GENDERED VULNERABILITIES: WOMEN'S HEALTH AND ACCESS TO HEALTHCARE IN INDIA

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FROM THE RESEARCH DESK

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts within the rights based approach especially so in the backdrop of weakening public health system, unregulated growth of the private sector and restricted access to healthcare systems leading to a near-total eclipse of availability and accessibility of universal and comprehensive healthcare. A rights-based approach to health uses International Human Rights treaties and norms to hold governments accountable for their obligations under the treaties. It recognises the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health and that it is one of the fundamental rights of every human being and that governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures. It gets integrated into research, advocacy strategies and tools, including monitoring; community education and mobilisation; litigation and policy formulation.

Right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It covers the underlying preconditions necessary for health and also the provisions of medical care. The critical component within the right to health philosophy is its realisation. CEHAT's main objective of the project, *Establishing Health as a Human Right* is to propel within the civil society and the public domain, the movement towards realisation of the right to healthcare as a fundamental right through research and documentation, advocacy, lobbying, campaigns, awareness and education activities.

The Background Series is a collection of papers on various issues related to right to health, i.e., the vulnerable groups,health systems, health policies, affecting accessibility and provisions of healthcare in India. In this series, there are papers on women, elderly, migrants, disabled, adolescents and homosexuals. The papers are well researched and provide evidence based recommendations for improving access and reducing barriers to health and healthcare alongside addressing discrmination.

We would like to use this space to express our gratitude towards the authors who have contributed to the project by sharing their ideas and knowledge through their respective papers in the Background Series. We would like to thank the Programme Development Committee (PDC) of CEHAT, for playing such a significant role in providing valuable inputs to each paper. We appreciate and recognise the efforts of the project team members who have worked tirelessly towards the success of the project ; the Coordinator, Ms. Padma Deosthali for her support and the Ford Foundation, Oxfam- Novib and Rangoonwala Trust for supporting such an initiative. We are also grateful to several others who have offered us technical support, Ms Sudha Raghavendran for editing and Satyam Printers for printing the publication. We hope that through this series we are able to present the health issues and concerns of the vulnerable groups in India and that the series would be useful for those directly working on the rights issues related to health and other areas.

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Gendered Vulnerabilities: Women's Health And Access To Healthcare In India

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I. INTRODUCTION

Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women's lives in the country, determining their 'life chances' and resulting in their qualitatively inferior status in the various socio-economic spheres. It permeates institutions and organisations and works in many insidious ways to undermine women's right to dignified lives. There are similarities in women's lived experiences due to such gendered existences. However, in a vast and socio-culturally heterogeneous country like India, women's multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women's lived experiences as also do rural-urban and regional disparities. New needs emerge as women progress through the life cycle. Talking about women's health and access to healthcare in such a complex setup thus poses a challenge.

If health is defined 'as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', it follows that existence is a necessary condition for aspiring for health. The girl child in India is increasingly under threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country. Access to technological advances of ultra sonography and India's relatively liberal laws on abortion have been misused to eliminate female foetuses. From 958 girls to every 1000 boys in 1991, the ratio has declined to 934 girls to 1000 boys in 2001. In some states in western and north western India, there are less than 900 girls to 1000 boys. The sex ratio is at its worst in the states of Punjab, Haryana, Himachal Pradesh and Gujarat, where severe practices of seclusion and deprivation prevail. Often in contiguous areas in these states, the ratio dips distressingly below 800 girls to every 1000 boys (RGI, MOHFW, UNFPA, 2003). Annexure I gives the child sex ratio in different states and union territories of India as per the 2001 census.

The discrimination against the girl child is systematic and pervasive enough to manifest in many demographic measures for the country. For the country as a whole as well as its rural areas, the infant mortality rate is higher for females in comparison to that for males (Annexure II). Usually, though not exclusively, it is in the northern and western states that the female infant mortality rates are higher, a difference of ten points between the two sex specific rates not being uncommon. The infant mortality rate is slightly in favour of females in the urban areas of the country (as a whole) But then, urban India is

marked by greater access to abortion services and unwanted girl children often get eliminated before birth.

It has been commented in the context of women's health that sustainable well-being can be brought about if strategic interventions are made at critical stages. The life cycle approach thus advocates strategic interventions in periods of early childhood, adolescence and pregnancy, with programmes ranging from nutrition supplements to life skills education. Such interventions attempt to break the vicious intergenerational cycle of ill health. The vulnerability of females in India in the crucial periods of childhood, adolescence and childbearing is underscored by the country's sex wise age specific mortality rates. From childhood till the mid twenties, higher proportions of women than men die in the country. In rural India, higher proportions of women die under thirty. The sex wise age specific mortality rates are given in Annexure III.

Risk factors in women's lives

Health is socially determined to a considerable extent. Access to healthcare, is almost fully so. This being so, the 'lived experiences' of women in India are replete with potential risk factors that have implications for their lives and well-being. The multiple roles of household work, child rearing and paid work that women carry out has implications for their physical and mental health. A study on the impact of work and environment on women's morbidity in a sample population in Mumbai found that cohabiting women with children engaged in paid work had the highest morbidity rates (Madhiwalla and Jesani, 1997), higher than that of either single women or housewives. The types of morbidity experienced by the women included reproductive problems, aches, pain and injuries; weakness, fever, respiratory problems; problems in the gastro intestinal tract; skin, eye and ear problems and a residual category of 'other' problems. The study also found, quite significantly, that degraded living environment, as in a slum, has deleterious effects on people's health and that the morbidity rates were highest for those adult women with children who were living in slums and were engaged in paid work (ibid). Another study of working and non working women in the slums of Baroda found that though working women contributed significantly to the household income, yet they had to face a burden of household work and childcare (in addition to their paid work). Such women put in more hours of work to fulfill their numerous responsibilities and had less leisure time. Women in both the categories had lower nutritional intake than what is recommended, with the working women faring worse than the housewives. Similarly, in the case of nutritional deficiencies such as anaemia, mottled enamel, etc, both the categories of women fared poorly, with the working women being worse off. The mean number of clinical signs of nutritional deficiency was 2.8 for the working women in comparison to 2.2 for housewives. Interestingly, the study showed that working women had greater access and higher utilisation of antenatal care services (Khan, Tamang and Patel, 1990).

There may be gendered risks to women's lives in the home environment. In India, a vast majority of the households rely on bio-fuels (wood, dung, etc) for cooking. Cooking being a female preserve in the household domain, the pollutants arising from the burning of such bio-fuels affect women (and young children) disproportionately, with consequences on their health - respiratory tract infections, blindness and

asthma being some of the diseases that affect them (Parikh, Smith and Laxmi, 1999; also Gopalan and Saksena, 1999).

In recent years, studies on domestic violence in the country have systematically debunked the myth of the home as a safe haven. Violence against women in India cuts across caste, class and other divides. Nationally it is estimated that 21 % of women have experienced beatings or physical mistreatment 'by husband, in-laws, or other persons' since the age of fifteen (IIPS and ORC Macro, 2000). The percentage of women having experienced such violence in the past one year is 11%. Women of all socio-demographic backgrounds experience domestic violence (Annexure IV). In fact, given the sensitive nature of the topic, it would not be erroneous to say that the low levels of violence reported by women of high standard of living or those having completed at least high school may be because of deliberate underreporting of violence rather than genuine differentials in levels of violence experienced. Such is the internalisation of gendered roles and the acceptance of violence that high percentages of women of varied backgrounds justify violence for different 'reasons', namely, the husband's suspicion of the wife's faithfulness; non giving of money or other items by the wife's natal family; wife's disrespect of the in-laws; wife's going out without telling the husband; wife's neglect of the house or children, and; wife's not cooking food properly.

Findings of smaller studies usually put violence faced by women at higher levels. Visaria's study of married women in five villages in rural Gujarat revealed that 66% percent of women were subject to either physical or verbal abuse (Visaria, 2000). INCLEN's multicentric study of urban and rural areas across seven sites of India found that 40.3% of the women reported at least one episode of physically abusive behaviour (INCLEN, 2000). Not only is domestic violence a violation of women's human rights, it can also have severe health consequences. A study of the casualty records of a large, multispeciality hospital in Mumbai, revealed that a fifth of all cases (22.4%) were 'definitely domestic violence' and another 44% of the cases pertaining to women were 'possibly domestic violence'(Daga, Jejeebhoy and Rajgopal,1999). (By rough estimates two-thirds of the cases pertaining to women in the casualty department of the hospital could be related to domestic violence).The form of assault experienced by the women ranged from kicks and beatings (with instruments or otherwise) to strangulation and burning. Attempted suicide by the ingestion of various substances was prominent in the cases of 'possible domestic violence'. Serious injuries were sustained in considerable percentages of the cases - comprising 13% of the cases of 'definitely domestic violence' and 60% of the cases of 'accidental stove bursts' (ibid).Another study that analysed records in healthcare facilities across the tiers also found evidence of violence in many cases of women accessing such facilities (Jaswal,1999).

Intimate relationships may be fraught with other dangers. Sexual relationships with one's spouse are not without risks, its acuteness heightened in this age of HIV/ AIDS. Across the country, sex within marriage is viewed as the man's right. Women may have some leverage in temporarily stalling off sex but to 'deprive' their husbands of it 'for too long' would invite social censure (George, 1997). If the man has been straying, then it puts the

woman at risk, inspite of her being in a monogamous relationship. In fact one of the tragic aspects of the HIV/AIDS epidemic in the country today is that it has spread to monogamous women in the rural interiors of the country, the infection having been contracted from the husband who has migrated to urban centres often in search of a livelihood. Transmission of the human immunodeficiency virus (HIV) in the country is overwhelmingly through sexual contacts, with other modes like perinatal transmission, blood and blood products, injection of drugs, etc together accounting for less than 15 percent of the total infection (CBHI,2003).

In general, women in India are restricted in matters of decision making, freedom of mobility and access to money, though wide variations exist depending on the socio-demographic context (IIPS and ORC Macro, 2000).Certain periods in a woman's life like early childhood, adolescence and old age may be especially vulnerable to discrimination and neglect. The discrimination/neglect faced by women in such ages is elucidated in the relevant sections of this monograph. The current section draws from socio-anthropological literature to understand the reasons for such vulnerability. The status of women in India is depressed on many socio-economic indices with low literacy rates, poor participation in political processes, concentration in low skilled and low paying economic activities and a culture that values motherhood and care giving roles in women. Born in such a milieu, the girl child (especially one born higher in the birth order to a family having older girls) is, in many ways, unwanted and disadvantaged. For varying reasons such as the safeguarding of the physical security and 'modesty' of the girl, the deeply embedded notions of patriliny and the cultural value placed on the son(s), dowry (and its consequences on the family's economic security), the girl child faces a battle even before her birth. An undesirable fallout of the declining fertility in India has been that lives of girl children have been compromised to restrict the family size of many middle and upper class families - a case of demographics and gender equity being at odds.

The discrimination against the girl child continues during adolescence and the lack of preparedness in meeting life situations underscores her vulnerability. Though, in the conventional sense adolescence is understood to be a period relatively free from morbidities that mark childhood and old age, the insularity of adolescence from morbidity is getting undermined in recent years owing to the risks associated with unsafe sex and the attendant dangers of contracting HIV/AIDS and RTIs/STIs. Late adolescence may mark initiation into sex that is usually ill informed and unprotected. In the Indian context, initiation into sex by adolescent girls is usually in the context of marriage, though premarital sex among girls is not unknown (Abraham, 2003; FPAI, 1994).The median age at first marriage for girls in India is only 16.4 years (IIPS and ORC Macro, 2000).In most states of the country, half the girls marry by the time they complete their teens; in states like Bihar and Rajasthan, the median age at first marriage being only 15 years. However, life skills that could enable them to respond preparedly to their life situations are found to be sorely lacking among adolescent girls (and boys). It has been reported how adolescent girls are taken unawares by the onset of menstruation (Garg, Sharma and Sahay, 2001) and have little or no knowledge about contraception and childcare (ANSWERS, 2001).

As the country undergoes demographic transition, people live longer, typically women outliving men. The National Sample Survey, for example, estimates that the share of the aged females is higher than that of males in both rural and urban areas of the country (NSSO, 1998a). But, old age is a period associated with morbidities (especially chronic ailments). It also signals a change in social status. With the active productive life of a person being over and the second filial generation having made its entry in the family, the position of the individual undergoes a change. Vulnerability during old age sets in due to physical, economic and psychological dependence, more so for elderly women among whom higher proportions are dependent on others 'for day to day maintenance' in comparison to elderly males (NSSO, 1998a).This is especially true if a woman has been widowed with little property against her name. Her status in the family is considerably reduced from the time when she was in her middle age, with telling implications for her health and well-being.

II. WOMEN'S HEALTH IN INDIA

Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors have profound and multifaceted implications on health. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various locational positions like caste and class. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well-being. The present section on women's health in India systematizes existing evidence on the topic. Different aspects of women's health are *thematically* presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments. The conditions of women's lives shape their health in more ways than one.

Nutrition

Nutrition is a determinant of health. A well balanced diet increases the body's resistance to infection, thus warding off a host of infections as well as helping the body fight existing infection. Depending on the nutrient in question, nutritional deficiency can manifest in an array of disorders like protein energy malnutrition, night blindness, iodine deficiency disorders, anaemia, stunting, low Body Mass Index and low birth weight. Improper nutritional intake is also responsible for diseases like coronary heart disease, hypertension, non-insulin-dependent diabetes mellitus and cancer, among others (Shetty,2004). Nutritional deficiency disorders of different types are widely prevalent in the countries of south east Asia, with some pockets showing endemicity in certain types of disorders. Iodine deficiency disorder is endemic to the Himalayan and several tribal areas and anaemia is a pervasive problem across most socio-economic groups of the country. Economic prosperity alone cannot be a sufficient condition for good nutritional status of a population, the state of Maharashtra in western India being a prime example in this regard. Maharashtra has one of the highest per capita incomes among states in the country, but is marked by poor nutritional profile of its people. More than half the households in both the rural and urban areas of the state receive less than the prescribed adequate amount

of calorific intake and the situation has worsened in the rural areas of the state in the past twenty years (Duggal, 2002).

The nutritional status of children and women in India has attracted the attention of academics and policy planners for some decades now. Despite the interest, these population subgroups continue to suffer from poor nutritional status. The girl child, disadvantaged from birth (or even before it) due to her sex, is systematically denied or has limited access to the often paltry food resources within the household. A recent study of three backward districts of Maharashtra shows that in the project areas of the ICDS (the Integrated Child Development Services-the state run programme designed to ameliorate the nutritional status of children and pregnant and nursing women with the help of supplementary nutrition), the girl beneficiaries consistently showed poorer weight for age results, compared to the boy beneficiaries (Mishra, Duggal and Raymus, 2004). This was true for all the three project defined age groups of children below one year; between one and three years and between three and six years. All the three districts of Jalna, Yawatmal and Nandurbar displayed such a consistency. (The three districts encompass considerable socio-cultural heterogeneity, Jalna being a predominantly non-tribal district while Yawatmal has a mixed tribal-nontribal population. The district of Nandurbar has a predominantly tribal population.)

National level estimates from the NFHS-2 also show that girls are more likely to be undernourished or even severely undernourished for the indicators of weight for age and height (Table 1). More girls than boys are thus underweight and stunted. Boys are slightly more likely to show undernourishment and severe undernourishment in the case of weight for height, that is, they are more likely to be thin than the girls.

Women's physiological makeup calls for special nutritional supplements. Menstruation and childbirth are iron depleting physiological processes. Calcium needs to be continually supplemented during a woman's life cycle as a bulwark against osteoporosis in later life. The predominantly vegetarian diet of Indians does not fulfill many of their nutritional requirements. Further, cultural practices disadvantage women in many ways and add to their poor nutritional status. It is customary in many households across the country that the women should eat last and eat the leftovers after the men folk have had their food (Dube, 1988). The choice of

Table 1: Nutritional status by sex of the child

	Weight for age		Height for age		Weight for height	
Sex of the child	% below -3 SD	%below -2 SD•	% below -3 SD	% below -2 SD•	% below -3 SD	% below -2 SD•
Male	16.9	45.3	21.8	44.1	2.9	15.7
Female	19.1	48.9	24.4	47.0	2.7	15.2

Source: NFHS-2
Note: The indices are expressed in standard deviation units (SD) from the median of the International Reference Population.
• Includes children who are -3 SD below the median of the International Reference Population.

dishes prepared is often in keeping with the preference of the male members of the household. The NFHS-2 estimates that 35.8% of women in the country suffer from chronic energy deficiency, with a body mass index (BMI) of less than 18.5 kg/m^2. The proportion of such women is highest in Orissa (48.0 %), followed by West Bengal (43.7%). On the whole, the eastern and central states of the country fare worse than the others in this measure. However barring a few small states, in the rest, a quarter or more of the women have a body mass index below 18.5 kg/m^2 (Table 2). The NFHS-2 also shows that, at the national level, more than half (51.8%) of the women in the reproductive age group suffer from some form of anaemia. With the exception of Kerala (22.7%) and Manipur (28.9%), levels of anaemia are consistently high for the other states, the proportion of women suffering from some form of anaemia often being more than 40.0%. Assam leads with 69.7% of its women anaemic. Bihar (63.4%), Meghalaya (63.3%) and Orissa (63.0%) follow (Table 2).

It is a sad observation on the enduring inequities in Indian society and the deprivation caused by the market economy that disadvantaged social groups suffer from poor nutritional status. As free access to natural resources gets curtailed and purchasing power increasingly determines one's well-being, tribals and poor rural communities (among others) inhabit the margins of the economy with telling effects on their health (and livelihood). Higher proportions of rural women have a BMI less than 18.5 kg/m^2 than urban women (Annexure V). Women belonging to the Scheduled Castes and the Scheduled Tribes are more likely to suffer from moderate and severe anaemia. At the same time, considerable proportions of women of socio-economically advantaged backgrounds (that is, those belonging to high standard of living; high education) are obese. Thus, the nutrition profile of the country is not only indicative of the deprivation that disadvantaged social groups suffer from but also provides a vivid picture of the double burden of nutritional disorders that differentially affect social groups in the country.

Table 2: Body mass index (BMI) and anaemia in Indian women

	Weight for height				% of women with		
	% with BMI below 18.5 kg/m²	% with BMI of 25.0 kg/m² or more	% with BMI of 30.0 kg/m² or more		Mild anaemia	Moderate anaemia	Severe anaemia
North India							
Delhi	12	33.8	9.2	40.5	29.6	9.6	1.3
Haryana	25.9	16.6	3.9	47	30.9	14.5	1.6
Himachal Pradesh	29.7	13.1	2.3	40.5	31.4	8.4	0.7
Jammu & Kashmir	26.4	13.8	3	58.7	39.3	17.6	1.9
Punjab	16.9	30.2	9.1	41.4	28.4	12.3	0.7
Rajasthan	36.1	7.1	1.6	48.5	32.3	14.1	2.1
Central India							
Madhya Pradesh	38.2	6.1	1.2	54.3	37.6	15.6	1
Uttar Pradesh	35.8	7.5	1.5	48.7	33.5	13.7	1.5
East India							
Bihar	39.3	3.7	0.5	63.4	42.9	19	1.5
Orissa	48	4.4	0.6	63	45.1	16.4	1.6
West Bengal	43.7	8.6	1.3	62.7	45.3	15.9	1.5
North east India							
Arunachal Pradesh	10.7	5.1	0.6	62.5	50.6	11.3	0.6
Assam	27.1	4.2	0.7	69.7	43.2	25.6	0.9
Manipur	18.8	10.8	1.2	28.9	21.7	6.3	0.8
Meghalaya	25.8	5.8	1.2	63.3	33.4	27.5	2.4
Mizoram	22.6	5.3	0.5	48	35.2	12.1	0.7
Nagaland	18.4	8.2	0.7	38.4	27.8	9.6	1
Sikkim	11.2	15.7	2.5	61.1	37.3	21.4	2.4
West India							
Goa	27.1	21.2	4.3	36.4	27.3	8.1	1
Gujarat	37	15.8	4.4	46.3	29.5	14.4	2.5
Maharashtra	39.7	11.7	2.9	48.5	31.5	14.1	2.9
South India							
Andhra Pradesh	37.4	12	2.2	49.8	32.5	14.9	2.4
Karnataka	38.8	13.6	2.9	42.4	26.7	13.4	2.3
Kerala	18.7	20.6	3.8	22.7	19.5	2.7	0.5
Tamil Nadu	29	14.7	2.7	56.5	36.7	15.9	3.9
India TOTAL	35.8	10.6	2.2	51.8	35	14.8	1.9

Source: NFHS-2

Women's morbidity

Evidence on different morbidities in India suffers from a problem common to many developing countries. Levels and types of morbidities experienced by different population subgroups in these countries are often not systematically documented leading to huge gaps in information that impair research and policy making. In India, for the better part of the post independence era, women's reproductive health (more specifically, contraception and maternity related events) were common subjects of enquiry with the topic of women's general morbidity receiving comparatively little academic attention.

Further, there are inherent methodological problems in exploring morbidity in low literate, third world societies. Household level studies mostly rely on self reported morbidity status – a task fraught with dangers. Self reported morbidity data are often a reflection of people's perceptions of their health status and their levels of health consciousness. It is for this reason that people belonging to the higher socio-economic classes often report higher levels of morbidity. Morever, proxy reporting may misrepresent morbidity related data. It has been seen, for instance, that in the NSSO surveys, members of a household may answer questions directed at other members.

Data on morbidity (for certain ailments) has also been collected in the two rounds of the NFHS. In NFHS-2, information was sought on asthma, tuberculosis, jaundice and malaria. Questions on morbidities afflicting different members in a household were addressed to the household head or 'other knowledgeable adult in the household'. (The overwhelming proportion of heads of households in both rural and urban areas of India is male). Almost consistently, prevalence rates of (reported) morbidities for the four ailments were lower for females in comparison to that for males (Annexure VI). Similarly in NFHS-1, for the country as a whole, barring (partial and complete) blindness, morbidity rates for the ailments of tuberculosis, leprosy, physical impairment of limbs and malaria are lower for females. The pattern replicates itself in the rural and urban areas of the country, except in the case of malaria in urban India, where the incidence was higher among females.

One of the signal contributions of the feminist movement worldwide has been the integration of gender concerns in theory and practice of research. In India, studies adopting gender sensitive methodology indicate higher levels of morbidity among women. For example, a study on women's morbidity in the Nasik district of Maharashtra exclusively employed trained and sensitsed female investigators, built rapport with the community and used a probe list to elicit greater information on women's health (Madhiwalla, Nandraj and Sinha, 2000). In a sample of more than 3,500 women, the morbidity levels reported were very high, with half the women reporting ill in the month prior to the survey. A large proportion of such illnesses were chronic and non-infectious in nature. Morbidity rates were higher among adult women in comparison to that of girls and the authors say that 'the pattern of morbidity among women showed linkages to their living environment (air, water, food), work and childbearing and contraception' (ibid:120).

From time to time, different rounds of the National Sample Survey Organisation (NSSO) have collected information on the morbidity and health seeking behaviour of people in India. In the survey, pregnancy and child birth related events are not

considered as morbidities though complications arising out of pregnancy and childbirth are. The 52nd round of the NSSO (conducted in the mid 1990s) reports that in rural and urban areas of India, for the 15 day reference period, greater proportions of women than men report acute as well as chronic ailments (NSSO,1998b). The gender differences in reported morbidities for both acute and chronic ailments are slightly higher in urban areas (Table 3). In the survey, point prevalence of morbidities is estimated in two ways - morbidity on the day prior to the survey and on the 15th day preceding the survey. The point prevalence of morbidities is higher for women on both the reference dates in rural as well as urban areas of India, the gender differentials (again) being sharper in urban areas (Annexure VII).

Strictly speaking, morbidity data in the various rounds of the NSSO are not comparable. This is owing to differences in the reference period taken for different rounds of the survey, the adoption of prevalence rates (PR) in an earlier survey instead of the proportion of ailing persons (PAP) calculated now. The survey report carries out adjustments to make indicative comparisons possible between the morbidity data reported in the different rounds. Roughly speaking then, the data from various rounds of the NSSO show that morbidity rates have increased for the people of India since the 1970s (Table 4). The early sixties, when the NSSO 17th round was carried out, show very high rates of proportions of people reporting ailments, across both the genders in rural and urban areas of the country. The morbidity rates declined in the 1970s (28th round), after which they showed an increase. This is true for both males and females in rural as well as in urban areas of the country. In fact, the increase in morbidity rates is higher for women in comparison to that of men in both the settings.

Gender differentials in morbidities are also evident among specific population sub groups. The elderly as a group (expectedly) reports very high prevalence of chronic ailments (NSSO, 1998a). Elderly females may be afflicted by certain ailments more (for instance, joint problems) in urban as well as in rural India. Apart from it, curiously, for urban India, greater proportions of elderly females suffer from chronic ailments with the prevalence rates of certain chronic diseases like cancer,

Table 3: Proportion of persons (number per 1000) reporting ailment (PAP) in the 15 day reference period, NSSO 52nd round

Area	Ailment	Male	Female	India
Rural	Acute	41	44	42
	Chronic	13	14	13
	Any ailment	54	57	55
Urban	Acute	39	43	41
	Chronic	13	15	14
	Any ailment	51	58	54

Source: NSSO Report no.441, 1998.

Table 4: Morbidity rates in different rounds of the NSS

	1995-96 (52nd round)			1986-87 (42nd round)	1973-74 (28th round)	1961-62 (17th round)
	PAP (estimated) (15 days)	Derived PAP (30 days)	Derived PR (15 days)	PAP (30 days)	PR (15 days)	PAP (30 days)
Rural						
Male	54	84	54	64	47	139
Female	57	89	58	63	40	123
Person	55	86	56	64	43	132
Urban						
Male	51	81	52	30	43	133
Female	58	89	58	33	41	128
Person	54	84	55	31	42	131

Source: NSSO Report no.441,1998.
Note: 1 PAP: Proportion of ailing persons (number per 1000); PR: Prevalence rate
2 The recall period is given in parentheses.

blood pressure problems (and the staple joint problems) being higher for them (Annexure VIII).

Reproductive health

The terms of the discourse on reproductive health of women in India have changed considerably in the last decade, largely owing to changed political expression post the International Conference on Population and Development (ICPD) at Cairo in 1994. Prior to it, engagements with the issue of women's reproductive health were limited. Topics like levels and trends in contraceptive prevalence, reasons for non acceptance of contraception and the like were the mainstay in the literature that ensued. The corpus of literature on women's reproductive health has triggered new areas of enquiry (and concerns), evidence on reproductive tract infections and abortions being two prominent ones. In the wake of the Cairo conference, women's reproductive health has assumed, in policy parlance a 'life span approach'. Reproductive health continues to enjoy the preeminent position on expositions on women's health in India, however, the connotations have widened implying a wider range of reproductive health conditions that women experience.

For example, the issue of gynaecological morbidities in women in India gained attention in the late 1980s. The pathbreaking study by Bang, et.al (1989) which highlighted the high prevalence of gynaecological or sexual diseases among rural Indian women opened the proverbial Pandora's box. The study carried out among 650 women in two villages of the backward Gadchiroli district of Maharashtra found an astonishing 92.2 percent of all women having one or more gynaecological or sexual diseases, with an average of 3.6 diseases per woman (Bang, et.al.,1989). The surreptitious nature of such diseases can be gauged by the fact

that only 55.38% of the women had one or more gynaecological or sexual complaints (apart from complaints of 'non-specific but related symptoms' of low backache and lower abdominal pain) and that even women without any symptoms were 'very likely' to have diseases of the reproductive tract. Such diseases were also more frequent among women who had used contraception (especially tubectomy). Quite notably also, only 7.8% of the women had sought gynaecological care in the past for their problems. Another study employing multiple methods on 385 women in rural and urban areas of Karnataka found that major gynaecological complaints (to a social worker) were bad odour/itching/irritation during vaginal discharge, lower abdominal pain or vaginal discharge with fever and menstrual problems (Bhatia, et.al., 1997). Subsequent history taking by a female gynaecologist reported higher levels of menstrual problems with 62.3% of the women reporting one or more menstrual problems. Further, it was seen that women with clinically diagnosed RTIs or Pelvic Inflammatory Disease are 'three times more likely' to report menstrual problems than those not so diagnosed (ibid).

Reproductive Tract Infections(RTIs)/ Sexually Transmitted Infections(STIs)

Recent literature on *Reproductive Tract Infections(RTIs)* point to the enormity of the problem afflicting women in India. Women's physiological getup and social vulnerability make them susceptible to RTIs. In an evocative piece, Wasserheit and Holmes say that:

'RTIs, and particularly STDs, disproportionately compromise the health of women. Women are less able to prevent exposure to an STD than men, because of the lack of available female controlled barrier methods and because the power dynamic in sexual relationships frequently limits their ability to negotiate the conditions under which intercourse occurs. For anatomic reasons, transmission of HIV or discharge syndromes (e.g. gonorrhea, chlamydia, trichomoniasis) following exposure appears to be more efficient from male to female than from female to male. When transmission occurs, women are far more likely than men to be asymptomatically infected, and as a result, not seek care. If a woman is "lucky" enough to develop symptoms, it is frequently socially unacceptable for her to seek care for a genital problem, particularly in an STD clinic' (Wasserheit and Holmes,1992:13).

The authors further say that the diagnosis of a number of STIs is more difficult in the case of women than men and that the spread of infection to the upper genital tract is greater in women. For such reasons, women are more likely to experience from severity of complications of RTIs and seek delayed treatment (if at all, one may add). The host of medical conditions that RTIs engender include infertility, ectopic pregnancy, cervical cancer, facilitation of HIV transmission and several adverse outcomes of pregnancy (namely, spontaneous abortion or still birth; low birth weight babies; congenital or perinatal infections) (ibid).

Bang, et.al (1989), found that infections constituted a major proportion of gynaecological morbidities among women. High prevalence of RTIs was found in a study in Karnataka (Bhatia, et.al.,1997). Thirty-six percent of the women were clinically diagnosed as having RTIs and the figures went upto 56 percent when

subjected to laboratory tests. About one-tenth of the women suffered from sexually transmitted infections. Another community based study among 451 young married women in rural Tamil Nadu found that 45 percent of the women reporting symptoms and 30 percent of the women not reporting any symptoms (initially) had laboratory diagnosed RTIs. About two-thirds (65%) of the symptomatic women had not taken any treatment. The majority among those not seeking treatment thought that the symptoms were 'not alarming', hence not necessitating treatment. Other reasons for not seeking treatment included absence of a female healthcare provider at the nearby facility, lack of privacy and distance of the facility from home (Prasad, et.al,2005).

At the national level, the Reproductive and Child Health-Rapid Household Survey (RCH-RHS) estimates that 29.7 percent of the eligible women in the country had at least one symptom of RTI/STI (IIPS, 2001a).The percentage of males having any such symptom was considerably less at 12.3%. (It may be reiterated here that RTIs/STIs are often asymptomatic. Further, as the RCH-RHS report points out, 'the culture of silence' (often) prevents people from admitting such ailments. Hence these figures are indicative at best). The levels of RTIs/STIs differ widely from state to state in the country, but consistently, with the exceptions of Orissa and (very marginally) Jammu and Kashmir, the prevalence rates are (considerably) higher among women in comparison to that in men.(Interestingly, the NFHS-2 estimates for reproductive health problems are considerably higher for the country and the states.) When it comes to seeking treatment, the RCH-RHS reports that for the country as a whole, 55.1 percent of the males with symptoms of the diseases sought treatment in contrast to 37.6 percent of the females who had symptoms. Treatment seeking is usually higher among males across the states of the country. Gender differentials in awareness of the diseases presented a mixed picture. Higher percentages of women reported awareness of RTIs compared to men, the figures being 45.4 percent for women and 37.2 percent for men, for the country as a whole. However, for both STIs and HIV/AIDS, higher percentages of men reported awareness of the diseases. Nationally, 36.4 percent of the males reported awareness about STIs as against 28.8 percent of the females. For HIV/AIDS, the figures were 60.3 percent for males and 41.9 percent for the females (IIPS, 2001a). The sample design of the RCH-RHS makes it possible to arrive at district level estimates. There are wide variations in the percentages of men and women reporting RTI/STI symptoms and awareness of AIDS across the districts of a state and across the states as well. This has implications for designing programmes for communication strategies to increase awareness of the diseases and service delivery for the diseases. Table 5 gives state-wise estimates with regards to symptoms reported for RTI/STI according to the RCH-RHS, (it is a reproductive health problem according to the NFHS-2) and treatment sought.

Table 5: Prevalence of RTI/STI and Treatment sought

	% having at least one symptom of RTI/STI†			Among those having at least one symptom of RTIs/STIs, % treatment sought †	
	Males	Females		Males	Females
State					
Andhra Pradesh	7.6	18.8	48.5	65	46.5
Arunachal Pradesh	13.3	20.6	42.1	33	35.3
Assam	15.1	28.5	50.6	40.9	38.3
Bihar	17.7	37.7	44.2	59.1	37
Goa	5.2	16.4	40.2	63.2	52
Gujarat	15.3	32	28.6	51.3	36.1
Haryana	9.8	32.3	38.2	54	38.2
Himachal Pradesh	2	19.1	33.7	56.3	49.2
Jammu & Kashmir	3.8	3	60.5	87.4	89.5
Karnataka	4.4	16.3	18.8	58.6	53.8
Kerala	4.9	27.7	42.4	58.6	50.8
Madhya Pradesh	10.2	26.1	44.9	54.6	43.7
Maharashtra	8.9	25.4	40	69.2	47.9
Manipur	12.7	23.6	56	46.1	46.1
Meghalaya	8.5	26.6	66.9	65.2	31.2
Mizoram	10.2	36.4	52.5	40.7	56.1
Nagaland	14.3	16.5	45.6	51.9	35.7
Orissa	17.3	15.6	27.5	52.4	38.1
Punjab	5.4	30	28.3	61	42.4
Rajasthan	12.5	45	43.2	51	22.6
Sikkim	8.7	11.3	48.6	60	49.8
Tamil Nadu	10.7	36.5	27.8	25.9	31.5
Tripura	15.1	39.8	*	51.6	45.4
Uttar Pradesh	18	36.4	38.1	55	35.8
West Bengal	18.1	30.4	45.3	53.4	30.2
Union Territory					
Andaman & Nicobar islands	2.1	13.7	*	36	50.5
Chandigarh	3.4	5.4	*	75	49
Dadra / Nagar Haveli	10	28.5	*	82.6	38.7
Daman & Diu	17	22.4	*	55.9	51
Delhi	6.3	14.5	36.5	73.3	78
Lakshadweep	3.8	14.2	*	68.2	54.8
Pondicherry	0.3	36	*	80.9	33.5
INDIA Total	12.3	29.7	39.2	55.1	37.6

Source: † according to RCH-RHS; • according to NFHS-2 (The symptoms for which information was sought are similar for the NFHS-2 and the RCH-RHS.)
Note: * not given in NFHS-2 report.

Maternal mortality and morbidity

Maternal morbidity and mortality are major public health problems in almost the entire south-east Asian region, signifying not only the poor status of women in the region but also the often appalling standards in basic healthcare. Maternal mortality has been defined as 'the death of woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes' (WHO,1977). About 40 percent of all maternal deaths in the world occur in the south-east Asia region (WHO, 1998) with India alone accounting for half of all such deaths. The number of maternal deaths in the country is estimated at 1,12,000 per year (UNFPA,2000). It is estimated that maternal deaths account for a tenth of all female deaths in the reproductive age group in the country (CBHI, 2003). The survey of causes of death estimates bleeding during pregnancy and childbirth, and anaemia to be the leading specific causes of maternal mortality (reported in CBHI, 2003). It has also been commented (Shiva, 1992) in this context that widespread anaemia in pregnant women, low height of many Indian women that puts them at risk of obstructed labour, poor weight gain during pregnancy among women of the low socio-economic groups and dietary deficiency during pregnancy are 'major causes of maternal deaths' in the country. Further, unsafe abortions are a 'leading cause of maternal mortality and contribute significantly to the maternal morbidity' in the country (UNFPA, 2000).

Glaring shortcomings in the healthcare services like poor coverage and quality of antenatal care, unsafe deliveries, lack of emergency obstetric care and poor referral services also contribute to high rates of maternal deaths (WHO,1998). The NFHS-2 estimates the maternal mortality ratio in the country to be 540 per 1,00,000 live births for the two year period before the survey. The ratio is more severe for rural India, being 619, in comparison to urban India which records 267 during the same period (IIPS and ORC Macro, 2000). Maternal mortality ratio in the country has been 'steadily falling' during the past decades. In the late 1950s, it stood at around 1,300, but was between 800-900 deaths in the 1970s, 500-600 deaths in the 1980s and 400-500 deaths in the 1990s (Bhat, 2002). Using the sisterhood method to estimate levels of maternal mortality indirectly in rural India, the ratio was found to be comparatively higher for certain social groups (for example, Scheduled Tribes, Scheduled Castes, less developed villages and illiterate women and Hindus). State level estimates of maternal mortality ratio have also been indirectly estimated from sex differentials in adult mortality (Bhat, 2002). Assam has the highest maternal mortality ratio in the country, followed by Uttar Pradesh and Madhya Pradesh. Maternal mortality in Punjab and Kerala is very low, because of which estimating it from sex differentials in adult mortality of a sample population is difficult. Among the states for which estimates could be arrived at, Tamil Nadu has the lowest maternal mortality ratio (Annexure IX).

Further, it is estimated that, for every maternal death, there are thirty other women who suffer from 'chronic, debilitating conditions, which seriously affect the quality of life' (UNFPA, 2000). Despite their stated limitations, various community based studies in different sites of India point to substantial levels of maternal morbidities. Bhatia and Cleland

(1996) report from their study of 3600 women near Bangalore in Karnataka that about 40 percent of all women suffered from at least one morbid condition during their antenatal, delivery or post natal period. About 18 percent of the women reported one morbid condition during their antenatal period, 8 percent experienced a problem (especially prolonged labour) during delivery and (quite notably), 23 percent had a problem during their post natal period. An average of 1.6 episodes per person was estimated for those reporting at least one morbid condition (Bhatia and Cleland, 1996). Another study by Bang, et.al located in Gadchiroli district of Maharashtra prospectively followed 772 pregnant women from the third trimester onwards to 28 days postpartum. The incidence of maternal morbidity was found to be 52.6 percent. It was observed that labour complications (17.7%) were more serious in nature while post partum morbidities were more frequent (42.9%). Prolonged labour and prolonged rupture of membranes were the most common intrapartum morbidities while breast problems and secondary postpartum haemorrhage formed the two most common post partum morbidities. The authors estimate that almost 15 percnet of the women who deliver at rural homes potentially need emergency obstetric care and 34.7 percent are in need of medical attention (emergency or non emergency). They also highlight the need of home based post partum care (Bang, et.al, 2004). At the national level, possible post natal complications are indicated by the NFHS-2 which reports that 11 percent of the women giving birth in the preceding three years reported massive vaginal bleeding and 12.6 percent reported very high fever within two months of the birth - both complications registering higher proportions in rural India (IIPS and ORC Macro,2000).

Further, there is considerable abortion related morbidity. In a recent community based study in Maharashtra, post abortion morbidities were reported in more than 60 percent of the cases of spontaneous as well as induced abortions (Saha, Duggal and Mishra, 2004). Excessive bleeding, pains and aches together accounted for almost half the reported morbidities. High blood pressure, breathlessness, vomiting, no control over urination, together formed a substantial percentage of the responses. Other complaints included early infections, menstrual irregularities and vaginal discharge. Complaints were more frequent in rural areas and marginally higher for cases of induced abortions.

Abortions

The issue of abortion thus merits attention not only for itself but also for the range of reproductive health problems that it can engender. Unsafe abortions can lead to infertility, maternal morbidity and mortality, among other undesirable outcomes. For a long period, since the early 1970s, the proportionate share of abortions to maternal mortality remained almost unchanged, accounting for about one in ten maternal deaths in rural India (Soman, 1994). Despite its manifold implications and protracted engagements with it at the policy level, it is only in recent years that abortion related data has been forthcoming. National level estimates of abortion (especially those related to induced abortions) are admittedly underestimates (IIPS and ORC Macro, 2000). The NFHS-2 estimates that for every 100 pregnancies in the country, there are 4.4 spontaneous abortions and 1.7 induced abortions. The rates for both types of abortion are higher

in urban India. State wise data shows that there are considerable variations across states in the rates for spontaneous abortions- the rates ranging from 2.1 percent in Sikkim to 7.1 percent in Goa. Induced abortion rates are usually low (rates of less than 1 percent of pregnancy outcomes not being uncommon). However, some states like Manipur (6.3%), Tamil Nadu (5.2%) and Delhi (4.7%) record high rates of induced abortion. Table 6 contains estimates of different pregnancy outcomes (spontaneous abortions, induced abortions, still births and live births) for the states of the country, as well as for rural India, urban India and the country as a whole.

Table 6: Pregnancy outcomes in India (for every 100 pregnancies)

	Spontaneous abortions	Induced abortions	Still births	Live births
North India				
Delhi	5.8	4.7	1.3	88.2
Haryana	5.7	1.4	3	90
Himachal Pradesh	4.5	1.6	2.6	91.3
Jammu & Kashmir	5.1	2.6	1.8	90.5
Punjab	4.1	3	2.9	90
Rajasthan	5	0.9	2.1	91.9
Central India				
Madhya Pradesh	3.8	1	1.8	93.4
Uttar Pradesh	4.5	1.4	1.8	92.4
East India				
Bihar	3.2	0.3	2.1	94.4
Orissa	5.4	1.6	2.1	90.9
West Bengal	4	2.2	1.8	91.9
Northeast India				
Arunachal Pradesh	2.6	0.7	3.1	93.5
Assam	6.1	3.3	3.2	87.4
Manipur	6.6	6.3	1.2	85.8
Meghalaya	5.2	0.7	3.3	90.9
Mizoram	5.3	0.6	2.3	91.8
Nagaland	5.8	2.3	2.3	89.5
Sikkim	2.1	0.9	2.9	94
West India				
Goa	7.1	3.9	1.1	87.9
Gujarat	4.9	2.1	1.4	91.6
Maharashtra	3.8	1.9	1.5	92.8
South India				
Andhra Pradesh	4	0.8	2.3	92.9
Karnataka	4	0.9	2.3	92.8
Kerala	5.7	1.9	1.2	91.2
Tamil Nadu	6.2	5.2	2.5	86.2
India (rural)	4.2	1.1	2.1	92.6
India (urban)	5.2	3.4	1.5	89.9
India TOTAL	4.4	1.7	2	91.9

Source: NFHS-2.

Exclusive studies on abortion report an increasing trend in abortions- a disturbing fact considering the country's long running family welfare programme. In a recent community based study in Maharashtra, for every 100 pregnancy outcomes for the reference period 1996-2000, spontaneous abortion stood at 5.1 and induced abortion at 4.5 (Saha, Duggal and Mishra, 2004). The rates for both types of abortions were higher in urban Maharashtra. Both spontaneous and induced abortions registered increased proportions in comparison to the mid 1970s. While this may be partly owing to recall lapse for the earlier time periods, it is also indicative of greater access to abortion services and greater demand for a smaller family with the preferred sex of the children. As the study showed, the percentage of induced abortions increased with the order of pregnancy. The widespread resort to curettage among providers can also engender post abortion morbidities apart from escalating costs (Duggal and Ramachandran, 2004). Qualitative field insights show that women may view abortion as a 'safer' option in comparison to spacing methods like IUDs, quite obviously oblivious of the serious health consequences that abortions can bring about (ibid).

Another worrying aspect of abortions in India is the widespread extent of sex selective abortions. The child sex ratio has declined (quite alarmingly) in the country. It is estimated that as many as ten million female foetuses were aborted in India in the final two decades of the last century, the phenomenon being present in major religious groups and states of the country (Jha, et.al, 2006). A girl child is clearly less wanted especially if a family already has a daughter. In the 1990s, the female to male sex ratio in the 0-6 age group has witnessed a sharp decline in urban areas of the country. Quite notably also, adverse female to male sex ratios in the 0-6 age group are now being observed in areas other than the northern and western parts of India (Agnihotri, 2003).

Infertility

Infertility-'a diminished (or absent) capacity to produce offspring where the possibility of achieving conception is not completely ruled out' (UNFPA, 2000) is at once a biological and a socio-psychological problem in India. The centrality of motherhood in women's lives in the country makes infertility an emotionally difficult experience for them, stigma and blame often being directed at infertile/ childless women. Infertility may impair social relationships, threaten the marital relationship, lower the woman's self-esteem and make her feel powerless (Widge,2004; Unisa,1999; Jejeebhoy,1998). It can be caused by anatomical, genetic, endocrinological and immunological problems (UNFPA,2000; WHO,1991). However, it is understood that such factors are responsible for a miniscule of about 5 percent of infertility cases world wide, a vast majority of the cases being caused by avoidable reproductive morbidities like sexually transmitted diseases and post partum and post abortion complications (WHO,1991). Thus, common reproductive morbidities in India like high levels of asymptomatic and untreated RTIs, tuberculosis of genital organs and post abortion and post delivery morbidities are also responsible for bringing about infertility among women in India (UNFPA,2000).

Globally, infertility remains a little understood phenomenon and may get obscured in high fertility settings (WHO, 1991). It has been observed that 'multiple

definitions' of infertility make it difficult to compare between different studies on infertility and measure levels of infertility in the population (Widge,2004; Jejeebhoy,1998).There are 8-10 million infertile couples in the country, the prevalence of primary infertility being 3% and that of secondary infertility at 5% (UNFPA,2000). The NFHS-1 estimates that for the country as a whole, 2.2% of the currently married women aged 40-44 years and 2.4% of such women aged 45-49 have never had a live birth. The rates for primary infertility are almost similar for rural and urban India (IIPS,1995).The prevalence rate of infertility may be high in some states- a study in Andhra Pradesh showing that 5 percent of the currently married women suffer from (majorly primary) infertility (Unisa,1999).

Menopause

Menopause marks the cessation of the reproductive life of a woman. Owing to hormonal changes that signal the end of a woman's childbearing phase (with the connotations of loss of youth and fecundity and allusions to being an old hag '*sadeli buddhi*'), menopause may be a mentally and physically unsettling process. Successful resolution may involve, among other things, a redefinition of self. However, despite the universality of menopause, social science literature on the subject is remarkably scanty in India. The problem remains largely hidden, the socio-psychological consequences as experienced by women in the country being little understood.

According to the NFHS-2, by the age of 48-49, two-thirds of Indian women have attained menopause. There are, however, considerable interstate variations in this regard. In West Bengal (48.4%), Madhya Pradesh (51.9%) and Kerala (53.0%), about half of the currently married women aged 48-49 have experienced menopause. Andhra Pradesh, on the other hand, is a state where 82.2 percent of the currently married women of that age group have already attained menopause. There are some states in the country where menopause sets in early (before the age of 40) for a considerable proportion of women. Andhra Pradesh is by far the front runner in this regard, with menopause being reported by 22.1 percent of the currently married women aged 35-39 years and another 12.8 percent of the currently married women aged 30-34 years. Early menopause is also seen in Gujarat and Karnataka, where more than 10 percent of the currently married women below the age of 40 have experienced menopause. Annexure X gives information on menopause among currently married women by age and state. Early menopause may be related to the poor health status of women. A study in rural Andhra Pradesh found that low haemoglobin and protein levels, high parity and infections (bacterial, fungal and viral) are 'major determinants' of early menopause in women (Mahadevan, et.al, 1982). A more recent study based on NFHS-2 data shows that women belonging to the disadvantaged social groups of the country (rural, illiterates, low standard of living, among others) are more likely to experience the early onset of menopause (Syamala and Sivakami, 2005).

Women and Disability

The disabled (the differently abled) in India represent diversities in their composition ranging from those with relatively inconspicuous and non-hindering disabilities (for example, minor orthopaedic handicaps) to those with more substantive ones. The social gaze that stigmatizes and discriminates the disabled is articulated from the vantage point of

those more 'privileged' in terms of fullness of limbs and organs. The very word disabled, for example, conjures up an image of one incapacitated in the carrying out of activities related to work and personal life. The disabled are also victims of stereotyping, the word being used in a monolithic sense without acknowledging the differences in the various categories of the disabled and their differing needs. Widespread exclusionary social practices characterise societal attitudes towards the disabled in the country, many of them stemming from sheer oversight of the needs of this group. An oft quoted example in this regard being the flight of steps that mark the entrance of many buildings in the country- a sight that would be formidable and a deterrent to people with orthopaedic and/or visual handicaps. Affirmative action on the part of the state and a more sensitive societal disposition are thus very much in order in order to help the disabled fight marginalisation and discrimination in society.

The census of 2001 puts the number of persons with disabilities in the country at 21,906,769. Of these, almost three-quarters are in rural areas, slightly more than the rural share in the country's population (Table 7). In some forms of disabilities (especially hearing disabilities), the proportion of the disabled in the rural areas is considerably higher than that in urban areas. Gender differentials in disabilities indicate that more than half the disabled (across the various categories of disabilities) are men. This is especially true in the case of those with movement disabilities, where almost 64 percent are men. This may be owing to the fact that motor accidents, which are a major cause of limb impairment, are mainly experienced by men.

Table 7: The Distribution of the Disabled by type of Disability, Sex and Residence, India 2001

	Total	Rural	Urban	% rural
Total disabled population	21,906,769	16,388,382	5,518,387	74.81
% male	57.54	57.42	57.91	
% female	42.46	42.58	42.09	
No. of people with visual disabilities	10,634,881	7,873,383	2,761,498	74.03
% male	53.9	53.63	54.66	
% female	46.1	46.37	45.34	
No. of people with speech disabilities	1,640,868	1,243,854	397,014	75.8
% male	57.41	57.4	57.46	
% female	42.59	42.6	42.54	
No. of people with hearing disabilities	1,261,722	1,022,816	238,906	81.07
% male	53.4	53.68	52.24	
% female	46.6	46.32	47.76	
No. of people with movement disabilities	6,105,477	4,654,552	1,450,925	76.24
% male	63.92	63.92	63.93	
% female	36.08	36.08	36.07	
No. of people with mental disabilities	2,263,821	1,593,777	670,044	70.4
% male	59.84	59.57	60.49	
% female	40.16	40.43	39.51	

Note: Computed from Census 2001 figures.

Women with disabilities constitute a substantial population subgroup in the country, totaling 9,301,134 (RGI, 2005c). The proportion of women with different disabilities to the total disabled women in India closely replicates the gender aggregated national pattern. Women with visual disabilities account for more than half (52.71%) of the total disabled women in the country (Annexure XI). The proportion of women with movement disabilities come a distant second at 23.68 percent. The proportionate share of mentally retarded women is 9.77 percent followed by those with speech (7.51%) and hearing disabilities (6.32%). State wise breakup *usually* follow the national pattern in the proportionate distribution of different types of disabilities. Visual disabilities constitute the single largest category of disabilities in women across all states and union territories of the country.

In some states like Jammu and Kashmir (70.83%) and Tamil Nadu (66.62%), the proportionate share of the visually impaired women is very high to the total population of disabled women. Women with movement disabilities usually constitute the second largest category of disabled in the states and union territories. However, the north-eastern states of Arunachal Pradesh, Mizoram, Nagaland and Sikkim have higher proportions of women with speech/hearing disabilities than movement disabilities. The third largest category of disabled women in the different states of the country may be either those with mental retardation or speech/hearing disability, the pattern differing from state to state.

In contrast to the age aggregated data, among the elderly, higher proportions of the women are disabled in comparison to the men (NSSO, 1998a). (Higher proportions of the disabled women have been reported in the NSS 47th round (1991) as well as in the 52nd round (1995-96)). The pattern of disability found among elderly women and men is also slightly at variance from that found in the general population. Visual disabilities continue to account for the largest share among the elderly women and men, but hearing disabilities constitute the second highest type of disability (Annexure XII).

The experiences of disabled women are complex. Disabled women constitute a 'neglected minority of women and disabled in a majoritarian world of men and of the non-disabled' (Hans, 2003). Asha Hans also observes that such women face 'triple discrimination', the discrimination being experienced on multiple fronts-as women, as disabled and as women with disabilities (ibid). However, despite their special (and gendered) needs, the concerns of disabled women have not been taken up actively by either the feminist movement or the disability movement. Disabled women are more vulnerable to neglect and abuse because of their disability. They are more likely to be 'physically, sexually and emotionally abused'; subject to forced sterilisation, contraception and abortion; and more likely to be malnourished than disabled males. In many countries, the mortality rates are higher for disabled females when compared to that of disabled males (Mobility International USA, 2003). It has also been observed in the Indian context that disabled women are deemed asexual- socially, biologically and psychologically- resulting in the denial of their sexuality. This has telling implications on growing up, disabled girls being confused about processes like breast development, menstruation and sex and their being under constant danger of sexual abuse (Limaye, 2003). Disability in women may make them susceptible to certain types of abuse that 'normal' women may not be subject to, for instance, being abused by caregivers or forcefully being shifted to another place (Depoy, Gilson and Cramer,2003).

Women and Mental Health

The *Tenth Revision of the International Classification of Diseases* (ICD-10) categorises mental and behavioural disorders into eleven broad categories, encompassing the wide variety of mental and behavioural disorders that are experienced by people in the world. The categories are: organic, including symptomatic, mental disorders; mental and behavioural disorders due to psychoactive substance use; schizophrenia, schizotypal and delusional disorders; mood (affective) disorders; neurotic, stress-related and somatoform disorders; behavioural syndromes associated with physiological disturbances

and physical factors; disorders of adult personality and behaviour; mental retardation; disorders of psychological development; behavioural and emotional disorders with the onset usually occurring in childhood and adolescence; and unspecified mental disorder. Though an estimated 450 million people in the world suffer from a mental or behavioural disorder, however, such problems are 'largely ignored or neglected' in many parts of the world (WHO,2001). The 2001 World Health Report observes that 'advances in neurosciences and behavioural medicine show that, like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors'(ibid:1). This being so, the mental health of a people/ population subgroup depends on the social environment and the individual's response to it. World wide, the levels of mental illness suffered by men and women are similar. However, both in the developed as well as the developing world, there are consistent patterns in the types of disorders that are *likely* to be found in the two sexes. Anxiety and depressive disorders are more likely to be found in women and substance use disorders and antisocial personality disorders in men (ibid). The higher prevalence of anxiety and depressive disorders among women has been attributed to hormonal changes at certain times of their lives (for example postpartum depression); psychological and social factors (like the possibility of actual and perceived stressors); and domestic and sexual violence that they face. Comorbidity (especially the presence of depressive, anxiety and somatoform disorders together) is also more common among women (ibid).

Studies on the mental health of women in India show consistent gender wise patterns. Reviewing a number of studies in India, Davar observes that while gender differentials in severe mental illnesses are not significant, women are more likely to suffer from common mental illnesses, the prevalence rates of such illnesses being often almost double in women in comparison to that in men (Davar,1999). Such gender differentials have been noticed in rural and urban India. A study of more than 11,000 patients from two hospitals in south India found that depression and somatoform and dissociative disorders were more prevalent in women (Vindhya, Kiranmayi and Vijayalakshmi, 2001). Such disorders are manifestations of the multiple burdens in women's lives and the role strain and role conflict that they experience. The resultant stress is compounded by women's powerlessness and their inferior social status. Interestingly, the study found five groups of women to be most affected by mental disorders. These are: married women; women in the reproductive age group; unskilled labourers; women with little education; and women who were 'principally housewives'.

Women and Work

The multiple burdens of paid work, childcare and household responsibilities that women shoulder and the manifold effects (health and otherwise) it engenders has been a *leitmotif* in feminist literature on women and work. However, as an area of enquiry in health research, the field of occupational health occupies an enclave of its own, with limited dialogue with other areas. Historically, much of the body of evidence focuses on the (male) worker in an industrial setting. Sex differentials in occupational injuries and deaths may be obscured because of non-presentation of such data. For example, labour statistics do not carry sex disaggregated data on fatal

and non fatal injuries in factories, mines, railways and ports (Government of India, 2003). Further in India, within the body of work on occupational health of women, a disproportionate share is claimed by enquiries into women's occupational health in low paying, low skilled (and often unorganised) sector. It is a truism that women in India concentrate in such jobs, often with no fixity of employment and little or no social security benefits. The 2001 census, for example, shows that considerably higher percentages of females than males are marginal workers for the country as a whole as well as its rural and urban areas (Annexure XIII). In such settings, out of pocket expenses typically mark any expenses incurred for health related events. Traditionally disadvantaged with respect to education and acquisition of skills, women's entry into the labour market is also hindered by childbearing and childcare. They constitute, what has been called in Marxist theory, a 'reserve army of labour'. However, women (especially those belonging to the upper castes/classes in urban areas) have also gained from education and employment opportunities in independent India, constituting a not so negligible population subgroup of female salaried professionals in the country.

A gendered analysis of the occupational health of women is necessitated due to the contexts of women's lives. As we have seen earlier, the multiple roles that women discharge can have deleterious effects on their health. Paid work coupled with childcare and household responsibilities, result in role strains and little leisure for women. For women, the 'spillover' of family related stress on work related stress is higher than it is in the case of men (Narayan, et.al, 1999 cited in Parikh, Taukari and Bhattacharya, 2004). The workplace can also be a site where women are subject to sexual violence and gender discrimination. In addition, the specific situational contexts of their employment may engender numerous health risks in women. As Kaila writes, 'research evidence indicates that women face certain work-related health problems such as psychosomatic symptoms, general health and women specific health problems, including menstrual disorder, anxiety, backache, anaemia, depression, abortion, miscarriage and other gynaecological problems' (Kaila, 2004a: iii).

Emerging evidence on occupational health point to a host of job specific occupational health hazards along with the role conflict and role strain that women experience. Nurses may suffer from workload, role ambiguity, problems in interpersonal relationships and death and dying concerns, as also emotional distress, burnout and psychological morbidity (Parikh, Taukari and Bhattacharya, 2004). In a study of women working in a small scale industry whose work entailed sitting cross legged on the floor for six to eight hours in a day, it was found that the prevalence of pain and discomfort among such women was higher than that in the control group of housewives. The pain experienced in the working women was more enduring and less amenable to amelioration from rest and it was inferred that work posture led to such pain among them (Desai and Gaur, 2004). For women managers, 'major stressors' include getting the work done, clashes with superiors, competition, dual responsibilities of household and job, meeting deadlines, and so on (Kaila, 2004b). A study of women construction workers revealed often long (10-12) hours of work in a noisy, dusty environment full of pollutants like tar and glass. Respiratory, eye and skin disorders

as well as noise induced hearing loss were common. More than half the women (56%) reported of injuries that led to work loss. About three-fourthsof the women reported gendered stressors like sex discrimination and balancing work and family demands, apart from 'general' stressors like excessive workload and underutilisation of skills (Lakhani, 2004). Occupations like agricultural labour have been seen to be a 'significant factor' in risk of sexually transmitted infections (STIs) (Prasad, et.al, 2005).

III. ACCESS TO HEALTHCARE

The concept of access, 'use of healthcare by those who need it' (Makinen et.al (2000) cited in Dilip, 2005), is multilayered in its meaning. In the context of family planning services, access has been synonymously used with accessibility and defined as 'the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of the population' (Bertrand, et.al., 1995:65). As the authors note, it is assumed in this definition that potential clients are interested in obtaining the services. Access has 'five key elements', namely, geographic or physical accessibility; economic accessibility; administrative accessibility; cognitive accessibility, and psychosocial accessibility (ibid). The term, 'access', thus not only connotes physical access (physical proximity, transportational mobility, etc) but also refers to dimensions of social access. In the Indian context, typically caste and class advantages play it out. Access being a function of many determinants, peculiarities in healthcare provisioning in India undoubtedly influence access to healthcare in the country. There is an urban bias in the country's healthcare infrastructure. Hospitals and clinics are disproportionately concentrated in urban centres to the literal neglect of rural areas. On the face of weakening public healthcare in the country and increasing privatisation, it is usually the urban elite which gets timely and competent care. Apart from such dimensions of access, women's access to healthcare is 'mediated by gendered experiences' (Mishra, 2004). Attitudes towards health and general well-being of girls and women, submissive gendered roles that translate into limited control over household resources and restricted involvement in decision making, and housework and care giving roles that consume much of women's time and energies reflect in their inferior health status and access to healthcare.

The household as a site of discrimination

Women's empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutionalised incapacity owing to low levels of literacy, limited exposure to mass media and access to money and restricted mobility results in limited areas of competence and control (for instance, cooking). The family is the primary, if not the only locus for them. However, even in the household domain, women's participation is highly gendered. Nationally, about half the women (51.6%) are involved in decision making on their healthcare (IIPS and ORC Macro, 2000). Women's widespread ignorance about matters related to their health poses a serious impediment to their well-being. The NFHS-2, for example, reports that out of the total births where no antenatal care was sought during pregnancy, in 60 percent of the cases women felt it was 'not necessary'(IIPS and ORC Macro,2000). And, at a time when AIDS is believed to have assumed pandemic proportions in the

country, 60 percent of the ever married women have never heard of the disease (ibid). Women's inferior status thus has deleterious effects on their health and limits their access to healthcare.

That the family provides care for the ill and is a resource in times of crisis is well-recognised in social literature. However, the receiving of care as well as access to familial resources can be highly gendered, favouring the males. The family has often been described in many feminist writings as the 'the primary site of oppression', an institution where differential access to healthcare is played out. Miller cites numerous ethnographic evidence to show how son preference shapes practices of feeding, medical care and (suggestively) 'love and warmth' in families in north India (Miller,1997).Weaning diarrhoea (a condition triggered by weaning and exacerbated by nutritionally poor food and improper medical attention) is more common among girls than boys. Boys in north India may be favoured when it comes to extra helpings of food and savouries. Notably such differentials are not as pronounced in south India and may favour the females there in certain circumstances (for instance, during menstruation) (Miller, 1997). Almost without any dissenting evidence, medical care is seen to be delayed and less expensive for girls. There may also be greater readiness to seek medical care for boys (ibid; also Khan et.al., 1987).

The household has been seen to be a prominent site for gender based discrimination in matters of healthcare in a number of other studies too. Marriage in India is predominantly patrilocal with the new bride relocating to her marital house after marriage. Early marriage usually follows a truncated education, disadvantaging girls in many ways. In such a setup, the new bride, already ignorant about health processes, may be in a difficult position to seek healthcare. Barua and Kurz report from their study on married adolescent girls in Maharashtra that 'girls had neither decision making power nor influence' in matters relating to seeking healthcare for their problems (Basu and Kurz, 2001). These illnesses that incapacitated girls from discharging their household responsibilities were treated quickly. The culture of silence prevented care seeking in problems related to sexual health. Some reproductive health problems went untreated because they were considered 'normal'. In the Nasik study by Madhiwalla, et.al, 45% of the episodes of ill health in women went untreated (Madhiwalla, Nandraj and Sinha, 2000). In most cases it was financial incapacity that precluded women from seeking treatment. But, quite notably, in almost a quarter of the cases, women thought that the illness did not require medical attention. Treatment was also not sought for reasons like inaccessibility /inadequacy of the health facilities.

In a study carried out in Mumbai and Bangalore on discrimination, stigmatization and denial (DSD) experienced by HIV/AIDS people in a variety of contexts-healthcare, home and the community, workplace, schools, etc., - the authors observe that discrimination is a 'gendered phenomenon' (Bharat, Aggleton and Tyrer, 2001). Such gendered discrimination may be experienced in a number of familial settings and is most prominent in the marital household. Both the son and the daughter-in-law may have been afflicted by HIV/AIDS, yet it is the woman who was most likely to be subject to discriminatory practices like refusal of shelter, denial of

household property, denial of access to the children, being blamed for the husband's HIV positive status (that she could not keep him 'under control'; that she was responsible for his state, the latter especially being true if the husband's HIV positive status came to light soon after marriage). The authors note that 'discrimination against daughters-in-law was blatant even when sons received good familial care'. Being denied access to treatment and care and the unwillingness of the family to expend money towards the daughter-in-law's treatment formed a recurrent theme in such discrimination. As Bharat puts it succintly, it is a case of 'shared fate: gendered experiences' (Bharat, 1996).

Old age usually signals a period of dependency for most women (and men). The period is one of loneliness (the husband usually having predeceased the woman) and reduced power within and without the household. In such a setting, the woman may be subject to discrimination/neglect or even abuse. Khan, et.al report from a study in Uttar Pradesh that the special nutritional needs of the old women in the household were usually ignored, though blatant discrimination with respect to food intake may not take place (Khan, et.al.,1987). Sudden and serious sickness may merit attention from members of the family but recurrent/chronic illness is often neglected, with old people usually being seen as a burden on the family (ibid).

That gender differentials in access to healthcare are pan Indian in nature is discernible from nationally representative surveys like the NFHS and the NSS. Discrimination against girls in the household spills over to public spaces and may militate against programmes aimed at ameliorating the community's health. Gender differentials are present in child immunisation. The NFHS-1 data shows that, with the sole exception of the polio vaccine given at birth, higher proportions of boys are vaccinated than girls (Table 8) and are more likely to be fully vaccinated than girls. The survey also shows that for common childhood ailments like acute respiratory infection, fever and diarrhoea, boys are more likely to be taken to a healthcare provider/facility than girls.

Table 8: Sex differentials in Child Immunisation and Treatment of Childhood Ailments

	Child Immunisation (% vaccinated)										Treatment of ailments (% taken to a healthcare facility/ provider)		
			DPT			Polio							
			1	2	3	1	2	3					
Male	64	4.6	68.2	61.3	53.5	69.1	63.4	55	43.7	36.7	70.8	70.1	63
Female	60.3	4.6	64.4	57.1	49.8	64.8	58.9	51.7	40.6	34.1	60.8	63.1	59.2

*Source:*NFHS-1.
Note: ± Refers to children who are fully vaccinated i.e. those who have received BCG, measles, three doses each of DPT and Polio vaccine (excepting Polio 0).

In both the 42nd (1986-87) and 52nd (1995-96) rounds of the NSS, the percentage of ailing males treated was higher than that of ailing females in both rural and urban areas (Table 9). The differences in percentage of males and females treated is narrow (the differences being one to three percentage points) in both the rounds and hence it is argued in the survey report that 'the reported rates of treatment of the sick do not indicate any perceptible gender bias in either of the surveys' (NSSO,1998b: 20). However, given the admission of proxy reporting in various rounds of the survey and the limitations of NSS survey data that are considered 'incomplete' with respect to economic class and gender (Sen, et.al, 2002), the actual differentials in treatment between the sexes may be higher than what is indicated by the rounds of the NSS.

As an event in healthcare, hospitalisation usually marks an extreme step requiring closer monitoring of and attendance to the patient's health through inpatient admission. Quite naturally, it is an event that entails considerable expenditure of money and time on the part of the patients and their relatives. For the working class, hospitalisation would mean foregoing work days. Thus, in many ways hospitalisation marks a distinct event in the health seeking behaviour of people and its reporting is believed to be free from errors. For the country as a whole, gender differentials are not evident in hospitalisation rates for males and females in either rural or urban areas (Table 9).

Table 9: Treatment of Ailments and Hospitalisation, NSS (42nd and 52nd rounds)

	% of ailing persons treated during 15 days		Number (per 1000) of persons hospitalised in 1995-96 and 1986-87	
	1995-96 (52nd round)	1986-87 (42nd round)	1995-96 (52nd round)	1986-87 (42nd round)
Rural				
Male	84	83	14	*
Female	82	80	13	*
Person	83	82	13	28
Urban				
Male	91	90	20	*
Female	90	88	20	*
Person	91	89	20	17

Source: NSSO Report no 441.
Note: * estimates not available

However, if hospitalisation data is disaggregated to fractile groups according to monthly per capita consumption expenditure (MPCE)-a proxy for the level of living of the household- valuable insights into access issues within and outside the household can be gleaned (Table10). Gender differentials are present, though not very discernible, in the lower fractile groups but become prominent in the two higher fractile groups. Further, in both rural and urban areas, rates of hospitalisation increase progressively with the increase in MPCE. It may be argued here that hospitalisation being a costly event both in terms of time and money, poor people may avoid/delay hospitalisation and do so for both the sexes. That the lowest fractile group usually reports a slightly higher hospitalisation rate for females may be suggestive of the fact that it must be in cases of extreme and incapacitating ill health that women of this fractile group get hospitalised. The gap in hospitalisation rates between the two sexes increases (almost progressively) with the increase in MPCE indicating that factors other than the purchasing power of the household influence women's hospitalisation rates in the higher fractile groups. Further, the disparity in healthcare provisioning in the rural and urban areas of the country is amply demonstrated by the lower hospitalisation rates in rural areas compared to the urban areas across *all* the fractile groups, even though rural India has poor health indices on many counts (including infant mortality rate often considered to be a robust indicator of a community's health). Considering that morbidity rates were lower and hospitalisation rates higher during the mid 1980s in the rural areas of the country (as reported by the NSS 42nd round), the decline in hospitalisation rates in the mid 1990s indicates not only deteriorating conditions in rural healthcare but also increasing inability of people to afford healthcare.

Table 10: Proportion of persons hospitalised (number per 1000) in the last one year by MPCE fractile group, NSS 52nd round

	MPCE fractile group							
	0-10	20-Oct	20-40	40-60	60-80	80-90	90-100	
	Rural							
Male	3	6	8	10	16	22	39	14
Female	4	5	8	9	15	21	34	13
Person	4	6	8	10	15	21	37	13
	Urban							
Male	12	13	17	19	20	26	39	20
Female	13	13	15	20	22	28	36	20
Person	12	13	16	19	21	27	38	20

Source: NSSO Report no 441,1998.

The unwillingness of families to expend towards healthcare of female members has been reported in a number of micro studies. The NSS data confirm the same for the country as a whole. For non-hospitalised as well as hospitalised treatment, the total expenditure incurred for males is considerably higher than that for females in both rural and urban India (Table 11). Though, as has been seen earlier, treatment for ailments and hospitalisation for females do not show very distinct differences (patterns can be read into them nevertheless), cost differentials between the sexes in accessing treatment show that services that are accessed for females are usually the ones that are convenient and cheap than those accessed for the males in a household. Typically such facilities are those that are cheaper and/or closer to the place of residence.

Table 11: Average Total Expenditure (in Rs.) incurred per ailment for Non-hospitalised and Hospitalised Treatment, NSS 52nd round

	Non-hospitalised Treatment		Hospitalised Treatment	
	Rural	Urban	Rural	Urban
Male	151	187	3,778	4,185
Female	137	164	2,510	3,625
Person	144	175	3,202	3,921

Source: NSSO Report no 441,1998.

Formal healthcare

The formal healthcare setup in India is huge and diverse. Sectoral plurality and functional diversities mark the provisioning of healthcare in the country. The privileging of the biomedical model in medical colleges across the country reflects in various ways, ranging from textbooks that are often gender blind/ insensitive to providers' attitudes that may display lack of understanding of socio-economic causes underlying ill health. The public sector has a considerable and diverse physical presence, largely owing to the gains made prior to the 1990s. The public healthcare infrastructure ranges from a subcentre in a village to multispecialty, multibedded hospitals in urban areas. Primary Health Centres, Rural Hospitals, Civil Hospitals as well as a host of facilities like municipal hospitals and clinics are some of the other public healthcare facilities. The state may also run health facilities dedicated to specific diseases (for example, leprosy clinics) or specific population sub groups (for instance, Central Government Health Scheme). The structure of the public health sector is thus fairly well defined. In the 1990s, there has been uneven growth in the number of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Subcentres (SCs) in the different states and union territories of India. While some states have witnessed considerable increase in such facilities, the progress has been very slow or stagnant in others (Annexure XIV). For the country as a whole, tribal areas are deficient in the three types of public facilities set up for providing primary healthcare, the deficiency being severe for Community Health Centres. Barring a few states and union territories, the others have deficiencies in the three types of public facilities (Annexure XV).

The private health sector in the country is large and amorphous, and chiefly engaged in curative care. The not-for-profit sector (including services by non governmental organisations) is also present in many urban and rural areas of the country. There is remarkable diversity in the private sector in terms of the systems of medicine practised, the type of ownership (ranging from sole proprietorship to partnerships and corporate entities), and the services provided. The private sector has a presence in most medium to big villages as well as in towns and cities. However, facilities with technologically advanced equipment and offering varied specialisations are almost always in the big urban areas. In terms of sheer numbers as well, the private sector is disproportionately concentrated in the urban areas. For example, in 2004, Jalna district of Maharashtra had nine private facilities for every public facility for the district as a whole. The ratio is higher in talukas having greater urban populations. Jalna taluka, where the administrative headquarters is located, had twelve private facilities to every public facility (Mishra and Raymus, 2004).

Large scale national surveys like the NSS and the NFHS, as well as numerous smaller studies report that the private sector is the dominant sector in healthcare. The 52nd round of the NSSO (carried out in the mid 1990s) estimates that the private sector accounts for nearly 80% of non-hospitalised treatments in both rural and urban areas, up by 7-8 percentage points from the estimates of the 42nd NSSO round in the mid 1980s (NSSO, 1998b). For hospitalised treatment, the public sector has lost out to the private sector in the 1990s, in contrast to the 1980s when the public sector accounted for the majority of the hospitalised treatments in both rural

and urban areas of the country (ibid). Client satisfaction is higher in the private sector along indices like behaviour of the staff, privacy accorded, amount of time spent, etc (IIPS and ORC Macro, 2000). Despite its ubiquity and appeal, the private healthcare sector in India is poorly regulated and operates with little accountability with respect to its actions (Nandraj,1994).Allegations of irrational practices and even malpractices are not uncommon against the private sector in India. A large number of studies (micro as well as large scale macro studies) have pointed out the high cost of treatment in the private health sector of the country, the costs being many a time more than double of that incurred in the public sector.

The Integrated Child Development Services (ICDS) is a centrally sponsored programme of the Government of India, operational since 1975. The programme, the largest of its kind in the world, provides a host of services,aimed at ameliorating the nutritional and health status of children and women. The programme operates on the premise that children below six years and pregnant and nursing women of the 'poorest of the poor families and living in disadvantaged areas including backward rural areas, tribal areas, and urban slums' constitute the 'most vulnerable groups'. Currently the scheme is operational in 4200 projects in the country with the number of stated beneficiaries being 2.77 crores. The scheme has 'universal/near universal coverage' in the states and union territories of Arunachal Pradesh, Goa, Haryana, Himachal Pradesh, Karnataka, Manipur, Meghalaya, Mizoram, Sikkim, Tamil Nadu, Tripura, Andaman and Nicobar islands, Chandigarh, Delhi, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Pondicherry. In some of the blocks in the country, the scheme also operates nutritional and educational programmes for adolescent girls.

Given its reach and the machinery, the ICDS has tremendous potential in realising its goals. However, it has often been criticised for being a tremendous drain on state resources with little benefits accruing thereof, widespread malnutrition related deaths of children in tribal areas being a case in point. The programme suffers from severe limitations. It rarely nets in all eligible children and women as beneficiaries. In the state of Maharashtra, for example not more than three quarters of eligible children and women are enrolled in the programme (the figures being lower for women). A little more than half the eligible women benefit from supplementary nutrition. In the case of children, the proportion stands a bit higher being a little above 60 percent (Duggal, 2002). Further, inspite of delivering services to pregnant and nursing women and to some extent, adolescent girls, the programme is child centric in design, its stated objectives focussing on child health and well-being. The inclusion of pregnant and nursing women as beneficiaries is owing to their maternal status. The focus on child health is deserving and merits the attention. However, it dilutes the other components of the programme. Among ICDS functionaries, pregnant and nursing women are seen as incidental to the programme. In one study, such women were never seen during random visits to *anganwadis* and programme functionaries admitted that the supplementary nutrition meant for women is often collected and supposedly consumed by the women at home (Mishra, Duggal and Raymus,2004).

Disability and access to healthcare

Many disabilities are preventable and by one account, over 70 percent of the

disabilities can be prevented (Mullick Alkazi, 1992). Disabilities owing to motor accidents, polio induced handicaps, minor speech and hearing problems, are avoidable and could be effectively circumvented where timely and competent care is readily available. In a more equitable society, where access to healthcare is not as skewed as it is in India, the burden of disabilities would not be as much.

Addressing the various needs of the disabled requires a multipronged strategy. As Mullick Alkazi points out, rehabilitation of the disabled includes physical management of disabilities (that includes the training of the disabled in the use of appropriate aids and appliances), 'early and adequate education' and vocational rehabilitation. It is estimated that only 0.2 percent of the disabled in India have access to rehabilitative services (ibid), there being many reasons for it. Typically class, geographical location and gender factors intersect resulting in poor rehabilitative services for the disabled. Physiotherapy centres are few and limited to big hospitals, usually in the private sector. There are very few training institutes for physiotherapy in the country. The reliance on expensive equipment and shortage of trained human power along with deficiencies in the courses (like the 'misplaced emphasis on electrophysiology') have resulted in gross shortcomings. Further, aids and appliances (for instance, hearing aids) are usually western in their design, which make them inappropriate in the Indian context resulting in a 'very high rate of rejection' by the disabled person (ibid). One may add that in a context where disability has attracted such little and lopsided attention, addressing gendered needs within disability takes a backseat. Across the world, disabled girls and women are disadvantaged in many ways that limit their participation in development. Denial (or limited) access to education, vocational training, employment, and rehabilitative services as well as limited mobility both on account of their disability as well as restrictive practices make disabled women lead secluded and isolated lives (Mobility International USA, 2003). It has also been observed that access to reproductive health services are denied to disabled women by a host of factors working in tandem, namely, 'cultural attitudes, physical barriers, financial constraints and unenlightened medical personnel and healthcare providers'(ibid).

Another indicator of the lopsided pattern in addressing disability based needs of the country can be gauged from the geographical distribution of medical specialists in the country. Personnel trained in the specialities of eye, ENT (ear, nose and throat), orthopaedics and psychiatry as also those trained in different therapies would be indispensable in addressing the needs of the different types of the disabled. However, such specialised doctors are minimally present in the public healthcare system of the country. Four types of specialists (gynaecologists, paediatricians, physicians and anaesthetists) are recruited to service the network of rural/cottage hospitals that form the backbone of the public healthcare network in the country, virtually leaving the vast ranks of the disabled in rural India to seek services from the private sector. On its part, the facilities in the private sector offering services to such a 'niche clientele' as the disabled (to borrow a not so inappropriate term from Management Theory) are few and present in big urban areas.

Women and access to mental healthcare

The development of mental healthcare in the country has a chequered history. The pre-independence era was characterised by the establishment of mental hospitals, facilities like the hospitals at Ranchi, Thana, Yerwada, etc, being embedded in the collective imagination of the people of the country. Mental health has attracted varying degrees of attention in the various health committees constituted by the Government of India. The first steps towards making mental healthcare more accessible to the communities came in the form of establishment of General Hospital Psychiatric Units (GHPUs). District Psychiatric Units (DPU) have also been set up, though barring some southern states, the DPUs are very rare in the rest of the country. The Alma Ata Declaration of 1978 recommended mental healthcare as an essential part of primary healthcare. However, mental healthcare continues to be not only an underserved area in healthcare in the country, both in terms of emphasis and human power, but also the orientation of the discipline betrays bias towards psychiatry. The mental health curriculum in undergraduate medical courses is deficient in terms of the hours of training and is biased towards the biomedical perspective to the virtual absence of socio-psychological orientation to mental health.

Bhargavi Davar observes that the mental health sciences, at least traditionally, have been individual in their orientation (Davar,1999). One should take cognizance of women's 'lived experiences' while addressing their mental health problems. Marriage, multiple work burdens, violence, membership in marginalised groups, are stressors that women are (more) subject to, that lead to somatisation and depression. Their experiences, more symptomatic of the fuzzy, less accepted concept of 'distress' than 'illness' and reflective of the socio-political context of their lives- is more suited to psycho-social research than to the medical discipline of psychiatry. But the mental health sciences (and the hierarchy operative therein with psychiatry being privileged) have been virtually blind to women's mental health vis-a vis the socio-political context of their lives. As the author puts it, there is a 'perceptual blackout' in the mental health sciences about the woman question.

Access to mental healthcare is gendered in various other ways. Male patients outnumbered females in both the hospitals from where data was collected for the study by Vindhya, Kiranmayi and Vijayalakshmi (*op.cit*, 2001). (Davar's review also indicates such gender differentials in the utilisation of facilities.) More than 50 percent of the patients in both the facilities were male, the gender gap being wider for the public hospital. (Out of a total bed strength of 300 in the public hospital, 225 were for men and the remaining 75 for women). Further, as the authors point out, the mental health services in the country, with their emphasis on electrotherapy and chemotherapy, are geared to handle severe mental disorders (conditions that usually affect men). The common mental disorders that usually afflict women require different lines of treatment like counselling and support structures. The present mental healthcare system in the country, with its emphasis on psychiatric services, thus is inappropriate to meet the needs of women's mental health problems. As has been observed earlier, not only is there a deficit in mental health personnel in the country, but also there is marginalisation of clinical psychologists, psychiatric social workers and psychiatric nurses in the dominant discourse on mental healthcare. The

services of the latter are critical to the successful integration of mental healthcare into primary care as also to make it responsive to the needs of women. Further, the National Mental Health Programme (NMHP) of 1982 betrays and perpetuates the psychiatric bias in mental healthcare. The programme singles out the severe disorders of epilepsy, mental retardation and the psychoses for intervention and is heavily informed by the biomedical model. It has been commented that, '(the NMHP) does not have a women's mental health agenda' (Vindhya, Kiranmayi and Vijayalakshmi, 2001). The programme is gender blind as well, planning only for 'illness' and not for 'distress' as Davar comments. She also observes in this context that the promotion of the 'community' paradigm in the national mental health policy is premature since there is as yet little acceptance or understanding of mental illnesses, with care being highly gendered even within the familial and community setting (Davar,1999). The community is also not being equipped, financially or otherwise, to address such issues (ibid).

Occupational health

Women's access to occupational health services is limited for various reasons. Access to occupational health services is limited for workers around the world. It is estimated that only 5-6 percent of the workers in the developing countries and 20-50 percnet in the industrialised world have access to adequate occupational health services (WHO,2002 cited in Kaila,2004a). Gendered vulnerabilities may further exacerbate the situation. For one, a substantial proportion of women in India work in the unorganised sector, where social security benefits are rare and routine job entitlements virtually nonexistent. Occupational health programmes of the WHO addressing women workers in the informal sector are yet to be in place in the developing countries (ibid). Perchance in the context of a labour surplus economy like India's, occupational health is one of the expendable luxuries for employers. In fact, in a recent study, discrimination in financial and career matters were associated with recurrent physical and psychological symptoms of the workers (Lakhani, 2004). As the author also notes, women may receive less on job safety monitoring than men, making them less trained to carry out their tasks. This leads to a 'potentially dangerous cycle in which tradeswomen are asked to do jobs for which they are not properly trained, then are injured when they do them or are seen as incompetent when they are unable to do them' (ibid:191). Further, across the world, there is little recognition of health risks in the occupational setting and the manifold consequences they can engender. It has been observed, for instance, that excepting a small minority of cases, very rarely do doctors enquire about work or work patterns of women coming with gynaecological or other complaints. Being multifactorial and having bearing on the worker's working capacity, occupational diseases are but a subset of occupational health. They are, as we have seen, determined by 'a complex set of social, cultural, economic, physical, and biological factors', necessitating preventive and promotive strategies to forestall disease and ensure health. It has therefore been articulated that occupational health be integrated in the primary health care system (Jeyaratnam,1992).

Reproductive health services

Decades of policy engagements with population control has spawned a genre of writings on the subject. Literature has

however been restricted to topics like contraceptive acceptance among women. Such writings on areas like programme impact and access that mainly flowed under the broad rubric of operations research were indispensable to the goals and objectives of the female specific Family Planning Programme in India. In the past decade or thereabouts, there has been a marked shift in the studies on reproductive health services in the country. Areas of enquiry broadly coincide with the (emerging evidence on) different reproductive health problems of women. In the wake of the adoption of the Reproductive and Child Health Programme by the Indian state, a series of studies (namely the RCH Facility Studies) have been undertaken to gauge the preparedness of the public sector in responding to the demands of the programme.

Knowledge and use of contraception in India have been, understandably, abiding themes for academicians and policy planners in the country. Over the span of fifty odd years, there has been increase in the levels of knowledge of contraceptive methods. The NFHS-2 reports that 99.0 percent of the currently married women in the country are aware of any contraceptive method (Annexure XVI). Even rural India reports very high levels of knowledge of any contraceptive method. The knowledge levels are higher for the programme driven modern methods of contraception in comparison to those for the traditional methods. The public sector is the dominant provider of contraceptive related services in the country as a whole, though its share has come down from 79 percent in NFHS-1 to 76 percent in NFHS-2 (IIPS and ORC Macro, 2000). However, inspite of nearly universal knowledge levels of any method of contraception, there is still a considerable unmet need for the same. It is estimated that if all women desirous of spacing or limiting their families were to use contraception, then the contraceptive prevalence rate would increase from the current levels of 48% to 64% (IIPS and ORC Macro, 2000). Interestingly, higher unmet needs of family planning are *generally* seen among groups that have higher fertility levels (e.g. rural India; women belonging to lower SLI; Muslims - groups often assailed by vested interests to be impediments in the realisation of the country's population goal) (Table 12) thus indicating programmatic shortcomings. In fact, NFHS-2 reports that 42.6% of the current users of a modern method of family planning reported that they were not motivated by anyone, instead they have adopted the method on their own. Further, imparting information on alternate methods of family planning and on the possible side effects of methods is also very infrequent (ibid). Keeping in mind the guiding principles of 'reproductive rights' and 'informed choice' emerging from the ICPD, such programmatic shortcomings need to be addressed as a policy mandate.

Table 12: Fertility and unmet need for Family Planning among select groups

		Unmet need for family planning		
		For spacing	For limiting	Total
Residence				
Urban	2.27	6.7	6.7	13.4
Rural	3.07	8.9	7.8	16.7
Education				
Illiterate	3.47	7.8	8.5	16.2
Literate (less than middle school)	2.64	8.4	6.1	14.4
Literate (middle school complete)	2.26	11.1	6.1	17.1
Literate (high school complete and above)	1.99	8.8	6.3	15.1
Religion				
Hindu	2.78	8	7.1	15.1
Muslim	3.59	11	11	22
Christian	2.44	8.7	6.1	14.8
Sikh	2.26	3.6	5.1	8.6
Jain	1.9	5.9	3.6	9.5
Buddhist/neo-Buddhist	2.13	7.4	5.3	12.7
Other	2.33	6.9	5.4	12.3
No religion	3.91	14.2	11.4	25.6
Caste/Tribe				
Scheduled Castes	3.15	8.6	8.2	16.8
Scheduled Tribes	3.06	8.8	7	15.9
Other Backward Classes	2.83	8.6	7.1	15.7
Others	2.66	7.7	7.5	15.2
Standard of Living Index				
Low	3.37	9	8.8	17.9
Medium	2.85	8.5	7.2	15.6
High	2.1	6.7	6.1	12.8
Total	2.85	8.3	7.5	15.8

Source: NFHS-2.

A characteristic feature of access to healthcare in the Indian context is the *unevenness* in the physical and functional provisioning of facilities across the country. The uneven access to antenatal care can, for example, be gauged from the fact that India is classified in the Class B category of nations in the world where between 11% to 50% of the districts are at 'high risk' of neonatal and maternal tetanus (UNICEF,WHO,UNFPA,2000). Neonatal and maternal tetanus can be prevented by universal coverage of antenatal services and safe delivery practices. The tetanus toxoid injections which form part of routine antenatal care in the country would help in countering the problem to a large extent. However, given the poor coverage in antenatal care services in the country, the elimination of neonatal and maternal tetanus remains an unrealised goal.

NFHS-2 indicates that nationally about two-thirds (66.8%) of the births in the three years preceding the survey had received two or more tetanus toxoid injections during the pregnancies (IIPS and ORC Macro, 2000). In no state is there universal coverage of such a service, though the southern states and some others in the rest of the country may have more than 75% coverage. In ten of the twenty five states of the country (for which the NFHS provides the figures), less than 60% of the births have received two or more tetanus toxoid injections. Meghalaya (30.8%), Mizoram (37.8%) and Arunachal Pradesh (45.6%) bring up the rear (Table 13).Other indicators of antenatal care services are as discouraging. Only 43.8 percent of the births in the preceding three years of the survey had received three or more antenatal checkups, there being large interstate variations in this regard, too. While states like Kerala (98.3%) and Goa (95.7%) are the leaders, Uttar Pradesh (14.9%) and Bihar (17.8%) are the tailenders. Similarly, less than half (47.5%) of the births received the supply of iron or folic acid tablets or syrup for three months and more. Further, women of certain backgrounds (tribals, illiterates, poor) are less likely to receive antenatal care during their pregnancy. For example, almost half of the births among illiterate women (48.4%) and poor women (45.1%) are not preceded by any antenatal checkups (Annexure XVII).

Table 13: Antenatal care services in the states of the country

	% recd at least one ANC checkup	% recd 3 or more ANC checkups	% recd 2 or more TT injections	% given any iron or folic acid tablets or syrup	% recd supply of iron and folic acid tablets or syrup for 3+ months
North India					
Delhi	83.5	68.2	84.9	77.8	69.5
Haryana	58.1	37.4	79.7	67	53.3
Himachal Pradesh	86.8	60.9	66.2	85.6	70.9
Jammu & Kashmir	83.2	66	77.7	70.8	55.8
Punjab	74	57	89.9	79.6	64.2
Rajasthan	47.5	22.9	52.1	39.3	30.6
Central India					
Madhya Pradesh	61	28.1	55	48.9	38.4
Uttar Pradesh	34.6	14.9	51.4	32.4	20.6
East India					
Bihar	36.3	17.8	57.8	24.1	19.8
Orissa	79.5	47.3	74.3	67.6	62.2
West Bengal	90	57	82.4	71.6	56.4
North east India					
Arunachal Pradesh	61.6	40.5	45.6	56.3	47.6
Assam	60.1	30.8	51.7	55	45.3
Manipur	80.2	54.4	64.2	50	38
Meghalaya	53.6	31.3	30.8	49.5	40.6
Mizoram	91.8	75.8	37.8	72.7	62
Nagaland	60.4	23.1	50.9	42.5	26.7
Sikkim	69.9	42.6	52.7	62.4	50.4
West India					
Goa	99	95.7	86.1	94.7	87.8
Gujarat	86.4	60.2	72.7	78	66.6
Maharashtra	90.4	65.4	74.9	84.8	71.6
South India					
Andhra Pradesh	92.7	80.1	81.5	81.2	70.7
Karnataka	86.3	71.4	74.9	78	74.2
Kerala	98.8	98.3	86.4	95.2	88.6
Tamil Nadu	98.5	91.4	95.4	93.2	84.1
India TOTAL	65.4	43.8	66.8	57.6	47.5

Source: NFHS-2
Note: Includes information on the two recent births in three years preceding the survey.

Like antenatal care, delivery and post natal checkups are limited and skewed across social groups in the country. (In more ways than one, seeking of antenatal care can be predictive of institutional delivery as well as post partum checkups. The NFHS-2, for example, reports that the highest proportion of institutional delivery and post partum checkups was among women who had received four or more antenatal checkups, in comparison to those who had had less ANC checkups. Seeking of antenatal care thus sets the stage for subsequent care seeking for delivery and post delivery related events).Only a third of all births in the three years preceding the NFHS-2 took place in institutions (public, private or NGO/trust run facilities), while almost the whole of the remainder took place in homes (IIPS and ORC Macro,2000). (Deliveries at health facilities have registered an increase between the two NFHS rounds, the corresponding figure being 26% for NFHS-1). There are large variations across the socio-economic groups (Table 14). In contrast to 64.6% of the births in high SLI group that took place in health facilities, 18.5% of the births in low SLI took place in facilities. While almost two thirds (65.1%) of the births in urban India took place in facilities, the figures come down to a quarter (24.6%) for rural India. Considering the high proportion of non-institutional births, especially among the disadvantaged groups, it is not surprising (but tragic all the same) that very few receive postnatal care. Considerable proportions of women suffer from possible postpartum complications (as is evidenced from the literature cited in the section on maternal morbidity). But, post natal care is a neglected area both by service providers as well as women. Among non-institutional births, only 16.5% were followed by a post partum checkup within two months of the delivery. Where post partum checkups did take place for non-institutional births, few were carried out within two days of the birth (14%) or the first week after delivery (31%) (Table 14).

Table 14: Place of delivery and post natal care in India

	Place of delivery					Among those non institutional births where postpartum checkup was carried out	
	Health facility/institution			‡			
	Public	NGO/trust	Private				
Residence							
Urban	29.1	1.5	34.5	33.9	19.6	14.3	32.3
Rural	12.5	0.5	11.6	74.3	16.1	14.2	30.5
Mother's Education							
Illiterate	10.2	0.4	6.8	81.5	13.6	14.5	31.9
Literate (less than middle school)	23.3	1.1	19	55.7	24	12.8	28.9
Literate (middle school complete)	28.5	1	25.6	43.9	23.2	19.7	31.1
Literate (high school complete and above)	24.2	1.5	49.3	24.3	27.4	10	26.7
Caste/Tribe							
Scheduled Castes	16	0.5	10.3	72.1	17	15.5	32.5
Scheduled Tribes	10.7	0.7	5.7	81.8	14.1	5	17
Other Backward Classes	16.3	0.8	19	62.8	15.6	11.2	31.5
Other	17.9	0.9	21.3	59	18.3	18.4	32.9
Standard of Living Index							
Low	11.9	0.4	6.2	80.3	15.5	14.4	30.5
Medium	18.1	0.8	16	64.1	16.5	13.6	29.4
High	20.3	1.1	43.2	34.6	20.5	15.8	37.6
Total	16.2	0.7	16.7	65.4	16.5	14.2	30.8

Source: NFHS-2.
Note: Table is based on the two recent births in the three years preceding the survey.
‡ includes own home and parents' home

A major public health problem like maternal mortality can be tackled by the provisioning of emergency obstetric care. Reduction in maternal mortality ratio can be effected by an equitable access to emergency obstetric care (as also safe abortion services). Bhat observes, for example, that 'the level of maternal mortality is clearly strongly related to amenities and infrastructure available in the village' (Bhat,2002) (emphasis added). It cannot be said of awomen, however normal and uneventful her pregnancy may be, that she is not in need of obstetric care. The role of antenatal care in preventing or even predicting obstetric emergencies is questionable (Maine and Rosenfield,1999; McDonagh,1996). Yet, access to emergency obstetric care services is a privilege usually reserved for the advantaged groups of urban India. As we have seen earlier, in the private sector technologically advanced facilities with skilled human power, more often than not, operate in urban areas. Very soon in this section we shall see how considerable proportions of the public health facilities (like the FRUs, CHCs, PHCs) are not adequately equipped in areas of staff, infrastructure, equipment and supply to provide for even outpatient care. With poor transportation facilities and a poorly functioning referral system, obstetric emergency cases from rural India become primary casualties, though urban India is not very far behind either.

Despite the legalisation of abortion (for chiefly biological reasons) in India, access to safe abortion services is neither assured nor uniform across social groups of the country. There are more number of certified abortion facilities in urban areas and in the developed states of India in comparison to those in rural India or the less developed states (Khan, et.al), equity being an obvious casualty in the process. The authors say that, 'until recently, increasing access to MTP services was not an important issue for the Ministry of Health and Family Welfare'(ibid: 518). Further, certified public facilities may not carry out abortions for reasons like lack of equipment, feeling of incompetence among the (trained) doctors and it is estimated that 1.6 million abortions in India are handled by informal providers (Duggal and Ramachandran, 2004). A recent study carried out in seven states (spread across north, west, central and southern India) found that informal providers were present and provided services in tribal, rural as well as urban areas of the states. The services of informal providers were varied, ranging from giving of oral herbal medicines to invasive methods like insertion of roots and sticks into the vagina or resort to 'modern' methods like injections. Some injections given by such providers are actually contraindicated during pregnancy (Ganatra and Visaria, 2003).

In the Maharashtra community based study, only a quarter of the induced abortions in the period 1976-2000 fell within the framework of the Medical Termination of Pregnancy (MTP) Act, the majority of the pregnancies being terminated for reasons such as unwanted nature of the pregnancy, economic reasons and sex selection. Further, care is not sought for a considerable percentage (21.6%) of spontaneous abortions with telling implications for maternal health. The private sector is the overwhelmingly dominant sector in abortion related services, often being situated closer than the public facilities. However, among both the private and the public providers, treatment (both medical and otherwise) varies according to the woman's background, especially the economic class

to which she belongs. Further, on an average, services in the private sector cost Rs.1300 (being almost eight times costlier than those in the public sector), a cost that may be formidable for many (Saha, Duggal and Mishra,2004).

Treatment for infertility is an expensive and time taking process. In a country where concerns of overpopulation have dominated the policy environment, infertility is seen as an 'ancillary issue'(Unisa,1999). Further, infertility being non fatal, it has not attracted requisite attention from policy and programme planners (ibid). Health seeking behaviour for infertility may range from seeking allopathic treatment on one hand to trying out other systems of medicine, traditional healers, home remedies, and visits to religious places and persons. Allopathy has been observed to be the preferred system for treatment (Unisa, 1999).However, the extremely limited presence of the public sector in this regard makes the private sector the dominant provider of infertility related services in the country. High costs of treatment are a major deterrent for seeking services for infertility. Unisa's study in Andhra Pradesh shows that the average cost of first course treatment was about Rs. 2,500 in a private sector hospital and about Rs.2000 for services availed at a private doctor's clinic. The cost for similar services availed at a government hospital was about Rs.1410. The protracted and expensive treatment for infertility resulted in many case dropouts. Also, service seekers tried other options in cases where allopathy did not work (*ibid*). Further, there are a number of Artificial Reproductive Technologies (ARTs) like artificial insemination, *in vitro* fertilisation, gamete intra-fallopian transfer and intra cytoplasmic sperm injection, the services being almost exclusively offered by the private sector. Recourse to such services are often the last resort, after the couples have tried out other 'less intrusive' options (Widge 2001 cited in Widge, 2004).The author also notes that there is difficulty in accessing information about ARTs and specialist doctors. Services are usually carried without imparting adequate information or counselling and there is poor observance of informed consent practices. In a poorly regulated environment, accessing services for infertility may also make the couple/ woman vulnerable to unscrupulous and exploitative practices of the providers (Widge, 2004).

The Facility Survey conducted under the aegis of the Reproductive and Child Health project indicate adequacies of public healthcare facilities in categories of staff, laboratories, operation theatres, drugs, equipment, training of staff for various services, etc. According to the survey, no hospital is fully equipped to discharge the services, though the District Hospitals (DH) in the country are found to be better placed in critical inputs than the First Referral Units (FRUs) which, in turn, are better situated than the Community Health Centres (CHCs) (IIPS,2001b). As is characteristic of facilities and services in the country, there are considerable interstate differences with the indices being *usually* (though neither always nor exclusively) poorer for the BIMARU states. Among district hospitals, 80 percent or more of the facilities have adequately equipped laboratory, generator, separate operation theatre for gynaecology and OPD facilities for gynaecology/obstetrics, but only 66 percent of the facilities have linkages with a blood bank. The proportion of the FRUs having such facilities falls with about 70 percent having adequately equipped laboratory, generator and

separate operation theatre for gynaecology. OPD services for gynaecology/obstetrics are available in 63 percent of the FRUs. At least 60 percent of the CHCs have adequately equipped laboratories and 57 percent have separate operation theatre for gynaecology. OPD facilities for gynaecology/obstetrics is available in only 43percent of the CHCs. In the area of staff, district hospitals are most likely to have the medical and paramedical staff required for reproductive and child health services. In the FRUs and the CHCs, excepting certain categories of paramedical staff (for instance, laboratory technician, staff nurse and pharmacist), the others (including specialist doctors) are more likely to be absent. Training of the staff in the fields of sterilisation, IUD insertion, emergency contraception, RTI/STI, new born care and emergency obstetric care was inadequate across the various types of facilities. Emergency obstetric care kits are available in about 30% of the district hospitals and FRUs and 15% of the CHCs. Normal delivery kits are available in about half or more of such facilities. About a third of the district hospitals and the FRUs and a quarter of the CHCs had attended to referred cases of delivery during the three months prior to the survey. Among the PHCs surveyed, 88 percent had a male medical officer and 20 percent had a female medical officer. Normal delivery kit was available in 46 percent of the PHCs, labour room table/equipment in 53 percent and MTP suction aspirator present in only 16 percent of the facilities. Barring contraceptive services, provision of reproductive services is very limited in the PHCs. Only 34 percent of the PHCs carry out deliveries and a meagre 3 percent conduct MTPs. RTI/STI services are provided in 16 percent of the PHCs. Indeed, a telling comment on the primary healthcare system in the country, built on an edifice of community location and a referral chain. Table 15 gives the percentage of adequately equipped facilities at various levels, percentage of hospitals attending to referred delivery cases and the proportion of the PHCs carrying out specific reproductive health services.

Table 15: Adequacy and select reproductive health services at public health facilities

	Hospitals						
	Dist. Hosp. -210	FRUs -760	CHCs -886				
	% adequately equipped			% adequately equipped		% carrying out select reproductive services	
Infrastructure	94	84	66	Infrastructure	36	Delivery	34
Staff	84	46	25	Staff	38	MTP	3
Supply	28	26	10	Supply	31	RTI/STI	16
Equipments	89	69	49	Equipments	56	IUD insertion	72
% attending to referred delivery cases•	33	34	25	Training	12	Sterilisation	65

Source: RCH Facility Survey
Note: Figures in parentheses refer to number of facilities surveyed.
• in three months prior to the survey.

Informal healthcare

The formidability of the formal healthcare system may drive women to seek care from the informal sector- a prospect riddled with dangers to life and limb. The poor quality of care (perceived to be) received at the public facilities and the sector's general inaccessibility (in terms of distance, time, and behaviour of staff), and the high costs of the private sector are often the guiding reasons for women to seek the services of the informal sector. Other reasons for seeking such care may include the privacy ensured by the informal sector (especially in sensitive matters like abortion and sexually transmitted diseases) and congeniality of behaviour of the providers. The size of the informal sector in the country is not inconsiderable. In the year 2004, in the economically average district of Jalna in Maharashtra, facilities run by informal providers constituted about a seventh of all healthcare facilities in the district (Mishra: personal observation). Such facilities were usually present in rural areas, where the formal (public as well as private) healthcare structure was either completely missing or dysfunctional. The 'qualifications' sported by such providers were often similar sounding to formal ones and the provider usually had some degree of familiarity with the formal healthcare, having either worked as an assistant to a doctor earlier or in a non-technical capacity in a formal healthcare facility. In another study, again in Maharashtra, providers with unknown qualifications/unqualified providers constituted 6.0 percent of the total providers in Ahmednagar district, the low figures for unqualified practitioners being understood to be underestimates (Kavadi, 1999).

Women's access of services provided by the informal sector has been reported in a variety of situations. The study on women's morbidity in Nasik district of Maharashtra,

revealed that there was 'extensive use of informal service' by the women, especially for chronic and non infectious cases (Madhiwalla, Nandraj and Sinha, 2000). Resort to the services of informal providers for abortion has been seen in contexts where formal providers are difficult to reach, are expensive or 'do not treat clients with respect or dignity' (Ganatra and Visaria, 2003). As the authors note, 'their (informal providers') personalized services, ready availability, congenial behaviour and the convenience also appeared important reasons for clients to use their services' (ibid:26) indicating the failure of the formal healthcare system in many respects. High costs for treatment of infertility may result in discontinuation of the treatment or resort to unqualified providers (Singh, Dhaliwal and Kaur, 1996 cited in Widge, 2004).

Services of the informal sector may hold appeal to women constrained by limited resources of time and money. Rural areas of the country being especially disadvantaged in terms of the provisioning of facilities, it is no surprise that informal service providers are especially present and active in remote reaches of the country. Some providers in the informal sector may be practising traditional medicine that may be efficacious (see, for example, Ganatra and Visaria, 2003). But, the sector is largely replete with practitioners with limited (and often dangerous) knowledge and practices that can be life threatening. For women to access such services exposes them to unknown and innumerable hazards. Women's multi faceted vulnerability (social, cultural, economic, etc) make them gullible customers of such a sector operating in the grey areas of the healthcare services. This does not suggest that vulnerable men may not be users of the informal sector, for they do, especially in rural areas and in health concerns that pertain to the intensely private and personal (for instance, sexually transmitted diseases). But the vulnerabilities of women are many a time, more complex and compelling. To reiterate, women's resort to informal care not only indicates the failings of the formal healthcare system in the country but also underscores the vulnerability of women in India with respect to access to healthcare.

IV. KEY CONCERNS AND RECOMMENDATIONS FOR POLICY

This monograph has attempted to highlight the vulnerability of women in India with respect to their health and access to healthcare. Women's experiences are played out in a variety of contexts, namely, age, caste, class, etc. That women experience inferior health status and restricted access to healthcare *vis-a vis* men similarly placed is perhaps trite yet true. The gendered nature of women's existences are experientially borne out in diverse contexts to produce consistent patterns of vulnerability therein. Women's health needs are numerous- nutrition, general morbidity, reproductive health, disability, mental health, occupational health,—and are interrelated. Moreover, as women progress through the life stages, unresolved health needs can have cumulative burdens on their health. For instance, poor nourishment during childhood and adolescence can lead to unfavourable reproductive health outcomes starting from early adulthood. Or, unresolved mental health needs early in life can have lasting consequences on the physical well-being of women during old age. Thus, throughout the life cycle, childhood, adolescence, old age and also, quite notably, middle age, (the latter often thought to be a period when women in

India enjoy maximum autonomy), women in India are vulnerable in terms of their health and healthcare seeking behaviour.

It is indeed unfortunate that a welfare state, founded on the principles of equality, social justice and democracy should display such inequities in health and access to health care. It is the 'usual suspects'- rural India, the poor, the lower castes (especially the Scheduled Castes), the Scheduled Tribes, the less developed states and regions of India, that show poor health status and restricted access to healthcare. In fact, with the considerable weakening of the public healthcare system and the gradual entrenchment of the market economy, differentials among socio-economic groups are widening.

Any programme that aims to address women's health needs should therefore be sensitive to such complexities in women's lives being staged on a social terrain of remarkable inequities. The following policy recommendations are offered to address the situation:

1 *Adopt comprehensive and gender sensitive primary healthcare* to address women's diverse health needs and to overcome the many limitations that they experience in accessing healthcare.
2 *Strengthen public healthcare.* For the poor and the marginalised, the public sector is the only sector that can potentially provide qualified and affordable care. In the rural interiors of the country, it is usually the *only* sector having qualified personnel.
3 *Regulate the private sector.* For a sector that is the dominant provider of curative services in the country, it is indeed surprising that it operates with so little accountability. The private sector should be subject to controls with regards to the charges levied, minimum acceptable standards for practice, geographical dispersal of services, etc that would make access to the sector more equitable for groups across this vast country. Equitable distribution of services is a non negotiable and will greatly facilitate access.
4 *Make the health systems gender sensitive.* Health systems should be sensitised to the multiple and interrelated health needs of women and the gendered nature of their existences. A gender sensitive health system will not only encourage women to seek care but will also respond to their needs appropriately.
5 *Institute community health insurance* schemes that would be bulwarks against catastrophic health events. It is imperative that such schemes be need based and cover vulnerable groups in the country and not be a privilege of a few. In a society where resources can be so inequitably distributed within and outside the family, it needs to be emphasised that community health insurance schemes should protect the interests of women.
6 *Strengthen civil society initiatives* that advance women's 'practical' and 'strategic' interests, for the two are intricately intertwined in women's lives.

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ANNEXURES

Annexure 1: Child sex ratio in states and union territories of India, 2001

Sr.no.	State	Child sex ratio	Sr.no.	Union Territory	Child sex ratio
1	Andhra Pradesh	965	1	Andaman and Nicobar islands	958
2	Arunachal Pradesh	975	2	Chandigarh	846
3	Assam	971	3	Dadar and Nagar Haveli	980
4	Bihar	957	4	Daman and Diu	923
5	Chhatisgarh	976	5	Lakshwadeep	967
6	Delhi	870	6	Pondicherry	971
7	Goa	936			
8	Gujarat	888		INDIA (2001)	934
9	Haryana	817			
10	Himachal Pradesh	889			
11	Jammu & Kashmir	938			
12	Jharkhand	976			
13	Karnataka	948			
14	Kerala	962			
15	Madhya Pradesh	938			
16	Maharashtra	913			
17	Manipur	958			
18	Meghalaya	975			
19	Mizoram	973			
20	Nagaland	978			
21	Orissa	960			
22	Punjab	794			
23	Rajasthan	913			
24	Sikkim	951			
25	Tamil Nadu	946			
26	Tripura	966			
27	Uttar Pradesh	929			
28	Uttaranchal	906			
29	West Bengal	966			

Note: Computed from Census 2001figures

Annexure 2: Infant mortality rate by sex and residence, India 2002 (for bigger states, smaller states and union territories)

Bigger states

	Total			Rural			Urban		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
India	63	62	65	69	67	72	40	40	39
Andhra Pradesh	62	64	60	71	69	72	35	47	23
Assam	70	70	71	73	72	73	38	34	43
Bihar	61	56	66	62	57	67	50	47	53
Gujarat	60	55	66	68	60	76	37	39	34
Haryana	62	54	73	64	56	75	51	43	61
Karnataka	55	56	53	65	67	62	25	23	27
Kerala	10	9	12	11	8	14	8	11	4
Madhya Pradesh	85	81	88	89	85	94	56	60	51
Maharashtra	45	48	42	52	54	49	34	38	29
Orissa	87	95	79	90	101	80	56	45	69
Punjab	51	38	66	55	41	73	35	28	43
Rajasthan	78	75	80	81	79	83	55	49	62
Tamil Nadu	44	46	43	50	51	49	32	35	28
Uttar Pradesh	80	76	84	83	78	90	58	66	47
West Bengal	49	53	45	52	55	49	36	45	25

Smaller states

	Total		
	Total	Male	Female
Arunachal Pradesh	37	38	36
Chhatisgarh	73	76	70
Goa	17	18	16
Jharkhand	51	47	56
Himachal Pradesh	52	57	45
Jammu & Kashmir	45	49	41
Manipur	14	14	14
Meghalaya	61	60	62
Mizoram	14	16	11
Nagaland	N.A.	N.A.	N.A.
Sikkim	34	34	33
Tripura	34	35	34
Uttaranchal	41	38	46

Union territories

	Total		
	Total	Male	Female
Andaman & Nicobar islands	15	14	16
Chandigarh	21	22	21
Dadra & Nagar Haveli	56	61	51
Daman & Diu	42	55	27
Delhi	30	29	32
Lakshadweep	25	20	29
Pondicherry	22	22	23

Source: SRS Bulletin, 2004.

Note:
- Due to part receipt of returns, data for Nagaland not given. Consequently the IMR estimates for India do not include figures for rural Nagaland.
- The IMR for smaller states and union territories are based on figures for three years. Due to wide annual fluctuations, the sex disaggregated IMR is not given for smaller states and union territories.

Annexure 3: Sex wise age specific death rates, India 1999

Age group	India			Rural			Urban		
	Persons	Male	Female	Persons	Male	Female	Persons	Male	Female
0-4	20.4	19.8	21.1	22.9	21.9	23.9	11.7	12.2	11.2
9-May	1.8	1.6	2.1	2.1	1.8	2.4	1	0.9	1.1
14-Oct	1.2	1.2	1.3	1.4	1.3	1.5	0.7	0.7	0.7
15-19	1.9	1.7	2.1	2.2	1.9	2.4	1.2	1.1	1.3
20-24	2.6	2.3	2.8	2.9	2.7	3.1	1.8	1.3	2.2
25-29	2.9	2.9	2.8	2.9	2.9	3	2.6	2.9	2.4
30-34	3.1	3.5	2.7	3.3	3.7	3	2.4	3	1.9
35-39	3.8	4.8	2.8	4	4.8	3	3.4	4.5	2.3
40-44	5	5.9	4	5.3	6.3	4.3	4.1	5	3.1
45-49	7	8.5	5.3	7.3	8.8	5.6	6.4	7.9	4.5
50-54	10.2	12.1	8.3	11	13.2	8.8	8.1	9.3	6.8
55-59	16.3	19.4	13	16.8	19.6	14	14.8	19	9.9
60-64	22.9	27	19.1	24.7	28.9	20.8	17.2	21	13.3
65-69	36.8	40.8	33	37.9	41.5	34.4	33.1	38.4	28.1
70-74	56.2	59.5	53.2	58.7	62.4	55.4	47.9	49.9	46
75-79	78.6	86.3	71.3	83	92.3	74.2	64.4	66.5	62.6
80-84	103.2	109.4	97.4	107.2	116.1	98.9	90.4	87.8	92.7
85+	165.8	171.8	160.5	167.4	175.8	159.6	160.9	158.2	163
All ages	8.7	8.9	8.2	9.4	9.7	9.1	6.3	6.7	5.7

Source: Central Bureau of Health Intelligence, 2003.
Note: Owing to part receipt of returns, estimates exclude Nagaland (rural) and Jammu & Kashmir.

Annexure 4: Women's experience of and attitude towards domestic violence

Socio-demographic characteristic	% beaten or physically mistreated since age 15	% beaten or physically mistreated in the past one year	% agreeing with specific reasons for violence						% agreeing with at least one reason for violence
			1	2	3	4	5	6	
Age									
15-19	15.4	11.5	37.2	8.6	38.7	41.7	43.1	28.8	61.1
20-29	21.1	12.4	32.6	6.8	34	36.6	40.4	24.9	56.3
30-39	23	11.3	32.8	6.5	33.6	36.1	40	24.1	56.3
40-49	20.3	7.6	31.1	6.5	32.1	35	38	22.9	54.1
Marital duration									
Less than 5 years	14.4	9.6	31	6.2	33.1	35.3	38	23	54.2
Between 5 and 9 years	21.2	12.8	32.9	6.6	33.2	35.6	40.1	24.9	56.1
More than 10 years	22.9	11.5	33.7	6.8	34.2	37.1	40.6	25.1	57.2
Not currently married	27.4	6.8	30.9	8.6	35.1	38.1	42	24.9	55.3
Residence									
Urban	16.8	7.7	24.7	3.9	28.2	29	34.1	17.7	47.1
Rural	22.5	12.2	35.6	7.8	35.9	39.2	42.1	27	59.5
Education									
Illiterate	25.5	14.1	38.6	9	37.3	41.3	43.7	29.1	61.6
Literate- less than middle school	19.2	8.8	29.8	5	34.4	36.6	41.8	23.6	56.4
Literate-middle school complete	15.2	7	25.3	3.3	30.9	32	36.3	18.6	51.2
Literate- high school completed or above	8.6	3.6	17.3	2.1	21.1	19.6	24.9	11.1	37.1
Religion									
Hindu	21.2	11.1	32.8	7	34.1	36.7	40.3	25.2	56.5
Muslim	21.2	11.4	34.8	5.9	33.6	38.1	38.7	23.2	56.5
Christian	21.8	10.3	34	9.4	41.9	42.8	52.4	20.7	65.2
Sikh	13.9	7.1	18.8	0.2	8.2	6.9	8.2	3.9	27
Jain	6.8	2.8	14	0.7	24.3	20.5	27.8	16.9	38.8
Buddhist/ neo-Buddhist	20.8	10	36.3	7.7	54	48.8	63	47.9	73.7
Others	16.8	11.4	16.6	5.8	26.3	31.8	34	18.5	44
No religion	26.1	11.2	36	13.1	35.4	51.6	66.7	27.2	75.4
Caste/tribe									
Scheduled Caste	27.4	15.4	34.6	7.3	34.6	38.4	41.1	26	57.9
Scheduled Tribe	23	13	40.2	11.2	40.1	41.4	45.9	28.7	62.8
Other Backward Class	23	11.7	34	7.6	36.8	40.3	44.8	26.7	61.7
Others	15.7	7.8	28.8	4.9	29.3	31.1	33.9	20.8	49.1

Socio-demographic characteristic	% beaten or physically mistreated since age 15	% beaten or physically mistreated in the past one year	% agreeing with specific reasons for violence						% agreeing with at least one reason for violence
			1	2	3	4	5	6	
Type of household									
Nuclear	24.5	12.7	32.8	6.8	33.9	37.2	41.1	24.7	57.1
Non-nuclear	18.1	9.5	32.8	6.8	33.8	36	39.1	24.5	55.5
Cash employment									
Working for cash	29	14.5	34.5	9.7	39.2	42.3	48.1	28.9	62.2
Working but not for cash	24	12.1	41.2	10.3	42.9	46.9	50.9	35.4	67.5
Not worked in past 12 months	16.9	9.3	30.3	4.7	29.7	31.9	34.3	20.5	51.3
Standard of living									
Low	29.2	16.6	36.9	9.1	38.1	42.3	45.1	29.1	62
Medium	20.1	10.1	34.4	6.8	35.5	38.3	42	26	58.8
High	10.1	4	22.3	3	23.3	23.1	27.3	14.2	40.9
Total	21	11	32.8	6.8	33.9	36.6	40	24.6	56.3

Source: NFHS-2

Note: Reasons for violence: 1: husband suspects of wife's unfaithfulness
2: wife's natal family does not give money or other items
3: wife shows disrespect towards in laws
4: wife goes out without telling husband
5: wife neglects house or children
6: wife does not cook properly.

Annexure 5: Body Mass Index (BMI) and anaemia among women of select groups

		Weight for height % with BMI				% of women with		
		< 18.5 kg/m²	≥ 25.0 kg/m²	≥ 30.0 kg/m²		Mild anaemia	Moderate anaemia	Severe anaemia
Residence								
Urban	22.1	22.6	23.5	5.8	45.7	32	12.2	1.5
Rural	19.6	40.6	5.9	0.9	53.9	36.1	15.8	2
Education								
Illiterate	19.5	42.6	5.1	0.9	55.8	36.7	16.8	2.3
Literate- less than middle school	20.6	32.6	12.9	2.7	50.1	34.4	13.8	1.9
Literate- middle school complete	21.1	28	15.7	3.2	48	34	12.6	1.3
Literate-high school complete and above	22.5	17.8	26	6.4	40.3	29.7	9.7	0.9
Caste/tribe								
Scheduled Caste	19.5	42.1	5.8	0.9	56	37.2	16.5	2.3
Scheduled Tribe	19.1	46.3	3.3	0.5	64.9	41.2	21.4	2.3
Other Backward Class	20.2	35.8	9.4	1.7	50.7	34.3	14.5	2
Others	21	30.5	15.4	3.7	47.6	33.3	12.9	1.5
Standard of living index								
Low	18.9	48.1	2.6	0.3	60.2	38.9	18.6	2.7
Medium	20.1	35.6	8.6	1.5	50.3	34.5	14.1	1.7
High	22.7	17.3	27.2	6.8	41.9	30.1	10.7	1.1

Source: NFHS-2.

Annexure 6: Morbidity levels according to different NFHS rounds

Morbidity*	Urban		Rural		Total	
	Male	Female	Male	Female	Male	Female
(NFHS-2)						
Asthma	1,955	1,978	2,784	2,508	2,561	2,369
Tuberculosis#	446	330	690	507	624	460
Jaundice during the past 12 months	1,354	1,085	1,675	1,134	1,589	1,121
Malaria during the past 3 months	2,133	2,180	4,320	4,184	3,734	3,658
(NFHS-1)						
Blindness (partial)	1,972	2,666	2,482	2,900	2,346	2,839
Blindness (complete)	366	386	411	450	399	433
Tuberculosis	397	286	625	393	564	365
Leprosy	104	79	162	95	147	91
Physical impairment of limbs	671	439	814	513	776	494
Malaria during the past 3 months	1655	1810	3984	3804	3363	3283

Source: NFHS-1 and NFHS-2.
Note: *number of persons per 1,00,000 suffering from the stated ailments.
includes medically treated tuberculosis.

Annexure 7: Point prevalence of morbidity (PPM) on the 15th day preceding and the day before the survey, NSSO 52nd round

Area	Reference day	Male	Female	persons
Rural	Preceding 15th day	23	25	24
	Day before survey	28	30	29
Urban	Preceding 15th day	21	26	23
	Day before survey	27	30	29

Source: NSSO report no. 441.

Annexure 8: Prevalence (per 1000 aged persons) of chronic ailments by sex and residence

	Rural			Urban		
	male	female	person	male	female	person
Cough	250	195	222	179	142	160
Piles	33	16	24	32	18	25
Joint problems	363	404	384	285	393	340
High/low blood pressure	108	105	106	200	251	226
Heart disease	34	27	30	68	53	61
Urinary problem	38	23	31	49	24	36
Diabetes	36	28	32	85	66	75
Cancer	2	3	3	2	4	3
Any of the above	527	514	520	528	560	545

Source: NSSO Report no.446

Annexure 9: Maternal mortality ratio in select states of India (indirect estimates from sex differentials in adult mortality),1982-86 and 1987-96

	Maternal mortality ratio	
	1982-86	1987-96
Andhra Pradesh	394	283
Assam	1068	984
Bihar	813	513
Gujarat	373	596
Haryana	494	472
Karnataka	439	480
Kerala	247	*
Madhya Pradesh	507	700
Maharashtra	439	380
Orissa	844	597
Punjab	207	*
Rajasthan	627	580
Tamil Nadu	372	195
Uttar Pradesh	920	737
West Bengal	561	458
India (rural)	638	528
India (urban)	389	311
India (TOTAL)	580	479

Source: Bhat, 2002.
Note: * Maternal mortality being very low, estimating from the sex differentials in adult mortality in the reproductive age group is not possible.

Annexure 10: Menopause among currently married women by age and state
(all figures in percentages)

	Age in years						
	30-34	35-39	40-41	42-43	44-45	46-47	48-49
North India							
Delhi	1.5	3.4	11.4	20.9	31.9	35.4	73.4
Haryana	1.7	4.8	10.7	23.3	37	43.6	66.7
Himachal Pradesh	0.9	5	9.6	22.4	32.1	46	72
Jammu & Kashmir	2.1	6.6	16.7	31.9	33.9	52.4	62.9
Punjab	1.4	4.4	20.8	20.6	35.4	52.5	63.3
Rajasthan	2.3	4.6	13.5	19.9	35.1	39.3	61.2
Central India							
Madhya Pradesh	2.9	7.3	15.1	23.5	32.6	44.8	51.9
Uttar Pradesh	2.1	7.3	20.2	31.3	42.3	58.5	68.8
East India							
Bihar	2.9	9.2	23.6	35.2	51.1	60.7	75.8
Orissa	1.7	5.3	19.5	23.8	31.7	50.6	62.4
West Bengal	1.5	4.3	12.8	22.1	34.9	46.1	48.4
Northeast India							
Arunachal Pradesh	1	3.8	6.9	*	-8.2	*	*
Assam	1.6	6.2	22.5	30.4	43.6	55.7	73.4
Manipur	0.8	4.8	9.6	14.4	21.8	-31.8	-48.9
Meghalaya	1.4	2.9	-4.1	-13.9	-21.7	*	*
Mizoram	1.1	2.3	7.6	10.1	-8.1	-9.2	*
Nagaland	2.9	1.5	-7.6	-20.1	-39.4	*	*
Sikkim	2.1	5.8	12.2	7.8	28.8	*	-68.9
West India							
Goa	1.7	4.7	15	17	27.6	40.9	66.1
Gujarat	3.1	10.7	24	27.5	42.3	55.5	62.7
Maharashtra	4.3	7.8	16.6	21.5	40.5	62.9	64.8
South India							
Andhra Pradesh	12.8	22.1	37.6	35.9	55	65.4	82.2
Karnataka	1.6	10.6	22.7	26.6	45.8	58.3	76.1
Kerala	1.2	3.7	8.2	12.5	21.1	37.4	53
Tamil Nadu	2	4.5	12.6	26.1	30.5	49.8	69.7
India (rural)	3.5	8.5	20.6	28.1	40.9	55.6	66.4
India (urban)	2.2	7	15.1	23.1	35.4	50	67.3
India TOTAL	3.1	8	19	26.5	39.3	53.9	66.6

Source: NFHS-2

Note: Figures in parentheses are based on 25-49 unweighted cases;
* less than 25 unweighted cases; percentages not shown.

Annexure 11: Women with types of disabilities in the States and Union Territories of India

			Of the women disabled				
			% visual dis.	% speech dis.	% hearing dis.	% movnt dis.	% mental dis.
1	Andhra Pradesh	591,010	44.48	10.65	6.34	26.96	11.58
2	Arunachal Pradesh	11,140	61.01	9.06	12.59	12.09	5.25
3	Assam	232,784	54.95	10.82	10.43	15.29	8.51
4	Bihar	756,085	59.37	7.05	4.04	21.89	7.65
5	Chhatisgarh	188,119	40.44	7.3	8.37	33.31	10.57
6	Delhi	91,014	54.24	6.68	4.27	24.38	10.43
7	Goa	6,860	30.28	12.11	7.71	26.65	23.25
8	Gujarat	440,501	50.15	5.86	7.92	27.07	8.99
9	Haryana	181,203	49.56	5.12	6.92	29.08	9.32
10	Himachal Pradesh	65,506	44.73	8.01	10.42	26.52	10.31
11	Jammu & Kashmir	130,854	70.83	5.51	4.94	11.2	7.53
12	Jharkhand	184,148	44.57	9.32	6.78	27.43	11.9
13	Karnataka	402,913	49.5	9.98	6.06	24.26	10.2
14	Kerala	402,444	41.56	7.43	10.75	23.7	16.57
15	Madhya Pradesh	583,835	49.61	5.18	6.32	31.31	7.58
16	Maharashtra	635,715	40.97	7.75	6.39	30.72	14.18
17	Manipur	12,920	42.17	9.81	11.44	20.67	15.91
18	Meghalaya	13,486	46.06	12.46	13.89	16.57	11.03
19	Mizoram	7,248	37.96	12.72	15.36	14.6	19.37
20	Nagaland	11,958	36.3	17.67	20.29	16.11	9.63
21	Orissa	452,421	53.04	6.86	8.49	21.61	10
22	Punjab	171,667	45.26	5.4	4.73	31.21	13.4
23	Rajasthan	571,329	56.6	4.65	6.19	25.77	6.78
24	Sikkim	8,958	52.36	16.97	16.88	9.67	4.13
25	Tamil Nadu	850,812	66.62	6.62	4.44	15.85	6.47
26	Tripura	25,479	46.61	8.82	11.35	21.48	11.74
27	Uttar Pradesh	1,376,865	58.81	7.59	4.01	22.44	7.16
28	Uttaranchal	81,560	48.1	8.35	8.8	25.59	9.16
29	West Bengal	788,489	49.86	9.56	7.66	18.41	14.51
	Union Territories						
1	Andaman and Nicobar islands	2,831	49.95	9.5	8.48	21.16	10.91
2	Chandigarh	6,000	56.35	5.52	4.22	22.13	11.78
3	Dadra & Nagar Haveli	1,719	57.77	7.5	9.37	18.5	6.86
4	Daman & Diu	1,392	59.55	5.96	5.39	19.83	9.27
5	Lakshwadeep	777	39.64	10.3	9.14	25.87	15.06
6	Pondicherry	11,092	42.79	7.55	11.09	29.63	8.94
	INDIA (2001)	9,301,134	52.71	7.51	6.32	23.68	9.77

Note: Computed from Census 2001 figures.

Annexure 12: Prevalence of disability (per 1000 persons) among the elderly by type, sex and place of residence (NSS 57th round)

	Type of disability					
	visual	hearing	speech	locomotor	Amnesia/senility	Any disability
	Rural					
Male	249	139	32	107	96	380
Female	291	156	38	115	113	425
Person	270	148	35	111	105	402
	Urban					
Male	225	111	29	80	61	333
Female	260	132	34	94	80	367
Person	243	122	32	87	70	350

Source: NSSO Report no. 446

Annexure 13: Male and female workers in India, Census 2001

	Proportion to total workers					
	Main workers			Marginal workers		
	Persons	Males	Females	Persons	Males	Females
Total	77.82	87.32	57.27	22.18	12.68	42.73
Rural	73.94	85.04	54.07	26.06	14.96	45.93
Urban	90.83	93.27	79.31	9.17	6.73	20.69

Source: Census 2001.

Note: A 'main worker' is one who has been engaged in an economically productive work for six months or more in the past one year. A 'marginal worker' is one who has been engaged in an economically productive work for less than six months in the reference period of one year.

Annexure 14: Establishment of Community Health Centres, Primary Health Centres and Sub centres in India

		Community Health Centres		Primary Health Centres		Sub centres	
		no. fning at the end of 7th plan (1985-90)	no. fning as on 31 March 2001	no. fning at the end of 7th plan (1985-90)	no. fning as on 31 March 2001	no. fning at the end of 7th plan (1985-90)	no. fning as on 31 March 2001
1	Andhra Pradesh	46	219	1283	1386	7894	10568
2	Arunachal Pradesh	6	20	24	65	155	273
3	Assam	60	100	449	610	5109	5109
4	Bihar	147	148	2001	2209	14799	14799
5	Chhatisgarh						
6	Goa	5	5	17	19	166	172
7	Gujarat	143	242	842	1001	6834	7274
8	Haryana	41	64	366	401	2299	2299
9	Himachal Pradesh	35	65	190	302	1851	2069
10	Jammu & Kashmir	33	53	266	337	1460	1700
11	Jharkhand						
12	Karnataka	156	249	1142	1676	7793	8143
13	Kerala	54	105	908	944	5094	5094
14	Madhya Pradesh	172	342	1181	1690	11910	11947
15	Maharashtra	290	351	1671	1768	9248	9725
16	Manipur	10	16	64	69	420	420
17	Meghalaya	3	13	56	85	272	413
18	Mizoram	4	9	35	58	220	346
19	Nagaland	4	9	33	46	244	302
20	Orissa	92	157	875	1352	5927	5927
21	Punjab	70	105	460	484	2852	2852
22	Rajasthan	185	263	1048	1674	8000	9926
23	Sikkim	2	2	20	24	132	147
24	Tamil Nadu	72	72	1386	1436	8681	8682
25	Tripura	8	11	49	58	506	539
26	Uttaranchal						
27	Uttar Pradesh	177	310	3000	3808	20153	20153
28	West Bengal	87	99	1250	1262	7873	8126
29	Andaman & Nicobar islands	3	4	14	18	84	100
30	Chandigarh	1	1	0	0	12	13
31	Dadra & Nagar Haveli	0	1	5	6	34	36
32	Daman & Diu	0	1	2	3	14	21
33	Delhi	0	0	8	8	42	42
34	Lakshadweep	1	3	4	4	14	14
35	Pondicherry	3	4	22	39	73	80
	India	1910	3043	18671	22842	130165	137311

Source: CBHI,2003
Note: Figures prior to reorganisation of states in the late 1990s.

Annexure 15: Community Health Centres, Primary Health Centres and Sub centres intribal areas of India (as on 31 March 2001

States	Community Health Centres		Primary Health Centres		Sub centres	
	Required	% in Required	position	% in Required	position	% in Required
Andhra Pradesh	34	26.49	137	82.48	918	89.76
Arunachal Pradesh	28	71.43	73	89.04	550	49.64
Assam	31	109.68	121	109.92	804	54.85
Bihar	122	15.57	489	42.54	3522	51.79
Chhatisgarh						
Delhi•						
Goa•						
Gujarat	64	87.5	319	82.76	2126	103.9
Haryana•						
Himachal Pradesh	2	200	11	154.55	77	128.57
Jammu & Kashmir	NA	NA	NA	NA	NA	NA
Jharkhand						
Karnataka	46	106.52	228	156.14	1520	124.74
Kerala	10	30	42	145.24	279	90.32
Madhya Pradesh	198	80.81	807	82.65	5993	82.75
Maharashtra	91	69.23	366	80.33	2439	76.75
Manipur	7	85.71	41	90.24	263	84.03
Meghalaya	NA	NA	81	104.94	447	92.39
Mizoram	12	75	60	96.67	324	106.79
Nagaland	12	75	63	73.02	418	72.25
Orissa	118	50.85	507	90.93	2634	70.8
Punjab•						
Rajasthan	34	88.24	171	107.02	1141	97.81
Sikkim	1	100	2	150	13	146.15
Tamil Nadu	2	100	58	89.66	67	74.63
Tripura	14	42.86	30	93.33	275	90.91
Uttar Pradesh	3	33.33	219	86.3	1381	99.64
Uttaranchal						
West Bengal	34	85.29	157	130.57	946	78.01
Union Territories						
Andaman and Nicobar islands	2	50	4	100	34	88.24
Chandigarh•						
Dadra & Nagar Haveli	2	50	8	75	54	66.67
Daman & Diu	0	0	1	100	4	100
Lakshwadeep	3	100	4	100	14	100
Pondicherry•						
INDIA	870	67.59	3999	88.52	26243	81.66

Source: CBHI (2003)

Note: Figures prior to reorganisation of states.

• no notified scheduled tribes.

NA - figures not available

Annexure 16: Knowledge of contraceptive methods

Method	Urban	Rural	Total
Any method	99.7	98.7	99
Any modern method	99.7	98.6	98.9
Pill	91.5	75.2	79.5
IUD	87.8	64.6	70.6
Condom	88	64.9	71
Female sterilisation	99.3	97.8	98.2
Male sterilisation	93.6	87.8	89.3
Any traditional method	60.3	44.9	48.9
Rhythm/safe period	56.7	41	45.1
Withdrawal	41.1	27.7	31.2
Other method*	3.1	2.6	2.7

Source: NFHS-2.
Note: * includes any other method (modern or traditional) not listed separately.

Annexure 17: Antenatal care received by select social groups in the country

		ANC outside home• from					
		Doctor	Other health professional	TBA, other			
Residence							
Urban	2	74.8	8.8	0.2	13.6	81.9	87.5
Rural	6.6	41.2	11.5	0.3	39.8	62.5	80.5
Education							
Illiterate	7.3	32.1	11.2	0.3	48.4	54.7	77.4
Literate- less than middle school	4.8	62.1	12.9	0.3	19.3	78.4	83
Literate- middle school complete	3	71.8	11.2	0.1	13.5	84.2	86.4
Literate-high school complete and above	1.2	85.4	7.2	0.1	5.8	91.2	90.4
Religion							
Hindu	6.2	47.2	11.2	0.2	34.5	66.5	82.5
Muslim	3.3	50.7	8.5	0.4	36.4	65.6	80.8
Christian	3	73.4	7.5	0.2	15.4	74	87.9
Sikh	1.3	44.7	29	0	24.9	87.5	80.7
Jain	3.1	84.7	6.5	0	5.7	87.9	85.5
Buddhist/Neo-Buddhist	1.4	74.9	9.2	0	14.5	65.3	90.8
Other	0.3	59.9	15.7	0.1	19.7	52	89
No Religion	10	53.7	0.7	0	35.6	43.5	86.6
Caste/Tribe							
Scheduled Caste	5.9	41.7	13.3	0.2	38.2	64.8	80.7
Scheduled Tribe	10	34.7	11.5	0.3	43.1	46.4	81.6
Other Backward Class	5.9	48.9	9.6	0.2	34.8	68.4	84.9
Others	4	56.5	10.6	0.2	27.9	72.2	82
Standard of Living Index							
Low	7.3	35.8	11	0.2	45.1	55.4	79.1
Medium	5.1	50.1	11.1	0.3	32.8	68.7	81.8
High	2.8	73.7	10.5	0.2	12.4	87.5	88.4
India Total	5.6	48.6	10.9	0.2	34	66.8	82.5

Source: NFHS-2
Note: Information based on two recent births in the three years preceding the survey.

• refers to births in which the women received ANC outside home, even if they might have received ANC at home. Though the woman might have received ANC from different types of providers, provider with the highest qualification shown.

Previous publications

Year of Publication

1 Review of Health Care in India: Country Health report 2005

2 Health and Health Care in Maharashtra: Health Status Report of Maharashtra (in English and Hindi) 2005

3 Health Facilities in Jalna: A study of distribution, capacities and services offered in a district in Maharashtra 2004

4 Health and Health Care Situation in Jalna, Yawatmal and Nandurbar 2004

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