Chapter-4
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Women’s Health and Hygiene in Post-Independence Period

During colonial rule, health care services in India were utterly inadequate, urban-based and curative in nature. Majority of the population, specially the poor and those residing in rural areas, did not access to modern health facilities. Consequently, the morbidity and mortality rates were quite high. Many women died while seeking abortion to get rid of unwanted pregnancy because access to contraceptives for preventing pregnancies was not available. Similarly, antenatal and postnatal care and services were poor and out of reach for majority of women and their families.¹

After independence Improvement in the health status of the population has been one of the major thrust areas in social development programmes. Efforts are continuing to improve the access to and utilization of health, family welfare and nutrition services with special focus on under-served and under-privileged segments of population. Technological improvements and increased access to health care have resulted in a steep fall in mortality rate, but the burden of communicable and non-communicable diseases, environmental pollution and nutritional problems continues to be high. Inspite of the fact that norms for creation of infrastructure and manpower are similar through the country, there remain subsential variations among states and districts within a state in availability and utilization of health care services and health indices of the population.²

Women related issues were covered during 1950s to 1960s, mainly by social welfare projects for improving their educational and health position. In the early 1970s, efforts at poverty alleviation ignored gender-based inequalities, and developmental efforts targeted only men, leaving women’s productive roles unrecognized. This led to women’s exclusion from mainstream development efforts in sectors such as agriculture and manufacturing. During the International Women’s Decade (1975-1985) and following it, the focus was on changing policies and legislation that led to women’s economic and social subordination, and also in

² Ibid
involving women in their own empowerment through consciousness-raising initiatives at the grass-roots level. ³

By the early 1990s, it became clear that trying to improve women’s status while ignoring the structures and processes that cause and sustain women’s subordination was a dead end. The focus shifted to examining gender-power inequalities between women and men. During the previous decade the exclusive focus on women had led to the creation of ‘add-on’ women’s programs and projects within the Women’s Bureau’s of countries or women’s departments of organizations, yet the country or organization’s overall policies and approaches continued with ‘business-as-usual’. ⁴

In modern times the evolution of the knowledge and discipline dealing with the gender-power inequalities and its consequential effect on women and men has enabled us to comprehend the gender inequalities in different sectors, including health. Differences between women and men in health needs, health-seeking behaviour, and ability to access health services and receive appropriate treatment have now been established by many studies, and have received endorsement in major international conferences, notably in the International Conference on Population Development (ICPD) in Cairo (1994) and the Fourth World Conference on Women in Beijing (1995). During the past decade, there have been numerous initiatives attempting to mainstream gender in health policies, programs, projects and research, and within institutions responsible for training health providers and delivering health care services. Brazil was the first country to create a comprehensive women’s policy, in 1983. The Australian National Women’s Policy was formulated in 1988, the Colombian ‘Health for Women, Women for Health’ policy in 1992. Efforts were also made in South Africa in 1994, to develop a women’s health policy agenda. In all instances, the policies have gone beyond sexual and reproductive health concerns to address violence against women, occupational health and mental health. They have also drawn attention to the health needs of women and girls in all age groups. ⁵

³ Ravindran TK Sundari, Arti Kelkar-Kambete, ‘Women’s Health Policies and Programmes and gender-mainstreaming in health policies, programmes and within health sector institutions’, June 2007, pp. 1-89 ravindran@usa.net aartikhambete@rediffmail.com
⁴ Ibid
⁵ Ibid
In all instances, women's health policies were grounded in a gender analysis of the causes of women's health problems, and sought to address these through programme strategies that were empowering to women. For example, information and counseling respect for women's choices and attention to quality of services was all given importance. The women's health approach was firmly based on an understanding of health as having both biological as well as social determinants. The approach extended attention to women's health issues beyond maternity such as mental health, domestic violence and occupational health. In addition, it applied a gender analysis to all women's health issues including maternal and reproductive health; and drew attention to the ways in which gender-based inequalities affected all dimensions of women's health. Women's health policies evolved through a participatory process with all stakeholders, and women's health services put people at the center of their service-delivery models.\(^6\)

International and regional mandates, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Beijing Platform for Action or the Regional Human Rights Declarations which national governments are called upon to ratify, often initiate paradigm shifts in thinking, as for example, the CEDAW did for women's rights and Cairo Program of Action did for reproductive health and rights. Governments who ratify these agreements are called upon to report on progress made at regular intervals, which can influence government-level action in the relevant area. International and regional mandates are important also because they influence the availability of donor funding for gender mainstreaming, without which implementation will be constrained.\(^7\)

**Poverty and Women’s Health**

The model of development in the post-colonial period rested on the belief that economic growth was a sufficient condition for removing poverty and triggering development. Poverty has been an important issue of concern in India since independence. The rate of poverty alleviation in the past decades-despite comprehensive planning has been retarded. While achievements such as increased life expectancy need to be acknowledged, one cannot lose sight of the fact that the fight

\(^6\) Ibid
\(^7\) Ibid
against poverty has not yet been a successful one. In the present days, the largest number of the global poor lives in India, about 40% of 1.3 billion worldwide. Although the relative numbers of poor people in India has increased from 200 million people in 1950 to 312 million in 1994. The proportion of the population living in poverty and the trends in poverty in India is a contested issue. Yet there is a consensus amongst Government and other organizations that poverty continues to be a major problem confronting the country.⁸

The Planning Commission has been estimating the number and percentage of poor at national and state level. Since March 1997 it has been using the Expert Group Method to estimate poverty. Using this methodology the value estimated by Planning Commission for various years are given below:

**Table 12: Poverty Ratio in India (% of population below the poverty line)**⁹

<table>
<thead>
<tr>
<th>Year</th>
<th>Poverty line (Rs.)</th>
<th>Poverty Ratios as per Expert Group methodology (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>1972-73</td>
<td>41</td>
<td>47</td>
</tr>
<tr>
<td>1973-74</td>
<td>49.63</td>
<td>56.96</td>
</tr>
<tr>
<td>1977-78</td>
<td>60.60</td>
<td>69.90</td>
</tr>
<tr>
<td>1983-84</td>
<td>101.80</td>
<td>117.50</td>
</tr>
<tr>
<td>1987-88</td>
<td>131.80</td>
<td>152.10</td>
</tr>
<tr>
<td>1988-89</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1989-90</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1990-91</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1991-92</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1992-93</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1993-94</td>
<td>205.84</td>
<td>281.35</td>
</tr>
<tr>
<td>1999-2000*</td>
<td>327.6</td>
<td>454.11</td>
</tr>
<tr>
<td>2004-2005</td>
<td>356.30</td>
<td>538.60</td>
</tr>
</tbody>
</table>

*Indicate estimates based on mixed recall period (MRP) method

Source: Government of India, National Sample Survey Organization and Planning Commission Reports.

⁸ Bhatt Rashmi, 'Feminization of Poverty and Empowerment of Women- An Indian Perspective & Experience', Townsville International Women's Conference, James Cook University, Australia, July 2002, pp. 3-7
It is estimated that 350-400 million people in India live under absolute poverty of 275 dollars per capita per annum and a majority of them are women. A short and snappy description, that poverty has a decided gender bias.\textsuperscript{10} The World Bank country study on “Gender and Poverty in India” presents the problems faced by poor women against a background of depressing statistics which shows how Indian women continue to be denied access to productive assets, in the form of financial credits, markets or land ownership and human capital such as education and skill-training which would enhance their abilities as economic agents.\textsuperscript{11}

Lifting women out of poverty will depend, to a large extent, on a better understanding of how many poor there are, where they live, why they are poor, and what are their precise circumstances. National Commission on Self-employed Women 1988 estimated the total number of women workers in India, about 94 per cent of the workforce are in the unorganized or informal sector, whereas just six per cent are in the organized or formal sector.\textsuperscript{12} The Indian census (2001) estimates that 80 per cent of economically active women are engaged in agriculture. Thus, it is no exaggeration to say that the unorganized sector in India is the women’s sector. However, the condition of women in this sector is miserable as they work for extremely low wages, with a total lack of job security and social security benefits, and they are not protected by any government labor organizations or labor legislation. There are hardly any unions in this sector to act as watchdogs.\textsuperscript{13}

**Notion of Poverty**

Poverty has traditionally been defined in terms of income or consumption. Thus it is “the inability to attain a minimum standard of living”. The level of income which ensures the minimum standard of living is taken as measure of poverty line. Those persons whose income is less than this poverty line fall in the category of “poor”. In India, all those who fail to reach a certain minimum level of income i.e. Rs. 49 for rural areas and Rs. 57 for urban areas per capita per month at 1973-74 price and having a daily calorie intake less than 2400 per person in rural areas and 2100 per

\textsuperscript{10} Human Development Report 1990, Oxford University Report, New York.
\textsuperscript{13} Census of India 2001
person in urban areas are regarded as poor.\textsuperscript{14} A new perception to poverty using one U.S. dollar per day as measure of the international poverty line, has estimated that 44.2 percent of the population was living below the poverty line in India in 1997.\textsuperscript{15} The National Sample Survey as reported by the Planning Commission in 1998 has recorded the figures of women poverty in India which has been tabulated in table-2. This can be clearly gauged that a large number of people in India live below the poverty line and a majority of them are women.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total population below poverty line in millions</th>
<th>Female population below poverty line in millions</th>
<th>Male population below poverty line in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973-74</td>
<td>321.3</td>
<td>192.7</td>
<td>128.6</td>
</tr>
<tr>
<td>1977-78</td>
<td>328.9</td>
<td>197.2</td>
<td>131.7</td>
</tr>
<tr>
<td>1983</td>
<td>322.9</td>
<td>193.7</td>
<td>129.2</td>
</tr>
<tr>
<td>1987-88</td>
<td>307.1</td>
<td>184.7</td>
<td>122.4</td>
</tr>
<tr>
<td>1993-94</td>
<td>320.3</td>
<td>192.0</td>
<td>128.3</td>
</tr>
<tr>
<td>1999-2000</td>
<td>260.2</td>
<td>156.0</td>
<td>104.2</td>
</tr>
<tr>
<td>2001-2002</td>
<td>246.8</td>
<td>148.0</td>
<td>98.8</td>
</tr>
</tbody>
</table>


Since health is an important determinant of productivity and countries like India are more labor dependent, it follows that there must be a higher value accorded to having a healthier workforce to maximize production. Nevertheless it is established that the productivity are seriously impaired. Thus, targeting the poorest of improved health would yield maximum dividends in terms of incomes, and thereby, their ability to access food and nutrition.\textsuperscript{16}

More than 500,000 women die every year in childbirth or from pregnancy-related causes. Virtually most of these (99 per cent) maternal deaths occur in low income countries. In developing countries, for every woman who loses her life due to pregnancy, between the age group of 15-30 suffers from lifelong illness and disability. Deeply ingrained gender inequalities exist in many low income countries where


\textsuperscript{15} Ibid

maternal deaths are high and health service utilization is low. Poverty is an important component of gender inequality, but the effects of unequal gender norms, like those of race, religion and ethnicity in some contexts, go beyond class differences. This is because gender inequality is defined and perpetuated by social norms and culture, and reflects differences in power between men and women both within the household and in the wider society. The effects include relatively higher rates of poverty and lower level of education among men and women, women’s lack of autonomy and mobility, intimate partner violence and, overall, lower social status and disempowerment of women relative to men.\(^\text{17}\)

It is generally recognized that poverty is a multidimensional phenomena. Nevertheless, in the measurement of poverty, priority is given to its economic dimension. The primary sources of national poverty statistics are, consequently, income and expenditure data collected through household surveys; those data are used as indirect measures of access to opportunities and resources by household members. Reliance on such data, however, has proved inadequate for capturing differences in poverty among women and men since it focuses on poverty estimates for households rather than on those for individuals. Such estimates do not readily show sex differences in patterns of distribution of food, income and the like, nor do they reveal the experience of poverty of individual women and men within households.\(^\text{18}\)

In addition, poverty statistics based on income and expenditure data do not assign an economic value to unpaid domestic work or to care giving activities that are most often performed by women. Failure to value those unremunerated activities introduces a significant bias in poverty statistics and may lead to underestimating the level of poverty experienced by women and by single-parent households, especially those headed by women. The underestimation can occur for two key reasons: first, unpaid domestic work and care giving activities performed by women in dual parent households is an economic asset, not readily available to single parent households who may instead need to purchase those services from the market. Second, the unremunerated activities also have a direct effect on women’s time, limiting their

\(^{17}\) Paruzzolo Silvia, Rekha Mehra, Aslihan Kes and Charles Ashbaugh, “Targeting Poverty and Gender Inequality to Improve Maternal Health” International Center For Research For Women (ICRW), 2010, p. 11, www.womendilever.org

ability to participate in other activities, including wage employment, education and training, and leisure.\(^{19}\)

However, despite the limitations, data collected through household surveys can be and have been used to provide preliminary evidence of the extent to which women may be at a greater risk of experiencing poverty as compared with men. Examples including the work carried out by the Women and Development Unit of the Economic Commission for Latin America and the Caribbean and by the International Food Policy Research Institute (IFPRI), which analyzed survey data from countries in Asia and sub-Saharan Africa.\(^{20}\)

The Millennium Projects have also contributed to improvements in the use of existing data on women and poverty, as reflected in the United Nations Development Program reports on the Millennium Development Goals. The review found that 22 percent of the reports included indications for poverty by sex.\(^{21}\) Although differences in poverty among women and men can at times be demonstrated using information available through standard household surveys, there is a need for new concepts, instruments and methodologies designed specifically to measure those differences. For instance, the concept of “time poverty” has been advanced as an alternative approach that captures both the social and economic dimensions of poverty. It can be analyzed on the basis of data from time-use surveys that show how women and men apportion their time between various income-earning and other tasks. Since 1995, at least 67 countries or areas have conducted a time-use survey. However, time-use surveys are not yet widely conducted by countries around the world.\(^{22}\)

Women’s participation in the informal sector is an important challenges dealing with strategy for households in poverty, and in that regards the work of the Delhi Group on Informal Sector Statistics is of particular interest. The Group’s 2004-2005 work program included identification, definition and development of a core set of indicators on informal sector and informal employment in line with important place on informal employment by the Task Force on Education and Gender Equality of the United Nations Millennium Projects.\(^{23}\)

\(^{19}\) ibid
\(^{20}\) ibid
\(^{21}\) ibid
\(^{22}\) ibid
\(^{23}\) ibid
The basic challenge for analysis on issues related to women and poverty is the lack of data on the level and incidence of poverty among individual women. The existing data do not allow for the examination of differences in the distribution and consumption patterns of individuals within households. Alternative data to address this challenge are already being considered. For example, indirect poverty indicators, such as the consumption of specific goods (for example, items of clothing) that can be linked to individuals and are therefore surveys in some countries with limited success. A second alternative that offers more potential is the use data on time poverty collected through time-use surveys. However, as stated earlier, at the present time not many countries carry out time-use surveys, especially in the less developed region where the levels of poverty are greatest.\footnote{Ibid, p. 88}

Underlying the general lack of adequate gender-sensitive data on poverty are also conceptual and methodological challenges that require attention. From a gender perspective, much of the economic data used in poverty analysis are deficient owing to and/or to conceptual limitations that excluded as from the System of National Accounts, whereas the same work done by women in other households is defined as market production and counts as economic activity.

Finally, although poverty is recognized to have both social and economic dimensions, poverty measurement and analysis tend to focus on the economic aspects. Both qualitative analyses and quantitative methods need to be used in measuring and assessing poverty. Such analyses would reflect factors related to the way in which poor people view themselves, the perception of poverty among poor women and men and the way in which they identify and express their needs. Analyzing poverty, both quantitatively and qualitatively would thus bring visibility to the non-material aspects of poverty.\footnote{Ibid}

The per capita income data is widely used as a means of establishment of the poverty line. Considered as an indicator, the “single factor” signifies a particular level of income denoting the capacity, or lack of it, to satisfy certain needs whose fulfillment assures subsistence. Once the line of poverty is established, it can be validated by means of identification of multifactor, such as housing, education,
employment, health, fertility, mortality, mental satisfaction, etc., whose main manifestation in a particular way are supposed to be the characteristics of poverty.  

Social transfer programs and poverty schemes in India have come with a greater reliance on identifying the poor. Yet, the official poverty measures have faced fierce criticism and have been seen as controversial. The Indian Planning Commission (IPC), who is in charge of the poverty figures, recently made substantial changes in their methodology for measuring the poor. An alternative structural approach to poverty measurement, which identifies the poor through the share of income spent on food.  

The relationship between poverty and poor health is not a simple one. It is multifaceted and bi-directional. Poor health can be a catalyst for poverty spirals and, in turn, poverty can create and perpetuate poor health status. The relationships work in both directions. As with poverty, poor health has an effect on both the individual and the household, and may have repercussions for the wider community, too.

Low productivity and low income lead to low nutrition. Low nutrition makes the poor highly susceptible to disease. In addition, low income leads to poor living conditions and sanitation facilities. These in turn increase the vulnerability of the household. The wage earner in the family remains unemployable for longer periods owing to frequent and prolonged illness. Increased vulnerability to disease may also compel a distress sale of assets, leading to indebtedness. As a result, productivity and income are further reduced. "The capabilities of poor individuals (low nutritional status, hazardous living and working conditions, inability to afford to adequately treat illness) mean that ill-health shocks are most often repeated for poor individuals." By illustrating how poverty, health and education are interlinked, the model in (appendix 2, Figure 1) allows us to identify appropriate entry points to break the spiral. Improved health contributes to economic growth in various ways: it reduces production losses caused by prolonged illness; it not only enhances the enrollment of children in school, but also makes them better able to learn; and it provides the opportunity for alternative uses of resources that would otherwise have to be spent on treating illness. Households with more education enjoy better health, both for adults

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27 Ibid
and for children. This result is strikingly consistent with a large number of studies, despite differences in research methods, time periods and population samples.\textsuperscript{28}

According to WHO, poverty and poor health for women doesn't correlate with each other. Until the benefits of economic growth are equally distributed, economic growth does not necessarily guarantee better health or higher status for all women. Human development is a process of expanding the choices available to people. It is not limited to a section of the society. Economic growth can, in fact, become an unjust and discriminatory process in itself if most women are excluded from its benefits. Progress in literacy in India in the twentieth century suggests an illustration of this problem. In India, the literacy rate has increased since 1901, but the male–female gap in literacy also increased considerably to 1981.

It is now widely accepted that poverty elimination cannot be based on a narrow approach that relies solely on rising incomes or macroeconomic growth. As the benefits of growth do not trickle down automatically to all households and to all household members, we need to address the gender differences and incidence of poverty in a contextualized way.\textsuperscript{29}

In less developed countries, there is a preponderance of surviving men over surviving women, despite the biological advantages that women seem to have over men in survival and longevity. This is happening because of unequal treatment in the allocation of survival related goods, such as nutrition, health care and medical attention. In developed countries, the situation is in sharp contrast. Whereas there are about 106 women per 100 men in Europe and North America, there are only 97 women per 100 men in the less developed countries as a whole. Since mortality and survival are dependent on care and neglect and are influenced by social action and public policy, even this extremely crude perspective cannot fail to isolate gender as an important parameter in development studies. In India, census data show that the trend in the sex ratio (the number of women per thousand men) since 1901 has also been declined. Much of this discrepancy can be understood in the context of women’s powerlessness and inequality, which are increasingly seen as important root causes of ill health. Gender inequity is the archetypal “inequality trap”. The interaction of

\textsuperscript{28} Ghosh Arbinda, “Pro-poor capacity-building in India’s Women’s Health Sector”, p. 247-271, www.researchgate.net
\textsuperscript{29} Ibid
political, economic and socio-cultural inequalities shapes the institutions and rules in all societies. Therefore, inequality prevails everywhere—in income, in education and in health. Inequalities in health often translate to inequalities in other dimensions of welfare. The combined effects of gender inequality and poverty on nutrition lead to poor health for women and girls. Intergenerational transmission of poverty may occur through the under-nourishment/overwork of pregnant or lactating women. Furthermore, certain conditions of poor health may lead to women’s social exclusion, incapacity and subsequent poverty, highlighting the importance of recognizing cycles of poor health and poverty. It is important to recognize that women’s health problems and access to health care are affected not only by poverty but also by gender inequality.  

Indian government has started some of the schemes to ensure health facility, to some extent, to women suffering from severest forms of poverty. To begin with The Janani Suraksha Yojana program (JSY), which provides benefits to all pregnant women in states with low institutional delivery rates and targets the most vulnerable in states with higher institutional delivery rates. JSY is a safe motherhood intervention scheme under the National Rural Health Mission (NRHM), implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Community health workers receive benefits in the most vulnerable parts of the country if they identify pregnant women, encourage institutional delivery, provide a postnatal care visit and arrange to immunize the newborn until the age of 10 weeks.  

One feature of the JSY is that only a woman, more than 19 years of age who is Below Poverty Line (BPL) can be a beneficiary in High Performing States (HPS). In case, if poor woman does not have a BPL card then the beneficiary can access the benefit upon certification by Gram Panchayat or Pradhan provided that the delivery takes place in a government institution. Cash assistance in HPS is limited to two live births. The disbursement is made at the time of delivery. Cash assistance of Rs. 700 in case of rural and of Rs. 600 in case of urban is given for institutional delivery and of Rs. 500 is given for home delivery. In rural areas, cash assistance for referral transport to go to the nearest health centre for delivery is provided. The JSY identifies only 10

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30 Ibid
states as low performing states (LPS) and the remaining as high performing states (HPS). What is to be borne in mind however is that the cash incentive is but one component of the JSY.\textsuperscript{32}

Another scheme, the Targeted Public Distribution System, is focusing on providing food for the poor. Under the TPDS, States are required to formulate and implement foolproof arrangements for identification of the poor for delivery of food grains and for its distribution in a transparent and accountable manner at the FPS level. A national Sample Survey Exercise points towards the fact that about 5% of the total population in the country sleeps without two square meals a day. This section of the population can be called “hungry”, in order to make TPDS more focused and targeted towards this category of population, The Government of India launched the scheme called Anna Yojana” with effect from 25.12.2000. The above scheme was implemented in Tamil Nadu with effect from 1.11.2001 in urban areas and with effect from 1.12.2001 in rural areas and the collectors is over all in charge for the implementation of this scheme in the Districts. The objective of the scheme is to ensure food security to the poorest of the poor. Originally at the time of introduction of “AAY” scheme, each beneficiary was given 25 kg per month at the rate of Rs.3/- per kg. This has been increased to 35 kg of rice per card per month at the rate of Rs.2/- per kg. through fair price shops from November 2006 onwards. The Government of Tamil Nadu launched the 1kg rice at Rs.1 scheme on the birth centenary of Perarignar Anna on 15.9.2008. The States are required to bear the distribution cost, including margin to dealers and retailers as well as the transportation cost. Thus the entire food subsidy is being passed on to the consumers under the scheme. The AAY Scheme has been expanded in 2003-2004 by adding another 50 lakh BPL households headed by widows or terminally ill persons or disabled persons or persons aged 60 years or more with no assured means of subsistence or societal support. With this increase, 1.5 crore (i.e.23% BPL) families have been covered under the AAY.\textsuperscript{33}

On 2\textsuperscript{nd} May 2003, the Supreme Court directed the Government of India to place on AAY category the following groups of persons:

\textsuperscript{32} \textit{ibid}

\textsuperscript{33} Dr. S.\textsuperscript{a} Mayilvaganan, B. Varadarajan, ‘Antyodaya Anna Yojana Scheme is to Ensure Food Security to the Poorest of the Poor’, Zenith International Journal of Business Economics & Management Research, Vol.2, Issue 2, February 2012, ISSN 22498826, pp. 178 to 182, http://zenithresearch.org.in
1- Aged, infirm, disabled, destitute men and women, pregnant and lactating 
women, destitute women;
2- Widows and other single women with no regular support;
3- Old persons (age 60 or above) with no regular support and no assured means 
of subsistence;
4- Households with a disabled adult and assured means of subsistence;
5- Households due to old age, lack of physical and mental fitness, social customs, 
need to care for a disabled, or other reasons, no adult member is available to 
engage in gainful employment outside the house;
6- Primitive tribes.

Class and Caste Dimensions

Caste in Indian society refers to a social group where membership is largely decided 
by birth. Members of such local group avoid entering into marital relationships with 
outsiders. Originally, these groups were associated with specific professions. The 
mutual relationship of one caste with the other is established on the principle of 
lineage and the resultant purity of blood, making the relationship between one and 
another caste distant. Dr. Ketkar defines Caste as a ‘social group having two 
characteristics: (a) membership is confined to those who are born of members and 
includes all persons so born; (b) the members are forbidden by an inevitable social 
law to marry outside the group’. According to Sir H. Risley, ‘a caste may be defined 
as a collection of families or groups of families bearing a common name which 
usually denotes or is associated with specific occupation, common descent from a 
mythical ancestor, human or divine, professing to follow the same professional 
callings and are forming a single homogeneous community’.\(^\text{34}\)

The decennial census, introduced by the British, recorded caste, and it 
unwittingly came to the aid of social mobility. Class and Castes were mainly 
distinguished by the colonial state. Getting the names recorded in the census was part 
of the struggle to achieve a higher status than before. While the British rule 
occasionally did confer economic benefits on low castes, it was more usual for these

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\(^{34}\) Mohanty Manoranjian (ed.), ‘Class, Casts, Gender: Readings in Indian Government and Politics’, 
Delhi, 2004, p. 133
benefits go to those castes which were already at the top of the hierarchy. The caste system being hierarchal and discriminatory to had its affect on the respective position of women in society and distribution of resources accordingly.

The caste system inherently permitted control over women's labor. Caste not only determines the social division of labor, but also sexual division of labor. Certain tasks have to be performed by women while certain other tasks are meant for men. In agriculture, for instance, women can engage themselves in water-regulation, transplanting, weeding, but not in ploughing. With the upward mobility of the group, women immediately withdraw from the outside work. Physical mobility is also restricted through caste norms. The significant symbol of the low status of women in society is that the women of lower castes are accessible to men of higher status, while there is a very severe punishment for men of the lower castes who dare to approach women of the higher groups. In brief, caste system not only provided a legitimization to feudal relation of production, but ideologically also provided justification for the subordination of women.35

The complex interface of class, caste and gender is rooted in the way capitalism grew in India. Originally, it was implanted by the British colonial regime as a dependent industrial sector to utilize local raw materials, such as jute in Bengal and cotton in western India. In post-Independence India, an attempt was made to develop agricultural production by improving irrigation and using modern technology with the hope that it would generate surplus to finance industrialization. This process, known as the Green Revolution, vastly expanded agricultural production generating surplus. But it did so only in some parts of India, mainly the Punjab, Haryana, western U.P. (now Uttrakhand) and some pockets in other states. Vast stretches of many Indian states remained underdeveloped and poverty-stricken with the persistence of semi-feudal relations in agriculture. These included major parts of Bihar, Madhya Pradesh and Orissa. Thus, Indian capitalism in the 50 years since Independence grew on the foundations of the pockets of the Green Revolution and stretches of poverty. This is the foundation for the prevailing structures of deprivation and inequalities. Hence, the bulk of the poor not only is landless poor peasants and unorganized workers, but is also from the scheduled castes, backward classes and scheduled tribes.

Among the poor household women suffer more, and also in general, women suffer more from poverty. Thus, understanding of poverty is incomplete without seeing the interface of caste, class and gender.\textsuperscript{36}

The most significant source of power in no doubt related to class or to the control over the means of production such as land and industry. But social history had created patterns of relationship based on certain values and beliefs rooted in social conditions. Caste order and patriarchy embodied values and beliefs operating in the social structure. Gender too is related to class and caste. Division of labor between men and women evolved in the course of history. Over centuries of evolution of class and caste society, along with power relations, men performed crucial roles in the production system and acquired greater power in the society. The status of women as dependent on men, they are mainly performing household work, producing children and nurturing them was the outcome of a long period of feudal and capitalist social history. Religious and caste ideology reinforced the evolution of this trend, and Hindu scriptures enormously contributed to this image of women. As contradictions became acute in society the gender question was reviewed. In the course of human struggle it became integrated with the struggle for social equality on all fronts- class, caste, ethnicity, race and gender. It was essentially a cultural and ideological statement rather than an empirical fact as patriliny was a practice in many parts of India. Women's potential for work outside the household was recognized to be at par with men's. Producing children were now valued as the most significant of all productive activities for keeping the human race going. Feudalism and Capitalism were critiqued as systems the dehumanized women as bodies or objects of enjoyment (as in feudalism) or as commodities for trade (as in capitalism). Religions were also reinterpreted innovatively to promote the idea of equality among men and women. Interestingly enough that practice among Shudras and the so-called outcasts and tribes already had relatively high degree of equality between men and women. Both participated in productive manual labor. The discrimination against women is more acute among the upper and middle castes in comparison to the lower castes. Like racism, caste too was a system of social hierarchy.\textsuperscript{37}

\textsuperscript{36} Ibid, p. 20
\textsuperscript{37} Ibid, p. 21
Women's Health and Rural-Urban Divide

After the independence, India was suffering on several counts, political, economic, modern education system, technologies and health. One third of Indian population was living in rural area where health was the major issue for the development. Health services were qualitatively very different and much more powerful during the freedom movement. The report of the Bhore Committee submitted in 1946, is to this day regarded as an authoritative document, not only because of its distinguished authorship but because many of its proposals and recommendations continue to be valid even today. It was guided by such snooty principles as 'nobody should be denied access to health services for his inability to pay' and that the focus should be on rural areas, with emphasis on preventive measures and training of what it called 'social physicians'.

Despite significant difficulties during new establishment of India, could develop an indigenous, alternative body of knowledge that was more suited to the social, cultural, economic and epidemiological conditions prevailing in the country. This led to the emergence of an alternative approach to education, training, practice and research in public health. In 1952 the set up of Primary Health Centers was meant to provide and encourage, preventive, curative and rehabilitative services to entire rural populations, as an integral component of a wider Community Development Programme. This was to be an integrated health services approach as a component of inter-sectoral action, as was envisaged much later in the Alma Ata Declaration on Primary Health Care.

An Independent Commission on Health in India (ICHI), set up by the Voluntary Health Association of India, which submitted its report to Prime Minister Atal Bihari Vajpayee in 1997, had pointed out that the health services 'are in an advanced stage of decay'. Documents from the Planning Commission also paint an equally gloomy picture. A study of a national sample of Community Health Centers (CHC) by the Programme Evaluation Organization (PEO) of the Planning Commission (1997) has revealed that virtually none of them is working at its optimal level. The 1992 and 1998 Rounds of the Family Health Survey revealed that India is among the countries having the highest rates of maternal mortality. The survey

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39 Ibid
conducted by the National Council of Applied Economic Research (1992) revealed that, among the poor, expenditure incurred to meet the medical needs is the second-most important cause of rural indebtedness.\(^{40}\)

Public health care system in rural areas in many states and regions is in shambles. Extreme inequalities and disparities persist both in terms of access to health care as well as health outcomes. This large disparity across India places the burden on the poor, especially women, scheduled castes and tribes. Inequity is also reflected in the availability of public resource between the advanced and less developed states. Urban growth has led to increase in number of urban poor. Though the coverage of health and family welfare services in urban areas is much better than the rural, lack of water and sanitation and the high population density in slums leads to spread of infections. These settlements have high incidence of vector borne diseases, asthma, TB, malaria, coronary heart diseases, diabetes etc. Poor housing conditions, exposure to heat and cold, air and water pollution and occupational hazards add to the misery of illness. Despite the presence of so many private and government hospitals in urban areas, large chunk of homeless and those living in slums or temporary settlements are left out of the proper health care system. Thus, even though there is a concentration of health care facilities in urban areas, the urban poor lack access; initiatives in the country to date have been limited and fragmented.\(^{41}\)

<table>
<thead>
<tr>
<th></th>
<th>CBR</th>
<th>CDR</th>
<th>IMR</th>
<th>Anemia among Children (6-35 months) (per cent)</th>
<th>Anemia among Pregnant Women (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>19.1</td>
<td>6.0</td>
<td>40</td>
<td>72.7</td>
<td>54.6</td>
</tr>
<tr>
<td>Rural</td>
<td>25.6</td>
<td>8.1</td>
<td>64</td>
<td>81.2</td>
<td>59.0</td>
</tr>
<tr>
<td>Total</td>
<td>23.8</td>
<td>7.6</td>
<td>58</td>
<td>79.2</td>
<td>57.9</td>
</tr>
</tbody>
</table>

The approach adopted by the NRHM provides a telling evidence of the lack of competence of the political and bureaucratic leadership of the Ministry of Health and Family Welfare (MOHFW) and its advisors to develop thinking to rectify what the

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\(^{40}\) Ibid
\(^{41}\) *Eleventh Five Year Plan (2007-12)*, Planning Commission, Government of India, Vol. II, p. 61,
\(^{42}\) Ibid, table 3.1.3.
ICHU had rightly termed in 1997 as an 'advanced stage of decay of the health services system, particularly the rural health service system of the country'. As mentioned earlier, the Mission has adopted a simplistic approach to a highly complex problem. Instead of considering health services as a complex, interacting system, they have selected a few catchy slogans such as 'Accredited Social Health Activist' (ASHA), Panchayat Health Committees, Rogi Kalyan Samities, health planning starting at the village and district levels, setting up rural health missions at the district, state and national levels, and so on.\textsuperscript{43}

Eleventh Five Year Plan recognizing the seriousness of the problem of urban health, considered urban health as a thrust area for the National Urban Health Mission (NUHM). Thrust areas of NUHM are the slums and other urban poor. At the State level, besides the State Health Mission and State Health Society and Directorate, there would be a State Urban Health Programme Committee. At the district level, similarly there would be a District Urban Health Committee and at the city level, a Health and Sanitation Planning Committee. At the ward slum level, there will be a Slum Cluster Health and Water and Sanitation Committee. For promoting public health and cleanliness in urban slums, the Eleventh Five Year Plan will also encompass experiences of civil society organizations (CSO) working in urban slum clusters. It will seek to build a bridge of NGO-GO partnership and develop community level monitoring of resources and their rightful use.\textsuperscript{44} NUHM would ensure the following:

- Resources for addressing the health problems in urban areas, especially among urban poor.
- Need based city specific urban health care system to meet the diverse health needs of the urban poor and other vulnerable sections.
- Partnership with community for a more proactive involvement in planning, implementation, and monitoring of health activities.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

\textsuperscript{43} Ibid

\textsuperscript{44} \textit{Eleventh Five Year Plan, 2007-2012}, Vol. II, Social Sector, Planning Commission, Government of India, p. 72
• Framework for partnerships with NGOs, charitable hospitals, and other stakeholders.

• Two-tier system of risk pooling: (i) women’s *Mahila Arogya Samiti* to fulfill urgent hard-cash needs for treatments; (ii) a Health Insurance Scheme for enabling urban poor to meet medical treatment needs.

The existing Urban Health Posts and Urban Family Welfare Centres would continue under NUHM. They will be marked on a map and classified as the Urban Health Centres on the basis of their current population coverage. All the existing human resources will then be suitably reorganized and rationalized. These centres will also be considered for upgradation. Intersectoral coordination mechanism and convergence will be planned between the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and the NUHM.\(^{45}\)

Rural women account for 359.8 million of the total rural population of 740.2 million. Estimates of the rural workforce indicate that 60.3 million women are main workers and 51.1 are marginal workers out of a total of 111.5 million rural women workers (Census, 2001). In the last decade or so, women’s health has received special attention the world over. From the Nairobi U.N. Conference through the Cairo ICPD 1994 and to the recently concluded Beijing Conference 1995 on women’s health and health care has been an important agenda item which has taken the growing share of attention. The Indian planners perceived women’s health primarily in the context of motherhood. The health of women depends primarily upon the social and environmental conditions under which they live and work, upon nutritional standards, upon educational facilities and upon facilities for exercise and leisure. A women’s health is perhaps the most potent single factor in determining the character and extent of development and progress.\(^{46}\)

The health care infrastructure in rural areas has been developed as a three tire system and is based on the following population norm:

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\(^{45}\) Ibid

Social discrimination against women results into neglect of women’s health from ‘womb to tomb’. Female infanticides are widely practiced. As per 2001 Census, there were 933 women per 1000 men. The vicious cycle of poverty generates the vicious cycle of ill health. To mother, poverty leads to low intake of food and nutrients, which results in under nutrition related diseases and infections.48

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. The tables below give selected data:

### Table 15: Differentials in Health Status- Rural and Urban

<table>
<thead>
<tr>
<th>Sector</th>
<th>Population BPL (%)</th>
<th>IMR/Per 1000 Live Births (1999-SRS)</th>
<th>&lt;5 Mortality Per 1000 (NFHS II)</th>
<th>Weight for Age- % of Children under 3 Years (&lt;-2SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>26.1</td>
<td>70</td>
<td>94.9</td>
<td>47</td>
</tr>
<tr>
<td>Rural</td>
<td>27.9</td>
<td>75</td>
<td>103.7</td>
<td>49.6</td>
</tr>
<tr>
<td>Urban</td>
<td>23.62</td>
<td>44</td>
<td>63.1</td>
<td>38.4</td>
</tr>
</tbody>
</table>

Eleventh Five Year Plan envisages inclusive growth by introducing NUHM which along with NRHM will form Sarva Swasthya Abhiyan (SSA). Aim of SSA for

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47 India Country Profile, World Health Organization, Department of Making Pregnancy Safer
48 Ibid
inclusive growth by finding solutions for strengthening health services and focusing on neglected areas and groups.\textsuperscript{49}

There are several important policies, strategies and acts that provide the framework for agriculture, forestry, rural development and tribal development, and which are central to IFDA’s efforts in India. For example, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) is considered the largest employment programme in the world. Its objective to provide wage labour and to generate productive asset in the process, which could lead to sustainable livelihood opportunities to gradually reduce dependence on public work programmes. During the period 2006-09, MGNREGA generated 6 billion person-days of work, involving an outlay of about US$ 16 billion.\textsuperscript{50}

The National Rural Livelihood Mission (NRLM), under the Ministry of Rural Development, provides livelihood development opportunities to poor rural families. NRLM emphasize formation, training and capacity-building of self-help groups and their federations, along with financial services and training.\textsuperscript{51}

The National Rainfed Area Authority (NRAA) emphasizes capacity-building, monitoring and evolution, learning and social audit. It introduces a livelihoods perspective from the very inception of a project, with special emphasis on families without assets.\textsuperscript{52}

Finally, Panchayat Act of 1996, and the Forests Rights Act of 2006 provide a legal framework for transferring rights to tribal communities for natural resource management, while protecting their heritage, rights, indigenous knowledge and cultures.\textsuperscript{53}

Reproductive Health in India

Every year about 500,000 women worldwide die from complications arising from pregnancy and childbirth. Thirty times suffers more injuries, infections and other

\textsuperscript{49} Ibid
\textsuperscript{50} Report of the International Fund for Agriculture Development (IFAD), November 2011, ‘Enabling Poor Rural People to Overcome Poverty in India’, pp. 1-8 Ifad@ifad.org, www.ifad.org
\textsuperscript{51} Ibid
\textsuperscript{52} Ibid
\textsuperscript{53} Ibid
complications related to pregnancy. To achieve Millennium Development Goal 5—reducing maternal mortality ratios by three quarters between 1990 and 2015—developing countries must expend access to skilled birth attendants, emergency obstetric services and reproductive health care, bringing these services together within a functioning health and referral system. Countries must also address the broader social issues that inhibit women from seeking health care. Increasing access to contraception can significantly reduce maternal deaths simply by reducing the number of times that a women became pregnant—and so the risks from related complications. If the unmet needs for contraception were filled and women had only the number of pregnancies at the intervals they wanted, maternal mortality would drop 20-35%. In addition, unsafe abortions—those performed by untrained providers, under unhygienic conditions or both kill an estimated 78,000 woman a year, or about 13% of all maternal deaths. Thus achieving Goal 5 will require rapidly expanding access to reproductive health care.54

The emergence of a new perspective on family planning was introduced in 1980s. The Ministry of Health and Family Welfare proclaimed in a policy statement that ‘compulsion in the area of family welfare must be ruled out for all times come. Even the name of the program changed from that of ‘family planning’ to ‘family welfare’. As a Family Welfare program, it brought a fresh perspective by emphasizing the importance of responsible or Planned Parenthood. It is focused on promoting change not only in attitudes about family size and planning, but related, issues such as age at marriage, dowry, son preference, and female foeticide. During the 1980s, the Indian State also reiterated its commitment to population control as an integrated part of general development.55

In fact, the global women’s movement had played a vital role in changing the course of the FPP. Women’s groups’ world-wide were critical of the over-emphasis on ‘demographic goals’ and the targeting of women solely as ‘procreators’ in FPP’s.


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Applying the feminist principle, women activists argued that every woman has the right to control and enjoy her own sexuality, to regulate her fertility through access to information and services, to remain free of reproductive morbidity and to bear and raise healthy children. As a consequence, the emphasis was to suggest changes in the existing family planning approaches to reallocate resources among different current programs, to adopt the life-cycle approach in order to include women of all age groups, and to empower women to enjoy and manage their sexuality without the fear of unwanted pregnancies. Therefore, the impetus provided by the women’s movement and the forceful voicing of concerns regarding women’s health at the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, led to a paradigm shift in India’s FPP. It moved from the existing numerical, methodspecific target approach towards an approach of reproductive health care and women’s rights and empowerment.\(^{56}\)

The concept based itself on the belief that it ‘moves birth control out from under the umbrella of family planning and planned parenthood, with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health’. Thus, reproductive health was posed as an ideal, a dream to move towards—but this necessarily requires us to come up with different strategies specific to the varying social contexts prevailing in different parts of the globe. In this regard, what needs to be pointed out is the fact that our planners often fail to understand that there is a common thread linking reproductive health, general health and socioeconomic conditions. And to our utmost surprise, the concept of reproductive health has failed to clearly articulate these inter-linkages.

However, reproductive health issues suddenly catapulted to center-stage by the media and by international agencies when the ICPD Program of Action focused centrally on these issues. At this historical juncture, it is important to state that the demand for reproductive rights and health did not originate in Cairo, and that it is not an original idea formulated by population control agencies or international agencies that have supported them. The women’s movements’ definition of reproductive rights since its inception has included reproductive health as an integral part of it.\(^{57}\)
The definition of reproductive rights is essentially understood as the right of women to:

- Regulate their own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies, and carrying wanted pregnancies to term;
- Bear and raise healthy children;
- Remain free of disease, disability, fear, pain or death associated with reproduction (and the reproductive system) and sexuality.

Reproductive health is thus seen as a part of women’s reproductive rights. In addressing the needs of women and men, such an approach places an emphasis on developing programmes that enable clients to make informed choices; receive screening and education and counseling services for responsible and healthy sexuality; access services for preventing unwanted pregnancy, safe abortion, maternity care and child survival, and for the prevention and management of reproductive morbidity including reproductive tract infections (RTIs), sexually transmitted infections (STIs), and gynecological problems. But the problem lies in the fact that there exists a wide social and cultural gap that exists between the providers and users of services. Thereby, the user’s perspective needs to be emphasized within the overall framework of the service delivery system and particularly that of women as they face a host of problems to access the health services. More important, the RH services must be integrated within the ongoing existing programs.

Population control programs have been too narrowly focused on limiting population through the provision of family planning services. In India, the focus has been primarily to achieve demographic targets by increasing coverage with contraceptives with a focus on female sterilization. Stressing only the family planning dimension of reproductive health and subsequently neglecting women’s choices has failed both to improve the reproductive health situation substantially and to satisfy the UN might need for family planning. The current focus on reproductive health, including the shift in 1997 to the reproductive and child health program, signifies the need to reorient program strategies. The need is to centre more on a holistic reproductive health approach, informed client choices and women-based services—services that respond to clients’ and especially women’s health needs in ways that are
sensitive to the socio-cultural constraints women and adolescent girls face in acquiring the services and expressing health needs. It is also required to encourage male participation by ensuring that men take responsibility for family planning, and child rearing.

Following, the Government of India set in motion a process to translate the ICPD Program of Action within the national context in the Cairo conference. In November 1994, a joint mission of the Government of India and the World Bank was set up to undertake a sectoral review. In 1995, the World Bank submitted a report entitled ‘India’s Family Welfare Program: Toward a Reproductive and Child Health Approach’ to the Government of India. The government decided to adopt the policy and as a first step, removed method-specific contraceptive targets nationwide. As part of India’s commitment to the ICPD, the government launched the National Reproductive and Child Health program in October 1997. The RCH program was designed to be ‘people centered’ and ‘rights-oriented’. The thrust of the program was on effecting changes both at the level of policy as well as at program management and implementation levels. The new approach encourages smaller families by helping clients meet their own health and family planning goals. Instead of birth control being the sole focus, it seeks to provide a full range of maternal and child health services.

The Reproductive and Child Health Programme, lays emphasis on a comprehensive approach which includes a ‘package’ of services for the prevention and management of unwanted pregnancies; promotion of safe motherhood and child survival; nutritional services for vulnerable groups; services for the prevention and management of reproductive tract infections; and reproductive health services for adolescents.

The magnitude of women’s reproductive health problems in India is immense. The rates of mortality and morbidity related to pregnancy and childbirth continues to remain high. This is primarily due to the inaccessibility of timely and quality emergency obstetric care for a majority of pregnant women in rural areas and lack of safe abortion care. India accounts for 19 per cent of all live births world-wide, and for as many as 27 per cent of all maternal deaths. It is essential to understand that women bear a disproportionate burden of reproductive health problems.
The first Health Survey and Development Committee constituted, way back in 1943, recommended that reduction of sickness and mortality among women and children should be amongst the highest priority issues in any programme of health development. Similar concerns were raised by the Health Survey and Planning Committee in 1961. Subsequently, maternal and child health issues have been recognized as priority development issues and maternal and child health issues have been identified as a priority for health services development in the country as is reflected through different Five-year Development Plans as well as through National Health Policies and National Population Policies. In fact, the rationale behind the introduction of family planning in India was the poor health status of women and children and not the rapid population growth.

Since 1952, the Indian family planning programme has evolved through a number of stages, has changed its focus and has vacillated in terms of intensity and manner of commitment to it. In the early years, the programme witnessed a period of caution and its impact was hardly felt; in the decade 1965-75, the programme was strengthened and consolidated and the integration of family planning with maternal and child health services was introduced. It was also during this decade that abortion was legalized and the ratio of health workers to population was increased. At the same time, the Minimum Needs Programme was formulated which combined health and nutrition with fertility reduction and the incentive system was tied up.

Reproductive and child health and mortality may also be viewed as an indicator of social and economic well-being. It reflects not only the magnitude of those health problems which are directly responsible for the death of women, infants and young children-the most vulnerable group of the society- but also the net effect of a multitude of other factors including appropriate health care and the environmental conditions to which women and children are exposed. The relevance of reproductive and child mortality in the processes of social and economic development may be

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60 First Five Year Plan, July 1951-56, Chapter 15, A Draft Outline, Planning Commission, Government of India, New Delhi, pp. 197-206
judged from the fact that maternal and child mortality are included in the list of the Millennium Development Goals that have now universally been accepted as the yardstick of development efforts by governments, donors and non-government organizations.

One of the Millennium Development Goals 8 (MDGs) that has made some progress, although the risk of death associated with the complications of pregnancy and delivery, known as the maternal mortality ratio in India, is estimated to be 555 per 100,000 live births in 1992, 301 maternal deaths for every 100 thousand live births for the period 2001-03. On the other hand, it has estimated a maternal mortality ratio of around 330 maternal deaths for every 100 thousand live births for the year 2002. This risk is estimated to have decreased from around 1355 maternal deaths for every 100 thousand live births during 1957-60 to about 330 maternal deaths for every 100 thousand live births in the year 2002. However, the prevailing level of maternal mortality is still well above the goal of a maternal mortality ratio of 200 maternal deaths for every 100 thousand live births by 2000 set under the Child Survival and Safe Motherhood Program and a goal of 100 maternal deaths for every 100 thousand live births set under the Reproductive and Child Health Program. An extrapolation of past trends suggests that there is little probability of achieving these goals.62

The replacement of the concept of 'women's health' by 'reproductive health' is yet another key contribution of the advocates of human development. Instead of visualizing health issues as women of different regions see it for them; they join themselves into universal reproductive health and rights issues. As a consequence of their own priorities, they never really examined either the epidemiological basis of reproductive health or the reasons behind some women's silence concerning on reproductive health problems. The immensity of women's health problems and the social constraints on women's lives would have revealed the inadequacy of their isolated strategy in the context of the expressed needs of women for land rights, freedom from atrocities, food, security systems, minimum wages and communal

harmony along with the need for health services. We explore in a later section, patterns of women's illness and its implications for planning health care services.63

Data from Sample Registration Sample (SRS) indicate that the major causes of maternal mortality continue to be unsafe abortions, ante partum and post-partum hemorrhage, anemia, obstructed labor, hypertensive disorders and post-partum sepsis. There has been no major change in the causes of maternal mortality over the years. A table is given below:

Table 16: Causes of Maternal Death (%) (2000)

<table>
<thead>
<tr>
<th>Causes</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>30</td>
</tr>
<tr>
<td>Anemia</td>
<td>19</td>
</tr>
<tr>
<td>Sepsis</td>
<td>16</td>
</tr>
<tr>
<td>Obstructed-labor</td>
<td>10</td>
</tr>
<tr>
<td>Abortion</td>
<td>8</td>
</tr>
<tr>
<td>Toxemia</td>
<td>8</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
</tr>
</tbody>
</table>

Causes of Maternal Deaths in India, 2001-03

![Figure 7]

Women's reproductive health and reproductive rights are among the most debated social issues during the past two decades. After a downturn during the politically conservative 1980s, the third wave feminist movement of the 1990s focused on issues of women's sexual rights, reproductive health care, and gender equality.

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Conducted researches, involved women's rights in the area of reproductive health as a neglected area and called for increased attention on the part of social scientists to reproductive rights and reproductive health policies.  

During the 1990s, maternal deaths in India decreased at an average annual rate of around 1.48 per cent year. During the same period, the risk of death associated with pregnancy and delivery, measured in terms of maternal mortality ratio, decreased at an average annual rate of more than 1.9 per cent year while the birth rate decreased at the rate of around 1.5 per cent per year. The decrease in the maternal mortality ratio and the birth rate, however, was compensated by an increase of around 1.95 per cent per year in the population. In the urban areas, the decline in the annual number of maternal deaths was slower than that in the rural areas during the 1990s, despite the fact that the decline in the birth rate was faster in the urban as compared to the rural areas. However, population growth in the urban areas was more rapid than that in the rural areas probably because of both rural to urban migration as well as classification of rural areas as urban areas.  

Operationalizing a comprehensive reproductive health care system, however, can have only a limited impact on reducing the lifetime risk of a maternal death. The reason is that the lifetime risk of a maternal death depends upon the probability of conception also. Repeated pregnancies at very short intervals increase the lifetime risk of maternal death considerably in terms of exposure to complications associated with pregnancy and delivery as well as in terms of poor health of the women. Reduction in the risk of conception either through spacing between successive births or through limiting the number of births is therefore essential for reducing the lifetime risk of a maternal death. Reduction in the risk of conception through fertility regulation may also be significant in situations where inadequate obstetric care facilities are available. To reduce the life-time risk of maternal death, therefore, a comprehensive reproductive risk avoidance system comprising of both comprehensive health care system and universal fertility regulation is necessary.

66 Ibid
Table 17: Reproductive and Child Health Goals in India\textsuperscript{67}

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR (Per 1000 live births)</td>
<td>&lt;45</td>
<td>&lt;30</td>
<td>&lt;30</td>
<td>Reduce by 2/3 by 2015</td>
</tr>
<tr>
<td>Under 5 Mortality Rate</td>
<td></td>
<td></td>
<td></td>
<td>Reduce by 3/4 by 2015</td>
</tr>
<tr>
<td>(Per 1000 live births)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (Per 1000 live births)</td>
<td>200</td>
<td>&lt;100</td>
<td>&lt;100</td>
<td></td>
</tr>
<tr>
<td>TFR (Births per woman)</td>
<td>2.3</td>
<td>2.1</td>
<td>2.1</td>
<td></td>
</tr>
</tbody>
</table>

Source: Government of India (no date).

MMR has reduced from 254 per 100000 live births in 2004-06 to 212 per 100000 live births in 2007-09 (SRS), a reduction of 42 points over a three year period or 14 points per year on an average. In the four southern states, Kerala and Tamil Nadu have already achieved the goal of a MMR of 100 per 100000 live births but, within the group, Karnataka lags significantly behind with a MMR of 178 per 100000 live births and at current rate of decline would only reach to about 130 per 100000 live births in the year 2012.\textsuperscript{68}

![Maternal Mortality Ratio](image)

Figure 8

\textsuperscript{67} Ibid, p. 187

\textsuperscript{68} Annual Report to the People on Health, December 2011, Government of India, Ministry of Health and Family Welfare, New Delhi, p. 22

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In the large states the MMR is 149 per 100000 live births. Many of these states have shown improvement in the last few years, notably Assam, Madhya Pradesh and Rajasthan. MMR declined at only 3 per 100000 live births during 2004-06-recorded a decline of 30 points per year- but still at a MMR of 390 per 100000 live births in Assam. Assam remains India's most maternal death prone state. It is the State with lowest MMR.\(^{69}\)

The IMR, according to SRS 2010 at national level was 47 per 1000 live births in 2010 as compared to 50 in 2009. The IMR has shown a steady decline from 129 deaths per 1000 live births in 1971 to the current level. The IMR is higher in respect of Female (49) as compared to Male (46). IMR is also higher in rural areas (51 per 1000 live births) as compared to urban areas (31 per 1000 live births) during 2010. The IMR varied very widely across the states; Kerala with an IMR of 13 is the best performing state among the bigger States in the country.\(^{70}\)

**Birth Control Programs in India**

India's achievements are in the birth rate to control population growth has been based on the adoption of the small family norm through the use of family planning methods. The justification that was put forward way back in 1952 in favour of family planning, however, was the rationale of health of family planning. The major challenge for the First Five Year Plan in regards of health was the population growth and therefore the greater emphasis was on population control through family planning. The application of medical knowledge and social care has lowered the death-rate, while the birth-rate remains fairly constant. This has lead to the rapid increase in the growth of population. While a lowering of the birth-rate may occur as a result of improvements in the standards of living, such improvements are not likely to materialize if there is a concurrent increase of population. It is, therefore, apparent that population control can be achieved only by the reduction of the birth-rate to the extent necessary to stabilize the population at a level consistent with the requirements of national economy. This can be secured only by the realization of the need for family limitations on a wide

\(^{69}\) Ibid
\(^{70}\) Ibid
scale by the people. The main appeal for family planning is based on considerations of the health and welfare of the family.\textsuperscript{71}

During the Second Five Year Plan, the Family Planning programme was primarily directed to the building up of an active public opinion in favour of family planning and the promotion of family planning advice and service on the basis of existing knowledge. At the same time demographic as well as medical and biological studies were taken up. Assistance in the shape of subsidies or grants was giving to States, local authorities, voluntary organizations and scientific institutions for about 115 family planning clinics and for 19 research schemes relating to biological and demographic problems. The establishment of a central training and clinical institute and a rural training unit near was planned. A contraceptive testing and evolution centre was developed at Bombay. It was made necessary that training in family planning should be imparted to all medical and nursing students. It was planned that all hospitals and an increasing number of dispensaries should develop in due course a family planning service. It was also proposed to promote actively medical, biological and demographic research. A provision of nearly Rs. 5 crore had been allocated for family planning programmes. It was expected that about 300 urban and 2,000 rural clinics would be set up in the course of the Second Plan.\textsuperscript{72}

According to the tentative programmes drawn up for the Third Plan, the number of family planning clinics was likely to be increased from about 1,800 at the end of the Second Plan to about 8,200. Of the latter, about 6,100 clinics was proposed to be in rural areas and 2,100 in urban areas. Distribution of simple contraceptives and general advice could be entrusted in a much larger measure to voluntary organizations, to paramedical personnel and to dais specially trained in family planning work. The additional personnel and other expenditure required for enabling every primary health center to provide family planning services was proposed to be incorporated in an integral manner into the programme for primary health centres. The main difficulty realized was of securing the, requisite trained personnel specially women workers. For expanding training facilities, it was essential to organize a large number of intensive short-term courses. In the urban areas it was proposed that the

\textsuperscript{71} First Five Year Plan, July 1951-56, A Draft Outline, Planning Commission, Government of India, part III, Chapter 15, pp. 197-206

\textsuperscript{72} Second Five Year Plan, 1956-1961, Planning Commission, Government of India, chpt. XXV, pp. 333-554
greater use should be made of private medical prectioners in providing advice, distributing supplies and, to the extent possible, in under taking sterilization.\textsuperscript{73}

A large-scale family planning programme had to be supported necessarily by indigenous manufacture of contraceptives. In this respect, although there had been some progress, the situation could not be said to be satisfactory. The estimates of supplies, which were current hitherto, were based on a programme of very small dimensions. In the early stages and for certain sections of the population, the provision of supplies free of cost and subsidized rates was necessary. It was recommended that detailed plans for the production of contraceptives, both by the Government and by private firms, should be drawn up as a matter of high priority, keeping in view the objective that scale needed.\textsuperscript{74}

An expended programme of research was to be undertaken in the Third Plan. Amongst others, the following aspects were to be investigated:

- Development of studies of human genetics
- Studies in the physiology of reproduction
- Development of more effective local contraceptives
- Development of a suitable oral contraceptives
- Follow-up of sterilization cases, both male and female, to investigate possible after effects in such cases.

Over the past five years (before the Third Five Year Plan), facilities for sterilization operations had been extended in several states and about 1,25,000 operations was carried out. Within the programme of family planning, sterilization undertaken on the basis of voluntary choice was a valuable contribution to be made in the Third Five Year Plan. It was visualized that during the Third Plan facilities for sterilization will be extended to district hospitals, sub-facilities for surgical work. With the help of mobile units, these facilities could be extended further.\textsuperscript{75}

The decline of population in 1968 in comparison to 1961, i.e. population in 1961 figure was 527 million while in 1968 it declined to 445 million was the result of

\textsuperscript{73} Third Five Year Plan, 1961-1966, Planning Commission, Government of India, chapt. XXXII, pp. 651-675
\textsuperscript{74} ibid
\textsuperscript{75} ibid
a sharp fall in mortality rate without any significant changes in the fertility rate. The birth rate appears to have remained unchanged around 41 per thousand populations during the greater part of the past two decades up to 1965-66. At the end of the Third Plan, there were 3,676 rural family welfare planning centers, 7,081 rural sub-centres and 1,381 urban family welfare planning centres. These centres provided supplies, services and advices on family planning. Twenty-eight centres were established for training in which 7,641 personnel took regular courses and 34,484 short-term courses. Some progress was made in research, conducted in seven demographic centres and seven communication action research centres. Eight centres conduct studies on biomedical aspects of family planning. For technical support, a Central Family Planning Institute was established at Delhi. 76

On the eve of Fourth Plan, five Central Institutes and 43 State Family Planning Training Centres were Functioning. There were 4,326 rural family welfare planning centres, 22,826 rural sub-centres and 1,797 urban family welfare planning centres in operation. The progress in opening sub-centres had been unsatisfactory. This was due to shortage of auxiliary nurse-mid-wives and want of suitable accommodation for Family Planning annexes to Primary Healthcare Centres had been constructed and buildings of 2,770 sub-centres had been taken up. 77

During the Fifth Plan 516.00 crore was provided for programmes relating to target family welfare planning. Maternity and child health programmes was to be vigorously pursued and funds for this purpose would be made available on the basis of performance. Research and evaluation facilities were to be strengthened. Funds for completion of incomplete buildings and for construction of essential buildings for Rural Family Welfare Planning Centres had to be provided. 288 New Rural Family Welfare Planning Centres was to be opened in a phased manner. 78

In the light of the progress made in the initial years of the Sixth Plan, the health policy targeted a net-reproduction rate of 1 by the year 2000- a review, however, indicated that this goal would be reached only by the period 2006-2011. The Family Welfare Programme envisaged the following goals for the year 1990:

77 Ibid
78 Fifth Five Year Plan, 1974-1979, Planning Commission, Government of India, chpt. VI, pp. 255-281
- Effective couple protection rate 42 percent
- Crude birth rate per thousand population 29.1 percent
- Crude death rate per thousand population 10.4 percent
- Infant mortality rate per 90 percent thousand population
- Immunization Universal coverage
- Ante-natal care 75 percent

To reach the above targets, particularly 42 percent couple protection, the Seventh Plan stipulated 31 million sterilizations, 21.25 million IUD insertions and, 14.5 million CC users.\textsuperscript{79}

Targets for family planning, particularly sterilization, were to be achieved through special drives and camps. There was need to develop the programme on a sustained and continued basis. Laparoscopic sterilization had become very popular and availability of laparoscopes and trained personnel had to be stepped up. Much greater effort was adopted for spreading the use of conventional contraceptives and oral pills and steps were taken to make them freely and widely available, through an effective social marketing mechanism.\textsuperscript{80}

To achieve the national long term demographic goals, educating and enlightening people on the benefits of late marriage and its social enforcement was greatly emphasized. Special programmes and incentives oriented towards eligible couples, particularly in the younger age-groups, were needed. Incentives for attracting couples with two children and younger age-groups were necessary.\textsuperscript{81}

High growth rate of the population continued to be one of the major problems facing the country on the eve of the Eighth Five Year Plan. Although the 1991 Census recorded a marginal decline in the annual growth rate of population from 2.22 percent in 1971-81 to 2.11 percent in 1981-91 this would still mean an addition of 18 million people to the country's population annually. The fast rate of population growth meant that the economy has to grow faster to protect the already low level of per capita availability of food, clothing, housing, employment and social services. The country

\textsuperscript{79} Seventh Five Year Plan, 1985-1990, Government of India, Planning Commission, Chapter 9, The Manager, Government of India Press, New Delhi, pp. 190-201
\textsuperscript{80} Ibid
\textsuperscript{81} Ibid
was committed to social and economic justice to the millions of people living under
the condition of poverty and deprivation. Failure to do so within a reasonable time
frame may generate social tensions and unrest. Beside this, the environmental
degradation which was associated with unchecked growth of population carried the
inherent risk of natural calamities and distress. In this context, population control
assumed an overriding importance in the Eighth Plan.82

Reduction in the population growth rate was recognized as one of the priority
objectives during the Ninth Plan period. The current high population growth rate was
due to (a) the large size of the population in the reproductive age-group (estimated
contribution 60 percent), (b) higher fertility due to unmet need for contraception
(estimated contribution 20 percent) and (c) high wanted fertility due to prevailing high
IMR (estimated contribution about 20 percent).

The enabling objectives during the Ninth Plan period, therefore, was to reduce
the population growth rate by (a) meeting all the felt-needs for contraception and (b)
reducing the infant and maternal morbidity and mortality so that there will be
reduction in the desired level of fertility. The strategies during the Ninth Plan was (a)
to assess the needs for reproductive and child health at PHC level and undertake area-
specific micro planning and (b) to provide need based, demand-driven high quality,
integrated reproductive and child health care. The planning were the following:

- Bridging the gap in essential infrastructure and manpower through a flexible
approach and improving operational efficiency through investment in social,
behavioural and operational research.
- Providing additional assistance to poorly performing districts identified on the
basis of the 1991 census to fill existing gaps in infrastructure and manpower.
- Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives,
adequate in quantity and appropriate in quality.
- Promoting male participation in the Planned Parenthood movement and
increasing the level of acceptance of vasectomy.

82 Eighth Five Year Plan, 1992-1997, Government of India, Planning Commission, Chapter 12, Vol. 2,
Efforts were intensified to enhance the quality and coverage of family welfare services through (a) Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H, (b) Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management and (c) involvement of the industries, organized and unorganized sectors, agriculture workers and labour representatives.\(^3\)

As a part of the Plan exercise the Planning Commission and the Department of Family Welfare laid down targets for health and family welfare activities and for demographic indicators. Over the years, there was progressive improvement in the achievements of most of these, because the targets set were realistic and necessary inputs were provided for their achievements.\(^4\) The major achievements of the Family Welfare Programme included the following:

- Reduction in Crude Birth Rate (CBR) from 40.8 (1951 Census) to 27.4 in 1996 (SRS 96).
- Reduction in Infant Mortality Rate (IMR) from 146 in 1951 to 72 in 1996 (SRS).
- Increase in Couple Protection Rate (CPR) from 10.4 percent (1970-71) to 45.4 percent (31.3.1997).

During the Ninth Plan period efforts were taken for all pregnant women. All pregnant women were screened for common problems such as anaemia, infections obstetric problems and the identified ‘high risk’ pregnant women and were referred to PHC/CHC for appropriate management. Analysis of service data on ANC registration and deliveries reported for the year 1995-96 from 350 districts indicated that there was an increase in the number of hospital deliveries and deliveries attended by trained personal. In States like Kerala over 90 percent of deliveries were in institutions and prenatal mortality rates were conducted by untrained persons. Consequently, maternal and prenatal mortality rates continued to be high. During the Ninth Plan efforts were made to promote institutional deliveries both in urban and rural areas. In States where majority of deliveries still occurred at home, efforts were made to train Traditional


\(^{4}\) Ibid
Birth Attendants (TBAs) through Incentive Dai’s Training Programme and to increase availability and access to Disposable Delivery Kits. In the Ninth Plan period and easy-to-follow protocol was developed and made available to all health care providers. In “low risk cases”, if home delivery is anticipated, provision was made for aseptic delivery by trained persons. Unpredictable complications could arise even during apparently normal labour; rapid transportation of these women to hospital for emergency obstetric care was essential to reduce morbidity and mortality during delivery. Local Panchayats, NGOs and women’s organizations were to play an important role in this respect. In the postpartum period early detection and management of infection, support for breast feeding and nutrition counseling would receive due attention.

The paradigm shift, which began in the Ninth Plan, was fully operationalized. The shift was from (a) demographic targets to focusing on enabling couples to achieve their reproductive goals, (b) method specific contraceptive targets to meeting all the unmet needs for contraception to reduce unwanted pregnancies, (c) numerous vertical programmes for family planning and maternal and child health to integrated health care for women and children, (d) centrally defined targets to community need assessment and decentralized area specific micro planning and implementation of programme for health care for women and children, to reduce infant mortality and reduce high desired fertility, (e) quantitative coverage to emphasis on quality and content of care, (f) predominantly women centered programmes to meeting the health care needs of the family with emphasis on involvement of men in planned parenthood, (g) supply driven service delivery to need and demand driven service; improved logistics for ensuring adequate and timely supplies to meet the needs and (h) service provision based on providers’ perception to addressing choices and conveniences of

85 Ibid
86 Ibid
the couples.\textsuperscript{87} Improvement in the health status of a population is recognized as
instrumental for increasing productivity and economic growth. The health system in
India is a mix of the public and the private sectors, with the NGO/civil society sector
planning a small but important role. The Tenth Five Year Plan envisaged devolving
responsibilities and fund for health care to Panchayati Raj Institutions, (PRIs),
reorganizing and restructuring public health care systems, mainstreaming Indian
Systems of Medicine (ISM), and strengthening interventions for the management of
communicable and non-communicable diseases. India was on the course in respect of
the decadal growth rate of the population, close to eradicating leprosy and polio, and
health outcomes were slowly improving. However, it was evident that the Tenth Plan
targets and goals on maternal and infant mortality were missing. Malnourishment was
an issue, and the proportion of chronically under-nourished children and anaemic
women remained high. The devolution of responsibilities and funds to the Panchayati
Raj institutions did not happen. Containing and reversing the spread of HIV/AIDS
was a big challenge. The management of tuberculosis is progressed well, while cancer
and malaria remained significantly under-funded, although the management of
malaria was revitalized. Several new initiatives in the health, family welfare and
AYUSH sectors between 2002 and 2005 were highlighted.\textsuperscript{88}
The two data annexure at the end indicate selected health demographic and economic
indicators and highlight the changes between 1951 and 2000.\textsuperscript{89}

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1951</th>
<th>1981</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>36.7</td>
<td>54</td>
<td>64.6 (RGI)</td>
</tr>
<tr>
<td>Crude Birth Rate</td>
<td>40.8</td>
<td>33.5 (SRS)</td>
<td>26.1 (99 SRS)</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>25</td>
<td>12.5 (SRS)</td>
<td>8.7 (99 SRS)</td>
</tr>
<tr>
<td>MMR</td>
<td>146</td>
<td>110</td>
<td>70 (99 SRS)</td>
</tr>
</tbody>
</table>

The impact of family planning on fertility can be measured in relation to the
official efforts towards population stabilization as well as in the context of regulating
fertility including both programme effects and non-programme effects. The impact of
the programme efforts can be measured on the basis of the programme service

\textsuperscript{87} Tenth Five Year Plan, 2002-2007, Planning Commission, Government of India, Academic
Foundation, New Delhi, 2003, pp. 75-95

\textsuperscript{88} Ibid

\textsuperscript{89} R. Srinivasan, “Health Care in India- 2025: issues and prospectus”, pp. 1-35
http://planningcommission.nic.in/reports/sereport/servision2025/health.pdf

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statistics as well as on the basis of the information on the prevalence of contraceptive but the impact of non-programme family planning efforts can be measured only on the basis of the information related to the prevalence of contraception.90

Estimates of the number of births averted through official family welfare programme are available on the basis of the programme service statistics. These estimates suggest that the annual number of births averted as the result of the official family welfare programme in India increased from around 3.03 million during 1974-75 to around 17 million during 2004-05. This means that, in the year 1974-75, the official family planning efforts could avert, on average, 29 births per 1000 eligible couple per year. This number increased to 63 in 1985-86 and 90 in the year 1995-96. This proportion increased to more than 37 per cent in 1995-96 but after this, the increase has slowed down considerably.91

The official programme service statistics do not provide state specific estimates of the number of births averted as the result of contraception. However, state specific estimates of the births averted derive through the contraceptive prevalence model indicate that the number of births averted as the result of contraception varies widely across the states. In Himachal Pradesh, Andhra Pradesh, Karnataka, Mizoram, and Maharashtra, more than 250 births per 1000 eligible couples were estimated to have been averted in the year 2004-05 as the result of the programme as well as non-programme contraception with Himachal Pradesh topping the list with an estimated 275 births averted per 1000 eligible couples during the year 2004-05. By contrast, in Manipur, only about 23 births per 1000 eligible couples could be averted during the year 2004-05. In addition, in Nagaland, Meghalaya, Assam and Goa, the number of births averted per 1000 eligible couples in the year 2004-05 was estimated to be less than 50 per 1000 eligible couples per year.92

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91 Ibid, p. 60
92 Ibid
**Figure 9**

**Child Mortality according to GOI report 2005-07**

- Under 5 years: 81
- In the 1 year: 58
- Within 7 days: 26
- Between 7 to 28 days: 11

**Figure 10**

**Utilization of Services**

- % of births assisted by SBA

- India 1998-99
- India 2005-06
Figure 11

Utilization of Services by Subregion 2005-06


Figure 12

Place of Delivery

Caesarean Section (C-section)

Utilization of services 2005-06


Figure 13

Utilization of Services by Wealth Quintile (2005-06)


Figure 14
**Utilization of Services by Wealth Quintile**

Figure 15

**Perinatal Mortality Rate**  
(2005-06)

Figure 16
Neonatal and Post-Neonatal Mortality
(per 1000 live births)


Figure 17

Nutrition, Anemia in Pregnancy
(1998-99)

India 1998-99

Mild anemia ▼ Mordrate anemia ▲ Severe anemia

25.4
21.8

India 2005-06

30.6
25.8


Figure 18
**Figure 19**

![Total Fertility Rate](chart)

- **India 1992/93**: 0.8
- **India 1998/99**: 0.7
- **India 2005/06**: 0.8

- **Wanted total fertility rate**
- **Unwanted total fertility rate**


**Figure 20**

![Teenage Pregnancy](chart)

- **Total**:
  - **India 1992/93**: 4
  - **India 1998/99**: 3
  - **India 2005/06**: 4

- **Rural**:
  - **India 1992/93**: 3
  - **India 1998/99**: 2
  - **India 2005/06**: 3

- **Urban**:
  - **India 1992/93**: 5
  - **India 1998/99**: 4
  - **India 2005/06**: 5


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