of vasectomy to achieve the State's desired population goals [7].

While population policy in India was not explicit in the early years of the nation's existence, its origins can be traced back to 1952 as part of the first Five-Year Plan, which included a plan for limiting population [8]. Prior to the "Emergency" of 1975-77, the use of incentives to persuade reluctant persons to use contraception was already a part of the Indian Family Planning Programme [9]. The Emergency period saw the use of vasectomy camps for men, along with enhanced incentives and extreme forms of coercion, to achieve targets based on the number of men sterilised [10]. Subsequently, the political party and Government that imposed the Emergency and carried out the coercive population policy was voted out [10]. Due to the backlash against the Emergency, the use of vasectomy shrank over the succeeding decades, and tubectomy was favoured as a primary choice. Throughout, the programme has relied largely on permanent methods. The National Family Health Survey 5 (2019-21) indicates that tubectomies constituted 67.1 percent of the overall use of modern methods of contraception; and vasectomy contributed a mere 0.5 percent [7]. Spacing methods used by women made up 13.8 percent and condom use the remaining 16.8 percent during the period 2019-21. While women are said to have accepted tubectomy voluntarily, this has been in the context of absence of male responsibility for contraception [7]. There is reason to believe that overt and covert forms of contraceptive coercion persist within the Family Welfare programme, obliging women to take on the responsibility for contraception [11].

The central place in this discussion should be that of the woman. The body of the woman who goes through pregnancy and childbirth is the physical means through which reduction or increase in human fertility is achieved, since only women can get pregnant. But when a state develops policies to increase or decrease fertility, and provides financial and non-financial incentives

to do so, it is invading the space which women need to make what should be voluntary reproductive choices. We should, therefore, view these policies as undue inducement to achieve the state's desired population goals.

The instrumental use of women's bodies is inevitable for implementing any policy to regulate human fertility. This has the potential to put the reproductive rights of individual women at risk because of the gendered context in which reproduction is negotiated within Indian families. Patriarchal norms position women lower in power relationships within a marriage, and in the marital family. This power imbalance prevents women from exercising their reproductive rights to choose when and whether to have children. The state's failure to acknowledge this renders policies to increase or decrease fertility unethical. It is in this context that we need to evaluate the policies of Andhra Pradesh and Sikkim seeking to reverse the low fertility levels in their states.

Policies to reverse low fertility in India

In March 2026, the Chief Minister of Andhra Pradesh tabled a Population Management Policy in the state's Legislative Assembly that aims to raise the TFR from 1.4 to 2.1 through the Poshana-Shiksha-Suraksha programme. This promises an amount of Rs 25,000 at the time of birth of a second child, Rs 1,000 monthly assistance for five years, and free education for the second or third or fourth child up to the age of 18 [12]. Making a statement on the policy, the Chief Minister observed that the State's TFR was well below the replacement level of 2.1, and if the trend continued, nearly 23% of the population would be aged 60 years or more by 2047. If the falling TFR was not reversed, the State's shrinking workforce would have to struggle to support a rapidly aging population, "crippling" the economy, he observed. The State therefore has set out to stabilise the TFR at 2.1, and also nearly double women's participation in the labour force to boost the Gross State Domestic Product by 15%, by making provision for workplace crèches, safe transport, and working women's hostels [12].

A very different approach was taken by the state of Sikkim which, in January 2023, developed a comprehensive intervention to boost the population of the indigenous communities of Lepcha, Bhutia and Nepalis [13,14]. The interventions include the Vatsalya Scheme which provides Rs 3 lakh to eligible couples experiencing infertility (in keeping with specified guidelines). Since 2022, the state has provided support for IVF treatment. Other measures include an initiative to plant 108 trees whenever a child is born; the Sikkim Shishu Samriddhi Yojana will also deposit Rs10,800 in the name of each newborn, withdrawable at age 18 [14]. The Sikkim Aama Sashaktikaran Yojana (SASY) supports non-working, unmarried, widowed, divorced and separated mothers, aged 18–59, with an annual grant of Rs 20,000 to set up or invest in small enterprises, and incentives of up to Rs 3 lakh for those who manage to double the amount they have invested in the enterprise. The SASY provision would help mothers support their children's education, enabling them to defray the costs of higher education. The state also provides maternity leave of up to 12 months for women and 1 month for men, as well as additional increments for government servants who have a second or third child [15].

Gendered contexts and potential consequences of incentivising births

In the present context, Andhra Pradesh's financial incentives are unlikely to make a large proportion of middle-class couples opt for another child; but they may act as inducement for vulnerable groups for whom the short-term benefit of this incentive could outweigh the long-term cost of child rearing [16]. Given that age at marriage is rising [17], it is likely that women bearing their second or third child will be doing so at later ages. Independent of other factors, maternal mortality risks rise with age and birth order. Andhra Pradesh's Population Management Policy (2026) has recognised this as it does mention "upgraded healthcare setups, including expanded maternal care facilities and targeted medical monitoring during pregnancy" [12]. However, such provisions alone cannot mitigate the intrinsic risks of maternity. These include the risks of higher order births at later ages among women who are otherwise vulnerable in terms of socio-economic status. Incentives may also have the effect of reducing the desired birth intervals between subsequent children, with adverse consequences for child and maternal health.

The gendered context also casts increasing care burdens on women. Andhra Pradesh has not developed the kind of services necessary for an aging population, which are different from the services needed for the care of children. In fact, most states have built hospitals that attend to maternity needs, schools for children and a modicum of social services. They have not anticipated the kinds of services that will be needed, including geriatric healthcare services in hospitals, and primary and community-based care for the elderly living alone. The elderly need these services to manage their health and possibly assist in the management of everyday life when familial support is diminished or absent. They may need social services tailored to their needs, structural changes in infrastructure, including transport to facilitate their travel, and a host of other services.

Building such services and infrastructure comes with a cost for communities which have to provide for both children and the elderly, with the burden of care falling on women. The AP policy does recognise the increase in care burden for women and has included training for child caretakers and elderly care assistance under the SHAKTI component of its policy. However, this policy does not explain how it expects families to pay for these services [12].

The choice to have a child is a personal decision made by a couple, and in the Indian context it is usually within a familial setting. In such settings, women may not be able to exercise their choice freely, as familial choices may be thrust upon the women. Poor women are more likely to be pressurised to have an additional child merely for the short-term benefit of the incentives.

The ethical challenges in these policies to reverse low fertility

A state may adopt supportive policies to try to reverse declining fertility rates. Both Andhra Pradesh and Sikkim have adopted policies that have many enabling components such as provisioning for educating the child till the age of 18, maternity benefits for men and women in government service, financial aid for women to be economically engaged, providing trained care workers to reduce women's care burdens, and other such initiatives. This is not intrinsically wrong. It may, however, not succeed in reversing the decline in fertility rates. Still, in the process of trying to do so, it may enable women's employment and empowerment through it.

South-East Asian countries such as Japan and Korea have grappled with declining fertility and developed extensive policies to reverse the trend but have not had sustained success with these efforts [18]. The policy interventions resulted in a form of stratified reproduction with slight increases in fertility only among women who were educated and in formal sector employment who could access these benefits. These slight increases did not off-set the overall declines in fertility [18]. Similarly, policies that provide paid maternity and paternity leave benefits, increments for government servants, and subsidies for children may be utilised by only a small proportion of women in formal sector work in Andhra Pradesh and Sikkim. It must be noted that paid maternity and paternity leave benefits are part of basic workers' rights, though poorly implemented in most cases.

The principle of justice requires the State to treat all its citizens fairly and equitably. The policies described above are unfair to women because they will enhance women's risk of maternal mortality and increase their care burdens within households. In India, a major segment of female labour force participation is in the informal sector, and these benefits and incentives may not operate for them. These women in the informal sector will be from socio-economically vulnerable households. It is in these settings that women's vulnerability is exacerbated and the monetary incentives that the programme offers may subvert their reproductive agency. That is what makes the instrumental use of women's bodies, using their biological vulnerability and ignoring their gendered vulnerabilities, unethical. By removing the financial incentives for childbearing the state can prevent this potential risk while implementing the other efforts to enable reversal of low fertility trends. These include efforts at finding solutions for household care responsibilities, enhancing women's labour force participation, providing maternity benefits including extended leave benefits for both parents following child birth, enhancing health facilities for management of high-risk pregnancies and other similar options that the Andhra Pradesh policy has listed. At best, they may meet with success and reverse the declines in fertility; and even if they do not, the process would not have vitiated women's already weak reproductive agency within households and communities.

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