

Trends and Differentials in Fertility and Family Planning Indicators of EAG States in India

September 2012

Authors: Dr. R.K Srivastava,¹ Dr. Honey Tanwar,¹ Dr. Priyanka Singh,¹ and Dr. B.C Patro¹
¹ Policy Unit

I. Intro

This brief presents a situational analysis of fertility and family planning (FP) indicators of the Empowered Action Group (EAG)¹ states in India, focusing on the levels of and trends in certain crucial indicators, such as the total fertility rate (TFR), the contraceptive prevalence rate (CPR), the current scenario of the method mix, and the unmet need for contraception.

Together, the eight Empowered Action Group states comprise 45.9 per cent of India's population.

The Policy Unit² of the National Institute of Health and Family Welfare (NIHFW) prepared the brief with support from the Health Policy Project (HPP). Recently published survey data

from the Annual Health Survey (AHS) 2010–11, Sample Registration System (SRS) 2010, and the second and third rounds of the District Level Household Survey (DLHS) were used. The analyses could be considered a ready reckoner for stakeholders involved at different stages

of planning and implementing family welfare programmes across the EAG states in India.

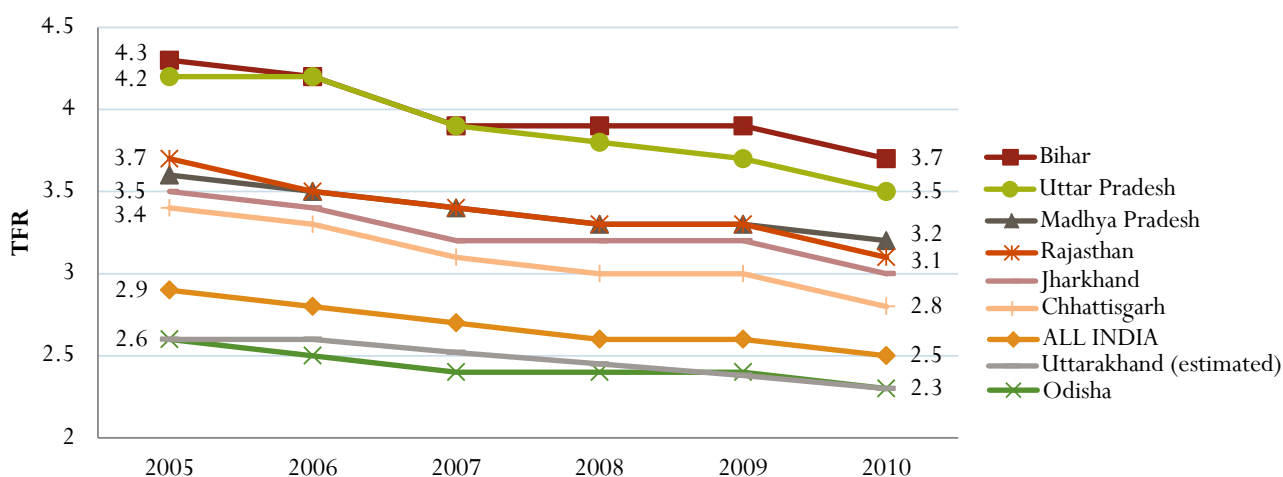
India's population has risen to 121 crores (1.21 billion) people over the last 10 years—an increase of 18.1 crores (181 million) (Census 2011). According to United Nations estimates, India will become the world's largest populous country and would overtake China before 2030 (United Nations, 2009). The EAG states comprise 45.9 per cent of the country's population; therefore, the future of India's population would largely be governed by the socio-demographic situation of these states. The population growth rate in rural areas of EAG states is nearly three times that of the growth rate in rural areas of non-EAG states, which can be attributed to various factors such as strong patriarchal and gender-based societal norms and structural socioeconomic inequalities. Despite a fall in the population growth rate in EAG states during the last decade, addressing FP issues for the 55.5 crore (555 million) people in the states remains a challenge for the country (Census 2011). Most EAG states are part of the northern belt of India. According to the National Family Health Survey (NFHS-1, -2, and -3), contraceptive use in the northern states has increased over the last two decades, but the increase in the population base is a major challenge for policymakers and planners.

Sixty-one of 70 districts in Uttar Pradesh and 36 of 37 districts in Bihar have a TFR of 3 and above.

¹ India's Ministry of Health and Family Welfare has defined eight states as Empowered Action Group states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Odisha and Rajasthan) to facilitate focused efforts to promote the reproductive and child health program. EAG states are those with high fertility rates and weak socio-demographic indicators.

² The Policy Unit was established at the NIHFW with initial support from the United States Agency for International Development (USAID) through the Health Policy Project. The mission of the Policy Unit is to improve people's quality of life through sustainable health, nutrition, and population development.

Figure 1: Trends in TFRs of major EAG states (SRS 2005–2010)



II. Levels of and Trends in Total Fertility Rate in Major EAG States

Recent evidence shows that the government, nongovernmental organisations (NGOs), and donor agencies have directed focused efforts to improve the health scenario in the EAG states. These contributions have made a definite impact on improving the overall health scenario in India. However, consistent efforts are required. This section presents fertility levels and trends in EAG states along with

a categorisation of districts based on TFR in these states. According to SRS 2010, there is a wide difference in fertility levels among the

The TFR of states like MP, Rajasthan, Bihar, and UP remains high at around 3.1–3.7.

states. Fertility levels have declined in all the major Indian states, including EAG states; however, TFR remains high—around 3.1–3.7—in Madhya Pradesh (MP), Rajasthan, Bihar, and Uttar Pradesh (UP) (SRS 2010).

In recent years, these states have experienced improvements in various socioeconomic indicators; nevertheless, they have reached the stage that southern states like Kerala and Tamil Nadu were at 30 years ago (SRS 1980–2010). This suggests that our policy and programmes focusing on family planning need a serious review.

Table 1 classifies the number of districts in each EAG state, based on the TFR. Out of a total of 261 districts in EAG states, only 17 have achieved the replacement level of fertility (TFR of 2.1); 84 districts have a TFR between 2.2 and 3; and 160 districts (65.4 per cent) have a TFR of 3.1 and above.

Table 1: Number of districts by total fertility rate (AHS 2010–11)

State	TFR 0–2.1	TFR 2.2–3.0	TFR 3.1 and above	Total Districts
Bihar	0	1	36	37
Chhattisgarh	0	12	4	16
Jharkhand	0	8	10	18
Madhya Pradesh	0	15	30	45
Odisha	10	18	2	30
Rajasthan	0	16	16	32
Uttar Pradesh	0	9	61	70
Uttarakhand	7	5	1	13
All EAG states	17	84	160	261

Of these 160 districts, 143 (90 per cent) belong to UP, MP, Bihar, and Rajasthan. In addition, 61 of 70 districts in UP and 36 of 37 districts in Bihar have a TFR of 3.1 and above (AHS 2010–11). This indicates a need to formulate focused strategies for action in these two states.

III. Level of and Trends in Contraceptive Use and Method Mix

The current level of modern CPR is a principal determinant of fertility. It is also one of the major indicators to measure the success of FP programmes. This section focuses on the current levels of, rural-urban differentials, and trends in the use of modern contraceptive methods in the EAG states. Table 2 presents the current levels of contraception use among currently married women, commonly referred as the contraceptive prevalence rate, or CPR (modern methods). CPR varies substantially across the EAG states—from 31.8 per cent in UP to as high as 58.8 per cent in Rajasthan. Other states in which less than

half of the currently married women use contraception are Bihar (33.9%), Jharkhand (38.0%), Odisha (44%), and Chhattisgarh (49.5%) (AHS 2010–11). The AHS data depict huge rural-urban

Only three out of 10 currently married women are using any modern method of contraception in UP and Bihar.

Table 2: Current use of contraceptive methods among currently married women (AHS 2010–11)

State	Any Modern Method (%)		
	Total	Rural	Urban
Uttar Pradesh	31.8	29.0	42.0
Bihar	33.9	32.4	44.5
Jharkhand	38.0	35.0	46.8
Odisha	44.0	43.4	47.0
Chhattisgarh	49.5	48.4	53.2
Uttarakhand	55.4	55.5	55.0
Madhya Pradesh	57.0	56.3	58.3
Rajasthan	58.8	57.4	63.1

differentials in modern CPR in states like UP, Bihar, and Jharkhand. The situation demands more concerted efforts in rural areas across these states to promote FP.

Figure 2 presents a comparison of DLHS figures on the use of modern contraceptive methods in the EAG states. The CPR for any modern method marginally increased during five years (2002–2007) in UP (2%), Bihar (1%), Chhattisgarh (7%), MP (6%), Rajasthan (12%), and Uttarakhand (1%). In addition, there was a decline in the use of modern methods of contraception in Jharkhand (-3%) and Odisha (-2%).

Current Method Mix

India was the first country in the world to initiate a national goal to slow down population growth in its first five-year plan in 1951. However, the actualisation

Figure 2: Percent distribution of modern contraceptive methods used by married women in the EAG states (AHS 2010–11)

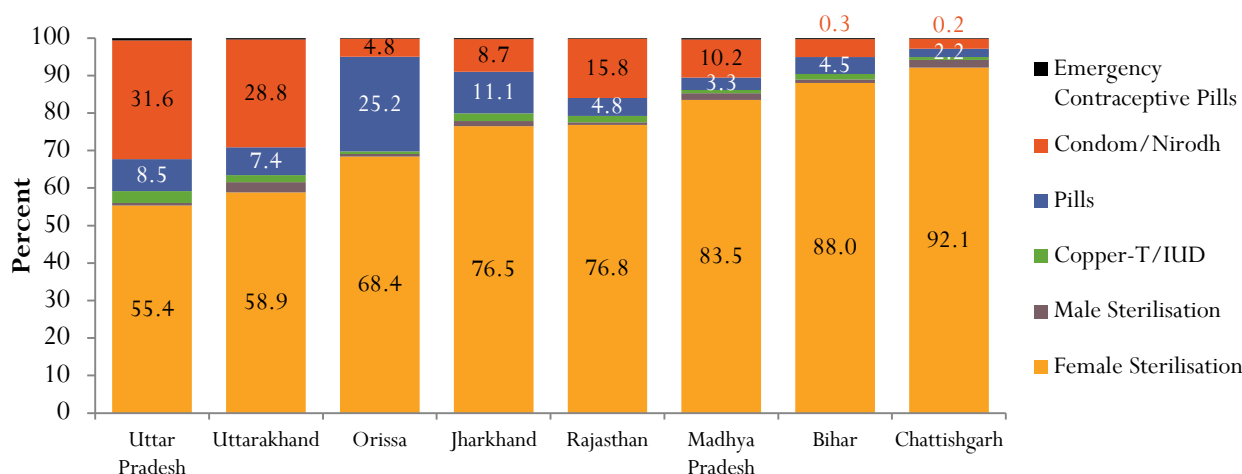
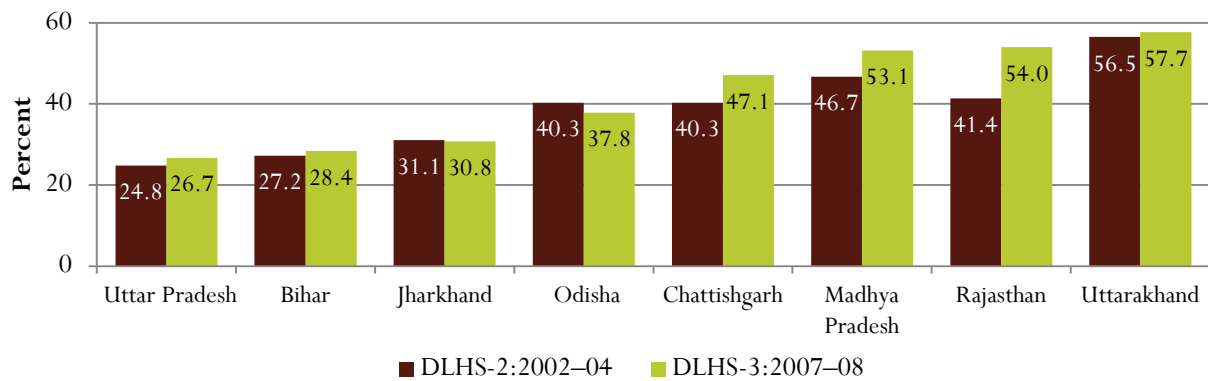


Figure 3: Trends in the use of modern contraceptive methods in different EAG states



of this goal at the ground level happened relatively slowly. The Population Policy of India (2000) clearly states the importance of population stabilisation in terms of achieving sustainable development with more equitable distribution. It emphasises the achievement of universal access to information, counselling, and services for fertility regulation and contraception with a wide basket of choices.

Moreover, the national family welfare programmes focused on giving equal importance to both spacing and limiting methods of contraception and assuring the quality of services while expanding the contraceptive choices available to eligible couples. Contrary to the national commitments, recent AHS data show a skewed scenario of method mix across all the EAG states. There is a huge variation across these states. Female sterilisation seems to be a predominant method of contraception. In EAG states like Bihar, Chhattisgarh, MP, Rajasthan, and Jharkhand, more than two-thirds of the women opt for sterilisation (AHS 2010–11). This suggests a need to expand the basket of choices available for contraception to include injectables, diaphragms, and the Standard Days Method (SDM). These methods are already available through the private sector and can be added to the current national basket.

IV. Unmet Need for Contraception

Unmet need for FP is an important indicator to assess the potential demand for FP services. DLHS-3 (2007–08), defines

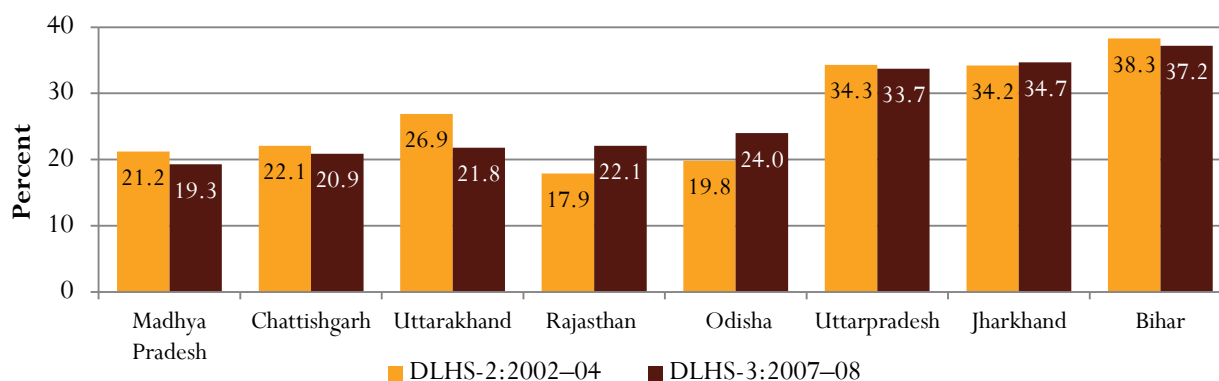
the unmet need as a sum of unmet need for spacing³ and limiting methods⁴ of contraception. In general, lower unmet need for FP services is considered to be a better indicator of the effectiveness of an FP programme. However, any efficient programme may generate demand for contraception. According to DLHS-3, India has a high unmet need for contraception (20.5%). The National Population Policy (2000) aimed to address the issue of unmet need for contraception by 2010. The large unmet need leads to a large number of unintended pregnancies, unsafe abortions, and poor maternal and child health outcomes. Figure 4 shows that the total unmet need is higher for Bihar (37.2%), Jharkhand (34.7%), and UP (33.7%). These states have shown a relatively slower pace of reducing of unmet need for contraception compared with the rest

A marginal increase in the use of modern contraceptives was observed from 2002–2007 in UP and Bihar.

³ Unmet need for spacing includes the proportion of currently married women who had not gone through menopause, had not had a hysterectomy, were not currently pregnant, wanted more children after two or more years, and were not using any family planning method. Women who were not sure about when to have their next child and were not using any spacing method were also included in the unmet need for spacing.

⁴ Unmet need for limiting included currently married women who had not gone through menopause, had not had a hysterectomy, were not currently pregnant, and did not want any more children but were not currently using any family planning method.

Figure 4: Trends in unmet need for contraception in different EAG states



of the EAG states during 2002–07 (DLHS-3, 2008). Unmet need for limiting methods is high in Bihar (22.6%), UP (21.9%), Jharkhand (20.8%), and Odisha (15.6%). Unmet need for spacing is higher than 10 per cent in Bihar (13.3%), Jharkhand (12.7%), and UP (10.7%) (DLHS-3, 2008). According to NFHS-3 (2005–06), 21 per cent of all pregnancies that resulted in live births in the five years preceding the survey (including current pregnancies) were unplanned (i.e., unwanted at the time the woman became pregnant). Ten per cent were wanted later and 11 per cent were not wanted at all. This reflects an urgent need to reduce unintended births by reducing the unmet need for contraception. The data show that the four major states of northern India (UP, MP, Bihar, and Rajasthan) need faster fertility transition because the levels of wanted fertility are already close to achieving the replacement level of fertility.

Table 3 shows a classification of the number of districts in each EAG state based on the unmet need for contraception. It shows huge intra-state differentials in the unmet need for contraception. Out of 261 districts in the eight EAG states, 61 have an unmet need for contraception of below 20 per cent; 166 districts have an unmet need for contraception of between 20 and 40 per cent, and the remaining 32 districts have an unmet need of contraception of more than 40 per cent (AHS 2010–11). Of 197 districts that have an unmet need for contraception that is more than 20 per cent, 143 districts (72%) are situated in UP, MP, Bihar, and Rajasthan. In addition, 61 of 70 districts in UP; all districts of Bihar; 27 of 45 districts in

Table 3: Unmet need for contraceptive methods (AHS 2010–11)

State	0–20%	20–40%	40% and above	Total districts
Bihar	0	20	17	37
Chhattisgarh	4	12	0	16
Jharkhand	2	13	3	18
Madhya Pradesh	18	27	0	45
Odisha	12	15	3	30
Rajasthan	16	16	0	32
Uttar Pradesh	9	52	9	70
Uttarakhand	2	11	0	13
All EAG States	63	166	32	261

MP; and 16 of 32 districts in Rajasthan have an unmet need for contraception of more than 20 per cent.

V. Conclusion

It is clear that the future of India’s population growth will largely be governed by the four north Indian EAG states. These states show a steady decline in fertility and relatively slower rise in contraceptive use. In the EAG states, concerted efforts are required to meet the unmet need for contraception by promoting the existing methods of contraception and adding newer methods, while ensuring wider access to contraceptive methods for eligible couples.

References

International Institute for Population Sciences (IIPS). 2010. *District Level Household and Facility Survey (DLHS-3), 2007–2008: India*. Mumbai: IIPS.

International Institute for Population Sciences (IIPS) and Macro International. 2007. *National Family Health Survey (NFHS-3), 2005–06, India: Volume I*. Mumbai: IIPS.

Office of the Registrar General and Census Commissioner, India. 2011. *Annual Health Survey, 2010–11*. New Delhi: Ministry of Health and Family Welfare.

Office of the Registrar General and Census Commissioner, India. 2011. *Census of India 2011, Provisional Population Totals*. New Delhi: Ministry of Home Affairs, Government of India.

Office of the Registrar General, India. 2010. *Sample Registration System (SRS)*. New Delhi: Ministry of Home Affairs, Government of India.

United Nations. 2009. *World Population Prospects, the 2008 Revision*. New York: United Nations. Available from <http://esa.un.org/unpp/index.asp?panel=2>, accessed on 01/11/2012.

The POLICY Unit is an apex body leading health policy research and analysis guiding the Ministry of Health and Family Welfare, health-based civil society organisations, advocacy networks and coalitions, academic institutions and other stakeholders to establish and improve health policies and strategies.

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. It is implemented by Futures Group, in collaboration with CEDPA (CEDPA is now a part of Plan International USA), Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.