Chapter V

Women's Development Programmes in Jammu & Kashmir
"Mother's laps is the first school of thought/Learning and at the same time first and universal seat of Socialization".

Women constitute 48% of the population of Jammu and Kashmir. From the ancient period till now, the status of women has undergone several changes. Although majority of them have been subjected to various socio-economic and legal difficulties in the past, yet they have played a vital role in the family and the community. Perhaps it is this historical fact that led the Late Prime Minister of India Jawaharlal Nehru to remark "Women in Kashmir have played a notable part in its history. Broadly speaking woman has greater rights there than in other parts of India".¹

Due to low status and lower educational standards, women have always been treated as servile and vulnerable section of society. No doubt, during the Muslim rule in Kashmir certain reforms like eradication of 'Sati' were introduced, but new social problems emerged in the society to which women became an easy prey. Following this, bold steps to check these problems were envisaged in the constitution of J&K.² According to the directive principles,

"For Women the State is directed to secure to them the right to equal pay for equal work. It orders the state to secure to them the right to maternity benefits as well as adequate medical care in all
employments. It advises the state to secure to the women the right to reasonable maintenance, extending to cases of married women who have been divorced or abandoned. It instructs the state to secure to them the right to full equality in all social, educational, political and legal matters. The constitution advises the state to strive to secure for women special protection against discourtesy, defamation, hooliganism and other forms of misconduct. Despite these strong constitutional injunctions, the status of women has not shown much improvement as was expected at the time of independence. In the following discussions an attempted will be made to analyse the social development of women in J&K in relation to the policies and processes both at micro and macro levels. A survey of this kind will be helpful in assessing the impact of the developmental policies adopted so far.

Development and women

Development today is human development\(^3\). The accent is on the formation of human capabilities such as improved health, knowledge and skills and the use to which these are put inorder to improve the quality of life. The development paradigm, therefore, puts the focus of development on people and their participation.

Human development implies that people should stand as kernel objective of development. This ensures people's participation in the development process. The recent UN Human Development Report quotes as, "development must be participatory and for this people must have the opportunity to participate and to invest in the development of their capabilities. They also must have the opportunity to put their capabilities to use to be fully involved in all
aspects of life, to express themselves freely and collectively.⁴

In the present day world, non-participatory development can be considered as out of context. Today's developmental theories consider people as focal point and it is believed that true development must centre round the people so that it is concerned with their education, health, organisation, discipline and well-being. It is also realised that people can not be developed, they have to develop themselves by participating in activities that affect their lives. Participatory development simply means putting people first, giving meaning to their own actions and enabling them to take development initiatives. Participation then, as a social process and experience is not just a means adopted by government agencies to improve delivery systems of the Projects they seek to implement. In that case, it would end once the task was done.⁵ participation is an end in itself whose purpose is to develop and strengthen the capabilities of people to spearhead development themselves. It means, people must involve themselves in decision making, implementation and evaluation of projects, which they have shaped and given to themselves.

In the delineation of the above discussion, we can argue that development is human oriented only when it encompasses the participation and empowerment of people. It
has not only to do with the policies and programmes but feelings, preferences and needs of people.

In this backdrop, let us discuss the status of women in India and look at the programmes and their performance in meeting these needs of women.

The extent to which women are integrated in the process of development in each country is examined from three broader perspectives propounded by United Nations as relating with:

(a) Their relative share in the benefits that accrue from social and economic development;

(b) How far they have been able to participate in modern economic activities on equal terms with men.

(c) To what extent have development activities had an impact on women's specific needs and problems.

Women and Developmental Programmes

In the following discussion the status of women will be analysed in the above broader framework. The hierarchical structure of Indian Society with its diverse and complex socio-economic institutions, organisational patterns and
cultural values makes it difficult for uniform policies and programmes to be equally effective and beneficial for different groups. Therefore, the planned intervention launched through Five Year Plans also could not bring about much significant changes in the socio-economic development of women in India. The situation remained more or less unchanged till early seventies. The year 1971 marks the landmark as it was during this year when a committee on 'The Status of Women in India' was set up to undertake a comprehensive examination of all questions relating to the rights and the status of women in the context of changing socio-economic milieu in India and problems relating to the advancement of women.

It was in the light of the recommendations of the committee, that the government came forward with a promising and integrative approach on women's development.

Women's development which continued as a part of social welfare sector till 1985, never received its due share and importance till it was made as a component of human resource development. Programmes for women's development from 1951 to 1974 were welfare oriented. The major areas focused during this period included education, health, maternity services and supplementary feeding. On the other hand Fifth Five Year Plan (1974-78) supported economic development, employment and training for women as the principal focus for
their socio-economic development. While as the sixth plan (1980-85) taking into consideration the report of the committee on the status of women, adopted a multi-disciplinary approach with a three pronged thrust viz education, employment and health with a view of inculating confidence and generating awareness of their own potential among women. The family was recognised as a unit of development and women being an important member of the unit, were given special attention. Priority was accorded to women in the implementation of programmes under different sectors. 

During the seventh plan period (1985-90) and onwards, there was a major shift in the developmental strategy. It upholds people oriented perspective of development, fully grounded in local realities. It calls for a certain degree of flexibility built into the programmes, leaving the choice to the people based at local level regarding their needs and priorities.

**State initiatives and the Development of Women in J&K**

Social development of women puts the spotlight on their education, health and nutritional status, and employment and training.
One of the main lessons to be derived from the aspirational and developmental explosion which has shaken the world during last 40 years, is the fact that education is a key variable in the process of economic and social development. In a very important sense education has never been an end in itself, but a means to an end; namely, a means of understanding controlling, altering and redesigning the human environment in its widest sense, to the end of achieving a better quality of life.  

The above remarks lead us to argue that the education can not be confined to a 'welfare framework'. Presently, this view is getting due recognition world over that education carries high potential for promoting development - socio-economic. This is much more relevant in the context of the changed meaning of development where emphasis on economic growth as a measure of development is replaced by a concern for improvement in living standards. Various studies have shown that high per capita incomes have not resulted in substantial improvements in social wellbeing. Education has a definite role to play in this context.

Soon after independence, the national and state leaders realised the importance of education as an important compendium for democracy and social order. The state was
likely to adopt. As such, it was imperative to begin with the process of the development of education according to the needs of society. Impetus was given to raise the literacy level of women and provide adequate opportunities for primary, higher and technical education. It was in this backdrop that the state government appointed in 1950 an Educational Reorganisation Committee with the main objective of Channelising the education at various stages and recognise the relevance of female education with particular reference to the changed conditions.\(^{10}\)

**Planning and Educational Development of Women**

After the recommendations of the Committee, certain positive steps were taken to establish a number of institutions to impart higher education at state cost. During 1951-52, there was only one university, 6 colleges for Arts and Sciences with an enrolment of 2417 students only. There were only 2 colleges for professional education and the enrolment in these colleges was only 65 students. There were a total 1266 High, Middle and Primary Schools with an enrolment of 128406 students. Due to the widespread illiteracy, traditions and customs and the non-availability of sufficient educational facilities, the number of female students was much less. Out of 0.64 lakh students at Primary level, there were only 0.07 lakh female students out of 0.19 lakh middle standard students, the number of females
was 0.05 lakh only and the figure for high school was 0.02 lakh out of a total strength of 0.21 lakh. The number of female educational institutions was very less. There were 175 (Primary), 37 (Middle), 7 (High School) and only 2 colleges in the state for female students only. On the other hand the total amount spent on education was Rs.35 lakhs only. But during VIII plan, outlay for education was raised to Rs.35,570.00 lakhs. For the same period, the number of female education institutions reached to 631. This increased the female enrolment from 15030 during 1951 to 60799 during 1960. Thus the recommendations adopted by the government started bringing desired fruits. Despite, this rise in the female enrolment due to lack of sufficient female institutions, poverty and other problems, most of the female students would leave their studies before reaching even middle standard. This was confirmed by the data collected under this study. Out of all the three hundred sample women, there are 54 cases who left their studies at early stages. The reasons varied and no common reason could be inferred. However, the majority of the respondents (83.33%) mentioned that due to financial problems and illiteracy of parents they left their studies. Out of 54 cases, only 7.40% argued that due to lack of educational facilities they left the studies. While 9.25% respondents mentioned that due to the burden of young children they had to leave their studies. These figures again confirm that the majority of the parents were illiterate and were engaged.
in agricultural occupations only and as a result they could not afford the expenses of the education of their children. At that time, the scholarship scheme was non-existent and the students from poor background could not be helped financially to continue their studies. In this context it is relevant to mention that the important reason for dropout is the illiteracy of parents as some of the studies (Mumtaz Ali-1984) show that financial support or financial wellbeing of parents does not necessarily help to change the attitude of parents. This is more acute when the mother is illiterate.11

The foregoing discussion lead us to argue that the general environment during the early decades of development in the state was adverse. Today there is a perceptible change in the outlook regarding women's development. Governmental Programmes for women now show an upward mobility from welfare to development. Despite all the infirmities of women's development, the progress in female literacy, though not satisfactory, has been on rise. Women have reached the literacy level of 28.22% (including all ages) in 1981 from a negligible percentage at the time of independence (see table 12).

Women's enrolment in institutions of higher education at national level has grown from mere 0.04 lakh in 1950-51 to 15.9 million in 1993-94. The enrolment of females for
the same period in J&K has grown from 15030 students in 1951 to 28.22 lakh in 1981. The institutions exclusively for women has also increased from 631 in 1951 to 4110 institutions in 1993-94. This includes 14 higher education institutions. There are two colleges which are exclusively for the professional training of women. Out of the total enrolment of women in the state, the number of women engaged in the professional courses has increased from 10 in 1951 to 1340 in 1994.12

On the other hand, the role of female teachers in promoting girl's education particularly in rural areas

<table>
<thead>
<tr>
<th>Census Year</th>
<th>Female Literacy</th>
<th>Birth Rate</th>
<th>Life Expectancy at birth</th>
<th>Infant Mortality Rate (Per Thousand)</th>
<th>Sex Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>09.28</td>
<td>32.3</td>
<td>44.70</td>
<td>68</td>
<td>14</td>
</tr>
<tr>
<td>1981</td>
<td>15.88</td>
<td>31.4</td>
<td>54.77</td>
<td>72</td>
<td>112</td>
</tr>
<tr>
<td>1991</td>
<td>28.22a</td>
<td>31.5</td>
<td>60.04</td>
<td>73</td>
<td>113</td>
</tr>
</tbody>
</table>


(a) Figures for 1991 are provisional
(b) Number of males against per hundred females.

has been emphasised as an important motivational factor. Therefore, during the last few years, women have got a preferential treatment in appointments as teachers,
particularly at elementary level. At the national level under the 'Black Board Operation' Scheme, a special provision for the creation of 93,303 posts at the primary level was included. Majority of the posts were to be filled with female candidates. According to the latest reports 69,926 posts have been filled. Of these, 57.39%\(^\text{13}\) have gone to females.

The State of J&K has also followed the suit in this direction and women are now given preference in the appointment as teachers. On the other hand the rising trend of female literates has allowed their increasing entry in to the higher institutions also. The total number of female teachers in school education was 19,641 in 1993-94. Out of this 6,384, 6,957 and 6,800 teachers were at Primary, Middle and High School level respectively. While, the total number of female teachers at school education level for 1950-51 was 609 only. The number of female teachers at higher education level in 1950-51 was 23 only. But there was a gradual increase in these figures during the last four decades and their number reached to 601 only in 1993-94. Out of these, their share in the professional education was 196 (32.61%)\(^\text{14}\) only. This sorry state of affairs can mainly be attributed to the low female literacy of 19% (excluding those below 7 years) for 1981. At the same time there was a lack of sufficient number of higher educational institutions and particularly the professional educational institutes. Till
1994 there were 15 such institutes and out of this only two institutes existed for females. Low female literacy at the same time is negatively related to the employment opportunities of women in the state. Available data reveals that out of the total employment in the state, the number of females has been very low. For example in the year 1983 there was a total number of 1.63 and 0.10 lakh persons employed in the Public and Private Sectors, respectively. Out of this, the number of females in the Public Sector was 13.5 thousand and 1.4 thousand in the Private Sector. These figures lead us to conclude that the percentage of female employees to the total employment was 8.6%\textsuperscript{15} in both the sectors.

Education and Occupation

The data collected under present study reveals that the majority of the women respondents in the sample households belonged to the income group of Rs.1000-25000. The number of such women was 166 (55.33%) and out of this 113 were illiterates and were generally engaged in the household activities. The number of literates (below graduates) was 51 and those graduates and above was two only. Those respondents who belonged to 26000 - 50000 income group were 92 (30.66%). Out of this 42 were illiterates, 45 literates and 5 were graduates and above. Finally the number of respondents in the income group of 51000 and above was 42

146
(14%) of the total 300 women respondents. Of this figure, 5 belonged to illiterate category, 25 to literate and 12 to college and above category. The figures in table 13 confirm a positive relationship between the education and employment. As the education level of the woman is high so are the employment avenues open for her. According to data in table 13, out of a total of 300 respondents the number of the illiterates is 160 (53.33%). Out of these the occupational status reveals that majority 99.37% women were engaged in the household chores. Only one respondent was doing a government job. This trend was found in all the urban, semi-urban and Rural areas. There were 121 (40.33%) respondents who were literate but below graduate level and their occupational status reveals that 99 (81.81) were doing household jobs and 16 (13.22%) respondents were employed in the public sector and 6 (4.95%) were in the private jobs. Out of these figures of 121 respondents 52 belonged to urban area and their occupational status was: household job 40 (76.92%), government job 9 (17.30%) and private job 3 (5.76%).

The number of illiterate respondents belonging to semi-urban area was 26 (16-25) and all of them were doing house jobs. The number of the literate respondents was 38 (31.40%) and out of this 31 (81.57%) were doing house jobs and 6 (15.78%) were engaged in the government jobs. Whereas, only one respondent was in the private job. Out of
160 illiterate respondents, 80 (50%) belonged to rural area. Out of all the 80 respondents a majority (98.75%) were doing household jobs. Almost the same trend was found among the literate respondents (90.32%) who were in the household jobs. This was followed by private jobs (6.45%).

It is interesting to note that as the educational level
Table 13
Nature of job of the sample women according to their educational status

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Educational Status</th>
<th>URBAN</th>
<th>SEMI-URBAN</th>
<th>RURAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Illiterate</td>
<td>54</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2.</td>
<td>Literate</td>
<td>40</td>
<td>9</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>3.</td>
<td>College &amp; above</td>
<td>01</td>
<td>8</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>Total</td>
<td>95</td>
<td>17</td>
<td>5</td>
<td>-</td>
</tr>
</tbody>
</table>

* Private job includes Business also.
** Literate includes from respondents below graduate level

Total:

- Household: 261 (87%)
- Government Job: 31 (10.33%)
- Private Job: 8 (2.66%)
- Labourers: Nil
of respondents goes high, there is a variation in the nature of occupation. According to the figures in Table 13, there were 19 (6.33%) respondents belonging to the graduate and above educational status in this area. Out of this only 15.78% were doing house job and the majority 73.68% were employed in government job. And 10.52% were engaged in the private job. This trend of education and employment correlation was found in all the three areas with minor variations.

Income and Education

Some of the recent studies have shown that there exists a definite relationship between the income of the parents and the educational status of their women and children. A study by P.V. Rajeev 1995 in the 15 states including Kerala, Bihar, Punjab, Haryana reveals that the states with higher per capita income are showing positive improvements in the quality of life and literacy rates. Haryana and Punjab with per capita income from Rs.7502 to 8373, are improving much better in the literacy rates (26.89%). The state of J&K is economically a backward state wherein the per capita income for 1989-90 was Rs.3636.16 On the other hand the number of families below poverty line was 13.34%.17 Thus it can be concluded that economic backwardness of the State has a direct bearing upon the literacy rates in the state. The same trend was found in the Anantnag district
under study.

This was again confirmed by the primary data collected in the same district. Figures in Table 14 reveal that out of a total number of 300 hundred respondents, 166 (55.33%) belonged to the families whose annual income was up to Rs.25,000. Out of 166 respondents a majority of 113 (68.07%) were illiterates. This was followed by the literates who were 51 (30.72%). There were only 2 respondents who had studied upto graduation level under this income category. For the rest of the respondents, the trend showed that with a rise in income level, the number of illiterates decreased and the number of literates increased. For example, the maximum number of illiterates was 5 which fell in the income group of Rs.51,000 and above. Out of a total (19) graduate respondents, 12 (63.15%) were found in the income group of Rs.51,000 and above. But this should not lead us to say that economic factor is the only determinant for educational status of the women. For this reason we have the example of Karela with per capita income of 3389 which is less than J&K. But the female literacy is much higher at 75.65% in Karela, while as it is only 28.89% in J&K. This was again confirmed by the data collected from the field. For example out of total 300 female respondents, 54 had left their studies at early stages. When they were asked about the reasons responsible for it, a majority (83.33%) said that it was due to the illiteracy of parents.
and then it was followed by the poverty factor. Thus from this analysis one can argue that economic factor is playing a vital role in the way of higher education. There is a need to help financially through scholarship scheme those students who are from poor background.
Table 14

Educational Status of the sample women according to the annual household income

<table>
<thead>
<tr>
<th>Education Level</th>
<th>URBAN 1000-25000</th>
<th>URBAN 25000 &amp; above</th>
<th>SEMI-URBAN 1000-25000</th>
<th>SEMI-URBAN 25000 &amp; above</th>
<th>RURAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Illiterate</td>
<td>32</td>
<td>18</td>
<td>04</td>
<td>11</td>
<td>14</td>
<td>01</td>
</tr>
<tr>
<td>2. Literate</td>
<td>19</td>
<td>16</td>
<td>17</td>
<td>09</td>
<td>23</td>
<td>06</td>
</tr>
<tr>
<td>(Below college</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>level)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. College &amp; above</td>
<td>02</td>
<td>01</td>
<td>08</td>
<td>-</td>
<td>02</td>
<td>03</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total</td>
<td>53</td>
<td>35</td>
<td>29</td>
<td>20</td>
<td>39</td>
<td>10</td>
</tr>
</tbody>
</table>

Overall average

- 1000-25000: 166 (55.33%)
- 2600-51000: 92 (30.66%)
- 51000 & above: 42 (14%)
The data collected in this regard reveals that out of the total 54 respondents who left their studies early, a majority of them, 52 (96.29%) belonged to the families whose annual income was below Rs.30,000. Least number of the cases was found in the income group of 51,000 and above.

Out of all the 300 households no female student after the middle level is getting any scholarship. The present scheme is to provide scholarship only upto middle classes. There should be a change in this policy and in order to attract the poor and deserving students who want to go for higher studies, they be provided financial and other help. This will particularly open the door of entry for women into the higher jobs. The other step should be to raise the amount which at present is Rs.150 for middle level and Rs.25 for primary level.

**Female Education, Marriage and Infant Mortality**

In the delineation of foregoing discussions one can argue that the present day theories of development cannot ignore one aspect for achieving another end. This will create a lag between different aspects of society. There is a need to analyse women's development in a holistic perspective. But again the beginning has to be made with the education. The famous maxim "That if we educate a male it means educating a person only; but if we educate a woman
it means educating a family" seems relevant in this context. This follows that social determinants such as female literacy, age at marriage, employment opportunities for women as well as the status of women in society are equal important for achieving a reduction in infant mortality, improvements in health and nutrition of pre-school children and the realization of the need for a comprehensive package of maternal health care. To quote, "Education empowers an individual in his or her interaction with the forces around and also makes him or her better equipped to reap the fruits of development.\textsuperscript{18} Sociologically speaking, the development of education in reality should be seen in the context of social relationships.

Some of the surveys\textsuperscript{19} have conducted to correlate female literacy to the female age at marriage, child mortality estimates and fertility rates. For example, in rural areas a very large proportion of married women are illiterate as compared to urban areas. Registrar of India's information for 1981 reveals that two thirds of them in rural and urban areas got married before reaching the age of 18 years, suggesting a positive correlation between age at marriage and the level of education. A gradual increase is also seen in the mean age at marriage with the rise in the educational level, but this is significant only when the woman was educated upto the matriculation level. Child mortality at national level is about five times more among
illiterate mothers compared to the graduates.

The link between educational level of the mother and the age at marriage in reducing infant and child mortality was also found positively related in the present study. For example, there were 33 infant deaths in all the 300 households during last five years. Out of this 21 were males and 12 females. Out of 33 cases a majority of 51.51% of the deaths were found among illiterate mothers. This was followed by the mothers who were below graduation level and the percentage among them was (42.42%) (see table 15). As
Table 15

Infant Mortality Rates according to the place, age, educational status of mothers

<table>
<thead>
<tr>
<th>Sex*</th>
<th>Illiterate**</th>
<th>Literate (below graduation)</th>
<th>College &amp; above</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Semi-Urban</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>Male*</td>
<td></td>
<td>03</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>03</td>
<td>-</td>
<td>14</td>
</tr>
</tbody>
</table>

* See status of the infant

** Educational status of mother of the infant

Age at Marriage of the mothers

<table>
<thead>
<tr>
<th></th>
<th>Below 20 years</th>
<th>20-25 Years</th>
<th>26-30 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(26)</td>
<td>(7)</td>
<td></td>
</tr>
</tbody>
</table>
the educational level of mother goes higher, percentage of infant mortality among them comes down. Out of 33 cases, only 6.06% infant deaths were found among the graduate mothers. Another finding was the correlation of age at marriage of the mother and infant mortality. Out of 33 cases, a majority of 78.78% infant deaths occurred among the women who had been married below twenty years of age. Rest of the 24.24% deaths were found among the women who got married after twenty years of age. No case of infant death was found among the women who were married between the age of 26 to 30 years.

Out of the total 18 infant deaths which occurred among the illiterate mothers, majority of them (99%) deaths were found among the mothers who got married at the age of below twenty years. Again among the literate mothers, the same trend was exhibited. Out of 14 cases the majority (57.14) were found among the mothers who were married in their teenage. This was followed by the mothers (35.71) who were married between 20-25 years of age. Only one case which occurred among the literate mothers who was married at 26 years of age. Among the graduate mothers only one infant death was reported. This case occurred to the woman who was married in her teenage. Another feature was that a majority of the infant deaths, 20 (60.60%) were found in the rural areas and this was followed by semi-urban area (21.21%). Finally, lowest number of cases were found in the urban
area. There were only 6 (18.18) cases in this area. From this again one can conclude that J&K, the percentage of rural female literacy is as low as 23.5%. This is definitely contributing to the high incidence of infant mortality (76) in the state. Besides this, lack of sufficient health facilities and poverty add to the gravity of the problem. As there is a definite relationship between the household income and the infant mortality. There is already 13% population under poverty line in the state. It is here that we find a majority (124) of the infant deaths in the households having an annual income of below Rs.5000. Out of this the number of the infant mortality in the rural areas for 1984 was 128.6 per thousand while as this figure for urban area was 85.4\(^2\) per thousand.

Health

The general level of health of women and children is a key component of the process of development. Therefore, any sincere attempt at improving their status in general and health in particular, must firmly and simultaneously deal with such hurdles as social customs and cultural traditions that impede health development of women in as much as devising effective means and efficient ways to provide adequate preventive, promotive and curative health care with special reference to maternal and child health.\(^2\)
Since the dawn of independence some important and meaningful interventions have been made and substantial resources have flowed into the programming and implementation of health services for women, mothers and children. The achievement in the overall health development of women does not appear satisfactory. The situation of women is still characterised by high rates of mortality (including infant mortality and morbidity), declining sex ratio (929 per thousand males), nutritional anemia and the prevalence of high pregnancy related risks.

Government Initiatives and Women's health in J&K

The basis for organization of health services in India through primary health care approach was developed broadly in line with the recommendations of The Bhore Committee in 1946. The Murkherjee Committee (1965) spelled out the basic component for strengthening the Public Health Centres at the block level. After the above mentioned two committees came the Jain Committee (1968) to review the situation of the health infrastructure and health manpower. It recommended that previous committee recommendations could not be implemented mainly because of shortage of trained personnel. The Planning Commission, therefore, envisaged the development of Public Health Centres. Whereas Jungalwala Committee (1967) recommended the integration of health
The Government of India's Statement on National Health Policy (1982) took a serious note of integrating the health services for women and children. It points out that the revised 20-point programme be given a high priority to the promotion of family planning as a people's programme, on a voluntary basis. It asks for a substantial augmentation and provision of primary health care facilities on universal basis. It calls for control of Leprosy, Tuberculosis, and Blindness and Pledges to ensure acceleration of welfare programmes for women and children. The statement called for development of a 'Health Team' approach to health manpower development. The statement also asked for planned and time bound attention to some of the important areas. These are:

1. Maternal and child health services
2. School health programmes
3. Universal immunization programmes
4. Nutrition
5. Prevention of food adulteration and maintenance of quality of drugs.

In implementing health measures, the first priority was to be accorded to people living in rural, tribal and backward areas. In order to meet the cost of these demands the states were provided funds in addition to the respective
state budget allocations. And definite guidelines were also provided in this direction.

**Family Planning and Maternity Services**

From the above discussion we come to observe that family planning programme emerged as a single largest programme in all the developmental plans to raise the health status of women. This was also applicable in case of J&K.

The quality care received at child birth is often critical for survival and the health of both infant and mother. A significant proportion of neo-natal deaths is attributed to poor birth practices. During 1987 only about 32% of births in rural areas and 74% in urban areas were attended by trained personnel. In the villages of J&K, Rajasthan and Madhya Pradesh, the figure is less than 10 percent. Traditional birth attendants are unable to attend the complications associated with childbirth and health professionals are contacted too late. Both these factors point to the need of identifying mothers at risk during the pre-natal period.

In conjunction with malnutrition, chronic illnesses like malaria, tuberculosis, hepatitis, iodine deficiency, sexually transmitted diseases, heart diseases and upper tract infection heighten the severity of the attack on
pregnant women and increase the risk of abortion and low birth weight. For example a study conducted by UNICEF in Alwar (Rajasthan) reveals that the maternal mortality rate was 592 per 10,000 live births; and for every maternal death, some 60 episodes of illness occurred. On an average, 16.5 episodes were related directly to pregnancy and childbirth and together represented the leading cause of a quarter of overall morbidity.

In the delineation of above discussion one arrives at the conclusion that the health status of a woman is determined by several factors. These include literacy, age at marriage, birth intervals, nutritional status and

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the Plan</th>
<th>Approved Outlay</th>
<th>Expenditure (a)</th>
<th>Expenditure (b)</th>
<th>Proposed Outlay</th>
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<td>-</td>
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<td>3.</td>
<td>III Plan</td>
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<td>379.53</td>
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<td>4.</td>
<td>IV Plan</td>
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<td>6.</td>
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<td>7599.74</td>
<td>899.14</td>
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<td>7.</td>
<td>VII Plan</td>
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<td>9436.27</td>
<td>2625.76</td>
<td>2244.39</td>
</tr>
<tr>
<td>8.</td>
<td>VIII Plan</td>
<td>13312.00</td>
<td>(Proposed Outlay)</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Source: - Information supplied by Department of Planning, Government of J&K; Eight Plan (Draft) J&K.

a&b: - These figures are out of total plan outlay and expenditure, exclusively for Family Welfare only.

c: - Expenditure upto the end of 1988.
after all maternity care. it was in this backdrop that the implementation of family planning programme was stepped up to reduce the population growth from 30% to 25%. Besides this, the other objectives included were to bring better social and personal adjustment among its recipients. In the light of its objectives, the programme has been successful in improving the health status of women in the state. On the other hand, the plan allocation for this scheme has been raised from Rs.21.01 lakh during Third Five Year Plan to Rs.2625.76 lakh during Seventh Plan (See table 16).

Family Planning has generally been pursued more from a demographic and policy angle than from the perspective of family, much less that of the would be mother in impoverished communities which contribute the most to the high birth rate. A number of studies²³ support the view that family planning would be more acceptable to the parents, if the basic health, education and needs of children already born were reasonably met. This may require a holistic approach to focus on family as a basic unit of social organization inorder to let the services be fruitful.

Demographically, early child bearing is associated with rapid population growth for two reasons: it shortens the span between generations and it leads to more birth, shorter birth intervals and large family size. Currently, an estimated 4.5 million marriages take place annually in

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India. Of these more than half appear to be in the 15-19 age group. According to a UNICEF scale, the highest risk groups among pregnant women have been identified as: Those under 18 years (too young), those older than 35 (too old), those with more than four births (too many) and those with pregnancies less than two years apart. Some 8% of all births (1978) in India occur to girls between 15 and 19 years of age. And within this young age group, the number of births in a year for 1000 girls is substantial at 187 (rural) and 218 (urban). The age specific fertility rate (1987) ranges widely among the states from 22 in Punjab and 33 in Kerala at one end of the spectrum to 103, 105, 131 and 139 respectively in Rajasthan, Bihar, Madhya Pradesh and Andhra Pradesh at the other end.

In case of J&K, out of total 9,35,990 (1981) married couples in the state, the number of couples in the too young age group (15-19) is 81539 (8.71%). Out of these figures the number of couples for rural area is 71851 (88.11%) and 9688 (11.88%) only. This leads us to infer that the majority of the marriages in this age group take place in the rural areas.

As a consequence, the number of births within this young age group for per thousand girls (1978) is fairly as high as 175.2 (Rural) and 197.3 (urban) per year. The age specific fertility rates varied from 73.2 (rural) and 42.8
Out of a total age specific fertility rate of 88.9 for 1982. The above figures reveal that the girls who get married in the age group of 15-19 have a high fertility rate and shorter birth intervals. This is much more acute in the rural areas where 88.11% such marriages take place, possibly due to the low literacy levels and biased attitude of the parents. This has created much more pregnancy related complexities for women. The order of births for 1978 in the state was 20.18 (Rural) and 12.16 for (urban) for the women having 6 and above children. This trend was also found in Anantnag.

Out of a total 300 households surveyed under this study, it was found that around 148 (49.33%) women have children numbering from one to three. The number of women having four to five children was 130 (43.33%). Around 22 (7.33%) women have the children from six and above in number. Areawise analysis reveals that majority of the women (48.24%) in the rural area have the number of children from four to five. As a result the overall death rated among females in the state was (71.91%) as compared to 28.1% among males. The same trend was found in the rural and urban areas of the state out of a total number of deaths registered for 1990 in the state the percent age of females was 42.23%. Out of this the female percentage for rural areas was as high as 78.67% compared to the percentage of 21.33 among males in the same period. Again the high infant
mortality rate for 1990 (76 per thousand) reveals the same state of affairs. The figures for 1990 in the Anantnag district reveal that the death rate of females was again as high as 45.38 percent. Out of this, the percentage in the rural areas was 45.92% as compared to 39.55% in the urban areas. The reasons responsible for this disparity can be attributed to the low female literacy in the district which stands at 22.93% as compared to total population. The share of the females in these figures is as low as 22.43% as compared to 77.57% for males. The other reasons are the low level of health measures, low economic position of the parents and a biased attitude towards female issues.

As an interventionist measure, the family planning programme was introduced to reduce the growth rate to 25% and provide maternity and M.C.H. Services to the women in order to cope up with the above mentioned problems.

Maternity Child Health and Immunization Programme

While the infant mortality has lately fallen, after remaining at a plateau for a decade, it is still unacceptably high. About a third of all deaths occur in the first year of life; two fifths of these in the first month of life; and nearly half of these in the first week. What is equally significant is that the fall in the infant mortality has mainly been on account of the improvement in
the post neo-natal period, from the 28th day of life through 11 months. This means that neo-natal mortality has hardly budged from an estimated 70 to 69 in urban areas and not at all in rural areas. (UNICEF 1991) Against this background, it would be useful to look at the pre-natal mortality rate which includes foetal deaths beyond 28 weeks of gestation, deaths of infants at birth and infant deaths within seven days of birth. This is a sensitive index reflecting standards of health care prior to and during pregnancy and child birth, as well as the effectiveness of social measures in support of vulnerable segment of the people.26

Towards catering the above mentioned problems the government and non-governmental organisations had resolved that highest priority needs to be accorded to redress the health problems of women. They recommended the launching of special programmes for improvement of maternal and child health with a special focus on the less privileged sections of the society. Thus was born the programme of MCH in the late 70's that was to integrated itself into the programme of family welfare. Simultaneously, increased child survival and safe motherhood efforts received a fresh impetus. The extended programme of Immunization and the universal immunization programme were visualised as major aids to MCH in the 80's and child survival and safe motherhood in the 90's.
In the state of J&K, family welfare programme actually started picking up in the year 1968-69, when eight district family welfare bureaux were established. The main objective was to take these services at the door steps of recipients. This was much more relevant in a state with low female literacy, lack of sufficient communication avenues and where most of the areas are out of easy access. This programme has always been voluntary in the state from the very inception. The performance has shown a great leap from 239 sterilisations in 1956-57 to highest 35130 in 1986-87. At the end of second plan 1956-61, the state achieved hardly 2522 sterilisations, and the performance of all other methods was nil or negligible during 1961-66, the state netted 7334 sterilisations 4007 IUD insertions and an estimated 366 Nirodh and other conventional contraceptive users. The performance showed upward trend plan after plan and during the first three years of VIIth plan period 1985-86 to 1987-88, the state achieved an all time high 92512 sterilisations, 40737 IUD insertions, 10418 and 2290 estimated C.C. users and O.P. users. As a result of achievements up to the end of March, 1988, 290692 (31.05%) married couples were protected and 438180 births averted.

The expanded programme of immunization was started in the year 1974 with the objective of reducing mortality and morbidity from Diphtheria, Pertussis, Tetanus, Polio-Myelitis and Tuberculosis by Immunization of children against these
diseases. Under this programme 522308 pregnant women have been protected upto the end of 1988. 837725 mothers were provided with propylaxis against Nutritional Anamia in the State.

According to the 1981 census, Anantnag has a population of 6.56 lakhs. These figures for 1991 have been estimated at 8.62 lakhs of these figures, the 89.21 percent of the population live in the rural areas and 10.79% in urban areas. The sex wise representation of Anantnag district stands at 52.97% for males and 47.03 percent for females. These figures show a higher variation in the sex ratio of males to that of females. The sex ratio for 1981 in the district was 112 males per hundred females. This reveals low socio-economic and health status of women in the district. In order to meet the challenges for the health problems of women several schemes have being implemented in the district to provide services like Maternity Services, MCH and immunization services.

To provide the above services various agencies are coordinating and a mention may be made here that the health department is playing a vital role in taking these services to the farflung areas where the access is very difficult. For an effective implementation the district has been divided into ten blocks. Each block is given due representation in the establishment of health institutions.
The state health Department has developed a guild of trained personnel in different blocks of the district. Funds are being diverted to construct new primary health centres at the nearest possible distance. The number of family welfare centres and sub-centres for Anantnag district upto the ending 1988 was 77. Out of this 14 were family welfare centres and the number of sub-centres was 63. Further, there was an increase in the number of family planning centres from 13 during 1950-51 to 1305 during 1993-94. Anantnag district also observed a rise in the number of such centres to 160 during the same period (see table 17). Majority of these centres were functioning in the urban areas of the district.

Maternity and child welfare centre, whether as an independent unit or as a part of the primary health centre, is the focal point from which the health care of mothers and children reaches out into the homes of people. These centres act as consultant homes both in case of a normal delivery or any other problem. Women who attend these centres are educated about the pregnancy related complexities, safe motherhood and the uses of small family norms. The objective behind it is to reduce the growth rate from 30% to 25%. There were 167 eligible couples with wives from 15-44 age group, per thousand population in the district.

It is in the backdrop of these efforts that the number
of couples who were provided services reached to 60% in the
district. During 1987-88, a total of 25669 sterilisations
were performed in the state. The share of the district was
more than 7.09%. During the same period, the target of
51.44% was achieved. Out of this the rural urban breakup
reveals that during 1987-88 the proportion of the rural
acceptors was 93.4%. It was higher than the figures 79.55% for
the period of 1986-87. Since the inception of the
programme, cumulative performance by 1988 in the district
was 47.96% per thousand population. During the same period
a total of 1655 IUD were effected and out of this a majority
93.4% were in the rural areas and 6.6% in the urban areas.
<table>
<thead>
<tr>
<th>Place</th>
<th>(a) District Hospitals</th>
<th>Dispensaries</th>
<th>Other Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sub-District</td>
<td>(a) Allopathic &amp; Unani Ayurvedic</td>
<td>P.H. Medical</td>
</tr>
<tr>
<td></td>
<td>Primary Unit</td>
<td>(b) District</td>
<td>&amp; Sub-Centres</td>
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<td>79</td>
<td>389</td>
<td>183</td>
</tr>
<tr>
<td>Anantnag</td>
<td>7</td>
<td>33</td>
<td>30</td>
</tr>
</tbody>
</table>

(a) Including Private Hospitals

Source: Director Health Services, J&K

(b) The figures are provisional
The average ages of Tubectomy, Vasectomy and IUD acceptors for the year 1987-88 works out to be 31.7, 32.2 and 27.2 years respectively. There were 66.0% and 72.6% couples below the year of 30 years who benefitted from sterilization and IUD services respectively, in the district.

The above figures in the district lead us to remark that the performance of the family planning programme has been quite noticeable during last developmental years. As a result of which the population growth was slowed down and it saved women from repeated pregnancy related risks. There was a steady decrease in the live births for example, the registered births for 1979 were 14262 births and these figures reached to 13192 births for 1990, thereby showing a decrease of 1070 births during the above mentioned year on the other hand the overall health situation improved in the district. The year 1979 witnessed a number of registered deaths, equalling 5893 out of this 44.68% were females and 55.31% were males. These figures for the period of 1990 reached to 3051. The percentage of males 56.40% and these figures for females were 43.6% only. The rural urban break up shows that there were 5457 registered deaths for 1979 in the rural areas. Out of this 55.23% were males and 44.77% females. This percentage did not show any improvement in 1990 and there were 54.07% and 45.92% deaths for males and females respectively. The health situation in the urban
areas showed a remarkable improvement. In 1979 the percentage of female deaths was 43.57%. In 1990, these figures dropped to 39.55\%^{30} only.

The expanded programme of Immunization was started in the year 1974 with the objective of reducing mortality and morbidity (which is 44 per thousand) from Diphtheria, Pertussis, Tetanus, Polio-myelitis and Tuberculosis, by Immunization of Children and expectant mothers. It was emphasised that there are certain disease which attack the child before birth and at the time of birth the child receives injuries and hence must be protected in advance. During 1985-86 there were 1.54 lakhs expectant mothers who benefitted from the programme. On the other hand out of a set target of 2,00,000 women for 1987-88 there were 85,761 women who were covered upto the end of 1988 as against the 54420 women in 1974. The coverage under prophylaxis against Nutritional Anaemia in 1974 was 127736 mothers. These figures reached to 837725 in 1988.\^{31}

Immunization programme which is being carried on in all the blocks of Anantnag, has shown a steady progress in raising the health status of women. Though there is a disparity between targets and achievements on the one hand and rural and urban areas on the other. Under this scheme, a target of 9000 mothers was to be covered in 1976 and out of this 7101 (78.9\%) were covered during this period. There
was a target of 21600 mothers to be covered and the performance was not at all satisfactory as only 23.0% mothers were covered in 1988. These low figures can be attributed to the lack of sufficient number of trained personnel in the district and the unawareness about the programme among the illiterate women living in the backward hilly areas of the district. There is only one private hospital which is servicing women. It has done a creditable job to provide immunization services to women in the district. Up to the end of 1987-88 around 3390 pregnant women were immunized against tetanus and nutritional anemia. In addition, there were 292 P.A.N.A. mothers who were benefitted.

Looking at the achievements of the health schemes in the district though the progress has been steady but cannot be said satisfactory. The low level progress as mentioned earlier can be attributed to the non-availability of these centres in the rural and backward areas, lack of sufficient trained staff, lack of female staff and finally low level awareness among the women about the objectives and utility of these services.

To render the already discussed services to women there have been attempts to increase the number of trained personnel in the state. During 1974-75 'Maternity camp' scheme was initiated to train the local women how to conduct
a delivery. This was followed by another scheme known as 'multi-purpose scheme' with the objective of making the staff position more wide. In 1984, 440 female health assistants and 210 female multipurpose workers were trained under this scheme. Out of this only 381 were working. During 1984 yet another scheme 'Rehbare Sehat' was started, covering 29 blocks. In 1985, only 13 such blocks were covered which included two blocks of Leh and Kargil. The idea was to make it sure that a large number of rural women were covered under the programme. During 1980-85, 6,000 trained volunteers were required for this purpose and out of this only 1000 personnel were available.

Although these training schemes were introduced, but the achievement at the state level was not satisfactory. Under the 'multipurpose scheme' out of a total 3877 for J&K only 342 were given training upto the end of 1988. There was again a low intake capacity under the 'Rehbare Sehat' Scheme and out of a total 2503 for J&K, only 327 were given training for the same period. Thus the figures reveal that one of the major flaws of the women's health programmes in the district is that not much attention is being paid to the training aspect. This is again confirmed by the data collected from the field. Out of a total 300 respondents (women) a majority of them 94.66% were knowing about the family welfare and maternity services. There were only 16 (5.34%) women who were not aware about this programme out of
these 16 respondents a majority (56.25%) were illiterates and rest were literates but below graduate level. There was no case found among the graduate respondents who did not know about this programme. A rural urban break-up shows that majority (75%) of them were found in the semi-urban and rural areas of the district. This supports the view that most of these family welfare centres are urban based and the kind of publicity needed to develop awareness among illiterate rural women, is not being taken up seriously.

Out of a total 160 family welfare centres, more than 80% of them are located either in urban or semi-urban areas. In the rural and backward areas, there are hardly 20% of them. It means that they are mostly serving urban areas which has a population of 10.71% only and only 20% of the family welfare centres are meant for a majority of 89.83% population in the district.

The level of awareness among the rural women is so low that most of them are not aware even about the kind of services provided in these centres. Out of total 300 respondents, only 171 women had visited the family welfare centres during last five years. Out of this 35.67%, 25.14% and 39.18% belonged to urban, semi-urban and rural areas of the district. When asked about the nature of services rendered by these centres, a majority 38.63% respondents said that counselling services are provided whereas 32.95% said no counselling was provided during their visit to these
centres. There were only 22.72% who said that medical checkup is done in these centres and only 5.68% were of the view that medicine is distributed in these centres. Out of all the respondents no one said that vaccination is also provided against tetanus and other diseases.

The opinion regarding the services also varied according to place and educational status of the respondents. Out of 171 women who visited these centres, 78 (45.61%) were satisfied with the services. Whereas 16.37% said that the staff demand money at the time of delivery and 8.18 questioned the sincerity of the health staff. Out of the total respondents and the staff in position is not well trained. Out of this a majority of the respondents (78.94%) were from semi-urban and rural areas. One of the important points raised was that out of 13 respondents who said no lady doctor was available, a majority 61.53% were from rural and backward areas.

Thus the above analysis leads us to argue that policies regarding health of women have remained an urban affair only. As a result the progress done is not upto the mark. The sex ratio which was 116 in 1961 has shown a slow decline. It was 113 in 1981. Similarly the infant mortality could not be arrested. It was 68 in 1976 and has increased to 85 per thousand in 1985. The figures for rural areas are much more distressing. There were 73 infant
deaths for the year 1976 and these reached to 93 in 1985. The contributing factors are that the still birth rate in the district is 21.5% and majority 23.8% of them occur in the rural areas. While as pre-natal mortality is 44.0% and Neo-natal 42 percent. These figures for rural area are as high as 47.4% and 45% respectively for pre-natal and neo-natal mortality. One of the important reasons responsible for this is that most of the deliveries are conducted through the local traditional practices by the untrained women. As per figures available, around 66% deliveries are conducted by these women. Studies confirm that majority of the morbidity rates are due to the causes related with pregnancy.

In Anantnag district, more than 78% deliveries are conducted locally, possibly due to the non-availability of trained dais, customs hindering the women's admission in the hospitals for delivery and above all the undespread corruption cannot be ruled out. The data collected under present study reveals that out of a total of 298 respondents surveyed, 68.45 percent favoured the delivery to be conducted in the hospital and 31.15% favoured the delivery at home. Among those, who favoured home, a majority of 68.08% were from the rural areas. When asked about the reasons for this preference most of the respondents 64.89% argued that privacy is maintained at home. According to the educational status break up, out of the respondents who
favoured home for conducting delivery, 55.38% were illiterates. There were only two respondents in the graduate category and none of them talked of privacy. This reveals that the rural society is still tradition bound and needs to be educated about the customs which effect the health status of women. A good percentage of respondents revealed that sometimes when trained personnel conduct the delivery in the hospital or at home, heavy fee is demanded. A person with low income cannot afford this. There were 17 (18.08%) respondents who said that due to lack of local maternity centres and difficulty to get ambulance at the time of delivery in order to reach a far away maternity centre. They favour home better for delivery. Out of 17 respondents a majority of 70.58% belonged to the rural areas.

One of the important points to be noted is that out of 94 respondents who favoured delivery to be conducted at home, a majority (69.14%) favoured the delivery to be conducted by a trained person. Out of this, 52 (80%) belonged to rural areas. It is in these areas that traditional practices of conducting delivery is still prevalent and non-availability of a trained person adds to the gravity of the situation. There is a need to organise special medical camps in the rural and hilly areas in order to train the local women about how to conduct a safe delivery. On the other hand, family welfare centres need to
be efficiently maintained and facilities like lady doctor,

Table 18
Preference for the Institute and the Person to attend the delivery according Urban/Semi-Urban/Rural

<table>
<thead>
<tr>
<th>Institute</th>
<th>Hospital</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td>(a) Nurse</td>
<td>(b) Dai</td>
</tr>
<tr>
<td>Urban</td>
<td>94</td>
<td>-</td>
</tr>
<tr>
<td>Semi-Urban</td>
<td>60</td>
<td>-</td>
</tr>
<tr>
<td>Rural</td>
<td>50</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>204</td>
<td>-</td>
</tr>
</tbody>
</table>

Grand Total 298 (C)
(a) Nurse - Means the hospital trained nurse who conduct deliveries.
(b) Dai - Means Local untrained women who conduct delivery through traditional practices.
(c) Out of three hundred two households had no elder women to answer these questions.

medicine and sufficient number of female nurses be made available to the clients who attend these institutions primarily with the hope of getting a better treatment. Out of a total number of 298 surveyed respondents, 204 (68.45%) favoured that the delivery be conducted in the hospital. When asked about the reasons for their preference, a majority of 161 (78.92%) respondents favoured hospital as better for delivery due to the availability of doctors and necessary arrangements like medicine. This was followed by 40 (19.60%) who said that due to the facilities of ambulance, trained nurses and sterilized equipments for attending delivery they favour the conducting of delivery in the hospital (see table 18).
From the foregoing analysis we come to conclude that though the performance of health measures in raising the health status of women has been gaining steady momentum. But there is still a gap between the requisition and demand of Health personal and health institutions. These aspects have been neglected inspite of the increasing plan allocations from Rs.44.83 lakh during 1st Plan (1951-56) to an amount of Rs.17,990.00 lakh for health and health education/training during 8th plan (1992-97). Besides this, the performance is not so satisfactory due to several socio-economic factors. There is a need to adopt an integrated approach if the policies were really to bring desired results. There is a need to do away with the urban oriented health policies and develop a decentralised health culture both at macro and micro levels, and about policy and process level.

**Employment and Socio-economic Development**

One of the most important changes that have taken place in recent times in the world is the improving status of women. Socio-economic advancement of a country can be best judged by the status and position which it can bestow on its women. So the level of economic equality and independence are the important indicators to measure the status of women in any society.
In India, the general economic situation is far from satisfactory, the situation of women being worse than that of men, women constitute half of the population but their share in the employment rate remains abysmally low. In absolute terms, the female labour force has grown from about 78.6 million in 1973 to 88.9 million in 1978 and 99.4 million in 1983. These figures shown an average annual addition of 2.1 million. However the women's participation rate, in proportional terms, has declined drastically from 33.7% in 1911 census to 20% in 1961 census.\textsuperscript{34} On the other hand, the figures for J&K reveal that there was a total work force of 30.37% in 1981. Out of this the number of main workers was 1818571 and there were 831473 marginal workers in the state. The number of female workers was 166725 (main workers) and 717104\textsuperscript{35} as marginal workers. These figures show that the employment of women in the state has remained very low. This reflects the socio-economic status of the women in the state.

**Government Initiatives and Women's Economic Development in J&K**

In order to raise the level of economic independence of women and expand their skill capability, government of J&K initiated a number of schemes for this purpose.
(a) Socio-economic programmes:

The socio economic programmes started in 1960 in J&K aim at training and providing employment to needy women in social welfare institutions. Much emphasis was laid on the activities resulting in the ultimate rehabilitation of needy women either through education or through involvement in economic activities. The main effort has been to provide economically backward women with the opportunity to work on full time or part time basis, either in homes or in the training cum production centres. The programme has been steadily gaining popularity and strength. During 1992 there were 68 such centres imparting training to women in different crafts like tailoring, paper machiee, doll making etc. Each centre has a strength of 25 women and hence every year about 1,700 women are benefited. These women, after completing their training either start their own units or join at some one's unit. In this way, they earn their livelihood independently. Those who start their own units are provided loans and equipments on subsidy basis for the establishment and expansion of their units.

(b) Ladies' Vocational Training Scheme

During recent past, there have been serious attempts aimed at shifting the training in traditional handicrafts to training in technical expertise. For this purpose, social
welfare department in the state in 1989 started a new scheme known as 'Ladies' Vocational Training Scheme'. The main idea behind this scheme is to give training to women in technical courses so that after receiving training, a woman can become certain of some job. The minimum qualification for admission to these centres is matric and above. The adult education centres provide condensed course of education to the women. After passing 10th Class, they become eligible for this training in technical professions like typing, stenography, shorthand etc. In this regard, the recent scheme, 'Training of Rural Youth for Self-employment, was launched in 1979 to provide technical skills such as softwear computer training to rural youth between 18 and 35 years of age from families below the poverty line. It was intended to enable them take up self employment in agriculture and allied activities, industries, services and business activities. This is a sub scheme of IRDP. Around 40% of the seats have been reserved for women.

Currently, there are 19 training-cum-productions centres-in the Anantnag district. Each centre is meant for 10 villages and employes 25 women for training. Every year, 475 women are trained in different crafts in the district. Each trainee is; paid an incentive of Rs.120\textsuperscript{36} per month. On the other hand, there are 146 co-operative and handicrafts societies providing employment to 4601 persons in the district. During 1976-77 the number of training
centres in the district was 7 only with a coverage of 175 for training. This number was raised to 38 during 1992-93 with a membership of 628 trainees. For the same period, out of total 87 handloom training centres, there are 7 such centres with a capacity of 82 trainees for 1993-94. Besides this there are 236-37 handicraft centres associated with the Ministry of Commerce.

The above mentioned socio-economic schemes have no doubt opened employment avenues for women to help them to become economically independent. But most of these centres were concentrated in the urban and semi-urban areas. Out of the 300 households surveyed, only 83 women have undergone such courses of training in various handicrafts. Out of this, 37 (44.57%) were found in the urban areas and this was followed by 32.53% and 22.89% for rural and semi-urban areas. Out of 83 respondents, 42.16% were illiterates, 25.30% literates but studied below High School and 32.53% were high-school and above. Out of all the cases, 37.34% belong to the family with annual income group of Rs.10,000 - 20,000. This was followed by 21.68 belonging to the family annual income group of Rs.21,000 - 30,000. Only 7 (8.43%) respondents were found in the income group of below Rs.10,000. It follows that few women from the low income groups are selected for these courses. Thus there is a need to look for genuine cases for the selection. Another important point is that after completing the training, most
of these women are in search of some job. A small number of them is able to find some suitable job. This was again attributed to the factors that very few women are able to get loans, equipments and the period for completing a particular course is not sufficient to attain mastery in that craft. This was confirmed by the data collected from the field. Out of 83 cases, there were only 68 cases who were able to find some job. Out of this 8.82% found a government job, 36.76% started their own unit and 54.41% work at some private unit. 18.07% were not able to find any job. Again the figures reveal the concentration of facilities in the urban areas. For example out of 8.82% who found a government job, 50% belonged to urban area, 33.33% to semi urban and only 16.99% belonged to rural area. Those who started their own units, a majority 60% belonged to urban areas and only 40% were from semi urban and rural areas. This was because the people in urban areas have access to facilities and approach the government officials to get their share properly. Out of the 37 cases who work on some private unit, a majority of 45.94% were from rural areas and it is in these areas that these women are exploited by the mediators. On the other hand, majority of the respondents said that the incentive given during training period was very low. The deposited money (refundable at the end of completion) was not returned. The time frame fixed for a course is not sufficient to learn it properly. A situation like this calls upon immediate
intervention both at micro and macro policy levels in order for the fruits of these schemes to trickle down at gross root level. There is a need to concentrate more in rural and backward areas if these women are to be brought out of abject poverty and customary exploitations.

During last few years, a significant change has emerged in the appointment of women in government services. Due to the general literacy rise, the women have become eligible for such appointments. The role of female teachers in promoting girls' education has been recognised. As a result under 'Operation Black Board' Scheme, a special drive was carried out and for VIII five Plan 93,303 posts were created at primary level mainly to be filled by women. Out of the appointments done so far, in 1993 out of a total 6149 teachers in Anantnag at primary level 1389 (22.58%) were females and 1344 (17.77%) and 906 (14.53%) were female teachers at middle and high school level respectively. Though not encouraging, the figures show marked progress. One of the interesting points is that a majority of the parents who were surveyed prefer teaching job for their daughter. Therefore, there is mankind to increase the share of women in the appointments as teachers and at the same time raise their representation in other sectors as well.

In the delineation of above discussions, we can abridge that women are the most important moiety of each and every
society. The future of nations lie in the web of women. thus the question which confronts one's mind is how well are the preparing women to be the architects of our future. In the dainty of this reality government initiated certain measures, as discussed in the past and to prepare them as the best role players in the society in future. In this regard mention may be made that in all the developmental plans special provisions to raise the socio-economic status of women were embodied. In the area of education for women, every plan commemorated increased budgetary allocations for providing free and compulsory education upto university level. Consequently there was a rise in the number of schools, teachers, and enrolment. Special arrangements were made to establish schools and colleges exclusively for female students. This led to an increase in the number of teachers, followed by a rise in female enrolment both at school and college levels. This ultimately resulted in an increase in the female literacy from 9.28 per cent in 1971 to 28.22 per cent in 1991. Once there was an increase in the number of educated women, their level of participation in the employment sector also improved considerably. A special quota has been reserved for the women in the medical training centres and the appointment as teachers. Compared with overall improvement in their educational and economic status, the health measures initiated by the government also began producing desired results. Consequently, there was a sharp decrease in the number of female deaths. The life
expectancy rate showed marked improvement from 44.70 years in 1971 to 60.04 years in 1991. There was also a decrease, though not much, in the birth rates from 32.2 per cent in 1971 to 31.5 per cent in 1991.

The increased female enrolment in schools and colleges led to an increase in the age of marriage for girls. Along with it, improved health services like immunization, pre-natal and neo-natal services helped in the overall betterment of women's health status. As a result, there was sharp decrease in the infant mortality rate from 127 per thousand at the time of independence to 73 per thousand in 1991. In order to make women economically independent a host of schemes were introduced. Those included schemes like imparting training in different crafts, modern stenotyping and computer software programmes etc. The idea is that once they receive training and become economically independent, they will be able to actively participate in the decision-making process of the society and their family. But these achievements are not sufficient enough given the huge population of women in the state as well as in the country. Much remains to be done in some areas of concern. For example, the declining sex ratio of women: this was 986 per thousand males in 1971 and has gone down to 985 per thousand males in 1991. Further, the improved female enrolment in school's should not mislead us as drop-out rate of girls students is a serious area of concern.
Various studies reveal that a majority of the female students drop before they reach even grade V and only a small percentage of them is able to complete grade VIII. Another discrepancy which merits exposition is the fact that most of the women's development programmes still remain confined to urban areas only. Since the urban population in the state remains between 15-20 per cent only, the majority of women living in the rural areas of the state are unable to get any benefits from these government measures. This calls for a rural-centric approach to the development programmes being implemented for the female millions.
Till recently, development was taken to mean economic development. One talked in terms of development theories and growth models and indicators like GNP and per capita income. Now, the economic aspect, though important and relevant, is not overemphasised for it is correctly perceived that development is a multi-dimensional process which involves not just an acceleration of economic growth to reduce inequality and eradicate poverty, but progression of a traditional society towards modernisation and march towards ideals of democracy, namely liberalism, egalitarianism and justice - social and distribute

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9. For example, the states of Punjab, Haryana which have high per capita income have low literacy, high infant mortality, morbidity compared to the states like Kerala which has processed well in these areas.

10. An Educational Reorganisation Committee consisting of same eminent educationists was appointed on 22nd April, 1950 under the Chairmanship of Director Education K.Kazmi. The Committee studied the various problems of the education and submitted its report in 1951.


Registrar General's data for 1981 reveal that average age at marriage in India was 16.7 years. As per the information from a survey conducted by National Institute of Public Cooperation and Child Development (NIPCCD) around 66% marriages in India are teenage marriages. Thus resulting in high fertility and high morbidity and infant mortality. Another study of ICMR shows that average age at marriage for rural girls is 13.8 years in six major States of India.

A large number of studies on Family Planning have candidly brought out that socio-economic status of a family plays a very significant role in the acceptance of family planning measures. The majority of these have reported the significance of socio-economic status of husband or male head of the household (Freeman, 1974; Pareek & Rao 1974; Jain, 1975). Yet another study by Rajyaguru, H.C.(Baroda, 1980) on Family Planning acceptance reveals that the age at marriage and educational status of woman are important factors than socio-economic study of husband.


(30) Op cit


(33) A study conducted by UNICEF in Rajasthan reveals that the maternal mortality rate was 592 per 100,000 live births and for every maternal death, some 60 episodes of illness occurred. On an average, 16.5 episodes were related directly to pregnancy and child birth.


