*International Journal of Applied Social Science* *REVIEW ARTICLE*
*Volume 4 (7&8), July & August (2017) : 261-272* ISSN : 2394-1405 (Print)
*Received : 03.07.2017; Revised : 19.07.2017; Accepted : 24.07.2017*

# Women health and political Governance in India: An analysis

**MALKIT SINGH**
Department of Human Rights, D.A.V. College for Girls
Yamuna Nagar (Haryana) India

## ABSTRACT

Women health is one of the important indicators of human development index of any country of the globalised world. The concept of human governance has changed the old concept of government and made the ruling class more responsible and sensitive to towards the citizens under the new democratic principles of social and gender justice. The old concept of human development index is changed with the concept of gender development index and the health of women has become one of the important components of the gender development. New initiatives has been taken to improve the Maternal Mortality, child mortality, fertility rate, Women's Sexual and Reproductive Health by the international organisation and declaration which are followed by the municipal governance also. In the paper any attempt has been made to analysis the global concerns for the women health and the responses of Indian government towards the health care women in India. A comprehensive analysis of government five years plan and health care of women and girl child has been duly focused upon along the special initiatives and programmes of the health care of the Indian government. The advent of global technology and the impact of globalisation on women health and care has been duly analysised and linked with the socio-economic and political set-up of Indian society.

**Key Words :** Globalisation, Women, Health, Health technology, Genders, Society, Socio-economic, Political, Girl child, Child Mortality, Health policy

## INTRODUCTION

Health is a personal and social state of balance and well-being in which one feels strong, active, creative, wise, where all one's diverse capacities and rhythms are valued, where one may make choices, express one and move about freely. Inequity in health is broadly defined as the systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, culturally and demographically.[1]

The socio-cultural factors have also an important role to play in determining the health status of a person or any group in given circumstances of society. It is found by various research studies that gender plays an important role in various societies while determining

**How to cite this Article:** Singh, Malkit (2017). Women health and political Governance in India: An analysis. *Internat. J. Appl. Soc. Sci.,* **4** (7 & 8) : 261-272.

the health status of different persons of the same family. The health and survival of a girl child or a woman have always been an issue of debate in the traditional as well as in the modern societies while comparing the biological factors of female health and survival of women.

Normally males have higher level of mortality, but in several countries of South Asia-namely India, Bangladesh, Nepal, Pakistan and Sri Lanka and in some countries of the Middle East, girls have a higher mortality rate during childhood than boys. Health care during pregnancy and child birth and health facilities for women are also under question.[2]

In India women's health has always remained crucial to the policy makers since Independence. The state control over the health services directly focused on the health of women and children. The Community Development and Family Welfare Programmes at the grass roots were initiated with special focus on health care of women and children in the early years of Independence. There has been a progressive increase in the plan outlays over the six decades of planned development to meet the needs of health care of women and children. The outlay of Rs.4 crores in the First Five Year Plan (1951-56) has been increased to Rs. 7, 81042 crores in the Ninth Five year Plan and Rs. 13,7800 crores in the Tenth Five Year Plan. There has been a shift from family welfare-orientated approach which was adopted in the First Five Year Plan to the "development" and "empowerment" of women in the consecutive Five Year Plan. Tenth Five Year Plan (2002-2007) laid emphasis on women component plan (WCP) and gender budgeting which are complementary to each other. Apart from the allocation of specific funds in the Five Years Plans various measures have been taken in order to eradicate atrocities against girls and women in India.

Women's police station, family courts, legal aid centers etc., have been set up and awareness programmes on rights of women and legal literacy have been conducted.[3] The Eleventh Five Year Plan proposed a five-fold agenda for gender equity. This includes economic, social and political empowerment and strengthening mechanisms for effective implementation of women-related legislations and augmented delivery mechanisms for gender mainstreaming. Recognising that women and children are not homogenous categories, the Eleventh Plan aims to have not just general programmes, but also targeted interventions, catering to the specific needs of different groups. Reducing the gender gap in literacy to 10% by 2011–12, Infant mortality rate (IMR) to 28%, Maternal mortality ratio (MMR) to 1 per 1000 live births, the Fertility Rate to 2.1and Malnutrition among children in the age group of 0–3, Anaemia among women and girls was also to be reduced to half of its present level by the end of the Eleventh Five Year Plan. Sex ratio for age group 0–6 children is to be raised to 935 by 2011–12 and to 950 by 2016–17. It ensures that at least 33% of the direct and indirect beneficiaries of all the government schemes should be women and girls. [4] Twelfth Five Year Plan (2012-2017) is expected to deliver more inclusive growth by creating jobs for women. In other words, 'women' as a category will be included in the development process, [5] 12th Five Year Plan emphasised on the development and empowerment of women by providing 'quota' or gender based reservation in jobs.[6]

Since April, 1996 Family Welfare Programmes have been re-oriented to provide an integrated package for family welfare, women and child health services. The new programme is known as Reproductive and Child Health (RCH) programme. Earlier versions were called

Family Planning and Maternal and Child Health (MCH) in the 7th five year plan and as Child Survival and Safe Motherhood (CSSM) in the 8th five year plan. The focus of the family welfare programmes has been widened to new areas like: Safe pregnancy and child birth and post natal care, contraception (Family Planning with Target Free Approach), Safe Abortion, Management of RTI, STD, HIV/AIDS, Adolescent health and increased male responsibility, etc.[7]

**Globalisation and women health :**

Globalisation has not only provided the global capital and new range of reproductive health and health technologies, which have potential for better caring for health and health hazards in India. Simultaneously, the issue of health care and health safety particularly the health care of women and children has become an important goal of the international society. The international Convention on the Elimination of all Forms of Discrimination Against women provided certain provisions for the mental and physical health of women beside a call to end all kinds of social, economic and political violence against women. United Nation Development Programme took a lead in measuring the gender development in 1995 by entitling the Human Development Index as Gender and Human Development Index.

The other important steps to improve the mental and physical health of women under the global partnership are Beijing Plan of Action, Beijing+ 5, Beijing+ 10 and Beijing + 20 etc. The UN efforts for women health has become more rigorous and action oriented by the end of 20th century and the United Nations General Assembly adopted a resolution on Women's Health Throughout the Lifespan in 1998 at the celebration of 50th anniversary of World Health Organisation, while reaffirming the commitment made in the Beijing Platform for Action and Beijing Declaration, the Programme of Action of the International Conference on Population and Development, the Copenhagen Declaration on Social Development and the Programme of Action of the World Summit for Social Development and the Obligations of the State Parties under the CEDAW and other relevant international agreements to meet the health needs of women throughout their life span.

The other important international documents on women health and concern are the call for the global action, the global capital, technology and partnership are; Voices of African Women Declaration 2008[8] , Kyiv Declaration on Women's Health in Prison: Correcting Gender Inequity in Prison Health 2009,[9] ASEAN Human Rights Declaration 2012[10] , South Asian – Joint Statement for 57th Session of the Commission on the Status of women February, 2012.[11]

The preparatory documents for both the World Summit for Social Development and the Fourth World Conference of Women scheduled for 1995, documents prepared by the UN Agencies, Regional conclaves or NGO forums and experts on Women's affairs, all attested to one fact *i.e.* this gap between men and women in control of productive assets, employment, income, education and training, hours of work, habitation, health and social welfare infrastructure leading to denial of development rights of women. The exact situation of the girl child belonging to extremely poor families and groups does not augur well for the future of generations of women to come, till a massive popular transformation in perception of women's roles in society and social attitudes in preparing them for their multiple roles take roots. The positive and negative impacts of the global health technology can be measured

from the various issues, facts and figures of the policy initiatives of the governance and the actual position of women in the contemporary world.

South Asia has seen momentous changes in the last two decades in terms of economic growth coupled with changing patterns of work, especially for women and today it is most "globally integrated" region of the world with the highest average ratio of trade to GDP with the largest inflow of foreign direct investment, substantial financial capital flows and even significant movement of labour.[12] Over the last two decades, South Asia has been the second fastest growing region after East Asia, with an average growth rate of 5.3 per cent. The pattern of growth has stimulated higher rates of migration among women and special situation of women migrants is a new and emerging issue in the region. The concern for the women health has become a major issue of the policy makers in South Asian and the national governments are spending a fixed amount of their GDP on women's health now. The efforts to reduce the issues related to women's health under the various national and international health programmes and special programmes for women health-care have also been designed by the international agencies like W.H.O, UNIFEM etc. along with the national government programmes to reduce the child mortality, infanticide, and foeticide, prenatal, post-natal, and maternal deaths. [13]

All countries in this region have made a commitment to the International Conference on Population and Developments (ICPD) Declaration and Declaration on Safe Motherhood. Specific targets have been set for reduction of maternal mortality and better coverage with maternal health services. The following is a quick glimpse at the key initiatives. The government of Bangladesh has adopted a comprehensive Health Policy and Health Nutrition and Population Sector Programme (HNPSP) for 2003 -2006. The HNPSPs was aimed at reducing Maternal Mortality from 3.3% to 2.75% per 1000 live births, reducing total fertility rate and ensuring access to reproductive health services. The Maternal and Child Health Programme of Bhutan has been expanded into Reproductive Health Programme. India's National Health Policy 2001 gives high priority to women health as reflected in the Reproductive and Child Health Programme (RCH) (second phase started in 2003). Women's health becomes the important concern of the political governance and an understanding has been developed by the municipal governments in South-Asia to fix the amount of their annual budget.[14]

Given the current global focus on universal health coverage, government spending on health from domestic sources takes an increasingly central role. The criteria for the government health expenditure as defined by the experts are ethical use of health technology, reduction of poverty, health equity and the rule of rescue.[15]

**Policy initiatives and women health in Globalised India :**

The economic development of any region or nation is relative to many other socio-economic and political factors. An economically weak society can prove better off in case of social knowledge and social development if the social parameters of that society are based on scientific and rational thinking rather than on the superstitions and religious bigotries. As everybody knows the issue of women's health and development is not only related to the health facilities & health technology in general but it is also an issue which is more enrooted into the social fabrics of society. The effects of the advancement in science and technology

on the health-care and safety can prove negative if the social set-up and social norms are not favourable. The recent examples of the misuse of the advance Ultra-sound technology on women to diagnose the sex of the unborn child rather than to use the technology to save the lives of women is a vital proof of the contradictions between the development of science and technology and social development.[16] The socio-economic and cultural set-up has a great role to play in the safety-security and health care of women in any society and nation. So, the actual picture of the impact of global health-care programmes and health-care technology is relative and can clear only after the analysis of other social variables which are in one or other way related to women's health.

The most important issue of women's health is acceptability of her as equal to male in the socio-cultural set-up of any society. As the discrimination against women starts from the womb and the social implications of technology on women's health and survival also start from the womb of the mother. A comprehensive analysis of the impact of global technology should cover the impact of advanced health technology on women from womb to tomb in the given circumstances in any society.[17] So the analysis of women health should start from the sex selective techniques of the pre-natal, post-natal child mortality, maternal health care and other issues related to women's health in India.

**Foeticide :**

Foeticide and skewed sex ratio of the girl child is an important issue of women and child's health in South Asia. Although foeticide is a very broad issue and is linked with the socio-religious conservatism, poverty, law and political set up of any society, it is also related to the medical lab –technology and the ethics of the medical practices in the globalised world. As explained by the experts, benefits of the advance medical lab technology *i.e.*, the ultra-sound technology shall help to improve the health facilities in developing countries. However, the ultra-sound machines are working as double-edged swords as the male members are duly benefited from this advance technology but the unborn girl child of the same societies is becoming a victim to the same technology.

Although the sex selective techniques are banned in India, however, easy and cheap access to this technology has created havoc like situation. The census of 1991has reported sharp decline in the birth rate of the girl child. It was noted that the sex of a girl child declined to 945 and even down to 927 in the census of 2001 and 914 in the census of 2011.

**The Government initiative for the improvement of girl child sex ratio: An analysis:**

The government of India launched a special campaign to improve the sex ratio and save the girl child. To involve the people at regional and national levels various schemes and laws like: *Pre-natal Diagnosis Test 1994,* special campaigns at the social level like: *Mukhya Mantri Kanya Suraksha Yojana ( Bihar), Dhan Lakshmi Scheme ( Karnataka) Ladli, (Haryana and Delhi), Balika Samridhi (Gujrat), and the Beti Bachao, Beti Padao* of Central Government are worth mentioning. Even the regional and national political parties launched a special campaign and made the protection of the girl child a part of their election campaigns.[18]

The real picture, however, reveals a different fact and all the government and civil

**Table 1 : Sex ratio (Females/1000 Males)**

| States | 1991 | 2001 | 2011 |
|---|---|---|---|
| All India | 927 | 933 | 940 |
| Andhra Pradesh | 972 | 978 | 992 |
| Arunachal Pradesh | 996 | 901 | 921 |
| Assam | 922 | 932 | 954 |
| Bihar | 910 | 921 | 916 |
| Goa | 966 | 960 | 968 |
| Gujarat | 934 | 921 | 918 |
| Haryana | 865 | 861 | 877 |
| Himachal Pradesh | 975 | 970 | 974 |
| Jammu & Kashmir | N.A | 900 | 883 |
| Karnataka | 959 | 964 | 968 |
| Kerala | 1036 | 1058 | 1084 |
| Maharashtra | 933 | 922 | 946 |
| Manipur | 957 | 978 | 987 |
| Meghalaya | 955 | 975 | 986 |
| Mizoram | 921 | 938 | 975 |
| Madhya Pradesh | 931 | 920 | 930 |
| Nagaland | 886 | 909 | 931 |
| Orissa | 970 | 972 | 978 |
| Punjab | 881 | 874 | 893 |
| Rajasthan | 909 | 922 | 926 |
| Sikkim | 878 | 875 | 889 |
| Tamil Nadu | 973 | 986 | 995 |
| Tripura | 944 | 950 | 961 |
| Uttar Pradesh | 878 | 898 | 908 |
| West Bengal | 917 | 934 | 947 |

Source: Government of India, Census of 1991, 2001, 2011, Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, New Delhi.

society initiatives have proved futile as the NSSO reported further decline in birth rate of the girl child, which continues to decline at the same pace and the 2011 round of NSSO reported decline of the girl child birth to 914. *The Pre-natal Diagnosis Test 1994* and the special campaigns at the social level proved to be a futile and fruitless exercise to improve the sex ratio and save the girl child. The finding of the foeties of the unborn girl children at many places and in the renowned hospitals after the launching of complaints by the social activists across India has exposed the well–established net-work of the doctors and agents across the country. Moreover, the large scale reports on the abandoning of the new born girl children by their parents at public places suggests that the development of health technology has less to do with the improvement of sex ratio of the girl child and it has more to do with the social conservatism and social set-up.[19] The efforts of government and technology inputs and innovations in health–care technology can't be successful to control the birth rate and save the girl child, until the mindset of the concerned society is changed. The lack of social

awareness, lack of medical ethics among the medical professionals and administrative corruption along with the lack of political will have been leading to the declining sex ratio of the girl child.

The reports on the abuse of sex-selection technology proved that it is the developed states and the middle –class families that are using the health techniques for killing the unborn girl child instead of promoting medical –care and safety of the girl child. Infact, the arrival of the advance health technology in India has intensified the foeticide in the middle class families of the developed states of India like Punjab and Haryana. The States of Punjab and Haryana are not only known to be rich economically but also culturally superior to the other states of India, but the real picture of their socio-cultural set-up is presented by the Census of India in 1991 under which the sex ratio has been noted to be below to 861 in Punjab and 874 in Haryana, whereas the other poor states have been better off than these model states of India.[20]

**Bad to worse: Pros and cons of global medical technology:**

The advancement of medical drugs along with the health care technology and the information technology have also proved dangerous to the medical-care and safety of the girl child and mother. Global awareness about reproductive rights of women has been coerced under the established social norms. Mother's control over the birth of her child has been reduced as the sex of the child can be detected by any doctor in the nearby city and the question of the delivering of child by her has becomes a matter of family prejudice rather than of her choice. The choice of the child's sex definitely affects the birth and safety of the child as it can be aborted if the unborn child is a girl.

It is found that the male sterilisation programme which was launched during the emergency has not only become a challenge to the patriarchal psyche of macho man but it has also become a political challenge to the government as it was a major issue against the Indira Gandhi government in the post emergency elections. It may be due to the political polarisation of male sterilisation during the emergency that till date no government could dare to popularise and implement male sterilisation programme as it became one of the factors for the defeat of Indira Gandhi in the parliament election of 1977.[21] Women became a soft target for population control programmers' in the post emergency period as the coercive measures for the population control against the male could defame the government. Harmonal pills (Estrogen- Projestone combination), injectible contraceptive (Depro-provera Depot Medroxy Progesterone Acetate, Net EN –Nortesteeone Enethate) and anti fertility vaccine have been foisted on Indian Women's body without any concern for collateral damage in terms of thyroid, migraine, chest pain etc.[22]

Although India signed CEDAW and the family welfare programmes of Indian government are under the media scanning and the government is also afraid of International criticism for encouraging women sterlisation more than that of men. The direct benefiters for the motivation of the sterilisation of women are also discouraged mainly due to the bindings of CEDAW, however, the clandestine policy of family planning has not only become the direct violator of the provisions of women health–care and safety provided under CEADAW and various international programmes, but it has also become the killer of women

who want to control their family size.[23]

The target which was fixed to reduce the fertility rate in 2011 was 2.1 and this target was to be achieved by 2015. Under the target-oriented approach of the government, a doctor has to perform 800 sterilisations every year, particularly in the states having high fertility rate. The studies show that the women sterilisation is one of the effective and major tools of population control in India as per the data 37.3 per 1000 women have got their sterilisation to control their family size instead of using the other techniques.

The most dangerous are the conditions and the manners under which the family planning programme is performing sterilisation to the women as revealed by the 16 deaths of women in a sterilisation camp at Bilaspur in the State of Chhatisgarh. It is found that the conditions under which the sterilisation camps are organised are against the established procedure of the sterilisation law and ethics of the medical health care. Health Ministry admits that Rs, 50.76 crore was released between 2001-2011 and 2013-14 for 363 deaths and 14,901 surgery failure according to the National family Planning Insurance Scheme ICICI Lombard Bank 2005. Under this scheme Rs. 2 lakh are provided to the family of the woman who dies following the sterilisation in a family planning camp and Rs. 50,000 to the family of a woman who die within 8 to 30 days of discharge from the camp.

The methods and concerns of health care of women followed by the government are also revealed by the women many times who go through the government and private camps of sterilisation in India. The agony tales can be revealed from the fact of the recent incident of Bilaspur where 16 women died within a day or two after sterilisation. As told by the survivors of the incident to the media that they only remember unclean beds where they lay shoulder to shoulder as someone administrated anesthesia. That the sedition was ineffective is clear from the fact that majority of these women woke up in pain screaming for relief while the doctor, now arrested, continued the procedure and finished 83 tubectomies in five hours. All participants were discharged within minutes of the operation despite the requirement of overnight post-operative care under the Government of India rules. They went off with the sachets of medicines later found contaminated with rat poison.[24]

**Sex difference and child mortality in India :**

**Health Equity and Globalisation** Equity in matter of health and survival is an important policy issue and a difference by sex is one of the areas which require special focus. The Programme of Action of the International Conference on Population and Development (ICPD) called on the leaders of world to act forcefully against patterns of discrimination within the family and to eliminate excess mortality of the girl child. This call was echoed in A World Fit for Children, the declaration of the twenty-seventh special session of the General Assembly of United Nations.[25] The survival of children is prominent on the international agenda in the light of the Millennium Development Goals and substantial reduction in child mortality has been achieved in many countries in recent decades. However, the question whether the recent increases in survival rate have benefited boys and girls equally has rarely been addressed on a global scale. The government and public policies regarding the child health and care has become a subject of social set-up and family intensions and preference of medical care of the male and the female child. The preference and acceptability of male child as *kul ka deepak* (the heir of family) along with the economic resources of the family have become a

crucial factor not only in the case of child education and development but also in case of child mortality. The data on the child mortality can clarify the actual scenario of the social acceptability and the survival rights of the girl child in comparison to the male child in India.

**Table 2 : Child mortality rate**

| Infant Mortality Deaths under age 1 per 1000 live births | | | | Under-Five Mortality Deaths under age 5 per 1000 live births | | | Ratio of male to Female Morality Per 1000 Infant Child Under Five | | |
|---|---|---|---|---|---|---|---|---|---|
| Decades | Male | Female | Both Sexes | Male | Female | Both Sexes | Male | Female | Both Sexes |
| 1970 | 113 | 115 | 114 | 162 | 180 | 171 | 98 | 75 | 90 |
| 1980 | 93 | 93 | 93 | 124 | 138 | 131 | 100 | 69 | 89 |
| 1990 | 74 | 74 | 74 | 99 | 113 | 106 | 100 | 63 | 87 |
| 2000 | 57 | 59 | 58 | 77 | 95 | 86 | 97 | 56 | 81 |
| 2010 | 46 | 49 | 44 | 54 | 59 | 55 | 55 | 64 | 59 |

Source : UNDP, Human Development Report 2000, UN Plaza, New York, 2002 and Human Development Report 2010, UNDP, UN Plaza, New York, 2012.

**Table 3 : Maternal Mortality Ratio (MMR) (per 100,000 live births) in the various countries of South-Asia**

| Country | 1990 | 2000 | 2010 | 2013 | % Change in MMR between 1990-2013 |
|---|---|---|---|---|---|
| Bangladesh | 800 | 400 | 240 | 170 | -67 |
| Bhutan | 1000 | 430 | 180 | 120 | -87 |
| India | 600 | 390 | 200 | 190 | -65 |
| Maldives | 830 | 190 | 60 | 31 | -93 |
| Nepal | 770 | 430 | 270 | 190 | -76 |
| Pakistan | 490 | 380 | 260 | 170 | -57 |
| Sri Lanka | 85 | 58 | 35 | 29 | -40 |

Source: UNDP, Human Development Report 2004, UN Plaza, New York, 2007, UNDP, Human Development Report 2010, UN Plaza, New York, 2012 and WHO Report, Trends in Maternal Mortality, United Nation Children Fund, UN Plaza, New York, 2014.

The above data proves that it is not only the investment but also the political and administrative measures along with the social initiatives which can help to improve the issues related to the health of women and children. As the table given above shows the poor and smaller countries of South-Asia like Bhutan, Sri Lanka and Maldives have improved a lot but the bigger countries like India and Pakistan have failed badly in this respect.

**The maternal health care and women in South Asia :**

Access to maternal health services is one of the important indicators of the development of health-care and health safety of the women in any society, simultaneously; it also indicates the social attitude towards women.

The poor medical help and the lack of medical facilities in case of attending to pregnant women and delivery of children by the semi-skilled and unskilled local mid-wives is a common feature of the developing countries. However, the concern for women's health is relative

| Table 4 : Access to maternal health services | | |
|---|---|---|
| Countries | Birth attended by skilled personnel (%) 1995-2002 | Birth attended by skilled personnel (%) 2000-2010 |
| Bangladesh | 12 | 18 |
| Bhutan | 24 | 72 |
| India | 43 | 47 |
| Maldives | 70 | 95 |
| Nepal | 11 | 19 |
| Pakistan | 20 | 39 |
| Sri Lanka | 97 | 99 |

Source: UNDP, Human Development Report 2004, Un Plaza, New York, 2007 and UNDP, Human Development Report 2010, UN Plaza, New York, 2012, also see, WHO, Child Mortality Report 2014, United Nation Children Fund, United Nations, New York, 2014.

and varies from country to country they are also connected more with the political will in the country than the economic development and the available facilities of health-care. As the above table shows, the smaller countries like Maldives and Sri Lanka have a higher number of child deliveries or women attended by the trained nurses rather than India. It is also true in the case of Pakistan which is lacking behind even small country like Bhutan.

**Fertility rate and population control :**

The population growth has both positive and negative impact on the development of any nation. The development of modern health sciences and health care has reduced the death rate among children and pregnant women which have resulted in the stable growth of population across the globe. The population growth has become a matter of concern for political governance particularly in the developing countries. The easy accessibility of the method controls fertility rate through contraceptive and sterilisation techniques, which are again to be experimented on women.

| Table 5 : Fertility rate of various countries (%) | | | | |
|---|---|---|---|---|
| Country | 1970-75 | 1995-2000 | 2000-2005 | 2010-2015 |
| Bangladesh | 6.2 | 3.8 | 3.5 | 2.2 |
| Bhutan | 5.9 | 5.5 | 5.0 | *2.2* |
| India | 5.4 | 3.3 | 3.0 | 2.5 |
| Maldives | 7.0 | 5.8 | 5.3 | 2.2 |
| Nepal | 5.8 | 4.8 | 4.3 | 2.3 |
| Pakistan | 6.3 | 5.5 | 5.1 | 3.2 |
| Sri Lanka | 4.1 | 2.1 | 2.0 | 2.3 |

Source: UNDP, Human Development Report 2005, UN Plaza, New York, 2007, also see, "Total fertility rate by country - Thematic Map – Asia-Mundi", *www.indexmundi.com/map/?v=31&r=as&l=en*, Accessed: 23-4-2015, 10:00am.

The common feature of all the developing societies is the relative lack of awareness regarding birth control techniques. The above data shows that despite the development of health-care infrastructure and information technology, the problem of over-population is yet to be solved. The spread of information regarding population control and contraceptive

techniques is not giving the desired results. The techniques of population control particularly in the developing countries are old and women sterilisation is still considered the cheapest and best option under the patriarchal set-up of the traditional society. India is also not an exception to the fact of high fertility and over-population. Despite the adoption of policies regarding population control India could not achieve the desired target of reducing the fertility rate to 2.1 which Sri-Lanka achieved in 2005. The other established fact that the government control in India is the lacking a comprehensive policy of population control and insensitivity towards health of women. Till date no strong alternative has been found by the government to replace the age-old practice of women's sterilisation.

Although the foreign capital and health technology has improved the health facilities and health care to a great extent in India, the gains of global health technology have been, however, proved to be a bane rather than a boon. Women health is still a secondary issue in comparison to the male health due to social conservatism. The misuse of the diagnostic technology and female foeticide will make the small girls a rare species if social awareness is not generated against female foeticide.

The conservatism and the lack of the government initiatives are costing the women health and rearing and bearing the children in India. The health issues and health policy in India is seems too designed and planed under the influences of the socio-economic and political set-up of the Indian society which is gender biased and lacked the gender sensitivity.

The need of the time is to change the social conservatism regarding the women health, reproductive rights, reproductive health and care. A better and progressive society can't be established until and unless the health issues of half of the citizens of the country are designed under the socio-political conservatism. The health issues and government policy in women health can only be changed with the increase of women participation in the socio-economic and political set of the Country.

## REFERENCES

1. Mathur, Kanchan (2008). Gender Hierarchies and Inequalities: Taking Stock of Women's Sexual and Reproductive Health. *Econ. & Political Weekly*, **XLIII** (49) : 54-57.

2. Braveman, P.N. *et al.* (2000). Health Inequalities and Social Inequalities in Health. *Bull. World Health Organization,* **78** (2) : 232–233.

3. Ibid

4. Ambaraya Hagaragi (2012). Policies, Programmes and Women's Status in India. *Third Concept*, **26** (30) : 33-35.

5. "Government of India, *Twelfth Five Year Plans (2012-2017),* planning commission, New Delhi, 2012, pp. 259-263.

6. Editorial "Good News for Single Women in 12th plan", *The Hindu* , 14 May 2013.

7. Gangoli, Geetanjali (1998). "Reproduction, Abortion and Women Health", *Social Scientist,* **26** (1) : 83-84.

8. Aggarwal, H.O. (2005). *Human Rights*, Central Law Agency, Allahabad, pp. 99-104.

9. World Health Organisation, *Women Health in Prison: Correcting Gender Inequalities in Prison Health*, United Nations Office on Drug and Crime World Health Organisation (UNDOC) , 2009, Denmark, pp.1-5.

10. Biju, M.R., "Globalisation, Democracy and Gender Justice", M.M. Verma (ed),*Globalisation, India and Third World*, New Century Publications, New Delhi, 2012, pp.15-20.

11. Ibid, pp .12-13.

12. Ghosh, Jayati (2004). *Globalisation and Economic Empowerment of Women: Emerging Issues in South Asia,* paper presented for Inter-governmental Meeting on Beijing Platform for Action, UN-ESCAP, September, pp. 7-9.

13. Biju (2011). n.14, pp.12-20, also see, Harini Narayanan, "Women's Health, Population Control and Collective Action", *Economic and Political Weekly*, vol. **XLVI**, no. 8,19 February, 2011,pp. 42-43.

14. "Progress of South Asian Women 2005: Accountability to the World's Women"*, A Series For the Fifth South Asia Regional Ministerial Conference Beijing Plus Ten,* Institute of Social Studies Trust, India Habitat Centre, New Delhi, 2005, pp. 21-24.

15. Musgrove Philip (2011). Public Spending on Health Care: How is Different Criteria Related?. *Health Policy,* **37** (3) : 207-223.

16. Gangoli, Geetanjali (1998). "Reproduction, Abortion and Women Health", *Social Scientist,* **26** (1) : 514-517.

17. Ibid

18. Nair, Jayshree Ramkrishan and Nair, Heema (2002). Engendering Health: A Brief History of Women's Involvement in Health Issues", *SAMYUKTA: A Journal of Women Studies,* **2** (1) : 13-14.

19. Deswal, D. (2011). "Ladoo and Jalebis: The Code of Killer Doctors of Jatland"*, Times of India,* 8 April , 2011, pp.1, 11, also see, Editorial, "Infant Mortality Rate Shows Slight Decline", *The Hindu*, 28 December, 2011.

20. Ibid

21. Patel, Vibhuti (2002). *Women's Challenges of the New Millennium*, Gyan Publishing House, New Delhi, 2002, pp. 130-131.

22. Mukherjee, Mukul (2001). Towards Gender-Aware Data Systems –Indian Experience. *Econ. & Political Weekly*", **31**(43) : 63-71.

23. Das, A.N. (2010). *Global Campaign for Women Human Rights,* MD Publication Pvt. Ltd, New Delhi, pp.43-45.

24. Tandon, Aditi (2014). "Oops, Sorry, We've killed you", *The Sunday Tribune*, 23 November, 2014, p. 14.

25. Das (2014). n. 27, pp. 43-55, also see, K.S.James, "Recent Shifts in Infant Mortality in India: An Exploration"*, Economic & Political Weekly*, vol. **XLIX** (3) : 14-16.

********