All India Ranking and Mapping of Districts

Population below Age 6

The percentage of population below age 6 years is an indirect indicator of the fertility level. In general, a large proportion of population under age 6 is symbolized with higher fertility norms. In other words, its higher proportion leads to young age-structure, i.e., a higher level of young dependency ratio. Therefore, lower the proportion of population below age 6, higher will be the index value, and better is the district. The index value \( X_{1d} \) for the \( d^{th} \) district may be symbolically calculated as follows;

\[
Index\ Value\ (X_{1d}) = \frac{Max\ (X_{1d}) - X_{1d}}{(Max\ (X_{1d}) - Min\ (X_{1d}))}
\]

where, \( X_{1d} \) is the proportion of population below age 6 years in the \( d^{th} \) district and the index value ranges between 1 and 0. The lowest proportion of population under age 6 is obtained for district Leh (Ladakh) of the state of Jammu and Kashmir (6.16 percent, i.e., Index Value \( X_{1Leh\ (Ladakh)} = 1 \)), whereas its highest value is recorded in district Rai Bhoi of the state of Meghalaya (23.5 percent, i.e., Index Value \( X_{1Rai\ Bhoi} = 0 \)). All the districts are ranked according to the index value. It would be worth mentioning that a majority among the bottom 100 districts belong to Arunachal Pradesh, Bihar, Jharkhand, Meghalaya, Rajasthan, and Uttar Pradesh (see Table 1 and Map 1).
Birth Order Three and Above

The percentage of births of order three and above is a direct measure of fertility and various researchers have studied the district level fertility in India using this indicator. They suggest that this indicator provides a reasonably good idea about the fertility at the level of smaller administrative units. Moreover, it requires minimum information, i.e. the distribution of births by order. (Bhat 2004; Ram, Chander Shekhar and Mohanty, 2005). The Indian census has been providing the information on birth order since 1981. Larger the percentages of birth of order three and above, higher is the fertility rate, and the impact of family welfare programmes is weak. In other words, lower the percentage of births of order three and above better is the district. The index value \( X_{2d} \) for \( d^{th} \) district may be symbolically calculated as follows:

\[
Index\ Value\ (X_{2d}) = \frac{Max\ (X_{2d}) - X_{2d}}{(Max\ (X_{2d}) - Min\ (X_{2d}))}
\]

where, \( X_{2d} \) is the percentage of births of order three and above to the total number of birth in the \( d^{th} \) district and the index value ranges between 1 and 0. The lowest percentage of births of order three and above is observed in Alappuzha district of Kerala (12.3 percent, i.e., Index Value \( X_{2Alappuzha} = 1 \)), whereas its highest value is estimated in Tuensang district of Nagaland (72.9 percent, i.e., Index Value \( X_{2Tuensang} = 0 \)). All the districts are ranked according to the index value. It is to be noted that a majority among the bottom 100 districts belong to Arunachal Pradesh, Bihar, Jharkhand, Madhya Pradesh Meghalaya, Mizoram, Nagaland, Rajasthan, and Uttar Pradesh (see Table 2 and Map 2).
Births below Age 20

The Indian census provides the number of births by age of women during one year preceding the enumeration date. It is well established fact that initiation of early childbearing aggravates health and survival risks to both mother and child. Therefore, occurrence of pregnancy among women below age 20 is not only disadvantageous to health but also deprives women from their rights. Further, early marriage leads to early initiation of childbearing under different socio-cultural norms prevailing in Indian society. Therefore, this indicator also has the potential to give an idea to what extent the law regarding minimum legal age at marriage is effective. On the other hand, it can measure the degree of success of family welfare programmes, specially, prevalence of spacing methods of family planning. This is because a woman getting married even at a younger age would like to delay or avoid pregnancy at an early age in the presence of effective family welfare programmes.

Thus, it can be inferred that the larger the percentage of births to mothers below age 20, higher is the risks to maternal and child health, and lesser is the impact of family welfare programmes. Therefore, lower the percentage of births to mothers below age 20, better is the district. In this regard, all the districts are ranked according to index value. The index value \(X_{B3d}\) for the \(d^{th}\) district may be symbolically calculated as follows:

\[
\text{Index Value} (X_{B3d}) = \frac{\text{Max} (X_{B3d}) - X_{B3d}}{(\text{Max} (X_{B3d}) - \text{Min} (X_{B3d}))}
\]

where, \(X_{B3d}\) is the percentage of births to mothers below age 20 to the total births in the \(d^{th}\) district. The index value ranges between 1 and 0. The minimum percentage of births below age 20 is observed in Una district in Himachal Pradesh (0.81 percent, i.e., Index Value \((X_{B3Una})=1\)), whereas its maximum is for Nalgonda district in Andhra Pradesh (20.5 percent, i.e., Index Value \((X_{B3Nalgonda})=0\)). It is interesting to note that the majority among the bottom 100 districts belong to the states of Andhra Pradesh, Karnataka, Madhya Pradesh, Rajasthan, and West Bengal (see Table 3 and Map 3).
Under-five Mortality

The infant mortality rate is an important indicator for planning in the health sector. It is the probability of dying for infants before completing one year of life. Similarly, the under-five mortality rate measures the probability of dying for children under age five. Brass (1968) has shown that the proportion of children dead to women in reproductive age groups provides robust estimates of probability of dying at age a. This study made use of his method to estimate the under-five mortality rate incorporating the district level information available on children surviving and children ever born to women in census. Infant mortality rate ($q_0$) and child mortality rate ($q_1$) can directly be obtained from Mortpak output. However, under-5 mortality ($q_{04}$) can be given as follows:

- Probability of surviving up to age one $p_1=(1-q_0)$
- Probability of surviving the age group 1 to 4 $p_2=(1-q_1)$
- Probability of surviving up to age 5 $p_1p_2$
- Probability of dying under age five $q_{04}=(1-p_1p_2)$

This indicator gives an idea about the children’s health status in a particular district, and therefore, can be used as an impact tool for universal immunization programmes and other family welfare programmes focusing on children. Lower the value of under-5 mortality rate better is the district, i.e., higher the index value. The index value ($X_{4d}$) for $d$th district is symbolically calculated as follows:

\[
\text{Index Value} (X_{4d}) = \frac{\text{Max} (X_{4d}) - X_{4d}}{(\text{Max} (X_{4d}) - \text{Min} (X_{4d}))}
\]

where, $X_{4d}$ is the under-5 mortality rate in the $d$th district. The index value ranges between 1 and 0. The minimum value of under-5 mortality is in district South Goa district (43 per thousand live births, i.e., Index Value ($X_{4\text{South Goa}}$)=1), whereas its maximum is for East Kameng district in Arunachal Pradesh (263 per thousand live births, i.e., Index Value ($X_{4\text{East Kameng}}$)=0). It is interesting to note that the majority among bottom 100 districts belong to the states of Arunachal Pradesh, Madhya Pradesh, Orissa, Rajasthan, and Uttar Pradesh (see Table 4 and Map 4).
Female Literacy

Female education is enough linked with the human development in a region or country. The right to education is a fundamental human right and occupies a central place in human rights. Therefore, States have an obligation to pursue the aim of education for all (UNESCO, 2000). The Indian Constitution also grants the cultural and educational rights as one of the fundamental rights, which is described as follows;

"Any section of the citizens residing in the territory of India or any part thereof having a distinct language, script or culture of its own shall have the right to conserve the same”.

It is evident that female education is a strong predictor of socio-economic, demographic and health status in all the settings. The simplest indicator to measure it is the female literacy rate. According to the census definition, the individuals of age 7 and above who can read and write with some understanding of any language are called literate. The major limitation of this indicator is that it does not differentiate between a postgraduate degree holder and a person who can just read and write some phrases. This indicator helps to locate the district which required immediate policy initiatives in the field of education as the Government of India adheres to the universal elementary education campaign. Higher the value of female literacy rate better is the district, i.e., higher the Index value. The index value ($X_{sd}$) for the $d^{th}$ district is symbolically calculated as follows;

$$\text{Index Value} (X_{sd}) = \frac{X_{sd} - \text{Min} (X_{sd})}{(\text{Max} (X_{sd}) - \text{Min} (X_{sd}))}$$

where, $X_{sd}$ is female literate rate of the $d^{th}$ district. The index value ranges between 1 and 0. The maximum female literacy rate is in Aizawl district of Mizoram (96.1 percent, i.e., Index Value ($X_{Aizawl}$)=1) and the minimum is for Kishanganj district of Bihar (18.5 percent, i.e., Index Value ($X_{Kishanganj}$)=0). It would be interesting to note that the majority of bottom 100 districts belong to Jharkhand, Jammu and Kashmir, Madhya Pradesh, Rajasthan, and Uttar Pradesh (see Table 5 and Map 5).
Households using Safe Drinking Water

In South Asia, around 19 percent people live without access to improved water resources (UNDP, 2003). The National Rural Health Mission (Ministry of Health and Family Welfare, 2005) relates good health to nutrition, sanitation, hygiene and safe drinking water. So, there is a need to assess variation among the districts of India by the proportion of households using safe drinking water, as its contamination may be fatal to human lives. The Indian census once again provides an opportunity to understand accessibility of safe drinking water at the district level.

The information was gathered at household level on eight types of drinking water sources. These were: Tap, Handpump, Tubewell, Tank/Pond/Lake, River/Canal, Spring and Any other source. In this study, Tap, Handpump and Tubewell are taken as safe drinking water sources. A household using water for drinking purposes from any of the three sources is defined as one using safe drinking or improved drinking water. The proportion of such households is calculated for all the districts. Higher the proportion of household using safe drinking water, better is the district. The index value ($X_{d6}$) for the $d^{th}$ district is symbolically calculated as follows;

$$\text{Index Value} (X_{d6}) = \frac{X_{d6} - \text{Min} (X_{d6})}{\text{Max} (X_{d6}) - \text{Min} (X_{d6})}$$

where, $X_{d6}$ is the proportion of households using safe drinking water in the $d^{th}$ district. The index value ranges between 1 and 0. The highest proportion of it is obtained in Chandigarh district (99.8 percent, i.e., Index Value ($X_{6\text{Chandigarh}}$)=1) whereas the lowest is in Lakshadweep district (4.6 percent, i.e., Index Value ($X_{6\text{Lakshadweep}}$)=0). It may be noted that the majority of the bottom 100 districts belong to the states of Jammu and Kashmir, Kerala, Madhya Pradesh, and Northeastern states (see Table 6 and Map 6).
Households having Toilet Facility

Access to toilet facility is no longer being incorporated only to understand socio-economic condition of individuals but also as an indicator that qualify them for a dignified life. In addition, the National Rural Health Mission (Ministry of Health and Family Welfare, 2005) recognizes sanitation and hygiene as determinants of good health. In the past, to improve the standard of living of rural poor, the Government of India has provided financial help to build the toilets under schemes such as Indira Awaas Yojana. The Indian census categorises the responses regarding the availability of latrine within the house in four groups; pit latrine, water closet latrine, other latrine and no latrine. Adding the first three groups and dividing them by the total number of households in a particular district gives the proportion of households having any type of toilet facility in this study. Higher the proportion of households equipped with toilet facility, better is the district, and all the districts are ranked according to index value. The index value ($X_{7d}$) for $d^{th}$ district is symbolically calculated as follows;

$$Index\ Value\ (X_{7d}) = \frac{X_{7d} - \text{Min} (X_{7d})}{\text{Max} (X_{7d}) - \text{Min} (X_{7d})}$$

where, $X_{7d}$ is the proportion of households having any type of toilet facility using safe drinking water in the $d^{th}$ district. The Index value ranges between 1 and 0. The maximum proportion is estimated for the Mamit district in Mizoram (97.3 percent, i.e., Index Value ($X_{7Mamit}$)=1), whereas the minimum is in Bilaspur district in Chattisgarh (4.7 percent, i.e., Index Value ($X_{7Bilaspur}$)=0). The bottom 100 districts in rank belong to the states of Bihar, Chattisgarh, Jharkhand, Madhyapradesh, Orissa, and Uttar Pradesh (see Table 7 and Map 7).
Households Connected with Electricity

There are several advantages associated with electrification of households. In various parts of the country, the electricity is also being used as main source of cooking fuel. Wherever household have an electricity connection it is not the prime source of lightening but has become essential in the use of several household appliances. In the present time, almost all the household accessories including television, radio, telephone and computer, which are main sources of mass media and communication, are electric power supply based. It is well documented that mass media and communication have significant positive impact on various aspects of human development. In addition, the use of electricity as a source of lighting and cooking fuel is much more environment friendly than oil or firewood.

The Census of India, 2001 collected information regarding the source of lighting and fuel used for cooking in the following categories;

Source of lighting: Electricity, Kerosene, Solar, Other oil, Any other and No light
Fuel used for cooking: Electricity, Crop residue, Cowdung cake, Coal/Lignite/Charchol, Kerosene, LPG, Electricity, Bio-gas, and Any other.

However, the direct information on availability of electricity in household is given in the census and has been used to calculate the proportion of electrified households in this study. Higher the proportion of electrified households better is the district. The index value \( X_{8d} \) for \( d^{th} \) district is symbolically calculated as follows;

\[
Index \ Value \ (X_{8d}) = \frac{X_{8d} - Min (X_{8d})}{(Max (X_{8d}) - Min (X_{8d}))}
\]

where, \( X_{8d} \) is the proportion of households connected with electricity in the \( d^{th} \) district. The Index value ranges between 1 and 0. The maximum proportion of electrified households is in Lakshadweep district (99.7 percent, i.e., Index Value \( X_{8Lakshadweep}=1 \)), and the minimum is in Sheohar district in Bihar (3.1 percent, i.e., Index Value \( X_{8Sheohar}=0 \)). The bottom 100 districts in rank belong to state of Assam, Bihar, Jharkhand, Orissa, and Uttar Pradesh (see Table 8 and Map 8).
Women Receiving Three or more ANC Visits during Pregnancy

Antenatal care can protect both mother and child from various risks during pregnancy. Four check-ups—one each during the third, sixth, eighth and ninth months of pregnancy are recommended (Park and Park, 1989). However, there are different opinions that exist in the literature about the number and the timing of Antenatal Check-Ups (ANC). In India, every pregnant woman is advised to have at least three antenatal care visits under the guidelines prescribed by the Reproductive and Child Health Programmes (Ministry of Health and Family Welfare, 1997). Moreover, a pregnant woman can have an antenatal check-up either by visiting a health professional at the facility or during a health worker’s visit to home, or both. The District Level Household Survey (2002-04) gathered information on ANC visits from those women who had delivered their last birth during three years preceding the survey date. The survey results reveal that around 50 percent women received three and more antenatal check-ups visits during pregnancy in the country as a whole. Thus, higher the level of prevalence, better is the district. The index value \(X_{9d}\) for \(d^{th}\) district is symbolically calculated as follows:

\[
\text{Index Value (} X_{9d} \text{)} = \frac{X_{9d} - \text{Min (} X_{9d} \text{)}}{(\text{Max (} X_{9d} \text{)} - \text{Min (} X_{9d} \text{))}}
\]

where, \(X_{9d}\) is the percentage of women receiving three or more ANC visits during pregnancy in the \(d^{th}\) district. The maximum and minimum prevalence of three and more ANC visits are found in Coimbatore district in Tamil Nadu (100 percent, i.e., Index Value (\(X_{9\text{Coimbatore}}\)=1) and in Kaushambi district in Uttar Pradesh (5.4 percent, i.e., Index Value (\(X_{9\text{Kaushambi}}\)=0) respectively. The bottom 100 districts in rank belong to states of Bihar, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh (see Table 9 and Map 9).
Women Receiving at least Two TT Injections

In India, a fairly high proportion of infant deaths occur in the neonatal period. One of the reasons behind a large proportion of neonatal deaths is tetanus infections among infants. It generally develops within the first fortnight of life and is proven to be fatal in more than three-quarters of the cases. It is to be noted that neonatal tetanus is a preventable disease. To prevent it, all pregnant women are required to receive two doses of tetanus toxoid at the early stage of pregnancy with a gap of one month. This is an important component of full antenatal care, and protects both mothers and newborns from tetanus infection. In India, the District Level Household Survey (2002-04) provides information on the percentage of pregnant women who received at least 2 TT injections in each district. Thus, higher the percentage of these women better is the district. The index value \( \left( X_{10d} \right) \) for \( d^{th} \) district is symbolically calculated as follows;

\[
Index Value (X_{10d}) = \frac{X_{10d} - Min (X_{10d})}{Max (X_{10d}) - Min (X_{10d})}
\]

where, \( X_{10d} \) is the percentage of women receiving at least 2 TT injections during pregnancy in the \( d^{th} \) district. The maximum and minimum percentage of women receiving at least 2 TT injections, respectively, are observed in Erode district of Tamil Nadu (99.3 percent, i.e., Index Value \( X_{10Erode} = 1 \)) and West Garo Hills district of Meghalaya (9.8 percent, i.e., Index Value \( X_{10West Garo Hills} = 0 \)). The bottom 100 districts in rank belong to the states of Arunachal Pradesh, Madhya Pradesh, Northeastern States, Rajasthan and Uttar Pradesh (see Table 10 and Map 10).
Complete Immunization Coverage

For the last three decades, the Expanded Programme on Immunization (EPI) has been promoted as one of the key child health interventions in developing countries. Vaccines for six childhood diseases (diphtheria, measles, pertussis, poliomyelitis, tetanus, and tuberculosis) have been shown to be effective in preventing disease-specific morbidity and mortality. The Government of India has on several occasions tried to improve the situation of child immunization through consistent efforts by launching programmes like Universal Immunization Programme (UIP), Child Survival and Safe Motherhood (CSSM), Pulse Polio Immunization Campaigns and the integrated Reproductive and Child Health approach.

The DLHS data have been used to study immunization coverage in this study. According to the definition in the survey, a child who received BCG vaccination (against tuberculosis), measles, three doses of DPT (against diphtheria, whooping cough, and tetanus) and polio (excluding polio 0; against poliomyelitis) is said to be fully immunized. The immunization status of children in the 12-23 age group is taken to compare districts, as a child should receive all the above vaccinations by the time of completing his first year of life. Thus, higher the level of complete immunization, better is the district. Index value \( (X_{11d}) \) for \( d^{th} \) district is symbolically calculated as follows;

\[
Index\ Value\ (X_{11d}) = \frac{X_{11d} - Min\ (X_{11d})}{Max\ (X_{11d}) - Min\ (X_{11d})}
\]

where, \( X_{11d} \) is the percentage of children in the age-group 12 to 23 months completely immunized in the \( d^{th} \) district. The maximum and minimum levels are observed in the Toothukudi district of Tamil Nadu (98.8 percent, i.e., Index Value \( (X_{11Toothukudi})=1 \) and Mon and Zunheboto districts of Nagaland (0.0 percent, i.e., Index Value \( (X_{11Mon/Zunheboto}=0 \) respectively. The bottom 100 districts in rank belong to the states of Arunachal Pradesh, Assam, Bihar, Madhya Pradesh, Jammu & Kashmir, Northeastern States, Rajasthan and Uttar Pradesh (see Table 11 and Map 11).
As discussed earlier, under the RCH approach, children are vaccinated to protect them from six childhood diseases (diphtheria, measles, pertussis, poliomyelitis, tetanus, and tuberculosis). A child receiving a dose of at least one of the prescribed vaccinations (BCG, measles, three doses of DPT and polio (excluding polio 0)) comes under any immunization status, whereas under fully immunization status s/he must receive all of them. In India, health workers follow up children who received at least one vaccination by issuing an immunization card. The card is having all details about the vaccination status of a child in a very simple format. Nevertheless, a significant level of dropout from full immunization is observed at the district level in the DLHS (2002-04). By definition, the dropout is the difference between the percentage of children receiving any vaccination and the percentage of children receiving all the prescribed vaccinations. These gaps are not only due to unavailability or inaccessibility of the immunization services at the facilities but also due to socio-cultural myths and misconceptions that are sometimes major factors in prohibiting children from receiving all the vaccinations. Thus, lower the level of immunization dropout, better is the district, i.e., higher the index value. Further, districts are ranked according to the index value. Index value \( X_{12d} \) for \( d^{th} \) district is symbolically calculated as follows:

\[
Index Value (X_{12d}) = \frac{Max (X_{12d}) - X_{12d}}{(Max (X_{12d}) - Min (X_{12d}))}
\]

Where, \( X_{12d} \) is the percentage of children in the age-group 12-23 months not receiving from complete immunization in the \( d^{th} \) district. The maximum and minimum dropout rate are observed in Toothukudi district of Tamil Nadu (1.2 percent, i.e., Index Value \( X_{12Toothukudi} = 1 \)) and West Tripura district of Tripura (95.5 percent, i.e., Index Value \( X_{12WestTripura} = 0 \)) respectively. The bottom 100 districts in rank belong to the states of Arunachal Pradesh, Assam, Madhya Pradesh, Jammu & Kashmir, Northeastern States, Orissa, Rajasthan (see Table 12 and Map 12).
Contraceptive Prevalence Rate

India is the first country in the world to launch a government family planning programme in 1952. The programme was mainly clinical in approach. Later on it went through various phases of structural changes, incorporating socio-economic and demographic characteristics of the population and political commitments towards population issues. The impact of programme can be easily seen as India's crude birth rate has declined from 41 in 1951 to 26 in 2001 (Chander Shekhar, 2004). Following the trends, it is expected that replacement level fertility (an average of 2.1 children per woman) will be achieved by 2010 (National Population Policy, 2000). However, some of the Empowered Action Group (EAG) states are showing a slower pace of fertility decline and will take much longer time in attaining the replacement level fertility. Specifically, the district level variations are quite large in the high fertility states (Ram, Chander Shekhar and Mohanty, 2005).

According to DLHS (2002-04), around 53 percent of currently married women age 15-44 use any method of family planning in India, but a majority of them have adopted a permanent method of family planning (35 percent). The findings from the survey suggest that unmet need for family planning still remains high in some of the regions. To improve the prevalence rate and to reduce the inter and intra-state differentials in the contraceptive prevalence rate, programme managers have implemented several strategies through the Reproductive and Child Health programme and the National Rural Health Mission. Therefore, ranking and mapping of districts by contraceptive prevalence rate will help the policy makers and programme managers to implement the programme more effectively in the districts lagging behind. Thus, higher the level of contraceptive prevalence rate, better is the district. Index value \( (X_{13d}) \) for \( d^{th} \) district is symbolically calculated as follows;

\[
Index\ Value\ (X_{13d}) = \frac{X_{13d} - \text{Min} \ (X_{13d})}{\text{Max} \ (X_{13d}) - \text{Min} \ (X_{13d})}
\]
where, $X_{13d}$ is the percentage of currently married women age 15-44 using any method of family planning in the $d^{th}$ district. The maximum percentage of contraceptive prevalence rate are observed in Leh (Ladakh) district of Jammu and Kashmir (90.7 percent, i.e., Index Value ($X_{13Leh}$)=1) and the minimum in Chandel district of Manipur (4.9 percent, i.e., Index Value ($X_{13Chandel}$)=0). The bottom 100 districts in rank belong to the states of Arunachal Pradesh, Bihar (29 out of the total 37 districts of the state), Uttar Pradesh and Northeastern states (see Table 13 and Map 13).
Composite Index

The composite index in this study reflects a concise level of development of a district with respect to socio-economic and demographic characteristics of the population. The value of the composite index is an average of all indices for a given district. Thereafter, all the districts are ranked on the basis of the average score. A district having a higher value of index gets better rank. Ranking from composite index score will help identify the relative backwardness of a district in the country. In this study, we have identified the 100 most backward districts for each indicator. The value of the composite index ($\overline{X}_d$) for a given district is calculated as follows;

$$\overline{X}_d = \frac{1}{13} \sum_{i=1}^{13} X_{id}$$

The results obtained from the above exercise are given in Table 14. It is found that Chennai district of Tamil Nadu holds the first rank, whereas East Kameng district of Arunachal Pradesh stood last. In particular, 22 districts each from Bihar and Uttar Pradesh, 13 from Jharkhand, 11 from Madhaya Pradesh, nine from Rajasthan and six from Meghalaya hold ranks among the 100 most backward districts of the country.

To understand the interrelationships among the indices, correlation and regression analyses were performed. This study indicates a very high degree of positive correlation (0.845) between the percentages of birth order three and above and the proportion of population from 0 to 6 years of age. An interesting finding is that the percentage of women who received three and more ANC visits during pregnancy is significantly and positively correlated with the level of full immunization. Therefore, it can be inferred that antenatal care ameliorates the health status of both mother and child. The regression analysis suggests that the composite index is significantly influenced by birth order three and above (13 percent) followed by the level of immunization dropouts (12 percent) and the percentages of women receiving three and more antenatal visits (11 percent). It is to be noted that multicolinearity among the indices is taken care of during the exercise.
Ranking of Districts within Each State Based on Composite Index

Considering the diversities in the level of development, it is necessary to implement the policies and programmes at the regional or sub-national level. It is also relevant as the states are responsible to formulate and implement the different schemes and programmes according to their needs. Ranking of districts within a state will help the planners to locate the districts and intervention areas where they need to focus to improve the quality of life. This will eventually help the process of population stabilization at the national and the sub-national. Table 15 provides the ranking of the districts within each state based on the average composite index value.