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Policy Options for Population Stabilisation
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Introduction

For more than 50 years, India's efforts towards population stabilisation have focussed on reduction in birth rate through fertility regulation. These efforts have definitely resulted in transition in fertility in the country, although the pace of transition has remained slower than expected. Population growth in India still hovers very close to 2 per cent per year which has created a large momentum for future growth despite the decrease in fertility. Projections carried out by the National Population Commission suggests that country's population will increase to around 1400 million by the year 2026; an increase of about 36 per cent in the 25 years between 2001 2026 (Government of India, 2006). On the other hand, projections carried out by the United Nations indicate that India is most likely to become the most populous country in the world surpassing China by the year 2040 (United Nations, 2008). It has also been projected that declining levels of fertility and mortality will induce significant changes in the age structure of the population which, in turn, will have implications for transition in fertility and mortality. Changes in the age structure of the population primarily as the result of declining fertility will first result in a bulging of the population pyramid and subsequently to population ageing and will have implications for both demographic transition and social and economic development.

What are then strategic options for India to address emerging population issues? In the past population related strategies and programmes in India have squarely been focussed on reduction in fertility through the promotion of the use of family planning methods. The situation appears to have turned more complex as declining fertility and mortality has brought up issues other than fertility reduction. In many states of the country, fertility has already reached below the replacement level. In these states, focussing on fertility reduction has little relevance. On the other hand, in some states of the country, desire for large family still appears to be quite strong. In these states, mere focussing on family planning may not result in achieving population stabilisation goals.

Discussing strategic options to address prevailing population issues has always been a challenging proposition in India because of its vastness and diversity as a nation, as a society, as a tradition, as a culture and as an economy. Constitutionally, the country India is a federation of states with clear division of responsibilities and powers between the Union Government and the State Government. Health including family planning has been a state subject in the Constitution of India right since independence. In 1976, family planning and population control was added to the concurrent list of the Constitution through a constitutional amendment which paved the way for direct involvement of the Union Government in population stabilisation related programmes and activities. However, even before the 1976 constitutional amendment, planning and implementation of population stabilisation efforts were largely influenced by the Union Government through the centrally sponsored National Family Welfare (Planning) Programme.

Although, the Union Government is fully committed to the cause of population stabilisation and meets most of the expenditure, if not all, related to

population stabilisation, it has no administrative machinery for implementing population stabilisation related programmes and activities. The Union Government is dependent upon State Governments for the implementation of population related programmes and activities planned at the national level in the context of national priorities. This is a piquant situation as the national priorities are rarely the state priorities because the political, social, economic and the demographic scenario at the state level is different from the national situation. Moreover, policy formulation and planning for population related issues at the national level rarely take into account the social and cultural sensitiveness of population related issues that are so pervasive at the local level. Often, the interventions and activities proposed at the national level are found to be out of context of the local social and cultural milieu. In such a situation, the state government and the local level administrative agencies interpret the national policy and national priority in their own way. This considerably dilutes the focus of national policies and programmes at the local level. Moreover, there is little scope to incorporate local context of demographic and development situation so that population stabilisation efforts are rarely owned by the people.

It is obvious that, because of the vastness and diversity of India, there is no one prescription that can address population related issues of all the constituent states of the country. Strategic options for population stabilisation at the national level should therefore be in the form of policy level directive principles that facilitate the constituent states to address state specific population issues in their own way by taking into consideration the local context of demographic behaviour. These directive principles ensure that state level action towards population stabilisation add up to addressing national priorities and concerns. This means that the guiding principles should be able to clearly establish the links between local issues and concerns and the national priorities. Since improvements in the quality of life has been the very basis for population stabilisation, a development orientation of these guiding principles is a logical necessity.

Fertility Differentials across States

The starting point for exploring strategic options for population stabilisation may be the prevailing level of fertility. Estimates of the total fertility rate available through the National Family Health Survey 2005-06 suggest that constituent states of India can be divided into the following three broad categories:

I States where the replacement fertility has already been achieved. These states are Andhra Pradesh, Goa, Himachal Pradesh, Karnataka, Kerala, Punjab, Sikkim and Tamil Nadu. These states accounted for almost one fourth of the country's population at the 2001 population census.

II States which are at the threshold of achieving the replacement fertility. These states are Assam, Chhattisgarh, Gujarat, Haryana, Jammu and Kashmir, Orissa, Tripura, Uttarakhand, West Bengal , Maharashtra, Delhi and Assam. In these states, the total fertility rate varies between 2.1-2.7 live births per woman. These states accounted for about 36 per cent of the population of the country at the 2001 population census.

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III   States where fertility continues to be well above the replacement level. These states are Arunachal Pradesh, Bihar, Jharkhand, Madhya Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Rajasthan and Uttar Pradesh. Total fertility rate, in these states, ranges between 2.7-4.0 live births per woman. They constituted around 39 per cent of the population of the country at the 2001 population census.

It would be revealing to analyse how future population growth in the three categories of states will contribute to the future population growth of the country. The state-specific population projections prepared by the National Population Commission suggest that future population growth in the category III states will account for more than 48 per cent of the net addition to the population of the country between 2001 and 2026. By contrast, population growth in the category I states will account for only about 16 per cent of the net addition to the country's population while population growth in category II states will account for about 36 per cent of the net addition to country's population. Thus, more than 50 per cent of the net addition to the population of the country between 2001 and 2026 will be in those states where total fertility rate is either below the replacement level or very close to it. Hastening the pace of population stabilisation should therefore address population growth in all the three category of states. In category III states, fertility in excess to the replacement level will be the primary contributor to future population growth while in category I and category II states, primary source of future population growth will be the population momentum.

Decomposition of Excess Fertility

Fertility in excess to the replacement level in category II and category III states can be divided into two parts - wanted fertility in excess to the replacement level and unwanted fertility. Unwanted fertility may be measured through the unwanted total fertility rate which is the difference between the total fertility rate and the wanted total fertility rate. Wanted total fertility rate may be estimated in the same manner as the total fertility rate but without taking into account the unwanted births. On the other hand, the wanted fertility in excess to the replacement fertility may be measured in terms of the difference between the wanted total fertility rate and the replacement fertility - the targeted total fertility rate according to the National Population Policy 2000.

Estimates of wanted total fertility rate for India and states are available through the National Family Health Survey, 2005-06 (International Institute for Population Sciences and Macro International, 1994). These estimates suggest that in the category II states, all fertility in excess to the replacement fertility is the unwanted fertility as the wanted total fertility in these states is estimated to be lower than the replacement fertility. On the other hand, in all but two of the category III states, fertility in excess to replacement fertility is due to both wanted fertility in excess to replacement fertility and the unwanted fertility. The two states where the wanted total fertility rate has been estimated to be equal to the replacement fertility are Jharkhand and Madhya Pradesh (Table 1).

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The above decomposition of the fertility in excess to the replacement fertility indicates that strategic options for achieving national population policy goals and hastening the pace of population stabilisation in different states of the country are different. In category I states, the strategy towards hastening the pace of population stabilisation should focus on addressing population momentum as the current fertility in these states has already reached below the replacement level. In the category II states and in Jharkhand and Madhya Pradesh, on the other hand, strategic concerns should focus on reducing the unwanted fertility as the wanted fertility in these states is already below the replacement level. There is no wanted fertility in excess to the replacement fertility in these states. Couples, in these states, do not want more than two children, on average, and if the unwanted fertility is addressed effectively, replacement fertility can be achieved in these states in the near future.

Finally, in category III states except Jharkhand and Madhya Pradesh, the immediate strategic concern is to address both unwanted fertility as well as wanted fertility in excess to the replacement fertility as couples, in these states, want more than two children, on average. In these states, wanted fertility remains above the replacement level. As such, even if the unwanted fertility is reduced to zero in these states, the actual fertility will remain above the replacement level. Moreover, because of high fertility, these states will be having the highest momentum for future population growth.

Issues in Population Stabilisation

Issues related to population stabilisation in India should therefore be discussed in terms of issues related to addressing population momentum, issues related to reducing wanted fertility in excess to replacement fertility and issues related to reducing and ultimately eliminating unwanted fertility. The current approach to population stabilisation in India focusses primarily on eliminating the unwanted fertility by meeting the unmet need for contraception as spelt out in the National Population Policy 2000 (Government of India, 2000). This approach may not contribute significantly to hastening the pace of population stabilisation in the country as it addresses neither the growth of population due to population momentum in category I states nor the wanted fertility in excess to replacement fertility in category III states.

The current approach to population stabilisation may also not be very effective in category III states in view of the fact that the demand for contraception in these states is very low. According to the National Family Health Survey 2005-06, the total demand for contraception in the category III states never exceeds 70 per cent with the only exception of Mizoram. The empirical relationship between the total fertility rate and the contraceptive prevalence rate based on the information available through the National Family Health Survey suggests that even if all the unmet need for contraception - spacing as well as limiting - is met in these states, it will still not result in achieving the replacement fertility in 8 of the 10 states of this category.

One reason for very low demand for contraception in these states is that the demand for modern spacing or temporary methods of contraception remains exceptionally low. National Family Health Survey 2005-06 suggests that the total demand for modern spacing methods of contraception in India was only 16.7 per cent. Moreover, there have been little increases in this demand over time. All increase in the demand for contraception in India between 1992-93 and 2005-06 has been confined to terminal or permanent methods of contraception. This means that family planning in India is practised primarily for birth limitation rather than for birth planning. As discussed below, family planning practices biased towards birth limitation contribute little to addressing population momentum.

Addressing Population Momentum. In 8 states of the country, where fertility has already reached below the replacement level, population will continue to increase at least in the first quarter of the present century because of the population momentum. Population momentum refers to the tendency of the population to continue to grow beyond the time when the replacement fertility is achieved (Keyfitz, 1971). Because of the population momentum, there is a time lag between achieving the replacement fertility and levelling off the rate of natural increase or achieving population stabilisation. Once the replacement fertility is achieved, it takes about the average life expectancy for the age structure of the population to stabilise (Ehrlich and Holden, 1977).

There are two basic ways to reduce the impact of population momentum on the growth of population. The first is to reduce the couple fertility further below the replacement level. Theoretically, it is possible to completely eliminate the impact of population momentum by reducing fertility to a level at which number of births equal number of deaths. This will however require significant decrease in the demand for children below the normative demand of two children per family. Such a decline is possible only when a one child policy is emphasized as a large proportion of couples in this option will have to contend with only one child.

The second option is to raise the mean age of childbearing. It has been observed that a delay in the onset of childbearing and wider spacing of births leads to a temporary decline in period fertility without changing the demand for children. This temporary decline in period fertility slows down population growth ((Bongaarts, 1990; Ryder, 1980). When fertility decline is based on the promotion of the terminal methods of contraception, the decline in fertility is associated with the decrease in the mean age at childbearing of women. For minimising the impact of population momentum, it is essential that decline in fertility does not result in the decrease in the mean age of childbearing of women.

The mean age of childbearing can be increased through either increasing the legal minimum age at marriage or increasing the age at first birth and the interval between successive births. Increasing the age at first birth and interval between successive births also provide substantial health benefits for mothers and children which, in turn, impact upon the demand for children.

Raising the legal minimum age at marriage through legislation has not been found to be an attractive strategic option to increase the mean age at childbearing

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of women for a host of social, cultural, family and other factors. Moreover, enforcing legislation often leads to coercion and community resistence and opposition. In India, marriage is associated with some very strong religious and psychological sentiments and so increasing the age at marriage through legislation has always been a problematic, although, India has a long history of legislation related to raising the age at marriage dating back to the famous Sarda Act of 1888. The reason appears to be the fact that the age at marriage of the girl or the boy, in India, is determined largely by a host of traditional, cultural and social factors and not just by demographic and development considerations.

By comparison, increasing the mean age at childbearing through postponing the first birth and increasing spacing between successive births are less coercive options. This approach essentially comprise of promoting the use of spacing methods of contraception and termination of unwanted pregnancies as the result of the failure of modern spacing methods of contraception. In order to ensure that despite the decline in fertility, there is no decrease in the mean age at childbearing, the family planning services must focus on birth planning rather than on birth limitation. It is important in this context that the family planning services should target young couples rather than couples who have achieved their family size norms.

Information available through the National Family Health Survey, 2005-06 suggests that the median age at first birth among women aged 20-49 years of age in the category III states varied from less than 19 years in Andhra Pradesh to more than 25 years in Goa. Similarly, the prevalence of modern spacing methods of contraception in these states varied from just 1.3 per cent in Andhra Pradesh to almost 24 per cent in Punjab. This shows that the future population growth in these states can be slowed down considerably just by increasing the age at first birth and prevalence of modern spacing methods of contraception. The current reproductive behaviour can be characterised in terms of few births at very short intervals very early in the reproductive life and then adoption of permanent method of contraception to prevent any further pregnancy or birth. This reproductive behaviour appears to have succeeded in bringing down fertility to below replacement levels in many states of this category. However, this approach has also resulted in a rapid decrease in the mean age at childbearing. Unfortunately, such an approach may not be effective in lessening the impact of population momentum on the future population growth in these states. There is a need to increase the average age at first birth to at least 25 years and the interval between successive births to at least 4-5 years so as to minimise the impact of population momentum. This would require a comprehensive reorientation of family planning services towards birth planning rather than birth spacing.

Eliminating Unwanted Fertility. In the category II states, replacement fertility can be achieved simply by eliminating unwanted fertility. Similarly, in category III states, eliminating unwanted fertility would lead to a significant reduction in the current fertility, although, it will not lead to achieving replacement fertility. Primary reason for the persistence of unwanted fertility is that many couples who wish to delay or stop childbearing are not able to do so. For these couples, the most direct

way is to regulate fertility through the practice of contraception. Experience from the world over suggests that an important reason for the observed inability of couples to practice contraception to avoid unwanted pregnancies is that contraceptive services and supplies are poor and limited in coverage (Ranjan, 2005). Improving the efficiency and effectiveness of family planning services is therefore critical to eliminating unwanted fertility. In India, the official National Family Welfare Programme continues to be the mainstay of family planning efforts since independence. However, programme performance including programme efficiency and quality of family planning services has been one of the most neglected areas of programme implementation because of the preoccupation with achieving numerical targets in terms of new acceptors to be recruited every year. Although, estimates of contraceptive failure rates and discontinuation rates are generally not available, yet it is well known that both the rates are abnormally high with the result that the impact of the programme on fertility has been substantially below the expectations.

In order to ensure that family planning services are able to reduce and ultimately eliminate unwanted fertility, it is imperative that a couple-based system of planning for family planning services delivery is evolved and institutionalised. This is a challenging task as the family planning efforts in India are known for top down approach of planning and implementation and bureaucratic dominance. Although, a community needs assessment approach has been introduced for the implementation of the National Family Welfare Programme in 1996, yet the experience with the new approach has not been very satisfactory (Ranjan, 2005). Modern family planning services are still not able to reach more than half of the currently married couples in the reproductive age group in the country according to the National Family Health Survey and this proportion is more than 70 per cent in states like Assam, Bihar, Manipur, Meghalaya, Nagaland and Uttar Pradesh.

Reduction in the unwanted fertility requires a comprehensive reinvigoration of family planning efforts. The focus of the family planning efforts must be on birth planning and promotion of spacing methods of contraception. Since the official National Family Welfare Programme continues to be the mainstay of family planning efforts in the country, a reorientation of the official programme is the need of the time.

Reducing Wanted Fertility. In category III states, replacement fertility cannot be achieved even if all unwanted fertility is eliminated. The reason is that wanted fertility in these states exceeds the replacement. Wanted fertility in excess to replacement fertility is an indicator of the demand for large family. It cannot be reduced through conventional family planning services. Reduction in the wanted fertility requires broader human development approach, with particular emphasis on education, gender equality and health of infants and young children. Although, universalising education, raising the status of women and reducing the risk of death during infancy and early childhood are policy measures that are essentially directed towards improvements in the quality of life of the people, yet they have relevance to reducing unwanted fertility. This means that mere focussing upon family planning services delivery in the category III states may not be sufficient enough for achieving

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replacement fertility. It is important that social and economic development programmes and activities lead to a decrease in the demand for large families thereby reducing the wanted fertility in excess to replacement fertility. It is therefore imperative that social and economic development processes are sensitive to prevailing population related issues and concerns, especially the family size norms and reproductive behaviour of couples. One essential requirement to this effect is that social and economic development programmes and activities should be directed towards human development and human capacity building that lead to empowerment of the common man. There are two options in this regard. First, population related concerns and issues should be integrated with the social and economic development processes right from the planning stage and second, achievements and impact of all development programmes and activities must be viewed through a population lense. For this purpose, the population impact analysis of all development programmes and activities should be carried out. For example, it has been observed that a population centred women policy and a programme of empowerment of women oriented towards reproductive behaviour may contribute to reducing wanted fertility substantially (Ranjan, 2005).

Strategic Options for Population Stabilisation

Addressing population momentum, reduction and ultimate elimination of unwanted fertility and reducing wanted excess fertility constitute the three dimensions of the strategy directed towards achieving national population policy goals and achieving population stabilisation. Strategic options for addressing the three dimensions are different. As such, a comprehensive approach is required for hastening the pace of population stabilisation in the country. Since different states of India are at different stages of fertility transition, the relative importance of the three dimensions of population stabilisation varies across states. In other words, a decentralised approach is needed. In this context, it is appropriate here to discuss the strategic options to address the three dimensions of population stabilisation separately.

The foregoing considerations suggest that a two dimensional strategy is required for achieving the national population policy goals and for realising population stabilisation in India. One dimension of the strategy should focus on reducing and ultimately eliminating the unwanted fertility while the other should concentrate upon reducing the wanted excess fertility. The unwanted fertility may be reduced and ultimately eliminated primarily through improving the efficiency and effectiveness of the family planning services in meeting the felt needs of the people. Improving the efficiency and effectiveness of family planning services requires a comprehensive reorientation of the National Family Welfare Programme towards birth planning rather than birth limitation. This reorientation will also contribute towards minimising the impact of population momentum in those states of the country where fertility has already reached below replacement levels. Elimination of the unwanted fertility may also require modifications in other key proximate

determinants of fertility - female age at marriage, termination of unwanted pregnancy, and promotion of breast feeding.

On the other hand reduction of wanted excess fertility requires investments in human beings. The wanted excess fertility cannot be removed just by promoting family planning either for birth limitation or for birth planning. It requires broader development efforts directed towards human capacity building in terms of investments especially in education, health and empowerment of women.

The two dimensions of population stabilisation, incidently, complement and reinforce each other. Reduction in wanted excess fertility through investments in human beings does not, by itself reduce fertility. Instead, it raises the demand for fertility regulation, which, when satisfied, leads to reduction in fertility. Conversely, reduction of unwanted fertility through family planning has been found to be more effective in societies with high levels of human development.

Evolving and institutionalising the comprehensive approach towards population stabilisation is a tall order in the current administrative and bureaucratic set up as family planning and population control has always been conceived, planned and implemented in a vertical manner with little linkages or integration with broader development efforts. There have been efforts to integrate the family planning services delivery with the primary health care services delivery but this integration has resulted in a techno-medical orientation of family planning services. The dominance of female and male sterilisation over other methods of family planning throughout the history of family planning efforts in the country is one reflection of the techno-medical orientation of population stabilisation efforts. Of late, there has been attempts to change the basic orientation of the family planning system from a institution-based, service provider driven delivery system to a system based on the felt family planning needs of the community but there has been very limited success so far because of the lack of an appropriate institutional framework. Population stabilisation efforts continue to be the part and parcel of the health care delivery system and continue to be driven by the service providers. The top down target-based system of implementing the official National Family Welfare Programme has been replaced by the bottom up community needs assessment based system but there has been little effort to facilitate the institutionalisation of the new system of programme implementation. The need to integrate population factors in the social and economic development processes at all levels is well recognised. However, there has been little effort to develop conceptual frameworks and models and building up capacities at different tiers of administration for such institutionalisation. Existing institutional arrangements for population stabilisation efforts as well as for social and economic development are basically vertical in terms of planning, implementation and monitoring and evaluation. Alternative institutional arrangements need to be evolved to institutionalisation the comprehensive approach of population stabilisation.

One way of evolving a population stabilisation programme that ensures linkages between the two dimensions of population stabilisation is the integration of population factors with social and economic development processes. It is argued

that explicit integration of population factors into social and economic development programmes and activities will both speed up the pace of development and poverty alleviation and contribute to the achievement of population stabilisation goals including improved quality of life of the people (United Nations, 1995). Since, both the social and economic development programmes and population stabilisation efforts are directed towards improving the quality of the people. It is therefore possible to integrate the two at least at the planning stage. The social and economic development strategy must realistically reflect the short, medium and long-term implications of population dynamics and human reproductive behaviour. At the same time, population stabilisation efforts must be oriented towards improving the quality of life of the people.

Conceptualising, institutionalising and practising population and development integration, however, is a very challenging proposition. The progress in this direction is not very encouraging and there are few examples of successful integration. Embedding population related concerns in the social and economic development programmes and activities may generate resistence by development policy makers and development planners because of their limited understanding of demographic dynamics and human reproductive behaviour. On the other hand, family planning programme managers may fear that recognising the role of social and economic development in population stabilisation may weaken support to organised family planning activities. The traditional wisdom of both social and economic development and population stabilisation has been very narrow. Practising population and development integration requires a re-specification of social and economic development goals and population policy objectives, the one that takes into account various social, economic and demographic interactions that are critical to both social and economic progress as well as population stabilisation. It is important that population and development integration leads to people centred social and economic development and development oriented population stabilisation policies and programmes. If despite integration, social and economic development processes fail to address the welfare needs of the people or if population stabilisation efforts continue to be narrowly targeted to achieve demographic goals, the very purpose of integration is lost.

Practising population and development integration requires development and institutionalisation of frameworks for such integration. One way is to evaluate the social and economic development programmes through a 'population lens' and assess the reflections of population stabilisation activities in a 'development mirror.' The challenge is to define the 'population lens' and describe the 'development mirror' at different tiers - from macro to micro levels.

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Table 1:   Future population growth in the three category of states, 2001-26.

Particulars	2001	2006	2011	2016	2021	2026
Population (million)						
India	1028.587	1112.184	1192.506	1268.961	1339.741	1399.840
Category I states	255.634	269.952	283.011	294.639	304.426	312.021
Category II states	456.143	493.736	529.594	564.424	597.073	626.167
Category III states	314.167	345.322	375.878	405.065	432.37	455.196
Rest	2.643	3.174	4.023	4.833	5.872	6.456
Net Addition to the population (000)						
India		83.597	80.322	76.455	70.78	60.099
Category I states		14.318	13.059	11.628	9.787	7.595
Category II states		37.593	35.858	34.830	32.649	29.094
Category III states		31.155	30.556	29.187	27.305	22.826
Rest		0.531	0.849	0.810	1.039	0.584
Relative contribution (Per cent)						
India		100.00	100.00	100.00	100.00	100.00
Category I states		17.13	16.26	15.21	13.83	12.64
Category II states		44.97	44.64	45.56	46.13	48.41
Category III states		37.27	38.04	38.18	38.58	37.98
Rest		0.64	1.06	1.06	1.47	0.97

Source: Estimated from Government of India (2006)

Table 2:   Potential demographic issues and concerns need to be addressed in different categories of states.

Category	States	Pertinent demographic issues and concerns
I	Kerala Tamil Nadu Andhra Pradesh Karnataka Punjab Himachal Pradesh Goa Sikkim	The emerging issue is population aging and rapid urbanisation. The current age structure is conducive to rapid economic growth if proper policies are in place. The social environment is also conducive to high productivity. Social and economic development processes need to be oriented towards the needs of the old population.
II	Jammu & Kashmir Tripura Assam West Bengal Orissa Gujarat Delhi Maharashtra	The situation is very similar to category one states but with a time lag. Efficient and effective implementation of current policies and programmes appears sufficient for these states to move to post transition phase. Development processes need to be oriented towards the old people.
III	Uttarakhand Haryana Manipur Mizoram Chhattisgarh	A reorientation of population policies and programmes in these state may hasten the pace of demographic transition. There is a need to evolve state specific approaches to address prevailing population concerns.
IV	Rajasthan Uttar Pradesh Bihar Arunachal Pradesh Nagaland Meghalaya Jharkhand Madhya Pradesh	These states will continue to be the problem states, at least, in the next 25 years or so. Poor demographic scenario appears to be a cause and an effect of extremely poor development scenario. The politico social environment is not conducive to demographic transition. Increased investment in human development may probably be the answer. There does not appear to be any short term solution.

Table 3:   Fertility in excess to replacement fertility in India and states, 2005-06.

Country/ State	Current fertility	Fertility in excess to replacement fertility	Wanted fertility in excess to replacement fertility	Unwanted fertility
	TFR	ETFR	EWTFR	EUWTFR
India	2.68	0.58	0.00	0.58
Category I states				
Andhra Pradesh	1.79	0.00	0.00	0.00
Delhi		0.00	0.00	0.00
Goa	1.79	0.00	0.00	0.00
Himachal Pradesh	1.94	0.00	0.00	0.00
Karnataka	2.08	0.00	0.00	0.00
Kerala	1.93	0.00	0.00	0.00
Maharashtra		0.00	0.00	0.00
Punjab	1.99	0.00	0.00	0.00
Sikkim	2.02	0.00	0.00	0.00
Tamil Nadu	1.80	0.00	0.00	0.00
Category II states				
Assam	2.42	0.32	0.00	0.32
Chhattisgarh	2.62	0.52	0.00	0.52
Delhi	2.13	0.03	0.00	0.03
Gujarat	2.42	0.32	0.00	0.32
Haryana	2.69	0.59	0.00	0.59
Jammu & Kashmir	2.38	0.28	0.00	0.28
Jharkhand	3.31	1.21	0.00	1.21
Madhya Pradesh	3.12	1.02	0.00	1.02
Maharashtra	2.11	0.01	0.00	0.01
Orissa	2.37	0.27	0.00	0.27
Tripura	2.22	0.12	0.00	0.12
Uttarakhand	2.55	0.45	0.00	0.45
West Bengal	2.27	0.17	0.00	0.17
Category III states				
Arunachal Pradesh	3.03	0.93	0.18	0.75
Bihar	4.00	1.90	0.30	1.60
Manipur	2.83	0.73	0.20	0.53
Mizoram	2.86	0.76	0.60	0.16
Meghalaya	3.80	1.70	1.00	0.70
Nagaland	3.74	1.64	0.55	1.09
Rajasthan	3.21	1.11	0.10	1.01
Uttar Pradesh	3.82	1.72	0.20	1.52

Source: Estimates of the total fertility rate wanted total fertility rate are from National Family Health Survey, 2005-06.

Table 4:   Median age at first birth among women 20-49 years of age and prevalence of modern spacing methods of contraception in category I states, 2005-06.

SN	State	Median age at first birth among women 20-49 years of age	Prevalence of modern spacing methods of contraception
1	Andhra Pradesh	18.8	1.3
2	Himachal Pradesh	21.2	16.0
3	Goa	25.0	11.6
4	Karnataka	19.9	6.3
5	Kerala	22.7	8.6
6	Punjab	21.4	23.9
7	Sikkim	21.9	20.1
8	Tamil Nadu	21.0	4.6

Source: National Family Health Survey, 2005-06

Table 5: Demand for contraception in India and states, 2005-06.

Country/State	Contraceptive prevalence rate					Unmet need of contraception		Demand for contraception			
	All methods	Modern methods	Modern terminal methods	Modern spacing methods	Other methods	Modern terminal methods	Modern spacing methods	Modern terminal methods	Modern spacing methods	Modern methods	All methods
India	56.3	48.5	38.3	10.2	7.8	6.8	6.3	45.1	16.5	61.6	69.4
Jammu & Kashmir	52.6	44.9	28.9	15.5	7.7	9.0	6.0	37.9	21.5	59.4	67.1
Himachal Pradesh	72.6	71.0	55.3	16.0	1.6	4.9	2.4	60.2	18.4	78.6	80.2
Punjab	63.3	56.0	32.0	23.9	7.3	4.7	2.7	36.7	26.6	63.3	70.6
Uttarakhand	59.3	55.5	33.9	21.4	3.8	6.7	4.6	40.6	26.0	66.6	70.4
Haryana	63.4	58.2	38.9	19.3	5.2	5.2	3.1	44.1	22.4	66.5	71.7
Delhi	66.9	56.4	23.8	32.8	10.5	4.7	3.3	28.5	36.1	64.6	75.1
Rajasthan	47.2	44.4	35.0	9.4	2.8	7.4	7.3	42.4	16.7	59.1	61.9
Uttar Pradesh	43.6	29.3	17.5	11.8	14.3	12.6	9.3	30.1	21.1	51.2	65.5
Bihar	34.1	28.8	24.4	4.2	5.3	12.4	10.7	36.8	14.9	51.7	57.0
Sikkim	57.6	48.7	25.7	20.1	8.9	11.2	5.6	36.9	25.7	62.6	71.5
Arunachal Pradesh	43.2	37.3	22.6	14.8	5.9	10.7	8.6	33.3	23.4	56.7	62.6
Nagaland	29.7	22.5	9.9	12.7	7.2	16.4	10.0	26.3	22.7	49.0	56.2
Manipur	48.7	23.5	8.6	14.9	25.2	7.6	5.0	16.2	19.9	36.1	61.3
Mizoram	59.9	59.6	42.9	17.2	0.3	5.0	12.4	47.9	29.6	77.5	77.8
Tripura	65.8	44.9	18.1	26.5	20.9	6.7	3.9	24.8	30.4	55.2	76.1
Meghalaya	24.3	18.5	9.6	8.9	5.8	11.9	23.2	21.5	32.1	53.6	59.4
Assam	56.5	27.0	13.2	14.0	29.5	7.2	3.6	20.4	17.6	38.0	67.5
West Bengal	71.2	49.9	32.9	16.8	21.3	4.4	4.4	37.3	21.2	58.5	79.8
Jharkhand	35.7	31.1	23.8	7.2	4.6	12.2	11.6	36.0	18.8	54.8	59.4
Orissa	50.7	44.6	34.1	10.8	6.1	8.1	6.9	42.2	17.7	59.9	66.0
Chhattisgarh	53.2	49.1	44.2	5.1	4.1	5.1	5.4	49.3	10.5	59.8	63.9
Madhya Pradesh	55.9	52.8	45.6	7.3	3.1	6.3	5.5	51.9	12.8	64.7	67.8

Country/State	Contraceptive prevalence rate					Unmet need of contraception		Demand for contraception			
	All methods	Modern methods	Modern terminal methods	Modern spacing methods	Other methods	Modern terminal methods	Modern spacing methods	Modern terminal methods	Modern spacing methods	Modern methods	All methods
Gujarat	66.6	56.6	43.5	13.1	10.0	3.8	4.4	47.3	17.5	64.8	74.8
Maharashtra	66.9	64.9	53.2	12.0	2.0	4.0	5.6	57.2	17.6	74.8	76.8
Andhra Pradesh	67.7	67.0	65.9	1.3	0.7	1.8	3.2	67.7	4.5	72.2	72.9
Karnataka	63.9	62.5	57.6	6.3	1.4	3.9	6.3	61.5	12.6	74.1	75.5
Goa	48.2	37.2	25.9	11.6	11.0	5.7	7.5	31.6	19.1	50.7	61.7
Kerala	68.6	57.9	49.7	8.6	10.7	3.0	6.0	52.7	14.6	67.3	78.0
Tamil Nadu	61.4	60.0	55.4	4.6	1.4	4.8	4.1	60.2	8.7	68.9	70.3

Source: National Family Health Survey 2005-06

Table 6: Contraceptive methods mix in India and states, 2005-06.

	All methods	Modern methods	Modern terminal methods	Modern spacing methods	Other methods
India	100.00	86.15	68.03	18.12	13.85
Jammu & Kashmir	100.00	85.36	54.94	29.47	14.64
Himachal Pradesh	100.00	97.80	76.17	22.04	2.20
Punjab	100.00	88.47	50.55	37.76	11.53
Uttarakhand	100.00	93.59	57.17	36.09	6.41
Haryana	100.00	91.80	61.36	30.44	8.20
Delhi	100.00	84.30	35.58	49.03	15.70
Rajasthan	100.00	94.07	74.15	19.92	5.93
Uttar Pradesh	100.00	67.20	40.14	27.06	32.80
Bihar	100.00	84.46	71.55	12.32	15.54
Sikkim	100.00	84.55	44.62	34.90	15.45
Arunachal Pradesh	100.00	86.34	52.31	34.26	13.66
Nagaland	100.00	75.76	33.33	42.76	24.24
Manipur	100.00	48.25	17.66	30.60	51.75
Mizoram	100.00	99.50	71.62	28.71	0.50
Tripura	100.00	68.24	27.51	40.27	31.76
Meghalaya	100.00	76.13	39.51	36.63	23.87
Assam	100.00	47.79	23.36	24.78	52.21
West Bengal	100.00	70.08	46.21	23.60	29.92
Jharkhand	100.00	87.11	66.67	20.17	12.89
Orissa	100.00	87.97	67.26	21.30	12.03
Chhattisgarh	100.00	92.29	83.08	9.59	7.71
Madhya Pradesh	100.00	94.45	81.57	13.06	5.55
Gujarat	100.00	84.98	65.32	19.67	15.02
Maharashtra	100.00	97.01	79.52	17.94	2.99
Andhra Pradesh	100.00	98.97	97.34	1.92	1.03
Karnataka	100.00	97.81	90.14	9.86	2.19
Goa	100.00	77.18	53.73	24.07	22.82
Kerala	100.00	84.40	72.45	12.54	15.60
Tamil Nadu	100.00	97.72	90.23	7.49	2.28