



Population Management

A Life Cycle Model for Andhra Pradesh

Operationalizing the Five-Pillar Model

GOVERNMENT OF ANDHRA PRADESH

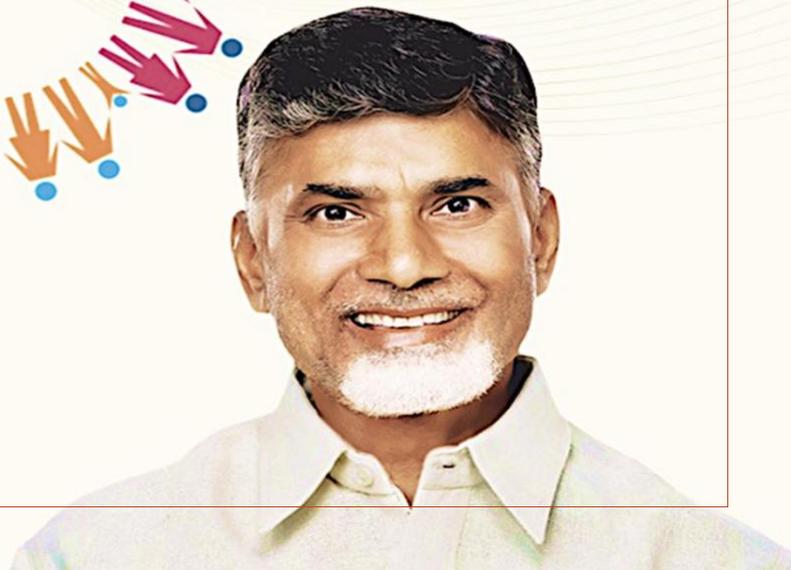


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GLOSSARY OF TERMS AND ABBREVIATIONS

Abbreviation	Full Form / Description
ABDM	Ayushman Bharat Digital Mission – India's national digital health mission.
ABHA	Ayushman Bharat Health Account – A unique 14-digit health ID for every citizen.
ANM	Auxiliary Nurse Midwife – A village-level female health worker.
ART	Assisted Reproductive Technology – Medical procedures used to address infertility (e.g., IVF).
ASHA	Accredited Social Health Activist – A community health worker.
APSSDC	Andhra Pradesh State Skill Development Corporation – The nodal agency for skill development.
CCC	Care Coordination Call Centre – A 24x7 call centre for proactive outreach and care coordination under SANJEEVANI.
CGA	Comprehensive Geriatric Assessment – A multidimensional assessment of an elderly person's health.
CHC	Community Health Centre – A secondary-level health facility.
CHO	Community Health Officer – A mid-level health care provider at a Health and Wellness Centre.
CPE	Continuing Provider Education – Ongoing professional development for healthcare providers.
CVAP	Constituency Vision Action Plan – A localized development plan for each assembly constituency.
DBT	Direct Benefit Transfer – Electronic transfer of subsidies/benefits directly to bank accounts.
DiNC	Digital Nerve Centre – The central command and control center for Project SANJEEVANI.
ECCE	Early Childhood Care and Education – Programs for children from birth to eight years.
FLFPR	Female Labour Force Participation Rate – The percentage of working-age women in the labour force.
GoAP	Government of Andhra Pradesh.
HFR	Health Facility Registry – An ABDM registry of all health facilities.
HIE-CM	Health Information Exchange and Consent Manager – ABDM's consent management framework.
HMIS	Health Management Information System – A government web-based system for monitoring health programs.
HPR	Health Professional Registry – An ABDM registry of all healthcare professionals.
HPSC	High-Powered Steering Committee – The apex body for strategic oversight of this framework.
ICDS	Integrated Child Development Services – A government program for children under 6 and pregnant/lactating mothers.
IEC	Information, Education, and Communication – A strategy for health behaviour change.
IHCDP	Integrated Healthcare Delivery Platform – The core digital platform of Project SANJEEVANI.
IMR	Infant Mortality Rate – Deaths of infants under one year old per 1,000 live births.
IUCD PPIUCD	Intrauterine Contraceptive Device / Post-Partum IUCD – A long-acting reversible contraceptive.

Abbreviation	Full Form / Description
IVF	In Vitro Fertilization – An ART procedure.
KPI	Key Performance Indicator – A measurable value used to track performance.
LHR	Longitudinal Health Record – A citizen's complete health record over time.
M&E	Monitoring and Evaluation – A process for tracking and assessing program performance.
MMR	Maternal Mortality Ratio – Annual maternal deaths per 100,000 live births.
MoHFW	Ministry of Health and Family Welfare (Government of India).
MTP	Medical Termination of Pregnancy – Legal and safe abortion.
MWRA	Married Women of Reproductive Age (usually 15-49 years).
NCD	Non-Communicable Disease – A disease not infectious (e.g., diabetes, heart disease).
NFHS	National Family Health Survey – A large-scale, multi-round household survey.
NHM	National Health Mission – The flagship program for strengthening health systems.
NPHCE	National Programme for Health Care of the Elderly – A central program for geriatric care.
NPV	Net Present Value – A method for valuing long-term financial commitments.
P4 Model	Public-Philanthropic-People's Partnership – A governance model promoted by GoAP.
PAP	Prospective Adoptive Parent – An individual or couple registered to adopt a child.
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act – An act to stop sex-selective abortion.
PHC	Primary Health Centre – The basic unit of public health services in rural areas.
PHWS	Population Health & Wellness Score – A composite health risk score under SANJEEVANI.
PMMVY	Pradhan Mantri Matru Vandana Yojana – A maternity benefit program.
POSHAN	PM's Overarching Scheme for Holistic Nourishment – India's national nutrition mission.
RKSK	Rashtriya Kishor Swasthya Karyakram – India's national adolescent health program.
RMNCH+A	Reproductive, Maternal, Newborn, Child, and Adolescent Health – India's national strategy.
RTI/STI	Reproductive Tract Infection / Sexually Transmitted Infection.
SBCC	Social and Behaviour Change Communication – A strategic process for promoting behaviour change.
SDG	Sustainable Development Goals – A set of 17 global goals adopted by the UN.
SRS	Sample Registration System – A large-scale demographic survey in India.
TFR	Total Fertility Rate – The average number of children a woman would have in her lifetime.
TSU	Technical Support Unit – The dedicated unit for implementing this framework.
UHI	Unified Health Interface – An ABDM framework for service discovery and interoperability.
UWM	Unified Workforce Management – A mobile application for frontline health workers under SANJEEVANI.
VHC	Village Health Clinic – The most peripheral public health facility.

EXECUTIVE SUMMARY

Andhra Pradesh stands at a critical juncture in its developmental trajectory, having successfully transitioned from high population growth to confronting the complex realities of **ultra-low fertility and accelerated population ageing**. With a **Total Fertility Rate (TFR) of 1.5** — significantly below the replacement level of 2.1 — and a **median age of 32.5 years** compared to the national average of 28.4, the state's demographic evolution increasingly parallels that of advanced economies such as Japan and South Korea. This transformation, however, is unfolding within a developing socio-economic framework, presenting unique challenges that threaten the **Swarnandhra@2047** vision.

The consequences of sustained low fertility manifest across three critical dimensions: a shrinking youth base, with the population aged 0–14 projected to decline to **15.7% by 2036**; a rising dependency ratio, with the share of citizens aged 60 and above projected to nearly double to **18.9% by 2036** and reach approximately **23% by 2047**; and significant economic risks — termed **Shrinkonomics** — wherein a shrinking workforce must support a rapidly ageing population. **Closing the Female Labour Force Participation (FLFP) gap has been identified as critical to raising State GSDP by 15%.**

This Framework marks a fundamental philosophical and operational paradigm shift: from **Population Control to Population Care**. The traditional approach — centred on sterilisation targets and two-child norms — is recognised as both outdated and counterproductive in the current context. The new approach positions **families** as the central unit of development planning, grounded in the understanding that sustainable demographic balance must emerge organically from empowered households making informed reproductive choices within a supportive environment. This shift is guided by core principles: being **rights-based and voluntary**; **gender-transformative**; **data-driven** via the SANJEEVANI platform; **fiscally sustainable** through NPV-based budgeting; and anchored in a **Public-Private-People Partnership (P4)** model. The state's role is defined as enabling and supporting — not directing — ensuring that population stabilisation is an outcome of a society in which individuals feel supported at every stage of life.

The policy adopts a **Life-Cycle Model**, recognising that an individual's journey is a continuum in which disruptions at any stage cascade through subsequent phases. The framework's logic is integrated: a healthy pregnancy under **MATRUTVA** leads to a healthy infant; digital tracking via **SANJEEVANI** ensures proactive wellness from childhood; empowered adolescents under **SHAKTI** and **NAIPUNYAM** become skilled adults capable of supporting both children and ageing parents; and **KSHEMA** ensures dignified ageing that allows seniors to remain active contributors through the Silver Dividend.

The strategic objective is to stabilise the population structure by supporting families, ensuring every pregnancy is wanted and healthy, empowering women economically, and skilling the population for a \$2.4 Trillion Economy.

A. THE FIVE-PILLAR STRATEGIC ARCHITECTURE

To operationalise the life-cycle approach, the Framework is structured around **five interconnected strategic pillars**. Each pillar addresses a critical life stage or foundational enabler; together, they form a comprehensive safety net and opportunity network. **SANJEEVANI serves as the central nervous system linking all pillars through real-time data and analytics.**

Pillar I – MATRUTVA: Transforming Reproductive Care

MATRUTVA constitutes the foundational element of the Framework, addressing the beginning of human life through a **comprehensive, rights-based approach**. Its strategic significance extends beyond conventional healthcare to address the demographic imperative arising from the declining TFR. Key interventions include **diversifying the contraceptive method mix** to reduce reliance on female sterilisation from 70% to below 50% over five years, while actively promoting spacing methods. To address the growing burden of infertility, the Framework establishes a **Hub-and-Spoke Model for infertility care** anchored by a **MATRUTVA Centre of Excellence**. Fertility support (IVF/ART cycles) will be **delivered through Government Facilities operating under Public-Private Partnership (PPP) mode**, ensuring these procedures are **available to eligible beneficiaries entirely free of cost**. The pillar further aims to **address high C-section rates through clinical audits and midwifery-led models**, and to **reduce teenage pregnancy from 8.80% to below 3%** through comprehensive sexuality education and strengthened adolescent-friendly health services.

Pillar II – SANJEEVANI: The Digital Backbone

SANJEEVANI represents a transformative reform shifting the public health system from episodic care to a continuous, citizen-centric health ecosystem. It is built on two core principles: **Continuous Lifetime Proactive Healthcare** and **Healthcare Coordination through Digital Intelligence**. The ecosystem comprises an Integrated Healthcare Delivery Platform hosting longitudinal health records, a Care Coordination Call Centre conducting proactive outbound calls, and a Unified Workforce Management application for frontline health workers. Statewide rollout is targeted for **June 2026**, covering **5.2 crore citizens** across 2,086 facilities, positioning Andhra Pradesh as a national leader in digital public health. This digital backbone enables predictive risk alerts, automated follow-ups, and closed referrals — creating an accountable, continuously evolving system of care across all life stages.

Pillar III – SHAKTI: Empowering Women

The **SHAKTI** pillar is the central engine of gender equity, premised on the principle that higher **Female Labour Force Participation (FLFP)** is a critical imperative for demographic stability. The Framework targets a **25% increase in FLFP** by removing structural barriers through workplace crèches, safe transport, and **Working Women Hostels**. A progressive policy reform proposes a **12-month Collective Parental Leave**, with two months per parent designated as non-transferable, to normalise shared caregiving responsibility. The pillar links with NAIPUNYAM to certify childcare providers through a **Child Caretaker Course**, creating dignified employment while enabling other women to enter or remain in the workforce. Entrenched social norms are addressed through the **Shared Parenting Campaign**, which targets men and communities to challenge patriarchal norms and normalise equitable distribution of parenting duties.

Pillar IV – KSHEMA: Dignity and the Silver Dividend

The **KSHEMA** pillar addresses the projected surge in the elderly population to **23% by 2047**, shifting the paradigm from adding years to life to **adding life to years**. Infrastructure goals include ensuring **100% district coverage** for geriatric wards and operationalising bi-weekly geriatric clinics at all 175 Community Health Centres (CHCs). The Framework seeks to monetise the **Silver Dividend** by establishing a **Silver Skills Registry** with a target of **50,000 registered senior consultants**, enabling healthy seniors to remain economically productive. Comprehensive care is further ensured by training

5,000 geriatric care professionals annually and integrating mental health support to address isolation and dementia. Social protection is strengthened through the NTR Bharosa pension scheme, with an additional proposal to explore supplementary pensions for households with larger family sizes.

Pillar V – NAIPUNYAM: Skilling for the Future Economy

The **NAIPUNYAM** pillar is the critical economic engine ensuring the population is sufficiently skilled and productive to realise the **Swarnandhra 2047 vision**. The strategy is structured across three tiers: Foundational Digital Literacy; a **Care Economy Workforce** through Child Caretaker and Geriatric Assistant training; and high-end skilling aligned with the **610 MoUs** signed at the CII Summit. The Framework mandates that skilling translate into tangible economic outcomes, tracked via the Family Card, with targets of a skilling completion rate of **>75%** and a placement rate of **>80% by 2035**.

B. IMPLEMENTATION, GOVERNANCE, AND FINANCIAL SUSTAINABILITY

- **Implementation Architecture and Governance.** The Framework is anchored by a **Population Management Mission** headed by the Secretary, Health and Family Welfare. A **High-Powered Steering Committee** chaired by the **Chief Minister** provides strategic political oversight, while a **Technical Support Unit (TSU)** under Project SANJEEVANI serves as the apex technical coordination body for data analytics and adaptive policy refinement. The **Family Card** is the single authoritative source of welfare data, used for precise beneficiary identification, prevention of duplication, and longitudinal outcome tracking across all five pillars. Dedicated teams at the State, District, and Mandal levels are responsible for execution, supported by real-time dashboards powered by SANJEEVANI data for all stakeholders, including District Collectors and Department Heads.
- **The Poshan Shiksha Suraksha Package.** To support family expansion, a comprehensive incentive package — the **Poshan Shiksha Suraksha Package** — is proposed for households welcoming a third child. This includes: a **Poshan** component providing a **₹1,000/month** direct cash transfer for the first five years, conditional on full immunisation and growth monitoring; a **Shiksha** component covering the full cost of education up to age 18 years at a government residential or public school of the parents' choice; a **Suraksha** component providing comprehensive, lifetime health insurance at the highest care bracket for the entire household; and a **Direct Birth Incentive** of **₹25,000** is proposed for second childbirth onwards. The estimated **Year 1 outlay is approximately ₹521.25 crore**, based on an assumption of **75,000 eligible families**.
- **Financial Modelling and Sustainability.** Expenditures under this Framework are treated as **investment in human capital**, not consumption. Long-term commitments are modelled using **Net Present Value (NPV) analysis** to ensure fiscal prudence. Funding will be sourced through reallocation of existing resources, dedicated budget lines, **P4 partnerships**, and CSR contributions, with specific exploration of a **Demographic Resilience Fund**. The Framework prioritises convergence and rationalisation of existing schemes before proposing new unfunded expenditures. Annual evidence-based policy reviews conducted by the TSU will analyse progress against Key Performance Indicators (KPIs) and propose targeted refinements based on emerging data.
- **Phased Implementation Roadmap.** Implementation follows a phased structure: **Year 1 (Foundation Building)** focuses on completing the SANJEEVANI statewide rollout by June 2026, launching social movement campaigns, and formally constituting the Population Stabilisation Task Force. **Year 2 (Statewide Scaling)** involves establishing the MATRUTVA Centre of Excellence, scaling the Child Caretaker Course, and maturing SANJEEVANI analytics with AI/ML

capabilities. **Years 3 and beyond (Consolidation and Adaptation)** focus on ensuring geriatric infrastructure reaches full maturity and developing robust long-term social security for the elderly. KPIs tracked over a 10-year horizon include: increasing **TFR towards the replacement level of 2.1**, increasing **FLFP by 25%**, reducing **IMR to below 5**, and stabilising the **Elderly Dependency Ratio by 2040**.

This Framework constitutes a **social contract for the future** — one that **reframes population from a problem to be managed into a dynamic asset to be nurtured**. Its success depends on a genuine **Public-Private-People Partnership**: The Government sets the vision; the Private Sector builds family-friendly workplaces; and the People engage actively in their own well-being. Together, Andhra Pradesh can convert its demographic transition into a national model, ensuring that today's **demographic dividend does not become tomorrow's demographic debt**.

CHAPTER 1: THE DEMOGRAPHIC IMPERATIVE – FOUNDATIONS FOR A NEW FRAMEWORK

Andhra Pradesh stands at a critical inflection point in its developmental trajectory. The state has successfully transitioned from the challenges of high population growth in the previous century to confronting the complex realities of sub-replacement fertility and accelerated population ageing. With a **Total Fertility Rate (TFR) currently estimated at 1.5 — significantly below the replacement threshold of 2.1** — the state's demographic evolution increasingly parallels patterns observed in advanced economies such as **Japan** and **South Korea**. This transformation, however, is unfolding within a socio-economic framework that remains distinctly Indian, presenting challenges and opportunities that demand nuanced policy responses. The **median age in Andhra Pradesh stands at 32.5 years, compared to India's national average of 28.4 years**, indicating an ageing trajectory that requires immediate strategic attention. The state's **demographic window of opportunity will last only until approximately 2040**, after which ageing pressures will intensify significantly.

Table 1.1: Key Demographic Indicators – Andhra Pradesh vs. National and Global Benchmarks

Indicator	Andhra Pradesh	India	Global Benchmark
Median Age	32.5 Years	28.4 Years	Japan: 49.5 (Oldest) / Niger: 14.5 (Youngest)
Total Fertility Rate (TFR)	1.5 (Below Replacement)	~2.0 (Replacement Level)	Replacement Level: 2.1
Life Expectancy	70.6 Years	72.03 Years	Hong Kong: 85.8 Years
Female Workforce Participation	31% (Gap vs. Male: 28%)	~37%	Iceland: ~80% / Sweden: ~80%
Productivity (GDP/Hour)	~\$9.20 (Estimated)	~\$8.70 (Rank 96)	Luxembourg: ~\$146

Source: Technical Group on Population Projections, MoHFW (2020); SRS Statistical Report 2023

A. THE CORE CHALLENGE: ULTRA-LOW FERTILITY AND ITS IMPLICATIONS

The most defining feature of Andhra Pradesh's demography is its sustained low fertility. The TFR has remained below the replacement level of 2.1 for over a decade. As per the most recent Sample Registration System (SRS) data and state government estimates, the TFR stands at approximately 1.5 — significantly lower than the national average of 2.0 and placing the state among the lowest fertility regions in India, comparable to its southern neighbours **Tamil Nadu** and **Kerala**.

Table 1.2: Trends in Total Fertility Rate (TFR) – Andhra Pradesh (2011-2025)

Period	Population Growth Rate (%)	CBR (per 1000)	Total Fertility Rate
2011-15	7.1	15.2	1.68
2016-20	5.4	13.8	1.61
2021-25	3.5	12.2	1.54
2026-30 (Proj.)	1.7	10.9	1.51
2031-35 (Proj.)	0.3	9.9	1.50

Source: Source: Report of the Technical Group on Population Projections for India and States 2011-2036

The consequences of sustained low fertility manifest in three critical dimensions:

- **Shrinking Youth Base:** The proportion of the population aged 0-14 years is projected to decline sharply from over 25% in 2011 to 15.7% by 2036. This translates to a smaller pool of future

workers, students, and consumers, potentially constraining long-term economic growth and innovation capacity.

- **Rising Dependency Ratio:** Concurrently, the share of the *population aged 60 years and above is projected to nearly double, from ~10% in 2011 to 18.9% by 2036*. By 2047, this figure is expected to reach ~23%, meaning nearly one in four persons in Andhra Pradesh will be a senior citizen. This structural shift places immense pressure on public finances, as a smaller working-age population must support a growing number of elderly dependents.
- **Economic Implications:** Closing the female labour force participation gap and increasing the women participation to 60% can raise State GSDP by an estimated 15%. This economic imperative underscores the centrality of the SHAKTI pillar, in which women's workforce participation is not merely a social objective but a critical driver of demographic stability and economic vitality.

B. FROM POPULATION CONTROL TO POPULATION CARE

This Framework heralds a fundamental philosophical and operational paradigm shift: from **"population control" to "population care."** The new approach positions families — not abstract population statistics — as the central unit of development planning. It recognises that sustainable demographic balance cannot be engineered through administrative directive but must emerge organically from empowered households making informed reproductive choices within a supportive social, economic, and institutional environment.

The traditional paradigm of **"population control,"** with its focus on sterilisation targets and two-child norms, is not only outdated but counterproductive in the current context. It fails to address the complex interplay of socio-economic factors that drive fertility decisions and ignores the profound implications of a rapidly ageing society. The shift to **"population care"** is not merely semantic; it is the foundational principle upon which the entire **Five-Pillar Strategy** is built.

C. THE REPRODUCTIVE HEALTH PARADOX

Andhra Pradesh's low fertility co-exists with a set of complex and often contradictory reproductive health indicators, suggesting that the fertility decline is not solely a result of conscious, well-informed choice but also of systemic health issues and programmatic legacies.

- **High Sterilisation Rates:** The state's family planning method mix is heavily skewed towards terminal methods. Approximately **70% of married women undergo sterilisation**, often at a **young age (23–25 years)**. The Kuppam Pilot data revealed a **69.6% sterilisation-driven family planning mix**, with **IUD uptake remaining negligible at 0.2%**, indicating provider bias, constrained informed choice, and low male engagement.
- **Alarming Hysterectomy Rates:** Andhra Pradesh has one of the **highest rates of hysterectomies in India among women aged 15–49 (approximately 8.7%)**. This points to potential over-medicalisation, unethical practices in the private sector, and inadequate access to quality alternative treatments for conditions such as fibroids or excessive uterine bleeding.
- **High Infertility Burden:** Current epidemiological data indicates that infertility affects approximately **15% of reproductive-age couples across India**, translating to an **estimated 3.5 crore couples** requiring medical intervention, according to multi-centric studies coordinated by the **Indian Council of Medical Research (ICMR)**. While state-specific surveillance remains limited, modelled estimates for Andhra Pradesh suggest a prevalence rate of approximately **15%**, **implying that roughly 11.7 lakh couples** in the state are affected — a figure derived from

National Family Health Survey-5 (NFHS-5) reproductive indicators and regional demographic audits. Despite this significant burden, public health infrastructure remains critically under-resourced: fewer than **15% of district hospitals** are currently equipped to provide basic infertility screening or first-line treatment, forcing the majority of couples to rely on costly private sector services. To align with Sustainable Development Goal (SDG) 3.7 on universal access to sexual and reproductive healthcare, population management policies must prioritise capacity building for **district-level OBGYNs**, expand **public-sector Assisted Reproductive Technology (ART) services**, and **establish state-level infertility registries**.

- **Persistent Adolescent Health Concerns:** Despite low overall fertility, the state grapples with a high prevalence of teenage pregnancy. The **state average stands at 8.80%**, well above the **5% benchmark target**, with **21 of 28 districts exceeding this threshold**. Only Visakhapatnam (3.98%) remains below target. The **highest-burden districts include Palnadu (14.94%)** and **Kurnool (13.50%)**, indicating **significant geographic clustering in the Rayalaseema and South Coastal regions**.

Table 1.3: Teenage Pregnancy Distribution by District Category (FY 2025-26)

Category	Percentage Range	Districts
Below Target	<5%	Visakhapatnam
Moderate	5-8%	Konaseema, West Godavari, Parvathipuram Manyam, Srikakulam, Vizianagaram, Krishna, Anakapalli, NTR, YSR Kadapa
High	8-10%	Alluri Sitharama Raju, Kakinada, East Godavari, Guntur
Very High	10-12%	Eluru, Annamayya, Chittoor, Tirupati, Sri Sathya Sai, Nandyal
Critical	>12%	SPSR Nellore, Prakasam, Anantapur, Bapatla, Kurnool, Palnadu

Source: Sample Registration System (SRS) Statistical Report 2023, Pg. No. 58

D. INSTITUTIONAL DELIVERY AND C-SECTION TRENDS

Analysis of institutional delivery patterns reveals significant public-private sector disparities requiring policy attention. During **April–January FY 2025–26**, the **private sector accounted for 57.1% of institutional deliveries (3,08,130 deliveries)** compared to **42.9% in the public sector (2,31,805 deliveries)**. More concerning is the **C-section rate disparity: private facilities recorded 67.6% of deliveries as C-sections**, compared to **42.1% in public facilities**. This wide disparity suggests possible over-medicalisation in private care, and warrants strengthened public obstetric services, enforced clinical audits, and scaled midwifery-led normal delivery models.

Table 1.4: Institutional Deliveries and C-Section Trends (April-January FY 2025-26)

Indicator	Public Sector	Private Sector
Institutional Deliveries	2,31,805 (42.9%)	3,08,130 (57.1%)
C-Sections	97,508 (42.1%)	2,08,227 (67.6%)

Note: C-sections as percentage of institutional deliveries within sector. HMIS

E. SOCIO-ECONOMIC DRIVERS OF DEMOGRAPHIC CHANGE

Fertility decisions are not made in a vacuum. Several powerful socio-economic factors are driving couples in Andhra Pradesh towards smaller families:

- **The Rising Cost of Child-Rearing:** The government's public consultation — which received over 4,33,000 responses — found that 53.7% of citizens cited high child-rearing costs as the greatest barrier to having more than one child. This economic reality cannot be addressed through health policy alone.
- **The Erosion of the Joint Family System:** The traditional joint family system, which once provided built-in childcare, emotional support, and financial security, is being eroded by urbanisation and shifting social norms. The rise of nuclear families places the burden of childcare squarely on individual parents, disproportionately on mothers.
- **Urbanization and Changing Aspirations:** As more people move to urban centres and pursue professional careers, young people increasingly prioritise financial stability, work-life balance, and personal fulfilment — trends that often lead to delayed marriage and childbearing.

F. ECONOMIC, SOCIAL, AND POLITICAL IMPLICATIONS

This demographic trajectory carries cascading consequences that threaten the foundations of the Swarnandhra@2047 vision.

- **The Shrinking Demographic Dividend:** With nearly 63% of the state's population below the age of 35, Andhra Pradesh currently possesses a significant demographic dividend. However, this window is closing. A shrinking youth population means a smaller future workforce. If this workforce is not healthy, educated, and skilled, the dividend will give way to a demographic debt.
- **The Rising Dependency Ratio and Fiscal Pressure:** The shifting age structure will place substantial pressure on public finances. Pension systems such as NTR Bharosa, healthcare infrastructure requiring expanded geriatric capacity, and social welfare programmes will all face increasing strain.
- **The Challenge of Political Representation and Federal Transfers:** In India's federal structure, population size influences parliamentary representation and the allocation of central resources through Finance Commission awards. States that have successfully stabilised their populations early risk being fiscally and politically disadvantaged as their share of the national population declines.

CHAPTER 2: A NEW PARADIGM – THE LIFE-CYCLE MODEL OF POPULATION MANAGEMENT

The demographic challenges described in Chapter 1 are deeply interconnected. The reasons for low fertility are not confined to the health sector; they are rooted in economics, education, gender dynamics, and social support systems. A couple's decision to have a child is influenced by their confidence in the healthcare system, their ability to balance work and family, the availability of quality childcare, their job security, and their prospects for a dignified old age. A policy response that addresses any single dimension in isolation is therefore insufficient.

The Life-Cycle Model represents a paradigm shift designed to address this interconnectedness. It moves away from viewing population management as a series of standalone programmes and instead builds a supportive ecosystem that nurtures human potential from conception to old age. The core logic is simple yet profound: disruptions or absence of support at any life stage have cascading effects on the entire life cycle and, consequently, on the state's demographic structure and economic prosperity.

- A healthy pregnancy (MATRUTVA) leads to a healthy infant.

- A well-nourished child, tracked by a digital health system (SANJEEVANI), becomes a capable adolescent.
- A healthy adolescent, supported by empowering social norms (SHAKTI) and quality education, becomes a skilled and productive adult.
- A skilled adult (NAIPUNYAM) contributes to the economy, supporting both children and ageing parents.
- A financially secure and healthy adult, with access to quality geriatric care (KSHEMA), ages with dignity and continues to contribute to society.

This Framework recognises that population stabilisation is not a goal in itself but an outcome of a society in which individuals and families feel supported and empowered at every stage of life.

A. INTRODUCING THE FIVE-PILLAR STRATEGY: AN INTEGRATED ARCHITECTURE

To operationalize this life-cycle approach, the Framework is structured around five interconnected strategic pillars. Each pillar addresses a critical life stage or a foundational enabler; together, they form a comprehensive safety net and opportunity network.

Table 2.1: The Five-Pillar Strategy – Overview and Strategic Focus

Pillar	Name Meaning	Focus Area	Strategic Objective
MATRUTVA	Motherhood	Reproductive Care & Fertility Ecosystem	Shift from family-size control to comprehensive family support; ensure every pregnancy is wanted and healthy
SANJEEVANI	Life-Giving	Preventive & Predictive Healthcare	Build digital backbone for life-course health; enable proactive, data-driven wellness management
SHAKTI	Power/Strength	Women's Workforce & Household Empowerment	Create enabling environment for women's economic participation; dismantle structural barriers
KSHEMA	Well-being	Active Ageing & Elderly Care	Reframe aging as opportunity; ensure dignified, productive old age
NAIPUNYAM	Skill/Expertise	Lifelong Skilling & Human Capital	Equip population with skills for \$2.4 trillion economy; professionalize care economy

B. THE SYNERGY IN ACTION: HOW THE PILLARS INTERCONNECT

The strength of the Five-Pillar Strategy lies not in the individual pillars but in their compounding synergy. A young woman's journey through life illustrates this clearly:

As an adolescent, she benefits from SANJEEVANI-enabled health screenings in school that detect and address nutritional anaemia. She is also exposed to foundational skills and career guidance through NAIPUNYAM programmes. As she enters marriage, SHAKTI policies and pre-marital counselling help her and her partner build a relationship grounded in shared responsibility. When she decides to have a child, MATRUTVA provides quality antenatal care, a safe delivery, and postpartum support — all tracked seamlessly in her SANJEEVANI digital health record. To return to work, she relies on an affordable crèche staffed by a caregiver trained through NAIPUNYAM's Child Caretaker Course. Her husband, influenced by the Shared Parenting Campaign, takes non-transferable paternity leave. As she ages, SANJEEVANI helps manage her health and flags early indicators of

chronic conditions. Eventually, KSHEMA ensures she ages with dignity, with access to geriatric care and, where appropriate, an opportunity to contribute her professional expertise as part of the Silver Dividend.

This integrated logic ensures that a family's decision to have a child is supported by a web of interconnected systems, making that decision a positive and empowering one.

C. GUIDING PRINCIPLES OF THE FRAMEWORK

The implementation of the Five-Pillar Strategy will be governed by the following core principles:

- **Rights-Based and Voluntary:** All interventions will be grounded in the principles of reproductive rights, bodily autonomy, and informed choice. There will be no coercion, no targets, and no discrimination. The state's role is to enable and support, not to direct.
- **Gender-Transformative:** The framework explicitly aims to challenge and change harmful gender norms. It promotes shared responsibility in childcare, equal opportunities for women in the workforce, and the active engagement of men in reproductive health and family life.
- **Data-Driven and Evidence-Based:** SANJEEVANI will serve as the central nervous system for the entire Framework. All policies and programmes will be continuously monitored, evaluated, and refined based on real-time data and rigorous evidence.
- **Fiscally Sustainable:** Long-term commitments, such as scholarships for the third child, will be modelled using Net Present Value (NPV) analysis. The framework will prioritise the convergence and rationalisation of existing schemes before proposing new, unfunded expenditures.
- **Public-Private-People Partnership (P4):** The Framework embraces a collaborative governance model that leverages government resources, private sector innovation, and community participation to achieve demographic objectives.

CHAPTER 3: DEMOGRAPHIC DEEP DIVE – GRANULAR ANALYSIS FOR TARGETED ACTION

A. DISAGGREGATING FERTILITY DYNAMICS

The state's aggregate TFR of 1.5, while confirming that Andhra Pradesh has firmly transitioned below replacement-level fertility, masks a complex tapestry of reproductive behaviour across its 28 districts. A granular analysis of this spatial heterogeneity is an essential prerequisite for calibrating interventions to local realities and directing resources to areas of greatest need.

Drawing upon validated administrative data from the FY 2023-24, districts may be classified into three distinct fertility regimes, each characterized by unique demographic dynamics and requiring correspondingly differentiated strategic responses.

Table 3.1: District-Wise Categorization by Total Fertility Rate with Strategic Implications

Fertility Category	TFR Range	Districts with TFR Values	Demographic Characteristics	Strategic Implications
High Fertility	> 1.7	Alluri Sitharama Raju (1.87), Kurnool (1.85), Srikakulam (1.77)	Predominantly rural districts with lower female literacy	Prioritize strengthening maternal and child health service delivery; address unmet family planning

Fertility Category	TFR Range	Districts with TFR Values	Demographic Characteristics	Strategic Implications
			and later age at marriage; higher unmet need for spacing methods	needs through comprehensive contraceptive access; promote optimal birth spacing via targeted community-based counselling
Moderate Fertility	1.4 – 1.7	YSR Kadapa (1.64), Anantapur (1.66), Tirupati (1.63), NTR (1.59), Visakhapatnam (1.58), Sri Sathya Sai (1.58), Parvathipuram Manyam (1.43), Prakasam (1.46), Palnadu (1.46), Vizianagaram (1.46), Bapatla (1.43), West Godavari (1.43), Guntur (1.48), Krishna (1.48)	Mixed urban-rural composition; transition zones with evolving reproductive norms; established health infrastructure	Sustain informed reproductive choice; expand access to modern spacing methods; initiate foundational work on fertility preservation and infertility care services
Ultra-Low Fertility	< 1.4	Annamayya (1.39), Chittoor (1.38), Nandyal (1.36), Eluru (1.35), Kakinada (1.35), Sri Potti Sriramulu Nellore (1.34), Dr. B.R. Ambedkar Konaseema (1.34), East Godavari (1.31), Anakapalli (1.29)	Predominantly coastal and delta districts; higher urbanization and female workforce participation; delayed marriage and childbearing	Designate as high-priority for fertility-supportive policies; expand access to affordable infertility treatment; cultivate positive social narrative around family formation; systematically mitigate structural barriers to childbearing

Source: National Family Health Survey (NFHS) 2019-21

This district typology is conceived not as a static classification but as a dynamic framework for ongoing policy refinement and resource allocation. It will serve as the foundational analytical tool for the proposed Technical Support Unit, enabling evidence-guided decisions regarding resource allocation, communication strategy, and intervention prioritisation.

B. TEMPO AND TIMING OF FERTILITY

Beyond the quantum of fertility, the tempo - or timing - of childbearing provides indispensable insights into evolving reproductive behaviours and identifies critical leverage points for policy intervention.

- **Adolescent Fertility:** Notwithstanding the state's low overall fertility, the proportion of pregnancies among adolescents aged 15 to 19 remains a significant public health concern, with current estimates placing the state average stands at 8.8% - well above the 3% benchmark target. This is inextricably linked to adverse outcomes including elevated maternal mortality and morbidity, higher rates of infant mortality and low birth weight, constrained educational attainment

and economic prospects for young mothers, and the intergenerational transmission of poverty. The strategic response must be comprehensive and multi-sectoral. Foremost, the Prohibition of Child Marriage Act, 2006 must be operationalised with renewed vigour through multi-departmental district task forces integrating the police, education, and women and child welfare departments.

- **The Prime Childbearing Years (Ages 20-29):** This cohort accounts for the majority of births in Andhra Pradesh while simultaneously navigating critical educational and career establishment phases. This convergence of reproductive prime with career formation creates inherent tension that increasingly shapes fertility outcomes. The strategic imperative for this cohort centres on enabling — rather than directing — reproductive choices, and on removing structural impediments to family formation. The SHAKTI pillar's commitments to flexible work arrangements, adequately funded parental leave, and accessible childcare infrastructure are of particular importance here.
- **Late-Age Childbearing (Ages 35 and above):** As women increasingly pursue higher education and professional trajectories, and as couples prioritize economic stabilization before family formation, the mean age at first birth is gradually rising across Andhra Pradesh. While this trend reflects positive developmental achievements, delayed childbearing is associated with elevated risks of infertility, prolonged time to conception, miscarriage, and obstetric complications.

C. THE EVOLVING CONCEPT OF UNMET NEED

The conventional demographic definition of unmet need captures the gap between women's desire to limit or space births and their non-use of contraception. In contemporary Andhra Pradesh, a more expansive conceptualisation is required – one that encompasses the emerging unmet need for quality, comprehensive reproductive health services extending well beyond traditional contraceptive provision.

- **Contraceptive Method Mix:** With approximately 70% of married women relying on female sterilization, Andhra Pradesh exhibits one of the most skewed contraceptive methods mixes not only in southern India but nationally. The Kuppam Pilot confirmed a 69.6% sterilization-driven mix, with IUD uptake at a negligible 0.2%, indicating provider bias, constrained informed choice, and low male engagement.
- **The Hysterectomy Phenomenon:** The elevated rates of hysterectomy observed in Andhra Pradesh – particularly clustered in specific districts and demographic subgroups – constitute a serious public health concern warranting urgent investigation and decisive policy response. While medically indicated hysterectomies are appropriate and necessary, the volume of procedures and their geographic and socioeconomic clustering strongly suggest widespread over-treatment.
- **Infertility: Modelled epidemiological estimates indicate an infertility prevalence of 10% in Andhra Pradesh, aligning with the national trends of 15% reported by the Indian Council of Medical Research (ICMR), and affecting an estimated 11.7 lakh couples who face significant barriers to diagnostic and treatment services. Involuntary childlessness represents a critical unmet reproductive need that must be addressed to ensure equitable reproductive health outcomes. The psychosocial burden of infertility is clinically significant, recognised by the World Health Organization (WHO) as a disease condition associated with elevated rates of anxiety, depression, and marital discord. Population management strategies must therefore include structured mental health support and subsidized treatment pathways within a rights-based healthcare framework.**

D. SYSTEMATIC MAPPING OF FLOWS FOR PROACTIVE MULTI-SECTORAL PLANNING

A critical data gap impeding evidence-based policy is the absence of a real-time, granular migration tracking system capturing the volume, direction, composition, and timing of population movements into, within, and out of Andhra Pradesh. The SANJEEVANI platform presents a transformative opportunity to address this gap.

- **Out-Migration of Skilled Youth:** Consistent evidence points to significant out-migration of educated youth from rural areas and smaller towns to metropolitan centres, driven by higher education and professional employment. If substantiated through systematic data collection, this trend constitutes a brain drain that depletes the state's most valuable human capital.
- **In-Migration as a Workforce Strategy:** Neighbouring states with comparable low-fertility profiles — notably Kerala and Tamil Nadu — have successfully mitigated labour market shortages by attracting migrant workers from higher-fertility states. Andhra Pradesh must prepare for a future in which in-migration becomes an increasingly significant demographic and economic phenomenon.

E. TRANSLATING GRANULAR ANALYSIS INTO DIFFERENTIATED ACTION

The analysis in this chapter reveals a state of substantial heterogeneity, requiring nuanced, differentiated responses.

The **establishment of a State Population Data Registry** is mandated as an urgent priority. Currently maintained in the form of Household and Resident Data by the SGSW Department, this registry shall be strengthened to integrate all demographic data streams — including civil registration systems capturing births, deaths, and marriages — and linked to the SANJEEVANI platform for real-time population tracking. It shall be further informed by periodic survey estimates (NPHC, SHS, and others) to consolidate and enrich the household database.

The **institutionalisation of annual district demographic profiles** represents an essential step towards decentralising evidence-based planning. These profiles shall extend well beyond the TFR to encompass contraceptive method mix, age-specific fertility rates, hysterectomy rates, adolescent fertility trends, infertility prevalence estimates, and migration flows.

Dedicated research funding shall be allocated for mixed-methods studies investigating priority questions, including the root causes of elevated hysterectomy rates.

The **Technical Support Unit** shall be mandated to operationalise data-driven, district-specific action plans that are authentically responsive to local demographic realities and strategic priorities, moving beyond one-size-fits-all approaches.

CHAPTER 4: PILLAR I – MATRUTVA: TRANSFORMING REPRODUCTIVE AND FERTILITY CARE

A. KEY IDEAS AND STRATEGIC OBJECTIVES

The MATRUTVA pillar constitutes the foundational element of the Framework's life-cycle model, addressing the beginning of human life with a comprehensive, rights-based approach that fundamentally reorients the state's reproductive health paradigm. This pillar represents a decisive shift away from the decades-old programmatic focus on population control and female sterilization,

toward a holistic vision of reproductive well-being encompasses the full spectrum of individual and family needs.

The strategic significance of MATRUTVA extends beyond conventional healthcare delivery. It addresses the quantitative imperative of demographic stabilization – in the context of a TFR of 1.5, substantially below the replacement level of 2.1 — and the qualitative dimension of reproductive health outcomes that determine maternal and child well-being across generations.

Table 4.1: MATRUTVA Pillar – Strategic Objectives and Expected Outcomes

Strategic Objective	Key Interventions	Expected Outcome
Enable informed, voluntary, and healthy reproductive choices	Comprehensive contraceptive counselling; full range of modern methods; rights-based approach	Couples make informed decisions aligned with life circumstances and aspirations
Ensure every pregnancy is wanted, safe, and leads to healthy mother and child	Preconception care; comprehensive antenatal care; skilled birth attendance; postnatal support	Reduced maternal and infant mortality; improved birth outcomes
Address the full spectrum of reproductive health needs	Adolescent services; infertility support; RTI/STI management; reproductive cancer screening; menopause care	Comprehensive reproductive health across life course
Transform the legacy of sterilization-centric program	Recalibrate incentive structures; retrain providers; reshape public perceptions; build trust	Balanced contraceptive method mix; genuine reproductive autonomy

B. DIVERSIFYING THE CONTRACEPTIVE METHOD MIX

The most critical task of the MATRUTVA pillar is to correct state's highly skewed contraceptive method mix, in which female sterilization accounting for over 70% of modern contraceptive use. The Kuppam Pilot conformed a 69.6% sterilization-driven mix with IUD uptake at 0.2%.

- **Supply-Side Readiness:** Ensuring consistent availability of all modern contraceptives at all levels of the health system is the foundational requirement for method diversification. This demands comprehensive procurement and logistics strengthening to prevent stockouts and maintain buffer stocks at district warehouses.
- **Demand Generation:** Supply-side readiness must be matched by sustained demand-generation efforts through comprehensive Information, Education, and Communication (IEC) campaigns that address pervasive myths deterring couples from adopting reversible contraception.
- **Post-Partum IUCD (PPIUCD):** The immediate postpartum period represents a critical opportunity to offer spacing methods, as women are highly motivated to prevent rapid repeat pregnancies, are already in contact with the health system, and can receive the method before discharge.
- **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 sterilization compared to spacing methods. **All incentives for sterilisation shall be eliminated and replaced by incentives for adoption of spacing techniques.**
- **Quality, Non-Coercive Counselling:** The transformation to a rights-based, choice-focused approach ultimately depends on the quality of counselling at every interaction between clients and the health system.

Table 4.2: Proposed Rebalancing of Contraceptive Method Mix Targets

Method Category	Current Share (%)	5-Year Target (%)	10-Year Target (%)	Strategic Priority
Female Sterilization	70	50	50	Gradual reduction through informed choice
Male Sterilization	0.5	5	10	Aggressive promotion through male engagement
IUCD/PPIUCD	0.2	20	50	Major expansion through quality services
Injectable Contraceptives	2	7	10	Rapid scale-up with community-based delivery
Oral Pills/Condoms	7.5	10	10	Sustained availability and promotion

C. BUILDING A COMPREHENSIVE INFERTILITY CARE PATHWAY

Addressing infertility represents a groundbreaking dimension of the **MATRUTVA framework**. For the estimated **11.7 lakh couples in Andhra Pradesh** facing infertility, the inability to have a child is a source of profound personal distress with significant social and psychological consequences. State-specific projection derived from NFHS-5 indicators indicate a prevalence of **15%**, underscoring the urgent necessity of integrating fertility care into public health services.

- **De-stigmatizing Infertility:** A sustained public awareness campaign will be launched to normalize the experience of infertility and reshape public understanding through multiple platforms.
- **Support for Infertility Treatment:** Fertility Support (IVF/ART cycles) will be **delivered through Government Facilities operating under the Public-Private Partnership (PPP) mode**, ensuring these procedures are **available to beneficiaries entirely free of cost**. The programme targets coverage of **50,000 couples annually**.
- **Hub-and-Spoke Model:** Access to IVF is currently limited to the private sector and remains prohibitively expensive for most couples, with a single cycle costing between ₹1.5 lakh and ₹2.5 lakh. The MATRUTVA Centre of Excellence in Reproductive Medicine will be established as a state-of-the-art facility at a major medical college – such as Sri Venkateswara Institute of Medical Sciences, Tirupati, or Andhra Medical College, Visakhapatnam – offering a full range of ART services. The state shall also incentives to establish such colleges of Fertility Management in PPP mode by providing land at subsidised rates and other eligible incentives.
- **Academic Architecture:** Andhra Pradesh aims to establish itself as India's first Fertility Education Hub, offering the following training pathways:
 - **6-Month Diploma:** Diagnostics, Ovulation induction, ART basics (IUI/IVF), Embryology exposure, ethics.
 - **1-Year Advanced ART Fellowship:** ICSI, IMSI, Embryo biopsy, Cryopreservation.
 - **International Observer Programmes:** Positioning Andhra Pradesh as a global training destination.

Table 4.3: MATRUTVA Centre of Excellence – Training Pipeline

Program	Duration	Key Components	Target Output
Diploma in Reproductive Medicine	6 Months	Diagnostics, Ovulation induction, ART basics (IUI/IVF), Embryology exposure, Ethics	District-ready fertility specialists
Advanced ART Fellowship	1 Year	ICSI, IMSI, Embryo biopsy, Cryopreservation, Research/Audits	Tertiary care specialists
Super Specialty Degree	2 Years	MD / PG Diploma Courses	Tertiary care specialists
International Observer Program	Variable	Global best practices, Advanced techniques	International trainees

D. ENSURING SAFE MOTHERHOOD AND QUALITY PERINATAL CARE

- **Addressing the High C-Section Rate: Over 67.6% of deliveries in the private sector and 42.1% in public facilities now occur by C-section** (April - January FY 2025-26). This exposes women to increased risks in current and future pregnancies, adds to healthcare costs, and may adversely affects fertility. **The incentives and package rates offering for C-Section deliveries under NTR Vaidya Seva / Universal Health Insurance for private healthcare facilities shall be withdrawn.**
- **Strengthening Antenatal and Postnatal Care:** A common database for pregnant women and lactating mothers that shall be maintained by Health Department and utilised by the Women & Child Development (WCD) Department for POSHAN and other related services. All antenatal and postnatal care services provided by both departments shall be tracked through the SANJEEVANI digital backbone.
- **Promoting Maternal Nutrition and Lifestyle Management:** Specific nutrition packages for pregnant women and lactating mothers shall be prescribed based on individual requirements assessed through antenatal and postnatal checkups, operationalising the principle that healthy mothers rearing healthy children.

E. ADDRESSING ADOLESCENT REPRODUCTIVE HEALTH

- **Comprehensive Sexuality Education in Schools:** The government will work with the Education Department to introduce a scientifically accurate, age-appropriate, and culturally sensitive comprehensive sexuality education (CSE) curriculum in all upper primary and secondary schools (Classes 6-12). School Health and Wellness Teams shall be established, with one or two staff members designated as School Counsellors. and Wellness Teams shall be established, with one or two staff members designated as trained School Counsellors. Adolescent-led peer educator groups (SAKHI) shall be formed as part of these teams, with clear Standard Operating Procedures (SOPs) and referral pathways to adolescent-friendly health clinics (AFHCs). A Knowledge Partner / Technical Support Agency shall be onboarded to provide domain knowledge and technical support.
- **Strengthening Adolescent-Friendly Health Clinics (AFHCs):** Under the Rashtriya Kishor Swasthya Karyakram (RKSK), every district shall have well-publicised, functional AFHCs providing confidential consultations on sexual and reproductive health concerns. Every PHC and CHC shall have a designated AFCH area with basic privacy, access to adolescent-appropriate commodities (iron-folic acid, sanitary pads, condoms, diagnostics), and standardised referral mechanisms with feedback loops to prevent loss to follow-up. Adolescent-friendly timing (evening and weekend sessions) shall be fixed per AFHC.

- **Preventing Child Marriage and Teenage Pregnancy:** The state average for teenage pregnancy stands at 8.80%, well above the 3% benchmark target. An early warning mechanism shall be established: any girl student who remains absent from school for more than one continuous week must be reported by the head of institution to the Mandal Education Officer (MEO), who shall maintain a line list of such cases. Monthly coordination meetings shall be held at State, District, and Mandal levels among functionaries of Health, Women and Child Welfare, and Education departments to identify girl dropouts aged 12–18 years. Monthly joint home visits shall be conducted by the Community Health Officer (CHO), the Superintendent of Women and Child Welfare, and the MEO to provide counselling and support to such households.

F. KUPPAM PILOT: EARLY SYSTEM-LEVEL GAINS AND WAY FORWARD

The Kuppam Pilot has demonstrated significant system-level gains that provide a proof of concept for statewide scaling:

- **Provider Knowledge:** Overall provider knowledge improved by 26%, with correct sterilization counselling rising from 37% to 74%, and adolescent health knowledge improving from 26% to 89%.
- **Community Engagement:** 137 counselling sessions resulted in a 37% conversion rate; male participation increased from 0% to 36%; significant reduction in family planning myths (e.g., Intrauterine Device (IUD) irreversibility).
- **Digital Adoption:** Health-seeking via app increased from 3% to 96%; 84% retention among return users.
- **Way Forward:** Validate HMIS uptake (Intrauterine Device (IUD), Oral Contraceptive Pill (OCP), condom distribution); institutionalise male engagement strategy; scale the structured counselling model across districts; complete capacity building of 345 providers (54% trained ahead of schedule).

G. KEY RECOMMENDATIONS FOR MATRUTVA

- **Governance, Strategy, and Quality Assurance**
 - **Launch the State Maternal & Newborn Action Plan (S-MNAP) 2026–30**, aligned with national frameworks (Ending Preventable Maternal Mortality (EPMM), India Newborn Action Plan (INAP)). The plan must **address critical gaps in human resources, referral logistics, and blood availability**, define targeted strategies for **high C-section clusters** and set district-level targets for **reducing maternal and neonatal mortality**.
 - **Strengthen Quality Assurance with Robust Clinical Governance** by implementing **mandatory C-section audits using the Robson Classification** system across all delivery facilities. **Reinforce provider training in evidence-based labour management practices**.
 - **Integrate Climate-Resilient Planning into MNCH Programmes** by **developing maternal vulnerability maps** linked to climate data, issuing heatwave advisories, **ensuring birthing centers are disaster-resilient**, and maintaining buffer nutrition stocks.
- **Enhancing Reproductive Health and Family Planning**
 - **Optimize the Contraceptive Method Mix with a "Spacing Suraksha" Campaign**, measurable reduction in sterilisation reliance **over 70% to below 50%** within five years through targeted provider training and incentive restructuring.

- **Launch a "Purush Shakti" Campaign for Male Engagement, normalize dialogue around male contraceptive methods, and vasectomy.**
- **Institutionalise a Comprehensive Postpartum Family Planning Package, ensuring every woman receives contraception counselling and services before discharge.**
- **Specialized Care: Infertility to Adolescence**
 - **Establish a Public-Sector Infertility Care Pathway providing advanced fertility treatments (In Vitro Fertilization (IVF) / Assisted Reproductive Technology (ART)) free of cost to eligible beneficiaries through Government Facilities under Public-Private Partnership (PPP) mode, structured as a hub-and-spoke model with a Centre of Excellence in Reproductive Medicine, targeting approximately 50,000 couples annually.**
 - **Position the State as a National Fertility Education Hub by developing a Clinical and Embryology Fellowship ecosystem with 6-month diploma and 1-year advanced ART fellowship programmes.**
 - **Curb Unnecessary Hysterectomies by mandating medical audits for all hysterectomies – especially among young women from marginalised communities – and disseminate conservative treatment protocols.**
 - **Scale Up Targeted Adolescent Health Interventions by activating multi-sectoral district task forces, implementing Comprehensive Sexuality Education (CSE) in all secondary schools and strengthening AFHCs.**
- **Optimizing Care Across the Continuum: Preconception to Early Childhood**
 - **Institutionalize Preconception Care at the Primary Level, with dedicated Preconception Clinics at PHCs and UHCs providing folic acid supplementation, anaemia screening, and digital tracking via SANJEEVANI-ABHA.**
 - **Mainstream Midwifery for Physiological Births by scaling up Midwifery Led Care Units (MLCUs) and introducing performance-linked financing to incentivise the reduction of avoidable C-sections.**
 - **Implement "C-Safe" Interventions including routine Robson Classification monitoring, quarterly clinical audits, and second-opinion protocols for elective Caesareans.**
 - **Develop a detailed action plan for establishing child care centers in workplaces, aligned with Department of Women and Child Development (WCD) and Andhra Pradesh-Labour Department provisions, with an effective monitoring mechanism. of the W&CD and Labour departments, and implementing a monitoring mechanism. Pre-School and Day Care Facilitator trainings shall be provided under the NAIPUNYAM pillar**
 - **Mandate and Digitally Track Postnatal Visits on Day 14 and Day 24, integrating maternal mental health screening, breastfeeding support, neonatal growth monitoring, and early childhood development (ECD) counselling.**
 - **Establish a State ECD Council to ensure cross-departmental convergence, mandating developmental screening at 6, 9, and 18 months, strengthening referral pathways to District Early Intervention Centers (DEICs).**
- **Leveraging Digital Technology**
 - **Mandate the Recording of All MATRUTVA Services on the SANJEEVANI Platform, linked to each woman's Ayushman Bharat Health Account (ABHA) identity. This integration shall enable personalised follow-up, automated health reminders, trimester-specific**

guidance, immunisation alerts, breastfeeding and newborn care messaging, and content designed to engage male partners.

Table 4.4: MATRUTVA Pillar – Key Performance Indicators and Targets

Key Performance Indicator	Baseline (2025)	Target (10 Years)	Data Source
Total Fertility Rate (TFR)	1.5	Towards Replacement Level	RTGS, SRS, HMIS
% Eligible Couples Receiving Incentive	N/A	>80% enrollment	Family Card
Contraceptive Method Mix (Sterilization)	70-82%	<60%	HMIS, NFHS
IUD Uptake Rate	0.2-8%	>20%	HMIS
Infertility Treatment Cycles (Subsidized)	N/A	7,500 annually	MATRUTVA CoE
Teenage Pregnancy Rate	8.80%	<3%	HMIS, SRS
C-Section Rate (Private Sector)	67.58%	<40%	Clinical Audits
Provider Training Completion	54%	100%	Training Records

CHAPTER 5: PILLAR II – SANJEEVANI: THE DIGITAL BACKBONE FOR LIFE-COURSE HEALTH & CARE COORDINATION

A. FROM REACTIVE TREATMENT TO PROACTIVE WELL-BEING

Project SANJEEVANI represents a transformative reform of Andhra Pradesh's public health system, shifting it from episodic, facility-based care to a continuous, citizen-centric health ecosystem. It is a systemic reinvention designed to create proactive health management across a person's lifetime, underpinned by a unified digital platform. SANJEEVANI rests on two core principles:

1. **Continuous Lifetime Proactive Healthcare:** SANJEEVANI adopts a life-course approach, viewing health as capital accumulated from childhood through old age and prioritizing proactive care at every life stage.
2. **Healthcare Coordination through Digital Intelligence:** Each citizen has access to their complete healthcare profile and records, ensuring continuum of care supported by a central Digital Nerve Centre (DiNC).

This structure uses integrated data for predictive risk alerts, automated follow-ups, and closed referrals, creating a modern system that evolves from real-world evidence to ensure continuous, accountable care.

Table 5.1: SANJEEVANI Strategic Shift – From Traditional to Transformative

Traditional Model	SANJEEVANI Model
Episodic, facility-based care	Continuous, citizen-centric health ecosystem
Reactive treatment when sick	Proactive health management across lifetime
Fragmented health records	Unified digital platform with longitudinal health records
Patient-initiated interactions	88.8% staff-initiated outgoing calls for care coordination
Siloed health programs	Integrated life-course tracking (Maternal, Adolescent, NCD, Mental, Geriatric)

B. THE SANJEEVANI DIGITAL ECOSYSTEM

The operational power of SANJEEVANI lies in its integrated digital architecture, designed from the outset to be fully compliant with the Ayushman Bharat Digital Mission (ABDM). The ecosystem comprises five key components.

- **Integrated Healthcare Delivery Platform (IHCDP):** The IHCDP is the core transactional system of SANJEEVANI, hosting ABHA-linked longitudinal health records (LHRs) for every citizen. Every clinical encounter — OPD consultation, laboratory test, pharmacy dispensation, admission, referral — is recorded in real-time.
- **Care Coordination Centre (CCC):** The CCC is the Digital Nerve Center of the SANJEEVANI system and its primary citizen interface. It is a 24x7 multi-channel centre that makes outbound calls and receives inbound calls across a range of services, linked to the IHCDP for real-time, consent-based data retrieval. In the Kuppam Pilot, 88.8% of all transactions were outgoing calls, demonstrating the acceptance of this proactive model.
- **Unified Workforce Management (UWM):** The UWM is a mobile application providing a single, unified digital interface for all frontline health workers — Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Community Health Officers (CHOs), and their supervisors – enabling intelligent, priority-ordered task management driven by real-time algorithmic triggers from the IHCDP.
- **State Health Data Lake and Analytics Engine:** This analytical powerhouse ingests data from the IHCDP, CCC, UWM, HMIS, and other sources into a secure data lake, powering population health stratification through sophisticated Population Health & Wellness Scores (PHWS).
- **ABDM Compliance Framework:** SANJEEVANI is built as an "ABDM-native" system, ensuring full compliance with all core components of the national digital health mission, guaranteeing long-term interoperability, scalability.

Table 5.2: The SANJEEVANI Digital Ecosystem Components and Their Functions

Component	Primary Function	Strategic Importance for Population Management
IHCDP	Core transactional system; hosts longitudinal health records (LHRs) for every citizen	Creates a unified, lifelong health journey for every citizen, linking reproductive, chronic, and geriatric care data across all facilities
CCC	24x7 multi-channel centre for proactive outreach, navigation support, and grievance redressal	Enables personalized follow-ups, targeted health education, and scheme linkage; 88.8% outgoing calls in Kuppam pilot
UWM	Mobile interface for frontline workers; provides intelligent task management and decision support	Empowers ASHAs, ANMs, and CHOs with prioritized tasks and clinical tools, ensuring efficient last-mile service delivery
Health Data Lake & Analytics Engine	Central repository for advanced analytics, AI/ML modelling, and real-time dashboard generation	Powers population health risk stratification, predictive modelling for disease outbreaks, and real-time, data-driven policy monitoring
ABDM Compliance Framework	Ensures interoperability with national systems, data security, and citizen-centric consent management	Guarantees a future-ready, secure, and interoperable system that aligns with India's digital health ecosystem

C. FROM PILOT TO STATEWIDE SCALE

- **Kuppam Pilot: Proof of Concept:** The Kuppam Pilot covered 2,98,045 digitally registered individuals, gender distribution nearly balanced (50.9% females (≈1.52 lakh) and 49.1% males (≈1.46 lakh)), indicating near-universal and equitable digital inclusion. A total of 106 public health facilities are integrated with the SANJEEVANI Digital Nerve Center (92 Village Health Clinics (VHCs), 13 Primary Health Centres (PHCs), and 1 Area Hospital (AH)). Service uptake is highest among women of reproductive age (20–39 years) and adults aged 40–59 years, reflecting strong Maternal and Child Health coverage (86%), and near-complete Non-Communicable Disease (NCD) screening (~100%)
- **Phase II –Chittoor District:** SANJEEVANI expanded to Chittoor district from 1st January 2026, covering 19.75 lakh population across 543 facilities (1 DH, 4 AHs, 6 CHCs, 68 PHCs, 464 VHCs. Digital workflows for registration, consultation, diagnostics, pharmacy, referrals, follow-ups, and reporting are being standardised.
- **Statewide Rollout:** Statewide rollout to 5.2 crore citizens across 2,086 facilities is targeted **June 2026**, which will constitute the largest implementation of a comprehensive, ABDM-compliant digital health system in any Indian state.

Table 5.3: SANJEEVANI Implementation Phases and Coverage

Phase	Timeline	Population Coverage	Facilities Integrated	Key Achievements
Kuppam Pilot	Completed	2,98,045 individuals	106 facilities (92 VHCs, 13 PHCs, 1 AH)	86% MCH coverage; ~100% NCD screening; 88.8% outbound calls
Phase II (Chittoor)	From 1st January 2026	19.75 lakh	543 facilities (1 DH, 4 AH, 6 CHCs, 68 PHCs, 464 VHCs)	Digital workflows standardized; infra, IT & training readiness completed
Statewide Rollout	From June 2026	5.2 crore	2,086 facilities	Largest ABDM-compliant system in India; complete digital health backbone

D. TRANSFORMING SANJEEVANI INTO A CITIZEN-OWNED HEALTH COMPANION

- **Citizen Health & Wellness App:** To be launched at scale with Telugu language support, offline functionality, and assisted onboarding through village and ward secretariats. The app will enable access to Personal Health Records (PHRs), visit history, laboratory reports, prescriptions, immunisation records, ANC/NCD tracking, and referrals. Appointment booking, tele-consultation, medication refill requests, service feedback, and grievance redressal shall be integrated as standard features. Behavioural nudges — medication reminders, follow-up alerts, lifestyle prompts, and preventive screening notifications — shall be embedded throughout.
- **Trust and Consent:** Citizen trust shall be built through transparent consent management, data privacy controls, and clear communication of citizen rights.
- **Life-Course Integration:** The platform shall institutionalise tracking for pregnant women and newborns, nutrition counselling, immunisation reminders, and growth monitoring. School-linked adolescent health modules shall cover nutrition, anaemia, mental health, substance use, and reproductive health awareness. Routine mental health screening and geriatric care journeys shall be integrated with chronic disease monitoring.
- **Emergency Integration:** Emergency transport systems (108/104, Thalli Bidda Express) shall be linked into the Digital Nerve Centre for digital triage, referral coordination, and outcome tracking.

- **AI-Powered Decision Support:** AI-powered Care Planogram and Health-cum-Wellness Meter tools shall be operationalised as decision-support instruments for clinicians and district administrators. Panchayat-level wellness indices shall be generated to identify high-risk geographies and underserved populations.
- **Predictive Analytics:** Risk stratification models for NCDs, maternal health, TB, and mental health shall enable proactive outreach. Predictive analytics shall be used for workforce planning, ambulance positioning, drug forecasting, and facility workload management.

Table 5.4: SANJEEVANI Way Forward – Key Features and Capabilities

Feature Category	Specific Capabilities	Expected Impact
Citizen Empowerment	Health App (Patient Health Records, labs, prescriptions, wellness score); Consent-based data sharing; Behavioural nudges for preventive healthcare	Increased citizen engagement and health literacy; empowered self-management
Life-Course Integration	All health programs - Maternal, adolescent, NCD, mental & geriatric tracking; 108/104 emergency integration; AYUSH integration	Comprehensive health tracking across entire life cycle
Predictive Governance	AI based Risk Stratification & Care Planogram; Community wellness score (Panchayat to State); Drug requirement & referral load forecasting	Shift from reactive to truly proactive and preventive care
Statewide Implementation	Citizen Health Screening for 71 lakh High Risk Cases + Hostel Children; Rollout to 5.2 crore population; All health facilities	Universal access to digital health benefits; national and global recognition

E. SANJEEVANI AS THE ENABLER OF THE FIVE PILLARS

- **MATRUTVA Linkage:** All Pillar I services shall be recorded in the SANJEEVANI IHCDP, enabling automated ANC and immunisation reminders, risk stratification for high-risk pregnancies, and robust programme evaluation. All referrals from School Health and Wellness Teams to AFHCs, and from AFHCs to specialist services, shall also be tracked through the IHCDP.
SHAKTI Linkage: The CCC shall serve as a proactive outreach tool for Pillar III, informing eligible women about crèche facilities, working women's hostels, and their entitlements under maternity benefit schemes.
KSHEMA Linkage: SANJEEVANI is the ideal platform for managing the complex health needs of the ageing population. The system shall automatically create cohorts of elderly citizens with chronic conditions and make regular scheduled check-in calls through the CCC.
NAIPUNYAM Linkage: Health and demographic data from SANJEEVANI shall provide valuable inputs for strategic workforce planning under Pillar V, including identification of districts with high rates of anaemia or malnutrition that may affect learning readiness and future workforce productivity.

F. MISSED OPPORTUNITIES AND THE PATH FORWARD

- **Integrating Mental:** Mental health must be explicitly embedded into the core workflows and data models of the IHCDP and UWM, with validated, culturally appropriate screening tools and clear, confidential referral pathways.
- **Leveraging AI for Predictive Analytics:** A strategic, sustained investment in building in-house AI/ML capability within the TSU is recommended to enable more sophisticated predictive analytics and personalised behavioural nudges.
- **Transforming the Citizen App:** The Citizen Health and Wellness App should evolve into a comprehensive, engaging, and personalised "Health Companion."
- **Establishing a Data Governance Framework:** The state must establish, publish, and enforce a robust and transparent data governance framework for SANJEEVANI, ensuring the highest standards of data privacy, security, and the ethical use of AI in full compliance with the Digital Personal Data Protection Act.

Table 5.5: Summary of Strategic Imperatives and Key Recommendations for SANJEEVANI

Strategic Imperative	Key Recommendation	Expected Impact
Integrate Mental Health	Embed screening tools and referral pathways into IHCDP/UWM; develop CCC protocols for high-risk groups; link to "Mano AP" network	Early detection and treatment of mental health conditions; reduced stigma; holistic well-being for all age groups
Leverage AI for Predictive Analytics	Build in-house AI/ML capacity within TSU; develop models for predicting NCDs, complications, and dropouts; generate personalized nudges	Shift from reactive to truly proactive and preventive care; optimized resource allocation; improved health outcomes
Transform the Citizen App	Evolve app into an engaging "Health Companion" with personalized feed, gamification, wellness challenges, and direct CCC/teleconsultation access	Increased citizen engagement and health literacy; empowered self-management; stronger citizen-system partnership
Complete Statewide Rollout	Maintain aggressive timeline with robust change management, infrastructure support, and continuous handholding for all users	Universal access to digital health benefits; largest ABDM-compliant system in India; national and global recognition
Establish Data Governance Framework	Create and enforce a transparent framework for data privacy, security, and ethical AI, in compliance with the Digital Personal Data Protection Act	Sustained public trust; ethical innovation; legal and social license to operate for all digital health initiatives

G. KEY RECOMMENDATIONS FOR SANJEEVANI

1. **Complete the statewide rollout by June 2026**, with robust change management, last-mile infrastructure support, and continuous handholding for all health facilities and frontline workers.
2. **Deepen ABDM integration**, positioning Andhra Pradesh as the national model for a fully ABDM-compliant state health ecosystem.
3. **Integrate mental health comprehensively** into the IHCDP, CCC, and PHR platforms, elevating it from peripheral to central within the holistic care model.
4. **Make a funded commitment to advanced analytics capabilities**, building sustained internal capacity for ethical AI/ML-driven predictive analytics.

5. **Transform the Citizen App into an engaging "Health Companion"** to activate citizens as partners in their own health and build a statewide culture of wellness.
6. **Establish, publish, and enforce a robust data governance framework**, ensuring compliance with the Digital Personal Data Protection Act.

CHAPTER 6: PILLAR III – SHAKTI: EMPOWERING WOMEN, STRENGTHENING HOUSEHOLDS

A. KEY IDEAS AND STRATEGIC OBJECTIVES

The SHAKTI pillar is the central engine of gender equity and economic empowerment within the Framework's Life-Cycle Model. It is constructed upon a fundamental macroeconomic premise: the prosperity of the state is inextricably linked to the economic and social empowerment of its women. As Andhra Pradesh pursues the Swarnandhra 2047 vision of a \$2.4 trillion economy, the utilisation of female human capital becomes a primary determinant of success.

Current female workforce participation stands at 31%, against male participation of 59% — a gap of 28 percentage points. Closing this gap can raise State GSDP by an estimated 15%. The demographic context amplifies this imperative: with a TFR of 1.5, a shrinking workforce supports a rapidly ageing population — a condition described as "Shrinkonomics" — those risks straining pension systems, eroding the tax base, and decelerating economic growth.

Table 6.1: SHAKTI Pillar – Strategic Objectives and Expected Outcomes

Strategic Objective	Key Interventions	Expected Outcome
Significantly raise FLFP across all sectors	Remove barriers to entry and retention; create compatible jobs; flexible work arrangements	Increase FLFP by measurable percentage over 10 years; contribute directly to state's GDP growth
Ensure universal access to affordable, quality childcare, safe housing, and reliable transport	Expand Working Women Hostels; establish Pink Toilets; ensure safe transport	Physical safety translates into economic opportunity; mobility constraints removed
Foster cultural shift towards shared responsibility for childcare and household work	Year-Long Communication Calendar; IEC campaigns on gender equality and work-life balance	Challenge patriarchal norms; normalize shared parenting
Ensure women's safety in public spaces, on commute, and within workplace	Strengthen Quick Response Systems; strict adherence to POSH Act	Sustain women's participation in workforce and public life
Position SHGs as powerful agents of economic and social change	Integrate SHGs into care economy and livelihood missions	Create sustainable, scalable livelihoods; solve childcare crisis

B. ENABLING INFRASTRUCTURE FOR WORKING WOMEN

- **Workplace Crèches:** The lack of reliable, affordable childcare is the single greatest structural barrier to women's workforce participation. The government will strictly enforce the Maternity Benefit Act's requirement for crèches in establishments with 50 or more employees. This mandate will be extended to all government offices and actively promoted among corporate and industrial

establishments as a core HR policy and CSR investment priority. In partnership with the WCD Department, the government will expand the crèche network in industrial clusters, urban poor settlements, and rural areas, developed as Anganwadi-cum-Crèches. Women shall be trained as Pre-School and Day Care Facilitators under the NAIPUNYAM pillar.

- **Working Women Hostels:** Safe and affordable accommodation is essential for women migrating to urban and industrial hubs. The 23 existing hostels will be comprehensively assessed and upgraded to meet modern standards of safety, hygiene, digital connectivity, and comfort. The three new hostels under construction in Visakhapatnam (combined capacity: 1,000 women; total cost: ₹172 crore) will be completed expeditiously. Going forward, one working women's hostel per one lakh population shall be established in urban and peri-urban areas by the Women and Child Welfare Department.
- **Pink Toilets and Safe Transport:** A widespread network of clean, well-lit "Pink Toilets" will be established at all public places, markets, bus stands, industrial areas, and along major highways by the Municipal Administration and Panchayati Raj Department, either through own funds or by mandating local business establishments to provide such facilities. The government will incentivise the expansion of women-only cab services and ensure public transport features GPS tracking, CCTV cameras, and well-lit stops.
- **Quick Response System:** Immediate reporting channels, helplines, and digital alert mechanisms (such as the DISHA App) will be integrated with local law enforcement to ensure timely intervention in safety-related incidents.

Table 6.2: Infrastructure Targets and Investment Overview

Infrastructure Component	Current Status	Proposed Expansion	Investment Estimate	Implementation Timeline
Working Women Hostels (Woman & Child Development Department)	23 Functional	3 New in Visakhapatnam (1000 capacity) + One for every One Lakh Population (PPP models in Urban and Peri Urban areas)	Rs. 172 Crore (Visakhapatnam)	Immediate Completion for Vizag; 3 Years for PPP
Workplace Crèches (Woman & Child Development Department & Labour Department)	Mandated for 50+ employees	Universal enforcement + Anganwadi convergence	CSR & State Budget	1-5 Years
Pink Toilets (Municipal Administration & Panchayati Raj Department)	Limited availability	All public places, markets, bus stands, highways	State Municipal Budget	2 Years
She Cabs/ Safe Transport (Transport Department)	Pilot stages	Statewide expansion with GPS/CCTV	Public-Private Partnership	3 Years

C. PROGRESSIVE POLICY AND LEGAL SUPPORT

- **Collective Parental Leave:** A Collective Parental Leave entitlement of 12 months is proposed, with 6 months allocated to each parent. Of this, 2 months per parent shall be non-transferable, requiring each parent to take a minimum of 2 months' leave. This policy signals that childcare is a shared responsibility, normalises paternity leave, and reduces workplace discrimination against women of childbearing age by making parental absence a shared rather than gendered risk. The policy will be piloted for government employees and promoted as a standard for the private sector.
- **Flexible Work Arrangements:** The government will issue binding guidelines requiring departments to offer flexible working hours and work-from-home options for employees with children under 3 years of age.
- **POSH Act Compliance:** The Labour Department will conduct regular, unannounced audits to ensure all registered establishments maintain a functional Internal Complaints Committee (ICC) as mandated by the Protection of Women from Sexual Harassment (POSH) Act, with annual reports mandatory and publicly accessible.
- **Pre-Marital Counselling:** The government's network of 26 One Stop Centres (under Mission Shakti) will offer voluntary pre-marital counselling to help young couples discuss and align expectations around gender roles, finances, careers, and family planning before marriage.

Table 6.3: Proposed Parental Leave Structure

Leave Type	Current Provision (AP Govt)	Proposed SHAKTI Model	Key Feature
Maternity Leave	180 Days (All childbirths)	Part of 12-month Collective Pool	Extended security for mothers
Paternity Leave	2 Weeks	6 Months (Part of Collective)	Significant increase to encourage involvement
Collective Entitlement	Not Applicable	12 Months per Couple	Shared responsibility
Non-Transferable Clause	Not Applicable	2 Months per Parent	Ensures fathers take leave
Eligibility	Government Employees	Pilot for Government; Nudge for Private	Phased rollout

D. BUILDING A PROFESSIONAL CARE ECONOMY (THE NAIPUNYAM LINK)

- **Child Caretaker Course (Childcare Provider Certification):** The government will scale a certified training programme for childcare providers, primarily targeting women from SHG networks and economically weaker sections. The curriculum shall cover child development, nutrition, health and safety, first aid, and positive discipline. Certification shall be mandatory for employment in all government and registered private crèches.
- **Geriatric Care Assistant Training:** Specialised training programmes will be developed for geriatric care assistants, home health aides, and nursing assistants to meet rising demand from the ageing population, creating a formal job market in the silver economy.

Table 6.4: Care Economy Workforce Development

Training Program	Target Audience	Curriculum Components	Employment Pathways
Child Caretaker Course	Women from SHGs; Youth seeking social sector employment	Child development, nutrition, health & safety, first aid,	Government & private crèches; Home-based daycare enterprises

Training Program	Target Audience	Curriculum Components	Employment Pathways
		positive discipline, breastfeeding counselling	
Elderly Caretaker Course	Women / Men with caregiving experience; Elderly seeking part-time work	Palliative care, mobility assistance, NCD management, medication management	Home care services; Old age homes; Community health programs

E. ADDRESSING SOCIAL NORMS: THE CAMPAIGN FOR SHARED PARENTING

The Andhra Pradesh Campaign for Shared Parenting — anchored by the hashtag **#TalliTandruLaSamanaBadhyata** — is designed to achieve a fundamental shift in entrenched social norms through sustained Social and Behaviour Change Communication (SBCC).

- **Multi-Channel Media Campaign:** Engaging video content featuring relatable couples, respected celebrities, and social media influencers will be distributed across YouTube, Instagram, and Facebook to model shared parenting in everyday contexts.
- **Targeting Men:** The campaign will positively engage men rather than simply directing them. Annual "Father's Day" campaigns will celebrate men who actively share parenting and domestic duties. Respected male public figures — athletes, local leaders, entrepreneurs — will be recruited as advocates.
- **Community Mobilisation:** Panchayats, SHG federations, and school PTAs will be activated as platforms for regular discussions and workshops on gender equality and shared family responsibilities.

F. IMPLEMENTATION GOVERNANCE AND FINANCIAL MODELLING

The Secretary, Women and Child Development shall oversee the SHAKTI pillar. Dedicated implementation teams shall be organised at the State, District, and Mandal levels.

Expanding hostels (e.g., the Visakhapatnam project at ₹172 crore) and subsidising childcare represent significant investments, framed as cost offsets against long-term pension and healthcare liabilities. Funding will be sourced through a mix of state budget allocation, rationalisation of existing welfare schemes, P4 partnerships, and CSR funds.

Table 6.5: Key Performance Indicators for SHAKTI Pillar

Indicator	Baseline (2025)	Target (2035)	Measurement Mechanism
Female Labor Force Participation	31% (Current State Average)	Increase by 25%	Labour Department Surveys
SHAKTI Certified Employers	0	1,000 Employers	Certification Body Audit
Crèche Compliance	Variable	100% for 50+ employees	Labour Inspections
Safety Incident Reduction	Current Report Rate	25% Reduction	DISHA App/ Police Data

Indicator	Baseline (2025)	Target (2035)	Measurement Mechanism
Paternity Leave Utilization	Low	50% of Eligible Fathers	Family Card Data
Certified Caretakers Trained	Limited	10,000 Annually	NAIPUNYAM

G. KEY RECOMMENDATIONS FOR SHAKTI

1. **Universalise Access to Childcare:** Mandate workplace crèches, aggressively expand public crèches (Anganwadi-cum-Crèches), and create a certified childcare workforce through NAIPUNYAM.
2. **Reform Parental Leave:** Pilot a 12-month Collective Parental Leave with a non-transferable portion for fathers, positioning Andhra Pradesh as a national leader in family-friendly policy.
3. **Launch "SHAKTI Certification" for Workplaces:** Create a formal recognition and incentive scheme to motivate private sector companies to adopt and exceed women-friendly policy benchmarks.
4. **Integrate SHGs into the Care Economy:** Train, finance, and support SHGs to become providers of professional childcare and eldercare services.
5. **Address the Unorganised Sector with "SHAKTI for All":** Design innovative, community-based solutions (mobile crèches, Anganwadi-plus models) specifically for women in informal employment.
6. **Implement the Shared Parenting Initiative:** Under the #TalliTandruLaSamanaBadhyata campaign, provide collective parental leave of 12 months (6 months per parent), with a mandatory minimum of 2 months' non-transferable paternity leave, to foster equitable distribution of parenting responsibilities.
7. **Scale the Shared Parenting Campaign:** Sustain a multi-channel media campaign and targeted male engagement programmes to shift social norms around gender roles and family responsibilities.
8. **Establish a Section 8 Company for Working Women Hostels under W&CD Leadership:** Establish a dedicated non-profit entity under Section 8 of the Companies Act — either through a new incorporation or by leveraging the existing framework of the Andhra Pradesh Industrial Infrastructure Corporation (APIIC) — to develop and manage Working Women Hostels. The Women and Child Development Department shall be the nodal agency, with active support from the Government of India, state government, industries, and the Labour Department.

CHAPTER 7: PILLAR IV – KSHEMA: DIGNITY, CONTINUITY, AND THE SILVER DIVIDEND

A. STRATEGIC OBJECTIVES AND CORE PHILOSOPHY

Projections indicate that by 2047, citizens aged 60 and above will constitute nearly 23% of the state's population, creating the condition of "Shrinkonomics" in which a shrinking workforce must support a rapidly ageing population. The KSHEMA pillar is not an optional welfare addendum; it is a core economic and social strategy essential for navigating this demographic transition.

The foundational philosophy of KSHEMA centres on a profound conceptual shift: from merely adding years to life, to adding life to years. This philosophy underpins every operational strategy within the pillar — moving systematically from reactive sick-care models to proactive health-care and social integration frameworks.

Table 7.1: KSHEMA Pillar – Strategic Objectives

Strategic Objective	Key Focus	Expected Outcome
Strengthen healthcare infrastructure and workforce capacity	Build robust geriatric-specific healthcare delivery system at district, community, and primary care levels	Meet specific and complex needs of aging population
Promote healthy and active aging through preventive interventions	Delay onset of disability and dependence through nutrition, physical activity, and chronic disease management	Preserve functional ability for as long as possible
Create economic opportunities for the elderly	Enable healthy seniors to remain productive members of society for as long as they choose and are able	Transform elderly from dependents to economic assets
Establish robust social safety net for vulnerable elderly	Specifically designed for "old-old" population aged 80 and above, along with most vulnerable elderly	Ensure dignity and security for those lacking family support or financial resources
Integrate mental health support into geriatric care systems	Address depression, dementia, and social isolation that frequently accompany aging	Preserve quality of life and functional capacity in old age

B. STRENGTHENING THE GERIATRIC CARE ARCHITECTURE

- **Expanding and Upgrading Geriatric Wards and Clinics:** Dedicated geriatric wards have been established in district hospitals across Vizianagaram, Visakhapatnam, East Godavari, West Godavari, Guntur, Kadapa, and Ananthapuramu (7 functional wards). Four additional wards are under construction and will be completed on an accelerated priority basis. The policy mandates 100% district coverage for geriatric wards. At the CHC level, bi-weekly geriatric clinics shall be operationalised at all 175 CHCs, each staffed by a medical officer and a physiotherapist. PHCs will continue and strengthen weekly geriatric clinics held every Thursday.
- **State Geriatric Excellence Centre:** A State Geriatric Excellence Centre will be established at a premier medical institution — likely the All-India Institute of Medical Sciences (AIIMS), Mangalagiri, or another major government medical college — to build expertise in geriatric care, training, and research.
- **Building a Cadre of Geriatric Care Specialists:** The shortage of trained geriatricians represents a national challenge that Andhra Pradesh will address proactively. The target is to train 5,000 geriatric care professionals annually.
- **Wellness Leave for Government Employees:** An estimated 50,000 government employees retire annually. To prepare them for healthy, productive post-service lives, eligible employees shall be granted 15 days of Wellness Leave within two years of retirement, with an entitlement of up to ₹50,000 to access government-empanelled wellness centres offering preventive and holistic healthcare practices such as Yoga and Naturopathy. This is expected to extend healthy lifespan and reduce public healthcare expenditure.

Table 7.2: NPHCE Service Architecture Expansion Plan

Component	Current Status	Strategic Target	Strategic Importance
District Geriatric Wards	23 functional, 3 under construction	100% District Coverage	Specialized inpatient and rehabilitation care

Component	Current Status	Strategic Target	Strategic Importance
CHC Geriatric Clinics	175 CHCs identified	Bi-weekly clinics at all CHCs	First-line screening, continuity of care
PHC Weekly Clinics	All PHCs (Every Thursday)	Weekly clinics with NCD focus	Early detection, NCD control
CGA Camps in Old Age Homes	54 institutions covered	100% Registered Homes	Frailty and disability prevention
Geriatric Care Professionals	Limited availability	5,000 trained annually	Addressing human resource bottleneck

C. MONETIZING THE SILVER DIVIDEND

- **Promoting Healthy Ageing through Preventive NCD Management:** KSHEMA advocates a strategic shift from defining working age by chronology alone to defining it by functional ability and health status. SANJEEVANI will play a central role in this transition through its digital health infrastructure and care coordination capabilities.
- **Creating Flexible Employment Models for Seniors:** A healthy 65-year-old with decades of professional experience is a valuable economic asset. The state will work systematically to create pathways for willing and able seniors to remain economically engaged. Government departments, public sector undertakings, and private companies will be encouraged to establish formal "Senior Consultant" or "Mentor" pools.
- **Establishing Senior Skills Registries:** In partnership with NAIPUNYAM, the government will create a voluntary online "Silver Skills" Registry where retired professionals can list their skills, availability, and preferences for consulting or mentoring roles. The target is to register 50,000 elderly individuals in the Silver Skills Registry over 10 years.

Table 7.3: Health Interventions and Productivity Link

Intervention	Functional Gain	Economic Impact
CGA & NCD Control	Delayed disability	Extended work life
Rehabilitation	Restored mobility	Continued farm/service work
Vision & Hearing Care	Improved communication & safety	Retail, teaching, supervision
Mental Health Support	Preserved cognition	Advisory & mentoring roles

D. ENSURING COMPREHENSIVE GERIATRIC CARE

- **Integrating Rehabilitation into Primary Care:** Every CHC must have a trained physiotherapist and basic rehabilitation equipment available for elderly patients.
- **Strengthening Community-Based and Home-Based Care:** The NAIPUNYAM pillar's training programmes for geriatric care assistants will create a professional pool of paid home-care providers, enabling elderly citizens to age in place within their own homes and communities.
- **Integrating Mental Health Support:** KSHEMA will work closely with the Mano AP Mission to integrate mental health services into geriatric care, addressing the isolation, depression, and cognitive decline — including dementia — that frequently accompany ageing.

E. SOCIAL PROTECTION AND INCLUSION

- **Strengthening Pension Systems:** The NTR Bharosa social pension scheme serves as a vital lifeline for many elderly citizens. The government is committed to strengthening and ensuring the long-term sustainability of this programme. A proposal to explore additional pensions for

households with large family sizes will be examined, simultaneously supporting elderly care and incentivising joint family systems.

- **Promoting Intergenerational Programmes:** The policy actively promotes the cultural and social value of large and joint family systems as a cornerstone of intergenerational support and community resilience.

Table 7.4: KSHEMA Key Performance Indicators

Pillar Focus	Key Performance Indicator	Target (10 Years)
Healthcare Infrastructure	Percentage of Districts with Functional Geriatric Wards	100%
Human Resources	Number of Elderly Caretakers Trained Annually	5,000
Health Coverage	Percentage of Elderly Covered by Health Insurance	100%
Social Protection	Pension Disbursement Efficiency through Direct Benefit Transfer	95%
Economic Participation	Number of Elderly Persons Registered in Silver Skills Registry	50,000
Demographic Balance	Elderly Dependency Ratio	Stabilize by 2040

F. STRATEGIC GAPS AND ENHANCEMENT OPPORTUNITIES

- **Adapting Digital Platforms for Geriatric Cohorts:** A dedicated Geriatric Care Module within the IHCDP should be developed, optimised for managing poly-morbidity and polypharmacy in elderly patients.
- **Age-Friendly Urban Planning:** Age-Friendly City and Village principles shall be integrated into all urban and rural planning policies.
- **Leveraging Technology for Ageing in Place:** A pilot programme on Technology-Enabled Ageing — including tele-geriatrics and wearable devices for high-risk elderly individuals — shall be launched.

G. KEY RECOMMENDATIONS FOR IMPLEMENTATION

1. **Complete the geriatric care infrastructure pyramid:** functional geriatric wards in all district hospitals, bi-weekly clinics at all CHCs, and weekly clinics at all PHCs, linked by a clear referral system.
2. **Establish a State Geriatric Excellence Centre** for training, research, and advanced care.
3. **Develop a SANJEEVANI Geriatric Care Module** adapted for poly-morbidity, polypharmacy, and comprehensive geriatric assessments.
4. **Create pathways for the Silver Dividend** through Senior Consultant pools, the Silver Skills Registry, and flexible employment models.
5. **Integrate age-friendly planning** into all urban and rural development plans.
6. **Pilot technology-enabled ageing programmes**, including tele-geriatrics and wearables for elderly citizens in remote areas.
7. **Track all interventions through established KPIs** with quarterly reviews to assess progress and adjust strategies.

CHAPTER 8: PILLAR V – NAIPUNYAM: SKILLING THE POPULATION FOR A \$2.4 TRILLION ECONOMY

A. KEY IDEAS AND STRATEGIC OBJECTIVES

The NAIPUNYAM pillar is the critical economic engine of the Framework. While the preceding pillars build a healthy, supported, and empowered population, NAIPUNYAM addresses the pivotal question of economic sustainability: once we have a healthy population, how do we ensure they are sufficiently skilled and productive to drive the Swarnandhra 2047 vision?

With a TFR of 1.5 and an elderly population projected to reach 23% by 2047, a shrinking workforce cannot sustain a rapidly growing dependency ratio without a substantial increase in individual productivity. Every person in the workforce must be maximally skilled and productive.

Table 8.1: NAIPUNYAM Pillar – Strategic Objectives

Strategic Objective	Key Focus	Expected Outcome
Bridge labour supply and demand	Eliminate skills mismatch through alignment of training outputs with state's priority economic sectors	Maximally productive shrinking workforce
Professionalize the Care Economy	Create certified, skilled workforce for childcare and geriatric care	Support SHAKTI and KSHEMA pillars; create employment
Equip youth with 21st-century competencies	Foundational digital literacy, critical thinking, and adaptability required for Industry 4.0	Future-ready workforce
Foster innovation and entrepreneurship	Shift mindset from "job seeker" to "job creator"	Job creation; local innovation
Ensure decent employment and livelihoods	Guarantee skilling translates into tangible economic outcomes	Tracked through MIS and Family Card

B. THE THREE TIERS OF NAIPUNYAM

The NAIPUNYAM strategy is structured across three interconnected tiers, creating a pipeline of talent from foundational skills to high-end expertise, catering to diverse demographic segments across the state's 28 districts.

- **Tier 1 — Foundational and Life-Course Skilling:** This tier builds core competencies from an early age and enables the existing workforce to adapt to technological shifts. It encompasses integration of vocational awareness into the **school curriculum from Class 6 onwards**, a **mission-mode Universal Digital Literacy programme** as a prerequisite for participation in the modern economy, and continuous upskilling and reskilling pathways for adults already in the workforce.
- **Tier 2 — Creating the "Care Economy" Workforce:** This is a landmark innovation of the Framework, directly linking NAIPUNYAM with SHAKTI and KSHEMA. The **Child Caretaker Training Programme — a comprehensive, certified programme delivered through State Skill Development Centres — targets women from SHGs and youth seeking employment in the social sector**, with an **annual target of 5,000 trained child caretaker professionals**. Alongside this, Elderly Caretaker Training develops specialised programmes for geriatric care

assistants, home health aides, and nursing assistants, with an **annual target of 5,000 trained elderly caretaker professionals**.

- **Tier 3 — High-End Skilling for a Future-Ready Economy:** This tier positions Andhra Pradesh as a hub for high-value talent. **Centres of Excellence (CoEs) will be established in partnership with industry leaders and academic institutions**, with focus on **high-growth sunrise sectors identified in the 610 MoUs signed at the CII Summit**. All high-end skilling programmes will be co-designed with industry partners to guarantee market relevance and immediate employment outcomes.

Table 8.2: NAIPUNYAM Integration with Other Pillars

Pillar	Integration Point	Expected Outcome
MATRUTVA	Fertility awareness in skilling centers	Informed reproductive choices among youth
SANJEEVANI	Health data for skilling readiness	Reduced dropout rates, healthier trainees
SHAKTI	Certified Child Caretaker Courses	Women enabled to join workforce
KSHEMA	Geriatric Care Training	Elderly care as employment opportunity
Family Card	Beneficiary tracking	Transparent incentive delivery

C. INSTITUTIONAL FRAMEWORK FOR SKILL DEVELOPMENT

- **Strengthening APSSDC:** The Andhra Pradesh State Skill Development Corporation (APSSDC) will be strengthened as the nodal agency for all skill development coordination. Its enhanced mandate encompasses Quality Assurance, Industry Partnerships, a real-time Skills Observatory, and Monitoring and Evaluation.
- **Centres of Excellence:** CoEs in strategic sectors will be established as autonomous bodies with strong industry representation on their boards.
- **Decentralised Planning:** The government's programme of 175 Young Professionals — one per assembly constituency — will work under the AP State Development Planning Society (APSDPS) to develop and implement Constituency Vision Action Plans (CVAPs).
- **The TSU's Role in Skilling:** The TSU under Project SANJEEVANI will inform resource allocation for skilling centres through data integration and feedback loops based on projected youth population shifts at the district level.

D. LINKING NAIPUNYAM WITH THE BROADER ECOSYSTEM

- **Aligning Skilling with Industrial Policy:** The 610 MoUs worth over ₹13 lakh crore signed at the CII Summit represent a substantial demand for skilled labour. NAIPUNYAM will serve as the talent-supply arm of this industrial policy.
- **Integrating SANJEEVANI Health Data:** Health data from SANJEEVANI can identify geographic pockets with high rates of malnutrition or anaemia among adolescents and young adults that reduce learning readiness and workforce productivity.
- **Ensuring Employment Linkages:** Skilling outcomes will be tracked relentlessly via the Family Card, with a focus on verified placement rates.
- **Financial Convergence:** Existing financial schemes, including Ambedkar Overseas Vidya Nidhi and NTR Bharosa Pension, may be reviewed to provide enhanced support to larger families or multi-skilled households.

E. MISSED OPPORTUNITIES AND STRATEGIC IMPLICATIONS

- **Creating a State-Level Skills Observatory:** A dedicated unit within APSSDC, supported by the TSU, shall generate real-time reports on emerging skill demands, wage trends, and sectoral growth.
- **Integrating Soft Skills and Financial Literacy:** A standardised module on soft skills (communication, teamwork, problem-solving) and financial literacy shall be integrated into all certified skilling programmes.
- **Fostering Entrepreneurship:** District-level incubation centres (T-Hubs) and entrepreneurship education shall be integrated into higher-level skilling to shift the mindset from job-seeker to job-creator.
- **Addressing Gender Disparities in Skilling:** Skilling programmes must account for gendered barriers — mobility constraints, safety concerns, care burden — to ensure the SHAKTI pillar's goals are fully realised.

F. KEY RECOMMENDATIONS FOR NAIPUNYAM

1. **Establish a State Skills Observatory** — a dynamic, real-time unit within APSSDC integrated with the TSU — to map skill demand and guide training investments.
2. **Launch the "Care Economy" Skilling Mission**, scaling certified Child Caretaker and Elderly Caretaker Training to **5,000 professionals annually in each stream**.
3. **Initiate Skilling for Grandparents** by designing programmes focused on digital literacy, financial management, and modern skills to enable older adults to remain engaged and contribute to intergenerational learning.
4. **Mandate Soft Skills and Financial Literacy** by integrating a standardised module into all certified skilling programmes.
5. **Foster Entrepreneurship** through district-level incubation centres (T-Hubs) and entrepreneurship education in higher-level skilling.
6. **Strengthen APSSDC** with the mandate, resources, and data capabilities required to function as a world-class nodal agency for skill development.
7. **Link Skilling to Industrial Policy** through a systematic mechanism to map the skill requirements of every major new investment under the 610 MoUs and develop customised training programmes accordingly.
8. **Leverage the Family Card** as the primary identifier for skilling beneficiaries to enable longitudinal outcome tracking and prevent duplication.
9. **Implement Risk Mitigation Strategies** addressing behavioural resistance, data fragmentation, and supply chain gaps in skilling infrastructure.

Table 8.3: Phased Implementation Plan for NAIPUNYAM

Phase	Timeframe	Key Actions	Responsible Agency
Foundation	Year 1	Launch Skills Observatory; Pilot Child Caretaker Courses in 5 Districts; Integrate Family Card with APSSDC	APSSDC, TSU, HM&FW
Expansion	Year 2	Scale Care Economy Training Statewide; Establish District T-Hubs; Align Curriculum with 610 MoUs	APSDPS, Industries Dept
Maturation	Year 3+	Full Digital Literacy Coverage; Geriatric Care Workforce Stabilized; Entrepreneurship Ecosystem Mature	Education Dept, APSSDC

Table 8.4: Key Performance Indicators (KPIs) for NAIPUNYAM

Indicator	Baseline (2025)	Target (2035)	Data Source
Skilling Completion Rate	60%	>75%	APSSDC MIS
Placement Rate	50%	>80%	Family Card/ TSU
Care Economy Workforce	Unorganized	50,000 Certified	WCD Dept/ HM&FW
Female LF Participation	~35%	Increase by 25%	PLFS/ TSU
Digital Literacy	65%	95%	Village Secretariats

CHAPTER 9: A NEW SOCIAL CONTRACT FOR FAMILIES AND IMPLEMENTATION ARCHITECTURE

A. THE POSHAN SHIKSHA SURAKSHA PACKAGE FOR FAMILY SUPPORT

The state recognises that the decision to have a third child is often constrained by the long-term financial commitment required for child-rearing. This Framework marks a paradigm shift from population control to population management, acknowledging that demographic destiny is not fixed but can be shaped by proactive, compassionate, and strategic intervention.

- **Stipend for Nutrition (Poshan):** A direct cash transfer of ₹1,000 per month for the first five years of the child's life, applicable from the third child onwards, conditional on full immunisation and regular growth monitoring. For an estimated 75,000 third-born children annually, this amounts to ₹90 crore in Year 1, rising to ₹450 crore annually by Year 5.
- **Education Support (Shiksha):** The third child and subsequent children shall be entitled to education in a residential welfare school or any other public school of the parents' choice, with all educational expenditure up to the age of 18 years borne by the Government.
- **Health Support (Suraksha):** Comprehensive lifetime health insurance at the highest care bracket shall be provided under the state health insurance scheme to any household that has three or more children, irrespective of the household's financial status.
- **Direct Birth Incentive:** A direct financial incentive of ₹25,000 shall be provided to mothers upon the birth of a second child onwards. The estimated Year 1 outlay is approximately ₹521.25 crore (based on 75,000 eligible families).

B. ENCOURAGING LARGE FAMILIES AND SCHEME CONVERGENCE

- **Promoting Joint Family Systems:** The Government will actively promote the cultural and social value of large and joint family systems as cornerstones of intergenerational support and community resilience. Departments are directed to design facilitative measures making family expansion and joint living more sustainable, including priority access to housing schemes, enhanced utility support, and simplified welfare entitlement processes for joint households.
- **Regulatory Facilitation for Adoption:** To encourage and facilitate child adoption, the Government will introduce measures to simplify and expedite the adoption process. Andhra Pradesh currently accounts for only 2% of India's legal adoptions despite having substantial numbers of orphaned and abandoned children.
- **Leveraging Existing Schemes:** Rather than creating entirely new, unfunded programmes, the strategy prioritises the convergence and rationalisation of existing schemes.

Table 9.1: Review and Enhance Existing Schemes for Better Beneficiary Impact

Scheme	Current Benefit	Proposed Enhancement for Large Families
Ambedkar Overseas Vidya Nidhi	₹1.5 crore grant (1 beneficiary/ family)	Review eligibility to allow multiple beneficiaries from medium/large families
Matsyakara Sevalo	₹20,000 seasonal relief (1 beneficiary/ family)	Revise beneficiary limits for households with medium/large family size engaged in fishing
NTR Bharosa Pension	One pension per family	Explore provisions for additional pensions for households with large family size
Deepam-2	3-cylinder refills per family annually	Review allocation norms for households with large family size
Chandranna Bhima	Insurance coverage (1 member)	Consider coverage for multiple earning members in medium/large families
PMAY – NTR Housing	Interest subsidy on home loans	Prioritize housing benefits for large families; provision for expansion of existing houses

C. IMPLEMENTATION ARCHITECTURE AND GOVERNANCE

- **The Family Card:** The Family Card is the single authoritative source of welfare-related data in Andhra Pradesh. It contains a unique digital identity for every family unit, storing information on members, eligibility, and utilisation history. Its primary function within this policy is precise beneficiary identification for the ₹50,000 incentive and scholarships, prevention of duplication, and transparent outcome tracking.
- **The Population Management Mission:** A dedicated Population Management Mission, headed by the Secretary, Health and Family Welfare, will serve as the central coordinating body, with teams at the State, District, and Mandal levels.
- **Technical Support Unit (TSU) under Project SANJEEVANI:** The TSU is the state's apex technical coordination and advisory nucleus for population stabilisation. An RFP for the selection of a Technical Agency has been issued. The initial tenure shall be 12 months, extendable to 5 years based on performance.
- **Governance Structure:** A Population Stabilisation Task Force chaired by the Chief Secretary, with Principal Secretaries/Secretaries of all key departments as members, shall oversee policy execution. For strategic guidance and political oversight, a High-Powered Steering Committee chaired by the Chief Minister shall be constituted.

D. FINANCIAL MODELLING AND FISCAL SUSTAINABILITY

Population management is an investment in human capital that yields economic returns through a larger, more productive future workforce. Expenditures shall be treated as capital investment in demographic stability, not consumption. Funding will be sourced through a combination of resource reallocation, a Dedicated Budget Line under the Finance Department for Demographic Stability, P4 partnerships, CSR contributions, and exploration of a Demographic Resilience Fund. NPV-based budgeting shall be adopted for all long-term schemes.

E. PHASED IMPLEMENTATION ROADMAP

- **Year 1 — Foundation Building:** Strengthening Anganwadi Centres; establishing crèches in government offices; launching statewide campaigns and Gram/Ward Sabhas; training healthcare

workers and local administrators; formally notifying the Five-Pillar Strategy; constituting the Population Stabilisation Task Force; completing the statewide SANJEEVANI rollout by June 2026.

- **Year 2 — Statewide Scaling:** Establishing the MATRUTVA Centre of Excellence and the State Geriatric Excellence Centre; statewide rollout of the Child Caretaker Course and geriatric care assistant training; maturing the SANJEEVANI analytics engine to include predictive AI/ML models.
- **Years 3 and Beyond — Consolidation and Adaptation:** Full maturation of geriatric care infrastructure; ongoing monitoring of demographic trends with periodic framework revision; development of robust long-term social security systems for the elderly.

F. MEASURING IMPACT AND MANAGING RISKS

Table 9.2: Key Performance Indicators and Targets

Pillar	Key Performance Indicator (KPI)	Target (10 Years)
MATRUTVA	Total Fertility Rate (TFR)	Towards Replacement Level
MATRUTVA	% Eligible Couples Receiving Incentive	>80% enrollment
SANJEEVANI	Infant Mortality Rate (IMR)	<5 per 1000 live births
SANJEEVANI	Maternal Mortality Ratio (MMR)	<15 per 100,000 live births
SHAKTI	Female Labor Force Participation	Increase by 20%
SHAKTI	# Certified Women-Friendly Employers	1,000 employers
SHAKTI	# Child Care Professionals Trained	5,000 annually
KSHEMA	Elderly Dependency Ratio	Stabilize by 2040
KSHEMA	# Elderly Care Professionals Trained	5,000 annually
NAIPUNYAM	Skilling Completion Rate	>75%

- **Real-time dashboards** powered by SANJEEVANI will serve as the primary monitoring mechanism. Role-based dashboards shall be provided for the Chief Minister, the Task Force, District Collectors, and Departmental Heads.
- **Risk Management:** Identified systemic risks include behavioural resistance to spacing methods due to socio-cultural norms; limited male participation in reproductive health; fragmented data systems limiting care continuity; low provider familiarity with digital platforms; and district-level supply chain gaps. Each risk shall be addressed through targeted mitigation strategies within the Risk Response Framework.

G. IMPACT OF TFR INCREASE PROJECTION MODELS

Under the **Baseline Scenario** (TFR remaining at 1.5), the population peaks early and declines rapidly, leading to an old-age dependency ratio potentially exceeding 30%. Under the **Target Scenario** (TFR stabilising at 2.1), the working-age population remains sufficiently robust to support the elderly, keeping the dependency ratio closer to 20–25% and significantly reducing the fiscal burden on the state.

H. GOVERNANCE FRAMEWORK AND IMPLEMENTATION STRATEGY FOR POPULATION MANAGEMENT

The governance framework for **Arogya Andhra — Population Management** is built on a robust, multi-tiered structure. At the apex, the **High-Powered Steering Committee** chaired by the Chief Minister provides the highest level of policy direction. This is supported by the **Population Stabilisation Task Force**, led by the Chief Secretary, which drives inter-departmental coordination. The **Technical Support Unit (TSU)**, conducting data-driven analytics under SANJEEVANI, transforms raw data into actionable intelligence. The integrity of the entire system is anchored by the

Family Card Database, which serves as the single source of truth for beneficiary tracking and outcome measurement.

The institutional mechanism is codified through the **Arogya Andhra Population Management Committee (AAPMC)**. A critical accountability mechanism is the mandate for **rigorous monthly outreach**, to be held every **4th Saturday of the month**, during which officials shall visit villages to discuss with local communities the state of population management, the urgency of the demographic challenge, and the measures being taken to promote **Arogya Andhra Pradesh**.

The **4th Saturday of every month** is to be designated as **Praja Vedika on Arogya Andhra — Population Management**, drawing inspiration from the successful **Swachh Andhra Swarna Andhra (SASA)** programme. This initiative transforms the governance structure into a participatory platform, fostering collective ownership and grassroots dialogue on population stabilisation. Detailed operational guidelines shall be issued for this programme.

I. KEY RECOMMENDATIONS FOR SUCCESS

1. **Strengthen Institutional Capacity:** Staff the Population Management Mission with professionals who have expertise in demography, public health, and social welfare. Grant the TSU sufficient autonomy to innovate and adapt strategies based on real-time data.
2. **Enhance Community Engagement:** Community engagement must go beyond awareness campaigns to active participation. Village-level debates and SHG networks shall be utilised to discuss demographic challenges openly.
3. **Ensure Fiscal Prudence:** NPV-based budgeting shall be strictly applied for all long-term commitments. Regular audits of the Family Card system shall be conducted to prevent leakage and duplication.
4. **Implement Monitoring and Adaptive Management:** An annual, evidence-based policy review shall be conducted by the TSU and presented to the Task Force, analysing progress against all KPIs, synthesizing lessons learned, identifying emerging challenges, and proposing specific recommendations for policy refinement.

The Andhra Pradesh Population Management Framework is a social contract for the future. It acknowledges that demographic destiny is not fixed but can be shaped by proactive, compassionate, and strategic intervention. It represents a fundamental and irreversible shift in philosophy — from viewing population as a problem to be controlled, to nurturing it as a dynamic asset to be developed.

This model is operationalised through five interconnected strategic pillars: MATRUTVA, ensuring every pregnancy is wanted and healthy; SANJEEVANI, building the digital nervous system for proactive health management; SHAKTI, dismantling barriers to women's empowerment; KSHEMA, reframing ageing as an opportunity; and NAIPUNYAM, equipping the population with skills for the future economy. Together, these pillars form a comprehensive safety net and opportunity network in which policies for reproductive health, digital healthcare, women's empowerment, elderly care, and skill development reinforce one another.

The ultimate goal is to move beyond policy-driven implementation to a self-sustaining social movement — one that normalises shared parenting, champions women's empowerment, values the silver dividend, and embraces lifelong health. This requires the full realisation of the P4 model: the Government providing policy vision and fiscal stewardship; the Private Sector creating family-friendly workplaces; Philanthropic Organisations supporting innovation; and the People actively engaging in their own well-being.

Together, Andhra Pradesh can not only navigate its demographic transition but emerge as a national and global model for converting a demographic challenge into a demographic dividend. The goal is clear: a wealthy, healthy, and happy Swarnandhra — for all its citizens, for generations to come. The time to act is now.

ANNEXURE I: COMPREHENSIVE POPULATION MANAGEMENT INDICATORS

Section 1: Demographic Profile & Population Structure

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
1	Total Population	Current population	Million	53.2	Census	UP 240; Maharashtra 126; Bihar 125	Sikkim 0.7; Mizoram 1.2; Arunachal 1.5	1,476.6	China 1,410; India 1,476; USA 340	Vatican 0.001; Tuvalu 0.012; Nauru 0.013	UN WPP 2024
2	Population Density	Population per sq. km	Persons/km ²	—	Census	Delhi 11,320; Chandigarh 9,252; Puducherry 2,547	Arunachal 17; Mizoram 52; Andaman 57	497	Monaco 26,000; Singapore 8,600; Bahrain 2,100	Mongolia 2; Namibia 3; Australia 3	UN WPP 2024
3	Number of Households	Total occupied housing units	Million	~11.8	Census (Projected)	UP ~48; Maharashtra ~28; Bihar ~28	Sikkim ~0.16; Mizoram ~0.27; Ladakh ~0.03	~328	China ~500; USA ~130; Japan ~55	Vatican ~0.0005; Tuvalu ~0.003; Nauru ~0.003	Census Projections / MOSPI / Esri India
4	Life Expectancy	Avg years expected to live	Years	70.7	Annual	Kerala 75.1; Himachal 74.4; Jammu & Kashmir 74.4	Chhattisgarh 64.6; MP 67.6; UP 68	70.3	Japan 84; Switzerland 84; Singapore 84	Chad 54; Nigeria 55; Lesotho 55	SRS 2023 / UN WPP 2024
5	Median Age	Population midpoint age	Years	35	Census (Projected)	Kerala 37; Tamil Nadu 36; Himachal 34	Bihar 23; UP 27; Rajasthan 28	30	Monaco 55; Japan 49; Germany 46	Niger 15; Chad 16; Uganda 16	MoHFW / UN WPP 2024

Population Management: A Life-Cycle Model for Andhra Pradesh

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
6	Gender Ratio	Females per 1000 males	Ratio	1045	NFHS-5	Kerala 1121; Bihar 1090; TN 1088	Haryana 926; Punjab 938; Gujarat 945	1020	Armenia 1140; Latvia 1130; Lithuania 1120	Qatar 640; UAE 690; Bahrain 720	NFHS-5 (2019-21)
7	Sex Ratio at Birth	Female births per 1000 male births	Ratio	943	Annual	Chhattisgarh 974; Kerala 971; Himachal 958	Haryana 884; Delhi 872; Uttarakhand 868	917	Liechtenstein 1,160; N. Mariana 1,150; Azerbaijan 1,120	Namibia 1,010; Zambia 1,010; Malawi 1,010	SRS 2023
8	Population Growth Rate	Annual % change	%	0.7	Annual	Bihar 2.9; Jharkhand 2.5; Gujarat 2.4	Odisha 0.6, Tamil Nadu 0.6, Telangana 0.7	1.78	Niger 3.8; Angola 3.3; Chad 3.1	Bulgaria -1.2; Latvia -1.1; Ukraine -0.9	MoHFW /UN WPP 2024
9	Net Migration Rate	(Immigrants - Emigrants)/1000 population	Rate	-0.3	Annual	Delhi +2.5; Maharashtra +1.8; Gujarat +1.2	UP -1.5; Bihar -1.8; MP -0.9	-0.3	UAE +28; Qatar +25; Singapore +18	Syria -45; Venezuela -30; Yemen -8	UN WPP 2024
10	Urbanization Rate	Urban population share	%	37.6	Annual	Delhi 98; Goa 62; Tamil Nadu 48	Himachal 10; Bihar 11; Assam 14	37.6	Singapore 100; Kuwait 100; Qatar 99	Burundi 13; Niger 16; Malawi 17	UN World Urbanization Prospects 2024

Section 2: Fertility and Birth Indicators

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
11	Total Fertility Rate (TFR)	Avg children per woman	Children	1.5	Annual	Bihar 2.8, UP 2.6, MP 2.4	WB 1.3, Tamil Nadu 1.3,	1.9	South Korea 0.7;	Niger 6.7; Somalia 6.2; Chad 6.1	SRS 2023/ UN WPP 2024

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
							Maharashtra 1.4		Singapore 1.0; Italy 1.2		
12	TFR (Urban)	Avg children per woman	Children	1.3	Annual	Bihar 2.2, UP 2.2, Rajasthan 2.1	WB 1.1, Himachal 1.1, J&K 1.2	1.5	South Korea 0.7; Italy 1.2; Japan 1.3	Niger 6.5; Chad 6.2; Somalia 6.0	SRS 2023
13	TFR Replacement Level	Stable fertility level	Children	2.1	Constant	—	—	2.1	—	—	Demography Standard
14	Crude Birth Rate (CBR)	Births per 1000 population	Rate	15	Annual	Bihar 25.8; Haryana 23.6; Karnataka 22.9	Assam 12.3, Himachal 12.9 MP 13.8	18.4	Niger 46; Somalia 43; Chad 42	Hong Kong 4; South Korea 5; Japan 6	SRS 2023
15	General Fertility Rate (GFR)	Births per 1000 women (15-49)	Rate	50.3	Annual	Bihar 95.5; UP 84.5; Rajasthan 81.7	TN 42.3, Kerala 44.6; WB 45	64.3	Niger 210; Somalia 195; Chad 188	South Korea 18; Japan 22; Italy 23	SRS 2023
16	Age-Specific Fertility Rate (ASFR) 15-19	Births per 1000 women 15-19	Rate	9.7	Annual	WB 23.3, Assam 18.7, Jharkhand 15.4	J&K 3.1, Kerala 4.8, Haryana 5	11	South Korea 1; Japan 2; Switzerland 3	Niger 170; Mali 165; Chad 160	SRS 2023
17	ASFR 20-24	Births per 1000 women 20-24	Rate	105	Annual	Bihar 147.7, MP 142.8, Rajasthan 132.6	J&K 38.6, Punjab 68.9, Himachal 70.5	107	South Korea 12; Japan 18; Italy 20	Niger 280; Mali 275; Chad 270	SRS 2023
18	ASFR 25-29	Births per 1000 women 25-29	Rate	125.5	Annual	Bihar 215, MP 174, UP 171.5	WB 75.4, J&K 82.9, Punjab 105.5	136.8	South Korea 45; Japan 48; Italy 52	Niger 260; Mali 255; Chad 250	SRS 2023
19	ASFR 30-34	Births per 1000	Rate	41.9	Annual	UP 121.4, Bihar 115.7,	AP 41.9, WB 44.4, Tamil Nadu 48.3	78.4	South Korea 68; Japan 72; Italy 70	Niger 210; Mali 205; Chad 200	SRS 2023

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
		women 30-34				Rajasthan 97.5					
20	ASFR 35-39	Births per 1000 women 35-39	Rate	12.8	Annual	UP 62.5, Bihar 49.1, J&K 44.7	AP 12.8, Tamil Nadu 13.6, WB 13.7	32.5	South Korea 32; Japan 35; Italy 30	Niger 150; Mali 145; Chad 140	SRS 2023
21	ASFR 40-44	Births per 1000 women 40-44	Rate	4.6	Annual	J&K 25.5, UP 25.2, Bihar 19	Tamil Nadu 4.1, WB 4.3, AP 4.6	11.5	South Korea 6; Japan 8; Italy 5	Niger 65; Mali 60; Chad 58	SRS 2023
22	ASFR 45-49	Births per 1000 women 45-49	Rate	2.2	Annual	J&K 11.8, Bihar 8.5, UP 7.1	Kerala 0.8, Tamil Nadu 0.9, Punjab 1.5	3.9	South Korea 0.5; Japan 0.8; Italy 0.7	Niger 18; Mali 16; Chad 15	SRS 2023
23	Ideal Family Size Preference	Avg ideal number of children	Children	1.8	Triennial	Kerala 1.5; Tamil Nadu 1.6; AP 1.8	Bihar 2.8; UP 2.6; MP 2.4	1.9	—	—	NFHS-5
24	Son Preference Index	% wanting more sons than daughters	%	12.5	Triennial	Kerala 4; Tamil Nadu 6; AP 12.5	Bihar 28; UP 25; Haryana 22	14.2		—	NFHS-5

Section 3: Mortality and Health Outcomes

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
25	Crude Death Rate (CDR)	Deaths per 1000 population	Rate	6.9	Annual	J&K 5.6, WB 5.7, Rajasthan 5.9	Chhattisgarh 8.3; Odisha 7.7; Punjab 7.3	6.4	Qatar 1.3; UAE 1.6; Kuwait 2.1	Bulgaria 15; Latvia 15; Ukraine 14	SRS 2023
26	Infant Mortality Rate (IMR)	Infant deaths per 1000 births	Rate	19	Annual	Kerala 5; TN 12; Maharashtra 14	Chhattisgarh 37; MP 37; UP 37	25	Iceland 2; Finland 2; Japan 2	Somalia 70; Nigeria 65; Chad 63	SRS 2023/ UN WPP 2024

Population Management: A Life-Cycle Model for Andhra Pradesh

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
27	Neonatal Mortality Rate (NMR)	Deaths under 28 days per 1000 births	Rate	16	Annual	Kerala 4; TN 9; J&K 10	MP 27; UP 26; Chhattisgarh 26	19	Iceland 1; Finland 1; Japan 1	Somalia 45; Nigeria 42; Chad 40	SRS 2023/ UN WPP 2024
28	Under-5 Mortality Rate (U5MR)	Deaths under 5 years per 1000 births	Rate	21	Annual	Kerala 8; TN 13; Maharashtra 15	MP 44; UP 42; Chhattisgarh 41	29	Finland 2; Japan 2; Sweden 2	Somalia 110; Nigeria 102; Chad 98	SRS 2023 / UN WPP 2024
29	Maternal Mortality Ratio (MMR)	Maternal deaths per 100k births	Rate	30	Periodic	AP 30; Kerala 30; TN 35	Odisha 153; Chhattisgarh 146; MP 142	88	Norway 2; Italy 2; Poland 2	South Sudan 1,150; Chad 1,060; Nigeria 1,040	SRS 2021-23
30	Healthy Life Expectancy (HALE)	Years lived in good health	Years	61.2	Annual	Kerala 68.5; AP 61.2; Tamil Nadu 60.8	Bihar 54.2; UP 55.1; MP 56.8	60.3	Japan 74.1; Singapore 73.6; Switzerland 73.1	Lesotho 42.5; Sierra Leone 43.2; CAR 44.0	GBD / National Health Profile

Section 4: Age Structure and Dependency

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
31	Population 0–14 years	Share of total population	%	19.3	Census	Bihar 34; UP 32; MP 30	Kerala 20; TN 21; Himachal 22	26	Niger 50; Mali 47; Chad 46	Japan 12; Italy 13; Germany 13	MoHFW / UN WPP 2024
32	Population 15–59 years (Working Age)	Share of total population	%	66	Census	Delhi 71; Goa 69; Kerala 68	Bihar 60; Assam 61; UP 61	65	UAE 84; Qatar 83; Singapore 80	Niger 46; Mali 48; Chad 49	MoHFW / UN WPP 2024
33	Population 60+ years (Elderly)	Share of total population	%	12.4	Census	Kerala 18; TN 16; Himachal 15	Bihar 8; UP 9; Assam 9	12.4	Japan 29; Italy 24; Germany 23	Qatar 2; UAE 2; Niger 3	MoHFW / UN WPP 2024

Population Management: A Life-Cycle Model for Andhra Pradesh

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
34	Youth Dependency Ratio	$(\text{Pop } 0-15) / (\text{Pop } 16-64) \times 100$	Ratio	38.5	Census	Bihar 52; UP 48; MP 45	Kerala 28; TN 30; AP 38.5	40.2	Niger 85; Mali 82; Chad 80	Japan 20; Italy 22; Germany 21	Census / UN WPP 2024
35	Old Age Dependency Ratio	$(\text{Pop } 65+) / (\text{Pop } 16-64) \times 100$	Ratio	13.5	Census	Kerala 22; TN 18; Punjab 16	Bihar 8; UP 9; Assam 9	13.5	Japan 48; Italy 38; Germany 37	Qatar 3; UAE 4; Niger 5	Census / UN WPP 2024
36	Total Dependency Ratio	$(\text{Pop } 0-15 + \text{Pop } 65+) / (\text{Pop } 16-64) \times 100$	Ratio	52	Census	Bihar 68; UP 65; MP 62	Kerala 42; TN 45; Punjab 47	53.7	Niger 92; Mali 88; Chad 85	Japan 48; Italy 49; Germany 50	Census / UN WPP 2024
37	Demographic Dividend (Working Age Share)	Pop 15-59 / Total Pop	%	66	Census	Delhi 71; Goa 69; Kerala 68	Bihar 60; Assam 61; UP 61	65	UAE 84; Qatar 83; Singapore 80	Niger 46; Mali 48; Chad 49	Census Population Projections

Section 5: Maternal and Child Health

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
38	Institutional Delivery Rate	Births in health facilities	%	95.2	Annual	Kerala 99.9; Tamil Nadu 99.8; AP 95.2	Nagaland 42; Meghalaya 51; UP 67	88.6	Ukraine 99.9; Belarus 99.8; Kazakhstan 99.5	South Sudan 16; Chad 22; Ethiopia 26	NFHS-5
39	Antenatal Care Coverage (4+ ANC Visits)	Women with 4+ ANC visits	%	72.5	Triennial	Kerala 95; Tamil Nadu 92; AP 72.5	Bihar 32; UP 38; Jharkhand 45	58.1	Belarus 99; Finland 98; Sweden 97	Somalia 7; Chad 15; Niger 18	NFHS-5
40	Full Immunization Coverage	Children 12-23 months fully immunized	%	78.3	Annual	Kerala 92; Punjab 90; AP 78.3	Nagaland 42; Meghalaya 48; UP 55	76.4	Iceland 99; Sweden 98; Finland 98	Somalia 25; Papua NG 27; Nigeria 31	NFHS-5
41	Low Birth Weight Prevalence	Births <2500g	%	16.2	Annual	Kerala 9; Tamil Nadu 11; AP 16.2	MP 23; Jharkhand 22; UP 21	18.2	Finland 4; Sweden 4; Japan 5	South Sudan 27; Bangladesh 22; India 18.2	NFHS-5

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
42	Teenage Pregnancy Rate	Women 15-19 pregnant or already mothers	%	12.6	Triennial	Himachal 3; Kerala 4; Punjab 5	Bihar 17; Tripura 16; WB 16	6.8	South Korea 1; Japan 1; Switzerland 2	Niger 36; Chad 30; Mali 29	NFHS-5
43	Anaemia in Pregnant Women	Hb <11 g/dL	%	53	Triennial	Mizoram 24; Kerala 27; Manipur 30	Bihar 63; Jharkhand 61; Assam 60	52	Japan 10; Switzerland 12; Norway 13	Yemen 60; Nigeria 57; India 52	NFHS-5
44	Postpartum Family Planning Uptake	Women adopting FP within 48 hours of delivery	%	42.5	Annual	AP 42.5; Telangana 41; Karnataka 38	Nagaland 8; Mizoram 10; Meghalaya 12	31.2	China 65; Vietnam 58; Thailand 52	Data not available systematically	NHM

Section 6: Family Planning and Contraception

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
45	Contraceptive Prevalence Rate (CPR)	Married women 15-49 using any method	%	68.4	Triennial	AP 68.4; Telangana 67; Karnataka 65	Mizoram 32; Nagaland 35; Meghalaya 38	66.7	China 85; Vietnam 76; Thailand 75	South Sudan 4; Chad 5; Niger 6	NFHS-5
46	Unmet Need for Family Planning	Women wanting to delay/stop childbearing not using contraception	%	9.4	Triennial	Kerala 6; Punjab 7; AP 9.4	Bihar 15; UP 14; MP 13	9.4	—	—	NFHS-5
47	Birth Spacing (≥3 years)	Births with interval ≥3 years	%	52.4	Annual	Kerala 68; TN 65; AP 52.4	Bihar 38; UP 40; MP 42	52.4	—	—	NFHS-5

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
48	Female Sterilization	Sterilized married women	%	63	Triennial	AP 63; Telangana 61; Karnataka 58	Mizoram 7; Nagaland 9; Meghalaya 10	38	China 35; Vietnam 34; Thailand 30	Niger 1; Chad 1; Mali 2	NFHS-5
49	Male Sterilization	Men sterilized	%	0.3	Triennial	Gujarat 1.2; Maharashtra 0.8; AP 0.3	All northeastern states <0.1	0.5	Bhutan 5; UK 2; USA 1.5	Data not available systematically	NFHS-5
50	IUCD Adoption Rate	Women using IUCD	%	2.8	Triennial	Delhi 6.5; Punjab 5.8; AP 2.8	Bihar 0.5; UP 0.8; MP 1.2	2.1	China 45; Vietnam 28; Thailand 15	Data not available systematically	NFHS-5 / HMIS
51	Oral Contraceptive Pill Usage	Women using OCP	%	4.2	Triennial	Punjab 12.5; Delhi 11.2; AP 4.2	Bihar 1.2; UP 1.5; MP 2.1	4.8	Netherlands 32; France 28; USA 26	Data not available systematically	NFHS-5
52	Condom Usage Rate	Couples using condoms	%	6.8	Triennial	Delhi 18.5; Punjab 16.2; AP 6.8	Bihar 1.8; UP 2.2; MP 3.1	9.5	Japan 42; Spain 38; Italy 35	Data not available systematically	NFHS-5 / HMIS
53	Injectable Contraceptive Usage	Women using injectables (Antara)	%	1.2	Annual	AP 1.2; Telangana 1.1; Karnataka 0.9	Bihar 0.2; UP 0.3; MP 0.4	0.8	UK 12; USA 10; France 8	Data not available systematically	NFHS-5 / NHM
54	Eligible Couples	Married couples eligible for FP	Million	9.1 (as on 30.06.2024)	Annual	UP 2.1; Bihar 1.4; Maharashtra 0.9	Sikkim 0.01; Mizoram 0.02; Goa 0.03	~250	China ~300; USA ~60; Japan ~25	Small island nations	Health Statistics 2024-25

Section 7: Female Education and Empowerment

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
55	Female Literacy Rate	Literate women 7+ years	%	74.8	Decennial	Kerala 95; Mizoram 91; Lakshadweep 88	Bihar 55; UP 62; Rajasthan 65	77.7	Russia 99.9; Ukraine 99.8; Kazakhstan 99.7	Afghanistan 30; Niger 31; Mali 33	Census 2011 / NSO
56	Female Secondary School Completion Rate	Girls completing secondary education	%	72.5	Annual	Kerala 95; Tamil Nadu 88; AP 72.5	Bihar 48; UP 52; Jharkhand 55	68.3	Finland 98; Norway 97; Switzerland 96	South Sudan 12; Niger 14; Chad 15	UDISE+ 2024-25
57	Female Gross Enrollment Ratio (Higher Education)	Girls enrolled in higher education / Pop 18-23	%	32.4	Annual	Delhi 48; Kerala 45; AP 32.4	Bihar 18; UP 22; MP 24	28.5	Greece 125; USA 88; Australia 86	Data not available systematically	AISHE 2024-25
58	School Dropout Rate (Girls)	Girls dropping out before secondary completion	%	18.5	Annual	Kerala 2; Tamil Nadu 5; AP 18.5	Bihar 42; UP 38; Jharkhand 35	21.2	Japan 0.5; South Korea 0.8; Finland 1.2	Niger 75; Chad 72; Mali 70	UDISE+
59	Average Age at Marriage (Female)	Mean age at marriage for women	Years	21.5	Triennial	Kerala 23.5; Punjab 23; AP 21.5	Bihar 19.2; Jharkhand 19.5; UP 19.8	21.2	Sweden 34; Norway 33; Denmark 32	Niger 17; Chad 17.5; Mali 18	NFHS-5
60	Child Marriage Rate	Women married before 18	%	29.3	Triennial	Kerala 6; Himachal 8; Punjab 9	Bihar 40; Tripura 40; WB 41	23.3	Sweden 0; Norway 0; Netherlands 0	Niger 76; Chad 67; Mali 54	NFHS-5 / UNICEF
61	Female Labour Force Participation Rate	Female workers / female pop 15+	%	28.3	Annual	Himachal 46; MP 38; Rajasthan 37	Delhi 12; Punjab 18; Kerala 20	28.3	Iceland 76; Sweden 74; Norway 73	Yemen 6; Iraq 12; Afghanistan 14	PLFS 2024-25 / ILO
62	Women Self-Help Group Participation	Women in SHGs / total women	%	42.5	Annual	AP 42.5; Telangana 40; Kerala 38	Delhi 8; Punjab 12; Haryana 15	32.8	—	—	SRLM MIS 2025

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
63	Women Bank Account Ownership	Women with bank account	%	85.2	Triennial	Kerala 98; AP 85.2; Tamil Nadu 84	Bihar 62; UP 65; MP 68	78.6	Sweden 100; Norway 100; Denmark 100	Afghanistan 8; Yemen 12; Somalia 15	NFHS-5 / PMJDY MIS
64	Women Asset Ownership (Land/House)	Women owning land or house	%	32.8	Triennial	Kerala 58; AP 32.8; Tamil Nadu 31	Bihar 15; UP 18; MP 20	28.5	Sweden 52; USA 48; France 45	Data not available systematically	NFHS-5 / Census

Section 8: Health Infrastructure and Access

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
65	ASHA Coverage	Population per ASHA worker	Number	985	Annual	Kerala 850; AP 985; Tamil Nadu 1,020	Bihar 1,450; UP 1,420; MP 1,380	1,082	—	—	NHM MIS
66	Doctor–Population Ratio	Allopathic doctors per 10,000 population	Ratio	8.2	Annual	Delhi 22; Kerala 18; AP 8.2	Bihar 3.2; UP 4.1; MP 4.5	7.5	Cuba 84; Greece 62; Austria 54	Niger 0.3; Sierra Leone 0.4; Ethiopia 0.5	National Health Profile
67	PHC Accessibility	Population per PHC	Number	28,500	Annual	Kerala 18,000; AP 28,500; Tamil Nadu 29,000	Bihar 52,000; UP 48,000; MP 42,000	32,500	—	—	Rural Health Statistics
68	Digital Health Record Coverage	Population with ABHA ID	%	42.5	Annual	Kerala 68; AP 42.5; Karnataka 40	Bihar 18; UP 22; MP 25	35.2	Estonia 99; Denmark 98; Canada 85	Data not available systematically	ABDM Dashboard 2025
69	Telemedicine Utilization	eSanjeevani consultations	Rate	125	Annual	Kerala 280; AP 125;	Bihar 22; UP 35; MP 48	98	—	—	eSanjeevani Portal

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S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
		per 1000 population				Tamil Nadu 110					
70	Social Protection Coverage	Households covered by at least one scheme	%	68.5	Annual	Kerala 92; AP 68.5; Tamil Nadu 65	Delhi 28; Punjab 35; Haryana 38	58.2	—	—	State Welfare MIS
71	Housing Security (Pucca Housing)	Households in pucca houses	%	72.5	Quinquennial	Delhi 98; Kerala 95; AP 72.5	Bihar 42; Odisha 48; MP 52	68.3	Japan 100; Germany 100; USA 99	Data not available systematically	NSS / PMAY MIS

Section 9: Socio-Economic and Development Indicators

S. No.	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
72	Workforce Participation Rate (15+)	Workers / population 15+	%	51.2	Annual	Himachal 53; MP 52; Rajasthan 51	Delhi 35; Kerala 41; TN 42	51.2	Iceland 80; Switzerland 79; Netherlands 78	Yemen 39; Iraq 40; Jordan 41	PLFS 2024-25 / ILO
73	Male Workforce Participation	Male workers / male pop 15+	%	74.5	Annual	Himachal 76; MP 75; Rajasthan 74	Delhi 58; Kerala 62; TN 64	74.5	Iceland 84; Switzerland 82; Netherlands 81	Yemen 72; Iraq 68; Jordan 67	PLFS 2024-25
74	Female Workforce Participation	Female workers / female pop 15+	%	28.3	Annual	Himachal 46; MP 38; Rajasthan 37	Delhi 12; Punjab 18; Kerala 20	28.3	Iceland 76; Sweden 74; Norway 73	Yemen 6; Iraq 12; Afghanistan 14	PLFS 2024-25 / ILO
75	Per Capita Income	Net State Domestic	₹ (Current)	₹2,18,000	Annual	Goa ₹4,50,000;	Bihar ₹58,000;	₹1,68,000	Luxembourg	Burundi \$260;	State Economic

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S. No	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
		Product / Population				Delhi ₹4,20,000; Sikkim ₹4,10,000	UP ₹75,000; MP ₹95,000		\$135,000; Switzerland \$92,000; Norway \$89,000	Somalia \$330; Malawi \$350	Survey 2024-25
76	Poverty Rate (MPI)	Multidimensional Poverty Index headcount	%	12.8	Periodic	Kerala 0.7; Goa 1.2; AP 12.8	Bihar 52.4; Jharkhand 42.1; UP 37.7	14.96	Iceland 0.1; Norway 0.2; Finland 0.2	South Sudan 85; Niger 82; Chad 80	NITI Aayog MPI 2024
77	Human Development Index (HDI)	Composite index (0-1)	Score	0.675	Periodic	Kerala 0.782; Goa 0.775; Chandigarh 0.768	Bihar 0.576; UP 0.596; MP 0.606	0.654	Switzerland 0.967; Norway 0.966; Iceland 0.959	South Sudan 0.385; Chad 0.394; Niger 0.400	NITI Aayog / UNDP 2024
78	Productivity per Worker	GDP / Total workers	₹ (Constant)	₹3,85,000	Annual	Goa ₹8,50,000; Delhi ₹7,80,000; Maharashtra ₹6,50,000	Bihar ₹1,20,000; UP ₹1,50,000; MP ₹1,80,000	₹3,20,000	Luxembourg \$235,000; Ireland \$185,000; Norway \$165,000	Data not available systematically	National Accounts Statistics / NSO
79	Intergenerational Education Mobility	% children with higher education than parents	%	42.5	Quinquennial	Kerala 68; AP 42.5; Tamil Nadu 40	Bihar 28; UP 30; MP 32	38.2	Finland 58; Norway 56; Denmark 55	Data not available systematically	NSS Social Consumption Surveys

Section 10: Infertility and Reproductive Health

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S. No	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
80	Infertility Prevalence (Overall)	Couples unable to conceive after 12 months of unprotected intercourse	%	15-20 (estimated)	Periodic	Urban centers higher (Mumbai, Delhi, Bengaluru)	Rural areas lower (secondary infertility higher)	15-20% (~30 million couples)	Japan 15%; UK 16%; USA 12%; Global avg 8-12%	Data not available systematically	INSIGHT S IAS 2026
81	Primary Infertility	Women unable to conceive after 12 months, never conceived	%	Higher in urban areas	Periodic	Urban metros (Mumbai, Bengaluru, Delhi)	Rural areas	Higher in urban areas (32.6% at DSM1+)	—	—	IJCM Feb 2026 / INSIGHT S IAS
82	Secondary Infertility	Women unable to conceive after previous birth	%	Higher in rural areas	Periodic	Rural areas with untreated infections	Urban areas	Higher in rural areas	—	—	INSIGHT S IAS 2026
83	Male Factor Infertility	Male contribution to infertility cases	%	—	—	—	—	40-50%	—	—	INSIGHT S IAS 2026
84	Female Factor Infertility	Female contribution to infertility cases	%	—	—	—	—	40-50%	—	—	INSIGHT S IAS 2026
85	PCOS Prevalence	Women affected by Polycystic Ovary Syndrome	%	—	—	—	—	20% (one in five Indian women)	—	—	INSIGHT S IAS 2026

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S. No	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
86	Delayed Parenthood Trend	Women seeking fertility treatment after age 35	% increase	—	—	Bengaluru, Mumbai (25% increase in 2025-26)	—	25% increase (urban hubs)	—	—	INSIGHT S IAS 2026
87	IVF Market Size	Annual value of fertility treatment market	USD Million	—	—	West India (largest market)	East India (smallest market)	\$961 Million (2024); projected \$1,492 Million (2030)	Global IVF market ~\$15 billion	—	GII Research 2025
88	IVF Market Growth Rate	Compound Annual Growth Rate	%	—	—	—	—	7.80% (2025-2030)	—	—	GII Research 2025
89	IVF Cycle Cost	Average cost per IVF cycle	₹ Lakhs	—	—	Varies by city and clinic	Varies by city and clinic	₹1.5-3 lakhs	USA \$15,000-20,000; UK £5,000-8,000	—	INSIGHT S IAS 2026
90	Health Insurance Coverage for IVF	Policies covering infertility treatment	%	—	—	—	—	<10%	UK 100% (NHS coverage varies); USA varies by state	—	INSIGHT S IAS 2026
91	Male Fertility Screening Delay	Average delay in men seeking first fertility screening	Years	—	—	—	—	3-5 years longer than women	—	—	INSIGHT S IAS 2026
92	Hysterectomy Rate	Women in reproductive age group	%	Higher than national average	Recent Study	Andhra Pradesh; Telangan	Assam; Mizoram	4.8% of women in reproductive age group	—	—	The New Indian Jan 2026

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S. No	Indicator	Formula	Unit	AP Value	Periodicity	Top 3 States (India)	Bottom 3 States (India)	National Value	Top 3 Countries	Bottom 3 Countries	Source
	(Reproductive Age)	who have undergone hysterectomy				a (highest rates)	(lowest rates)				
93	Hysterectomy Rate (All Women)	Women reporting hysterectomy (NFHS-5)	%	4.5	Triennial	AP 4.5; Telangana 4.2; Bihar 4.0	Mizoram 0.5; Nagaland 0.7; Manipur 0.8	3.3	Data not available systematically	Data not available systematically	NFHS-5

Summary of Key Data Sources

Source	Full Name	Periodicity	Key Indicators Covered
UN WPP 2024	United Nations World Population Prospects 2024	Annual	Population, median age, TFR, growth rate, urbanization, migration
NFHS-5	National Family Health Survey 5 (2019-21)	Triennial	TFR, CPR, unmet need, anemia, marriage age, sterilization, son preference
SRS	Sample Registration System	Annual	CBR, CDR, IMR, MMR, age-specific fertility
HMIS	Health Management Information System	Monthly/Annual	Institutional delivery, ANC, immunization, SRB, postpartum FP
PLFS	Periodic Labour Force Survey	Annual	Workforce participation, male/female LFPR
UDISE+	Unified District Information System for Education	Annual	School enrollment, dropout rates, completion rates
AISHE	All India Survey on Higher Education	Annual	Higher education enrollment, GER
CRS	Civil Registration System	Annual	Birth rate, death rate, SRB
NSS	National Sample Survey	Quinquennial	Migration, housing, consumption, education mobility
NHM MIS	National Health Mission Management Information System	Monthly/Annual	ASHA coverage, family planning uptake

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Source	Full Name	Periodicity	Key Indicators Covered
NSO	National Statistical Office	Various	Dependency ratios, productivity, income
NITI Aayog	NITI Aayog	Periodic	MPI poverty, HDI
INSIGHTS IAS 2026	Educational Resource (citing government data)	2026	Infertility prevalence, male/female factors, IVF costs, PCOS prevalence
GII Research 2025	Market Research Report	2025	IVF market size, growth rate, regional distribution
The New Indian 2026	News Media (citing recent study)	Jan 2026	Hysterectomy rate among reproductive age women (4.8%)