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9

How Healthy Are Health and Population Policies? The Indian Experience

IMRANA QADEER AND NALINI VISVANATHAN

Unhealthy Trends

INDIAN POPULATION POLICIES have tried to regulate family size by promoting contraceptives through incentives and penalties, arguing for family planning in the cause of maternal and child health. When these policies adversely affect the welfare and long-term interests of the majority while favoring only a small section of the population, then we *must* consider them to be "unhealthy." This chapter identifies the unhealthy trends in India's health and population policies, assesses the impact on India's people, attempts to understand the underlying politics, and explores the possible lessons. These unhealthy trends began in the mid-1980s and were formalized in the 1990s. The first trend was the drastic cutting of total investments in the welfare sector, especially in health—although the family planning budget remains double that for general health. The second trend was privatizing medical care and introducing user fees and private investment in public hospitals, thereby weakening the referral system and distorting integrated services. The third was emphasizing technological solutions to public health problems, thereby marginalizing the principles of equity and development that underlie comprehensive primary health care (PHC). The fourth was the verticalization of disease and population control interventions, further weakening the integrated approach and promoting imports of drugs and equipment. The fifth comprised transforming reproductive and child health (RCH) services into instruments of population control rather than channels for providing health services to this vulnerable section, and the continuing dependence on female sterilization to limit family size without assessing women's general and gynecological health status.

The Rationale

What are the assumptions behind these policies in the Indian context? The first assumption is that private care is more *efficient* and of *better* quality (World Bank 1993). The *World Development Report 1993* defines "efficiency" purely in terms of cost reduction and not in terms of coverage or self-sufficiency in the long run—a definition that may help the state, but not the majority of the sick. An expert group at the Planning Commission calculated one episode of hospital admission to cost 320 rupees (US$7.30) (excluding food and drugs that may be purchased by patients) for public hospitals and Rs. 735 (US$16.70) for private hospitals (Government of India [GOI] 2001b). Similarly, for "quality," dimensions such as outcome, costs, and patient satisfaction are ignored (Baru, Qadeer, and Priya 2000). Thus, with doubtful quality and increased costs, private care may have value as additional high-tech institutional care, but is not of any epidemiological significance.

The second assumption is that a public-private mix increases *coverage* and is a step toward *equity* (World Bank 1993). However, an area may have both public and private health care institutions, but these are not necessarily accessible to socially and economically deprived people. National statistics definitely show a rise in the overall use of private health care, but they also illustrate that the proportion of the poorest 40 percent (the lowest monthly per capita expenditure [MPCE] groups) opting for admission to public hospitals has gone up from 42.95 to 60 percent between 1989 and 1998, and 16 percent of the sick in this group do not get any treatment (National Sample Survey Organisation [NSSO] 1989, 1998). Thus, restricting the growth of the public sector deprives them even more of health services.

The third assumption is the primacy of *technology* over welfare services and economic and social development. Although the policies state that they "empower" women, they actually propagate the notion that "liberation" comes through the use of contraceptives. Similarly, "targeting" the underprivileged (GOI 1992) is a euphemism for public provision of second-rate (and cost-saving) primary services, now dissociated from the privatized secondary- and tertiary-level care. This goes contrary to the Alma Ata declaration that the choice of technology should be based on the epidemiological needs of population, affordability within the framework of self-sufficiency, and acceptability (WHO and UNICEF 1978). As we shall see later, the current prime movers for technological choice are the interests of the "free market" led by multinational corporations.

The fourth assumption is that the state should change from a *provider* to a *regulator* of health services; however, it is unclear how a state that is unable to perform its current regulatory functions of monitoring, registration, and standardization will become more effective (Baru, Qadeer and Priya) 2000). In fact, the state is now actively promoting the private sector through subsidies for capital investments, imports, products, drugs, contraceptives, services, reimbursements, and social marketing (GOI 2002b). In a situation where "unmet needs" have been officially recognized, opening health services to the "free" market is not justifiable, neither for reducing costs nor for ensuring regulation. Social marketing to promote "socially desirable behavior" is irrelevant for the needy, but it ensures subsidies for the private sector.

Policy Prescriptions

In the above context, the National Population Policy 2000 (NPP) marks a turning point in the history of population planning. On paper it strives for a welfare strategy that is voluntary, target-free, and integrated with the key components of welfare. It promises economic and social development to improve the quality of lives of the people and their welfare through provision of opportunities and choices "to become productive assets in society" (GOI 2000a). However, the NPP leaves many loopholes for political and economic processes to be manipulated by the elite. Thus, while the rhetoric is of integrating communicable diseases and malnutrition, the focus is only on family planning through RCH.

Similarly, the National Health Policy 2002 (NHP) verticalizes disease control programs and, by failing to link health and population planning, lets RCH occupy the entire domain of essential health care. Together, the two policies shift the focus of primary health care from comprehensive care to family welfare (planning). Even while RCH professes to cover maternal and child health, sexually transmitted diseases including HIV, reproductive tract infections, abortion and sterility treatment facilities, gynecological services, treatment for anemia and malnutrition, along with communicable disease control, it is actually restricted to the so-called essential RCH, with contraception becoming the first and the foremost priority (GOI 1997).

Thus, the inherent Malthusian inclination of the policy is reflected in the adoption of a technocentric and demographically oriented objective of achieving a replacement-level fertility rate by 2010 and a stable population by 2045 (GOI 2000a). It is, therefore, not surprising that the demographic obsession that had, in the past, isolated and demonized the Family Welfare Program continues to distort the expressed intent of the NPP. Inevitably, both emergency medical care and childcare services get linked to a small-family norm through incentive schemes rather than to essential services. Instead of ensuring safe abortion, the policy proposes "making abortion attractive" by doing away with the requirement for registering service providers to ensure minimum institutional standards.

In addition, as spacing of births is promoted, a deluge of new technologies has flooded the market. Those technologies that are not accepted by the official

program are now promoted through the private market and NGOs. Depo-Provera, Net-En, Norplant, and RU 480 are the controversial hormonal contraceptives in use (Sathyamala 2000; Akhtar 1995). Two U.S. citizens, Stephen Mumford and Elton Kessel (a physician), both with well-known anti-immigrant inclinations and Malthusian views, tested the sterilant action of the malarial drug quinacrine on 25,000 poor women in ten countries (Hieu et al. 1993) without the permission of the national regulatory authorities in at least India. Even after its ban in India, quinacrine sterilization is being pushed through private providers. Thus, while the policy underscores "safety," it offers no regulatory mechanisms to prevent illegal and unethical human experiments.

Regional Policies

The policies at the regional level take their cue from the NPP and make use of loopholes to introduce coercive incentives. The policy of the most populous state of Uttar Pradesh, for instance, proposes to introduce untested and known harmful contraceptives and continues to use camps and campaigns for sterilizations. Even though it has acquired massive World Bank funding, it proposes to introduce user charges for RCH services (Government of Uttar Pradesh 2000). Similarly, Madhya Pradesh makes the two-child family a condition for participating in the local elections to the grassroots democratic institutions—the "Panchayats." It also bans government jobs for those who were married before the age of 18 years (16 in the case of girls) and, in the process, penalizes the very women whom it purports to empower (Government of Madhya Pradesh 2000).

Despite the NPP's emphasis on spacing and a nontargeted approach, demographic compulsions enforce strategies geared to increase sterilizations for the surest results. As the boundaries between goals and targets dissolve, the pressure on doctors to perform increases, especially in states like Uttar Pradesh, Bihar, Rajasthan, and Madhya Pradesh that are considered major blocks in bringing down overall fertility rates. The illiterate poor become the targets in the name of "reaching out to the poor." This is the very purpose of transforming the content of primary health care, which now essentially consists of family planning services and basic curative care. Instead of promoting women's health, it uses both maternal and child health services as instruments of population control with unhealthy consequences.

Impact Assessment

Despite prolonged civil strife, Sri Lanka has impressive health and demographic indicators that should set standards for assessing the impact of India's health and population policies.[1] India's demographic achievements over the 1990s were not

impressive: an infant mortality rate (IMR) of 68 per 1,000, a life expectancy of 63.6 for men and 64.9 for women, a birthrate of 25.8 per 1,000, a death rate of 9.0, estimated maternal mortality of 54.0 per 10,000, and an under-six mortality of 94.5 per 1,000 (GOI 2002c). The repeated failure to achieve policy objectives has made demographers question unrealistic goals. They point out that population momentum will slow growth rates (Visaria and Visaria 1996), taking 60-odd years to move from replacement-level fertility to a stable population. This makes the objective of achieving a stable population by 2045 unrealistic (Visaria 2002).

Vulnerable Populations

In a country where the estimates of absolute poverty are around 34.7 percent (United Nations Development Programme [UNDP] 2003), the significance of these two health policies cannot be underestimated, especially when an almost equal proportion of the population is barely above the poverty line. An expanding "free" market can only reach the middle and upper classes (about 300 million), while the rest are either sold dreams through the media or appeased—and, if neither works, the state resorts to control and coercion. Who are the vulnerable sections in India? The poor lie within the Scheduled Castes and Tribes (8.08 and 16.08 percent of the population, respectively; Kulkarni 2002) and a significant proportion of the backward castes and sects among the Hindus and Muslims. The economic differentials are reflected in the MPCE categories, where the lowest 40 percent and the highest 20 percent respectively spend Rs. 3,336 (US$76.10) and Rs. 10,350 (US$236) in rural areas and Rs. 4,728 (US$107.80) and Rs. 21,183 (US$483.20) in urban areas (NSSO 2001).

Absolute and relative poverty generate extremely unhealthy environmental conditions that are conducive to disease.[2] Inadequate access of the poor to education brings the average literacy rates to 65 percent (75.85 percent for males and 54.1 percent for females) in the 2001 census (GOI 2001a). India's socioeconomic realities not only indicate a substantive proportion of underprivileged, but also a subset within them of the most vulnerable—the poorest women, children, and men who constitute over 33 percent of India's population. These averages, therefore, contain inherent inequalities when seen through the lens of economic and social stratification.[3]

Gender Dimensions

Patriarchy pervades these hierarchies to create gender inequality around work, sexuality, entitlement, inheritance, access to opportunities, and freedoms. Patriarchal biases also consolidate social divisions and the inherent aggression and frustration by providing a common outlet through violence against women. Women bear the

double burden of working and caring for the family under conditions of daunting poverty where procuring drinking water and food, collecting firewood and fodder, and cleaning are demanding tasks. In addition, socially, women's fertility is seen as their prime function, making them an easy target for the state. The result is declining sex ratios, especially for those under six. The overall female-to-male sex ratio in 2001 was 933 but the 0–6-year child sex ratio was 927. Of 577 districts, 48 had a ratio less than 849 and only in eight was the ratio 1,000 or above (GOI 2001a). The situation has worsened since 1991, and ratios under 880 were reported from rich states like Haryana, Punjab, Gujarat, and Delhi (Nanda 2002).

Pushing the two-child norm in a patriarchal society promotes the killing of female fetuses and infants in order to acquire a balanced family within the prescribed limits, if not one with many sons (Dasgupta 1998). This norm also promotes the misuse of technologies such as ultrasound and amniocentesis. The postabortion minor complications, like uterine and cervical erosion and hemorrhage, and major complications, such as delayed infections, sepsis, embolism, and other life-threatening sequelae, were 3.1 and 1.0 percent respectively in the 1980s (Indian Council of Medical Research [ICMR] 1981). Since then, provision of abortion services remains inadequate, a significant proportion of induced abortions are failures, hospital studies still report deaths following postabortion complications (Vasundhara, Shah, and Misra 2000), and practitioners continue to report bleeding, secondary infertility, and irregular periods (Bandewar 2003). In rural areas, antenatal and natal care by trained personnel, including trained traditional birth attendants, is available to only 43.8 and 33.6 percent of the women (GOI 2002c). Overall couple protection rate is only 55.1 percent, of which 36.2 percent is through sterilizations (International Institute for Population Sciences [IIPS] 2000).

The overuse of sterilization among women is yet another form of gender discrimination. A hospital-based study that followed up sterilized women over several months showed that the procedure had an adverse impact on both physical and mental health status (Purkayastha and Bhattacharyya 1992). A reproductive health survey of women in the state of Karnataka records higher prevalence of morbidity symptoms in sterilized women across all economic strata and demographic characteristics (Bhatia and Cleland 1995). Evaluating sterilization practices and procedures followed by 55 Harayana gynecologists, Tewari and associates found that most of the doctors relied on lay staff to counsel patients and administer informed consent forms, and left it to the general practitioners to assess the patient's eligibility for surgery (Tewari and Rathee 1997). Official guidelines, however, require surgeons to interview the patient prior to surgery (Government of India, Ministry of Health and Family Welfare 1989). These guidelines state the criteria to be used by medical personnel for selecting men and women candidates

for sterilization. For women, the lower age limit stipulated is 20 years, reflecting a social milieu where early marriages, if not unions, are common. Nevertheless, it is questionable whether a 20-year-old woman can anticipate a need to reverse the procedure for such reasons as infant and child mortality, or even a second marriage in the event of widowhood or divorce.

In the United States, EngenderHealth, formerly the Association for Voluntary Surgical Contraception, warns against accepting women for the procedure at an early age (EngenderHealth 2002). Women who are less than 30 years old are more likely to consider reversal (Westhoff 2002). Counseling and informed consent are critical steps in the protocol followed before surgery is scheduled in the United States (Baill, Cullins, and Pati 2003). Long-term studies of the effects of tubal ligation have been conducted mainly in the United States. A prospective cohort study followed U.S. women for five years and concluded that sterilized women were no more likely than nonsterilized women to suffer from menstrual abnormalities (Peterson et al. 2000). These findings have challenged the validity of a post–tubal ligation syndrome centered on menstrual changes.[4] Yet, psychological and cultural factors and the issues of procedural safety are not comparable across settings, where there are gross disparities in health care resources.

By making gender the thrust of population policies, the state ignores the importance of poverty and blames certain marginalized groups, whose relatively higher fertility is symptomatic of their condition rather than the cause (Kulkarni 2002). The acceptance of family planning methods is greater among the educated upper-class women due to lower IMR, maternal mortality rate (MMR), child mortality, and son preference. Yet, the Family Planning Program (FPP) targets the poor and the less educated in isolation and irrespective of any welfare inputs. This is in spite of a number of studies that show the lowest family size or fertility among the poor (Patel 1994; Rao 1997), and goes against substantive arguments that favor developmental inputs to promote generating demand for family planning services in situations where levels of productivity as well as literacy among women are low (Kim, Sinha, and Dev Gaur 2002). Not surprisingly, an important recommendation for legislative changes to ensure property rights for women, by an earlier draft of the NPP (GOI 1993), was deleted from the final document. Why does the Indian State follow these regressive policies?

Funding Pressures

In Uttar Pradesh, USAID has invested US$30 million over the 1990s in a special project—State Innovations in Family Planning Service Agency (SIFPSA)—to improve family welfare service in 28 districts (U.S. Agency for International Development [USAID] 1997). The World Bank has been actively funding the same

through its India Population Project. Between 1994 and 2002, US$79 million were given to five states—Uttar Pradesh, Madhya Pradesh, Andhra Pradesh, Karnataka, and Delhi (GOI 2000b). Another Rs. 4950 million (US$13.1 million at the current exchange rate) were given to Uttar Pradesh for five and a half years in 2002 (GOI 2002a). Uttar Pradesh, Madhya Pradesh, Rajasthan, and Bihar are the most poorly developed states—both socially and economically. They contain over 40 percent of India's population and have the highest levels of IMR, MMR, and child mortality rates. Owing to strong patriarchal values, acceptance of family planning is linked to two or more surviving sons (Satia and Jejeebhoy 1991).

A study conducted in 1999 in eight states, including Uttar Pradesh, Rajasthan, and Madhya Pradesh, to assess the impact of the paradigm shift after ICPD found some improvements in the provision of services. While there were marked interstate variations among the eight states, the three states under consideration demonstrated that the official mindset remained unchanged, the lowering of targets by auxiliary nurse midwives (ANMs) was not appreciated, and officially fixed targets continued in practice. Coercion of workers was also reported in Uttar Pradesh. Sterilization remained the mainstay of the program, and safety of abortion was negligible (Health Watch Trust 1999).

USAID's own evaluation of its project SIFPSA shows that, of the 28 districts covered, the focus was only on six, and nine were a second priority. This not only left out 13 of the project districts, but also the remaining 42 districts of Uttar Pradesh. Hence, the evaluator's claims of improved performance and personnel capacity have to be judged while keeping in view the concentration of funds in a limited area (USAID 1997).[5]

Yet another study from Uttar Pradesh estimates 31 percent unmet needs in comparison to a national estimate of 18 percent, serious deficiencies of women doctors and PHC equipment, poor ANM functioning, and the use of mini-camps for catching up with goals. Only half the respondents reported a visit of paramedics over the past three months, and 70 percent believed that they are not of much use anyway (Prasad, Khan, Ram and Patel 1993). A recent report of a campaign against oppressive population policies in Uttar Pradesh interviewed 1,689 persons in 31 districts. It dispels illusions of any progress since 1993. A fear of coercion, the nonavailability of all kinds of health and family welfare services including abortions, and the need for strategy change if the no-target approach has to succeed were evident in the study (Health Watch UP-Bihar 2002). The role of the U.S. government and private foundations in introducing an aggressive sterilization campaign in the 1970s provokes a comparison, of women's experience, between these two democracies.[6]

In the United States, sterilization has become the leading method of permanent contraception, and approximately 11 million women (15 to 44 years) are users (Farrington 2003). Its popularity was established in the 1970s when surgical advances made tubal sterilization highly safe and effective. At the same time, its appeal was enhanced by the availability of insurance coverage and concerns over the safety of the oral contraceptive pill, both of which resulted in the large-scale acceptance of the method, particularly by black and Hispanic women (Westhoff 2002). In India, political exigency, not medical rationale, led to the shift from the relatively simple and safe procedure for vasectomy to female-centered surgical procedures that carry greater risk for complications and long-term morbidity. During the same period, the popularity of the method spread worldwide. For women in societies, where reversible methods were scarce, expensive, or too obtrusive, sterilization was both right and reliable.

The median age at sterilization in India (26.6) is not much below that in the United States (28.8) but only 2 percent of the Indian women have education beyond secondary schools in contrast to 33 percent of the women in the United States (EngenderHealth 2002). Discrete demographic data that characterize sterilized women, however, do not portray the clinical protocols followed before surgery in different regional settings, or the medical response to surgical complications and ongoing morbidity related to menstrual dysfunction. After more than three decades and tens of millions of tubal ligations, Indian family planners have gathered little epidemiological evidence on the long-term side effects of the procedure. The predominant users are women with little schooling and low and unstable incomes, who are often residents of urban slums and shantytowns, and who were within reach had the government shown an interest in tracking their health status. Nag (1973), in a review of the early years of the Indian sterilization program, found complications in 20–30 percent of men (pain and discomfort) and 50 percent of women (menstrual disorders). When women were followed up postsurgery, general physical and mental health problems and menstrual disorders were documented as well as improved conjugal relations (Das Gupta, Jain, Prasad, and Vidyabhushan 1970).

Women behind the Numbers

The Health Watch survey cited above collects 38 fully documented reports of complications and deaths due to negligence of reproductive health care providers and of cases of contraceptive failure where, instead of penalizing those responsible, the state had protected them and pressurized the victim's family to withdraw cases. Some of these case briefings are as follows (Health Watch UP-Bihar 2002).

- Chutki Devi of Barabanki district went to a health center for an abortion. She was instructed to take pills and was told that the pregnancy was still in an early phase, so the abortion would be safe. After two days of taking the pills, she developed severe abdominal pain and died on her way to the health center. The doctor at the district hospital said she was four months pregnant and should not have undergone abortion.

- Leelawati, 29 years, went to her district hospital at Kushinagar for sterilization. She died immediately after surgery, and the family was refused a death certificate.
- Rajrani of Dewa was refused hospitalization and brought back home. With the help of a midwife, she delivered twins but fell unconscious and died by the evening. Both her babies also died.
- Rampyari, 30 years of age, was asked to pay Rs. 1,000 (US$22.80) at the district hospital and, when she could not do so, she was thrown out. She delivered outside the hospital gate.
- Dhokhia had her abortion and then a tubectomy at the Manikpur government hospital. Just after the operation, she was thrown out by the doctor and the nurse and also badly beaten as she was complaining. Her stitches became septic and she had to spend Rs. 1,500 (US$34.30) for treatment.
- Rani Jaiswal, 15 years old, was abducted and forcibly taken to an RCH camp where the doctors operated on her without bothering to check. She was neither given a certificate of sterilization nor any postoperative care. Stitches were not removed for 42 days. An FIR was lodged in the police station against the abductor.

Despite an improved policy that recognizes the importance of well-being and equity in fertility declines, what makes the mode of implementation so contrary to its stated purpose?

Politics and Policies

The FPP has a checkered history. Beginning as a voluntary program, with a clinic and then cafeteria approach, it slipped into an extremely coercive population control drive that treated human beings, especially the poor, without respect or dignity. During the National Emergency (1975–1976), the FPP touched the nadir, when the poor were caught and sterilized like animals (Banerji 1997). The political fallout of this was a national election that threw out the oppressive regime of the Congress Party and brought in a new regime. In time, the new regime and its successors became increasingly dependent on international loans and accumulated huge debts. Funding thus became an instrument of domination by agencies such as the World Bank and International Monetary Fund (IMF), and the multinational drug and equipment companies linked with them. The agencies proposed restructuring the Indian economy, with its large consumer market, through structural adjustment policies (SAP), with the agreement of an elite establishment fully vested in this arrangement.

This alliance used an aggressive strategy of population control, blaming the victim and diverting attention from economic issues to justify expanding the contraceptive market. Despite accumulating evidence pointing out the structural roots of the problem and contradicting the alliance's myths, the return to Malthusianism became widespread.[7] Divisive forces used the demographic profile itself to divide people on religious grounds. Ignoring the fact that the largest minority was also the poor and the least literate, who had a fast-declining fertility rate (Kulkarni 2002), the higher fertility of the poor became a source of political propaganda against them (Jeffery and Jeffery 1997). The concept of a "social safety net"—propagated along with SAP—was dropped as soon as South Asia accepted the SAP. However, vigilant activists foiled a move to include a two-child norm in the NPP (Rao 2002). The Uttar Pradesh Population Control Bill 2002 subsequently attempted to codify a number of anti-human rights features of the State Population Policy.

Assessing these issues, actions to counter unhealthy policies must include a series of strategies. The first is mobilizing politically to ensure that the entire set of policies that promote disintegration, commercialization, and technological fixes are reviewed. The second is instituting welfare measures and mechanisms to regulate health markets, with the state assuming responsibility for provision of services. These actions must take priority over subsidizing and supporting the private sector. Significantly, in most First World countries undergoing structural reforms, the state continues to invest 60 to 100 percent in public sector health services (WHO 2002). Third is strengthening primary health care infrastructure to enable an integrated approach to health and family welfare that is critical for success. Fourth comprises channeling contraceptive drugs and services to those with high unmet needs rather than to those not creating the demand. For the latter, there should be an effort to improve economic and social circumstances to bring about shifts in behavior. Finally, basing medical and surgical practices on health outcomes (evidence) is needed, by reevaluating India's dependence on female sterilization through epidemiological studies of short- and long-term health effects. This approach should also be followed in other countries with high rates of female sterilization. Contraceptive donors should be required to fund such research.

Theoretical Lessons

For example, the newfound wealth of "social capital" is currently being projected as a panacea for communities (Organization for Economic Cooperation and Development [OECD] 2001) that do not have economic capital. In India, the metropolises are first breaking and uprooting vulnerable communities, then resettling them afresh, and in the process destroying even their precarious wealth of social capital. An

emphasis on a political economy approach that contextualizes the value of social capital, underlining class distinctions, would be much more crucial to policy formulation.

Anthropologists must move beyond understanding the "native" and the "local community" and illuminate the cultures and mindsets of all classes—particularly those that make policies. Little is known about those who do not necessarily understand or care about the underprivileged and yet constantly use them and determine objective reality for them. Such an exposition will clarify the real nature of conflicts and reveal the connecting thread of vested interests. By incorporating the lessons learned from India, the health movement will be strengthened and its struggles consolidated.

Notes

1. In Sri Lanka, while there was an aggressive family planning campaign increasingly using both pills and condoms, traditional contraceptives remained an important source of fertility control (Nichter and Nichter 1996), in marked contrast to the Indian campaign. While Sri Lanka succeeded in creating and maintaining an effective primary health care infrastructure with full support of secondary- and tertiary-level institutions (Dulitha 2001), India has reduced the same to "primary-level care" by neglecting its public sector referral system. In Sri Lanka, the public sector focuses on inpatient care with the private sector dealing mainly with outpatients; but in India the private sector has captured institutional care, to the detriment of a more vulnerable population.

2. For example, in rural India, 70.8 percent use wells, tube wells, and hand pumps, while only 23.2 percent have tap water to drink. In fact, 5.4 percent people drink from tanks, ponds, rivers, and canals directly. There is no provision for latrines or for drainage for 84.4 percent and 62.0 percent of rural households respectively (NSSO 1998).

3. Thus, among the 20 percent of households with the lowest MPCE, only 15.0 percent can access tap water, latrines are not accessible to 94.3 percent, and the Scheduled Castes and Tribes bear the brunt of this deprivation (NSSO 1998). The infant mortality among Scheduled Castes and Scheduled Tribes is 83 and 84 per 1000 live births in comparison to the national average of 72 per 1000 (Kulkarni 2002). Of the lowest 20 percent MPCE groups, only 48.3 percent and 33.3 percent in urban and rural areas respectively reported registration of pregnant women, in comparison to 74.8 percent and 55.9 percent in the highest MPCE groups (NSSO 1998). Also, just 40 percent of poor women received advice from lady health visitors (LHVs) and ANMs; they were far behind the better off in their knowledge and information about immunization and oral hydration. The literate had higher couple protection rates (57.0) in comparison to the illiterate (42.0), but sterilizations were much higher among the illiterate (IIPS 2000).

4. Such changes have been documented by women's groups and health acrivists in India (Sabla, Swatija, and Meena 2002; Sathyamala 1989), and statistically supported with survey data from college-educated women in the United States (Visvanathan and Wyshak 2000). The late Dr. Malini Karkal, feminist demographer and health activist, observed a trend in earlier menopause for sterilized women in national health surveys.

5. A previous study conducted in 1995 by the same agency had pointed out that 22.2 percent of the public facilities lacked essential sterilization equipment, 45 percent districts were short of workers, and only 38.5 percent of the providers themselves had correct knowledge of contraception. Just 15.4 percent of the sterilized couples received follow-up for needs and only 7 percent of the eligible women reported contact with providers of family planning services in the past six months. Of those who discontinued contraceptive use, 20.7 percent had health problems (side effects), 16.2 percent reported contraceptive failure, and 50.4 percent desired pregnancy (USAID 1995).

6. Deepa Dhanraj's 1991 film, *Something like a War*, documents the role of USAID and the Ford and Rockefeller foundations in the Indian sterilization program as well as live footage.

7. This is reflected in the emergence of a new set of political agents who are today busy "cleaning" the metropolis of the "slum dweller," closing so-called polluting industries, and denying the poor the constitutional right to shelter and work (Roy 2000). Among the well-off who, in the 1960s and 1970s, had accepted Nehru's idea of socialist democracy and the challenge of progress of all, a new value has surfaced. It is respectable today to blame the poor for the ills of the society, be it filth, pollution, or population. It is widely propagated (and believed) that the rich were all through with "subsidizing" the poor, and it is now time to stop "spoiling" them. It is also considered a universal truth that the poor are so because they reproduce more and that their excessive illness is due to their ignorance.

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II

NATIONAL HEALTH POLICIES AND SOCIAL EXCLUSION