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REPORT ON VITAL STATISTICS

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Superintendent of Census Operations, Uttar Pradesh*

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NOTE

The author considers it his duty to state that the statements made and conclusions drawn in the *report on 'Vital Statistics'* are author's own and do not necessarily reflect or represent the views or policies of the Government.

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PREFACE

The Report on Vital Statistics as a part of Census publications is being published in this State for the first time. It is based on data collected from various sources and is a modest attempt to piece together valuable information relating to vital statistics. Indian vital statistics suffer from grave deficiencies, with the result that they fail to meet the needs of demographers, public health workers and medical men. Still they serve some useful purpose, even though it be only to focus attention on the extent and nature of the deficiencies. The 1961 Census has very clearly demonstrated that the growth of population has undergone accelerations, in a large measure due to the sharp decline in the death rate. This downward trend in mortality is continuing, and should be expected to continue in the future also. In such a situation, registered statistics have an added significance, particularly for chalking out health programmes, family planning programmes and population prognosis. Every precaution has been taken to ensure accuracy, still some errors factual or otherwise, are bound to creep in. They are much regretted.

Collection of data for this Report commenced prior to Enumeration. It took considerable time and labour to copy out the data from manuscript records, so kindly made available by the Director of Medical and Health Services, Uttar Pradesh. The task of eliciting information was particularly difficult, as numerous records were not available owing to the damage caused by the unprecedented floods of October, 1960. In spite of the best co-operation extended by everyone concerned, the data for certain years could not be had from any source. In this connexion, the help given by Dr. Murthy, Assistant Director Epidemiology Branch is especially acknowledged.

As the analysis of vital statistics with reference to its future trends would have remained incomplete without taking note of positive measures undertaken in this regard, particularly those of family planning, a *Note on the Physiology of Conception and Birth Control Measures* has been added at the end.

I am grateful to the authorities of the maternity hospitals of Kanpur, Lucknow, Agra, Varanasi, Allahabad, Meerut, Bareilly, Gorakhpur, Dehra Dun and Faizabad for supplying data relating to hospital maternities which have been used in Chapter II.

A large number of books and publications have been consulted in the writing of this Report, which have been acknowledged at proper places. I owe a debt of gratitude to the authors of these books and publications.

Collection of information and preliminary work in connexion with this Report was entrusted to Shri Fateh Bahadur Nigam, Statistician of my office, and the preparation of Tables to Shri Shyam Narain Bhatnagar, Statistical Assistant. I am thankful to them for the pains they took in this behalf.

Above all, I am extremely grateful to Shri A. Mitra, Registrar General, for his guidance and encouragement and to the Vital Statistics Section of his Office for detailed suggestions in regard to chapter headings and topics to be dealt with in each, which have greatly enriched the Report.

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*Dated Lucknow :
The 23rd November, 1964.*

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INTRODUCTION

1. History of Vital Registration

Growth of population is effected by four factors—births, deaths, immigration and emigration which are taking place every day, but it is only births and deaths which are included in *vital statistics*. The recording of births and deaths is, therefore, essential. Registration has a long history. Its need was recognized as early as 1250 B. C. in Egypt, when in the reign of King Rameses II an elaborate registration system was set up. Different countries began registration of vital events in different periods and for variety of reasons. Realizing the importance, churches started keeping records of baptisms, marriages and deaths of their members in some countries from beginning of the 15th century. This system was later on extended to cover the entire community and not to church members only, and then it became a civil rather than a purely clerical responsibility. However, in some countries, such as Sweden and Finland, the clergy continued to perform the functions of registration. Credit goes to these countries for maintaining a continuous series of vital statistics indices since 1749 A. D.

2. France, Spain, England and Ireland also maintained records of ecclesiastical registration. Various other countries of Europe from the 17th century began to adopt laws making registration of still births, births, deaths and marriages compulsory. This continued in 18th and 19th centuries. The middle of the 19th century is a landmark in this respect when a number of countries of America, Oceania and Asia started to introduce compulsory registration of vital events. Realizing the need and importance of registration, countries of Africa followed suit in the present century.

3. Mere collection of vital events is of no use, unless the information is processed. The first use of these data was made by an English clergy, John Graunt. A close study led him to demonstrate four important facts which vital statistics disclosed, namely, (1) that a certain regularity exists in the occurrence of these phenomena, (2) that there is always an excess of male births over female births, but in the population alive at any moment, the number of the two sexes is approximately equal, (3) that the mortality rate is relatively high in the earliest years of life, and (4) that the death rate is lower in rural areas than in cities.

4. The publication of the above results encouraged many other workers such as Huygens in Holland and Halley

in England to carry out further investigations in the same field. Much credit goes to Dr. William Farr who contributed greatly to the early development of vital statistics. He started a series of mortality statistics, analysed them and published their results. Willcox in 1833 estimated that births and deaths were being registered for about one-tenth of the world's population, but in 1933, a century later, the registration laws covered about one-half of the world's population, gradually increasing to 60 per cent in 1955.

5. India had a complex and a quasi-religious system of registering births, marriages and deaths in rural communities, although their accuracy or the use to which they were put is not known. The registration of vital events in the days of Hindu and Muslim rulers of India was, however, not obligatory. They were, however, noted by the temple priests and the *Kazis*. Matters began to improve from the middle of the nineteenth century. Registration of births and deaths in the modern connotation of the term was introduced in 1844 in Madras, in 1848 in Bombay, in 1870 in Bengal and in the next decade 1870-1880 in most other places. The Imperial Act VI of 1866 on this subject did not uniformly apply to the whole country. The provinces had their own legislation on the subject. In 1886 birth and death registration was first introduced on a voluntary basis, but made compulsory only for Municipalities. The U. P. Municipalities Act of 1916 was a decisive step in this part of the country for civil registration in the urban areas. Owing to lack of facilities registration was not made obligatory for rural areas. Formerly the reporting of births and deaths was done by the village *chaukidar* and a record thereof was maintained at the police station, which the *chaukidar* used to visit periodically. But now the duty of recording has been transferred to village Panchayats. Under the Panchayat Raj Act, 1947 it is compulsory for heads of families to report births and deaths occurring within the jurisdiction of Panchayats.

2. Scope, Meaning and Uses of Vital Statistics

6. In recent years *vital statistics* has come to mean 'facts systematically collected and compiled in numerical form relating to or derived from the records of vital events, viz., live-births, deaths, foetal deaths, marriage, divorce, separation, adoption, legitimation, recognition, annulment or legal separation,¹ In fact it includes all data derived from legally registrable events except population or morbidity data.

1. *Principles for a Vital Statistics System—Recommendations for the Improvement and Standardisation of Vital Statistics.*

7. Vital Statistics have a variety of uses. They indicate trends of births and deaths occurring among the community, the nature and incidence of diseases from which the community suffers, the seasonality of various diseases and the extent of preventive measures required to be taken against them. This information is also needed for matters pertaining to the age at which the various diseases generally occur, equal distribution between both the sexes, and areas most subject to them. It enables the State to formulate its health policies. Experienced public health administrators have described vital statistics as the 'eyes and ears of the public health worker for without them he would be blind and deaf to his responsibilities'. It provides knowledge about the relationship existing among the various factors responsible for incidence of diseases. In 1937 the Inter-Governmental Conference on Rural Hygiene held in Java passed the following resolution:—

'As ultimately the preventive and curative work must be organised on a basis of accurate knowledge of the diseases and disabilities in an area, the importance of collecting accurate vital statistics cannot be over-emphasised'.

8. The need of accurate and up-to-date statistical data on births, deaths, and incidence of individual diseases are necessary not only for such specialised fields as combating malaria, tuberculosis, cancer, heart disease, general epidemiology, but also for the study of problems like nutrition, maternal and child health, mental health and environmental sanitation.

9. In advanced countries where proper records are kept, vital statistics records are utilised

- (i) to establish date of birth,
- (ii) to establish place of birth,
- (iii) to establish family relationship,
- (iv) to establish fact of death,
- (v) to establish cause of death, and
- (vi) for purposes of marriage and divorce.

10. Availability of the diagnostic material can be useful for health examination and continuous check up of a community, and herein lies the value of the records of births, deaths, and foetal deaths, to which the vital registration organization makes its real contribution. We need vital and health statistics to diagnose the ills of the community.

11. An important use of birth registration is that it helps the health workers to get in touch with the mother and new-born child, so as to offer domiciliary service and health protection such as immunization and home-nursing. Birth records have also been used to investigate failures

in various kinds of programmes, e.g., birth control, family planning, etc.

12. Deaths by various causes are studied to find out what is being done and required to be done by health agencies to bring them under control. Special significance is attached to deaths occurring among infants, because mortality among them is recognized as providing a sensitive index of the general sanitary level of the community. Similarly, maternal deaths are analysed to assess the circumstances leading to them. For example, maternal deaths when studied in relation to the type of attendance (physician, trained or untrained midwife) at birth or without attendance reveal that maternal lives can be saved through skilled care of the expectant mother during child-birth. Their analysis by the place of occurrence of birth—hospital or home—the social and economic status of parents, the age of mother and birth order is extremely useful in planning maternal and child care.

13. Adequate morbidity figures are generally unobtainable from many parts of the world. In their absence the public health worker has to rely mostly on mortality figures for planning health programmes and evaluating results. Indeed, the solution of most public health problems, whether of environmental sanitation, communicable disease control or nutrition, has been revealed through the analysis of vital statistics. These data on critical analysis reveal the peculiar features of each disease or injury, its tendency to occur in certain seasons or years, and its differential effect on age, sex, occupational and economic groups.

14. In recent years instead of merely measuring the loss of life by the number of deaths, the age at death is taken into account to assess the loss in terms of 'years of productive life'. A person dying in the prime of life is a greater loss to community than a dozen dying in old age. A list of priorities for health action can be drawn up keeping in view the amount of economic loss resulting from particular causes of death or injury.

15. Besides the above uses of vital statistics, a number of government agencies use them to formulate their social and economic plans with an eye on population change, age and sex distribution. They are utilized in connexion with housing, educational, and social security programmes. Commercial firms not only base the production of commodities on vital statistics records, but also anticipate future requirements. Life insurance premia are varied in accordance with changes occurring from time to time in the expectation of life.

16. Definitions of the terms used in the discussion of vital events are necessary for correct understanding. They are given below:—

(1) *Live Birth* is the complete expulsion or extraction from the mother of a product of conception, irrespective of the duration of pregnancy, which after such separation breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

(2) *Death* is the permanent disappearance of all evidence of life at any time after a live birth has taken place. It, therefore, excludes foetal death, which occurs prior to the complete expulsion of or extraction from its mother of a product of conception, irrespective of the duration of pregnancy.

(3) *Maternal death* is death caused to a woman by delivery or complications of pregnancy.

(4) *Foetal death*² is death occurring prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. This definition was recommended by the WHO Expert Committee on Health Statistics and adopted by the Third World Health Assembly.

(5) *Still birth* means late foetal death i.e., a foetal death occurring after twenty-eight completed weeks of gestation or over.

(6) *Neo-natal death* is death occurring to a child under 28 days of age.

(7) *Infant death* is death occurring to a child under one year of age.

3. Registration and Collection of Vital Statistics

17. It is by no means an easy task to set up a system that may ensure accurate and timely collection of information relating to each vital event occurring in the country, town and village for every individual. Herculean efforts are required to be made to achieve the avowed object.

18. Rules and regulations for reporting and registering vital events differ from one country to another. The general practice prevalent amongst advanced countries is that registration takes place at the village level. In many countries a single registration office covers up a large group of 50 to 100 villages, and the reporting agent in each village is provided with a notebook in which details of births and deaths are recorded datewise. At periodic intervals, a week or a fortnight, the reporting agents are required to carry the information to the registration office, where per-

manent registers are maintained. In the registration of vital events, accuracy rather than speed should be most important, but in the case of epidemics and outbreaks of infectious diseases the primary consideration must be speed.

19. No uniform procedure has been adopted for collecting vital statistics all over India. Generally the village *chaukidar*, watchman, or headman is required to report births and deaths, etc., to some local authority such as the police, which maintains regular registers. This type of registration system has severe shortcomings. The *chaukidar* is often an illiterate, ill-paid and overburdened official. Since the system of collecting information about births and deaths in rural areas proved defective, the responsibility for the registration of these vital events was entrusted to the village Panchayats from 1951 under the U. P. Panchayat Raj Act, 1947. Under this Act the reporting of births and deaths is obligatory on the part of the head of the family. Unfortunately the hope of its framers has not been realised, and gaps in registration are now far more than before.

20. In urban areas the reporting of every birth and death within three days of the occurrence is the primary responsibility of the head of families, keepers of hotels, *dharamshalas*, etc. To avoid omissions sweepers, midwives and *dais* have instructions to report every occurrence that comes to their knowledge. All the five Nagar Mahapalikas (Corporations) in KAVAL cities and some bigger Municipal Boards employ *Moharrirs* at burning ghats and burial grounds for recording deaths. Registration in urban areas is fairly accurate.

4. Compilation of data

21. The system of compilation differs in urban and rural areas as explained below:—

Urban Areas

- (i) Municipalities—Births and deaths recorded at the Municipal Registration Offices are reported each month to the Municipal Medical Officer of Health, if one exists, or to the Executive Officer or the Secretary.
- (ii) Cantonments—In Cantonments these data are reported to the Executive Officer. Monthly summaries of all births and deaths in Cantonments are then forwarded by him to the District Medical Officer of Health.
- (iii) Notified Areas and Town Areas—They submit their monthly statements to the District Medical Officer of Health.

² *Foetal, Infant and Early Childhood Mortality Vol. I (U. N. 1954), page 4.*

Rural Areas

In rural areas the primary unit or circle of registration is now the Gaon Sabha and a register of births and deaths is maintained. Compilation sheets of births and deaths are maintained by the Panchayat Secretary. On his monthly visit to each Gaon Sabha he is required to copy out the figures in his compilation sheet from village registers. The figures are then consolidated at the Block level and then submitted to the District Medical Officer of Health.

22. Three types of returns are prescribed for submission to the State Director of Medical and Health Services :—

- (1) Weekly Returns—They relate to births and deaths in Municipal towns having population 30,000 and over
- (2) Monthly Returns—Of both rural and urban areas
- (3) Annual Returns—Of both rural and urban areas

The Weekly Return is submitted direct by the Municipal Medical Officers of Health to the State Director who compiles the figures received from various Municipalities and submits the same to Dy. Registrar General (Vital Statistics) for publication. As the District Medical Officers of Health are required to submit returns for the entire district to the State Director of Medical and Health Services by the 21st. of every month, the Monthly Return is submitted by local bodies and the Assistant Development Officer (Planning) to him. A copy of the Monthly Return is required to be sent to the Director of Economic Intelligence and Statistics, the Dy. Registrar General (Vital Statistics), and the Director General of Health Services so as to reach them by the 15th of the next month. But in many cases the dates are not strictly adhered to. The Annual Return is required to be submitted by the District Medical Officers of Health to the State Director of Medical and Health Services by the 15th February of the succeeding year, but all the returns are not received by this date, which results in undue delay in the publication of the Annual Report. According to schedule the Annual Report has to be submitted to the Deputy Registrar-General (Vital Statistics) and to the Public Health Department of the State Government by the State Director by the June of the succeeding year, but there is often a great time-lag. A study of the time-lag reveals that the Annual Returns received by the State Director on checking are generally found to suffer from many deficiencies leading to unnecessary correspondence with the District Medical Officers of Health. The need and importance of timely publication of statistical data cannot be disputed, and it is desirable that bottle-necks, wherever they exist, must be removed.

23. The new system of collection of vital statistics through the agency of Panchayats has not improved matters. On the other hand there has been considerable deterioration. There is a thinking that the registration work might be handed back to the village *chaukidar* who might be paid some remuneration or given suitable incentive for the work. The scrutiny and compilation of data also needs attention. It is not only essential that the data are received in time, but also that the entire registration area has been completely covered. Uptil now there is no fool-proof method in the State Medical and Health Directorate to know the completeness or otherwise of weekly or monthly returns and the number of Development Blocks or villages missing in a particular district. This seriously affects the reliability of the data. There is a proposal to establish a Central Compilation Bureau at Lucknow to receive the basic reports directly from collecting agencies to avoid mistakes creeping in at intermediate levels. Some States have already set up their Central Compilation Offices. Madras was the first, and West Bengal, Punjab and Andhra Pradesh have followed suit. The state of affairs in regard to the collection and compilation of vital statistics is far from satisfactory. This important work needs especially trained staff, both in technique and administration.

5. Limitations and Reliability of Registered Data

24. Indian vital statistics have long been known for inaccuracy. The deficient data fail to meet the needs of demographers and public health and medical workers. If only a little more attention were paid to the collection and compilation of data, much useful vital information could be obtained. The remark of Prof. Clark that people often speak about population growth in India as if they were dealing with ascertained facts, but in truth, our knowledge is very uncertain and our conclusions should, therefore, be tentative is quite true and points to the great amount of inaccuracy in our vital data. The inaccuracy lies not merely in under-registration, but also in reporting of the causes of deaths.

25. Another limitation of vital statistics is the weak type of registration system obtaining in rural areas where most of the births and deaths take place. The villagers themselves, not realising the importance of such data, do not bother to report vital occurrences. The urban data too are not free from defects, but errors are not so palpable. Indifference and apathy on the part of the people, coupled with inefficient and insufficient organization, result in gross under-registration.

26. Statistics of births (live and still) and deaths quite often lack in details, such as sex, religion, age, time of occurrence, names of parents, and cause of death. One of the great defects in birth registration is that the name

of the child is not given. The under-registration of births leads to another difficult and rather embarrassing problem, that of deciding the age of an individual at any time or at death. The Public Health Commissioner to the Government of India, in his Annual Report for 1924, observes :

'The persistent high mortality of infants may be ascribed in part to defective registration, not only of births but of infant deaths, through the inclusion of still births, since a distinction between the two is not always made by the illiterate *chaukidar* and police *moharrir* and partly to the tendency of the more illiterate of the population to underestimate the age of the deceased infants.'

It, therefore, follows that quite often the number of infant deaths is inflated on account of incorrect recording of age. A comparative study of death registers and vaccination registers maintained in urban areas would confirm this view.

27. The successful working of social legislation in India as elsewhere, depends on the availability of accurate vital statistics. Registration of marriages is not compulsory or uniform all over India. An overwhelming number of Indian marriages and religious ceremonies are not registered. Only a small fraction are civil marriages in which registration is compulsory. Accurate vital statistics are needed not only for formulating public health programmes, but also for proving legitimacy of birth, succession, inheritance, etc. Statistics about age of marriage, fertility, health and ailments, deaths and their causes are necessary to formulate an effective health policy.

28. Almost every Commission or Committee that has inquired into some aspects of Indian economy has lamented the absence of accurate vital registration. At the third All-India Sanitary Conference held at Lucknow in 1914 the delegate representing the Government of India pleaded for more accurate vital registration as follows :

'In India the only certain thing we know about statistics at present is that they are highly inaccurate. They are more inaccurate in some areas than in others. We do not know the extent of their inaccuracy. We can only guess'.

The Royal Commission on Industries in India, 1916-18, the Indian Economic Enquiry Committee, 1925, the Royal Commission on Agriculture in India, 1928, the Age of Consent Committee, 1929, and the Royal Commission on Labour, 1929 have all made recommendations in favour of correct and accurate vital statistics. The Royal Commission on Labour in India 1929 examined the value

of Indian vital statistics. They observed that medical certification of death even in large cities were hardly available because few sick persons saw a doctor. Deaths were registered under one or other of only six or seven heads, three of these being smallpox, cholera and plague so that by far the largest number was entered under 'all other causes.' They recommend that still births should be excluded from both birth and death registers and that they should be separately recorded. The Famine Enquiry Commission, Government of India, Report on Bengal, 1945 passed strictures on the value and validity of Indian vital and health statistics. They reported that all public health statistics in India were inaccurate. Mortality figures indicated trends in the death rate, but could rarely be accepted as absolute. Even in normal times, deaths were not fully recorded and the number of births registered might be 20 or 25 per cent below the number of births that had actually occurred. The Population Data Committee in their Report of 1945 went into the question of the organisation of the Census and Vital Registration, and commented on the nature of available Indian Vital Statistics thus :

'There is knowledge about them. It is well known that the birth rates and death rates run much higher than in countries of the West. And that infantile and maternal mortality rates are very much higher. But there is a great difference between declaring that piece of undoubted knowledge and stating the actual rates themselves. There is then no real contradiction between the fact that the birth and death rates in India run consistently higher and the inability to say with confidence that they are precisely this and not that particular figure. Policies and departures in policy should, however, always refer to accurately recorded facts and now that population questions in India are receiving so much attention the time has come (is in fact long overdue) for the actual organisation of the information itself to receive attention.'

The Committee recommended that the Government of India should take positive steps to bring about ultimately complete, regular and accurate vital statistics in India. The records should invariably show in the case of births, the age of the mother and the number of births and for all births and deaths should invariably show the community and means of livelihood of the parents of the child or of the deceased person. Besides, an officer should be appointed at the Centre definitely charged with the co-ordination of all information on population growth, covering not only the Census but also Vital Statistics and allied matters.

29. The Health Survey and Development Committee under the Chairmanship of Sir Joseph Bhore appointed by the Government of India in 1943 surveyed the country's health and allied problems. The Committee examined the nature and methods of registration of vital statistics and their defects. They observed, 'the term vital statistics can, in its wider sense, include information relating to a wide range of human activities, but it is usually applied to a narrower field covering births, deaths, marriages and the incidence of disease in the community. In India registration of marriage does not take place among the two communities, the Hindus and Mohammadans who together form over 90 per cent of the total population. We shall confine ourselves to statistics of births, deaths and morbidity. As regards the last, no country can claim reasonably accurate statistics for the population as a whole, except in the case of certain diseases which are made notifiable by law. In India the available statistics in respect of births, deaths and notifiable diseases are all defective. Such defects are associated partly with the registration of these vital events and partly with their compilation'. Defects in registration according to the Committee were mainly (i) omission to register appreciable number of births, deaths and cases of notifiable diseases, and (ii) incorrectness of the recorded cause of death. They held that reasonable degree of accuracy in the registered cause of death could be attained only by certification by a medical man who has had the opportunity of examining the patient before his death, and that the large omissions in the registration of births and deaths and errors in compilation applied also to notifiable diseases, except in the case of small-pox, cholera and plague, symptoms of which are clear to everybody.

30. Following the recommendations of the Bhore Committee, the Government of India decided to take steps for developing and improving the systematic collection of statistics bearing upon the size and growth of population. To that end a single organization under the Registrar General was established at New Delhi to deal with population statistics including vital statistics. Central legislation to regulate vital registration in the country is believed to be in the offing.

31. Medical Certification of cause of death in the international form has been recently introduced in 12 large hospitals of this State since August, 1962, covering the five KAVAL cities, in order to effect improvement in mortality statistics. The names of the Hospitals in which this scheme has been enforced are :

- (i) Sarojini Naidu Hospital, Agra
- (ii) Lady Lyall Hospital, Agra
- (iii) Lajpat Rai Hospital, Kanpur

- (iv) Employee's State Insurance Hospital, Kanpur
- (v) Alice Horseman Memorial Hospital, Kanpur
- (vi) Medical College Hospitals, Kanpur
- (vii) Balrampur Hospital, Lucknow
- (viii) Dufferin Hospital, Lucknow
- (ix) Gandhi Memorial & Associated Hospitals, Lucknow
- (x) Dufferin Hospital, Allahabad
- (xi) Lovett Hospital, Ramnagar (Varanasi)
- (xii) Ishwari Memorial Hospital, Varanasi

6. Good and Bad Areas of Registration in India

32. Vital Statistics play an important role in assessing the health of a nation. In India registration of births and deaths is not perfect. Registration of these events is non-existent in some parts of the country and incomplete in varying degrees in many.

33. Shri S. P. Jain, the Census Actuary of 1951 Census and now Dy. Registrar General (Vital Statistics) divided the States and Union Territories of India into four zones after the last Census according to the degree of completeness and efficiency of registration as under :

(1) Areas from which birth-death registration data were available for all the three decades 1921-30 to 1941-50 and where omissions were not large, and the registration could be regarded as reasonably satisfactory. These areas comprised Madras, Coorg, Bombay, Madhya Pradesh, Punjab, Ajmer-Merwara and Delhi excluding 'merged areas'.

(2) Areas for which birth-death registration were available for all the three decades 1921-30 to 1941-50 but registration could not be regarded as satisfactory. They were Uttar Pradesh, Bihar, Orissa, West Bengal, Assam (Plains) and Mysore, excluding 'merged areas' within these States.

(3) Areas from which births and deaths data were available only for 1941-50, but registration could not be regarded as reasonably satisfactory. They were Hyderabad, Travancore-Cochin and Himachal Pradesh.

(4) Areas from which no data were available at all. Such areas were Assam (Hills), Manipur, Tripura, Saurashtra, Kutch, Madhya Bharat, Bhopal, Vindhya Pradesh, Rajasthan, PEPSU, Bilaspur, Jammu & Kashmir and 'merged areas' in other States.

34. There was a slight extension in registration areas during 1951-60. Jammu & Kashmir and the towns of Rajasthan were included. But still some areas in Orissa, Rajasthan and West Bengal remained without any arrangement for registration.

The accuracy of registration has gone down all over during the decade, and has declined even in areas where

it used to be high. Madras and Punjab have not fared so badly, but Bihar, Uttar Pradesh and West Bengal are now the worst registration areas. Up to 1940 the registered data of Uttar Pradesh were fairly accurate and reliable, after which conditions worsened. During 1941-50 the registered birth rate was 24.8 as against the computed rate of 38.6 per thousand. In the next decade the gap further

widened, the registered birth rate declining to 15.9 and the computed rate rising to 41.5 per thousand. It is a paradox that a system of registration which was quite efficient in some States and not too deficient in others should have in these years of development have deteriorated so much that it has become of little use.³

³ *State Growth Rates and their Components by Shri S. P. Jain.*

CHAPTER I

VITAL STATISTICS (REGISTERED)

1. Growth Rates

This Chapter deals with such registered vital data as could be made available by the office of the Director of Medical & Health Services, U. P. Complete data for 1951 and from 1956 to 1960 were obtained from there but very few for the years 1952-55. These could not be available as they had been washed away in the unprecedented floods of October, 1960. This hiatus has seriously affected the analysis of registered data. Some data were also obtained from the *Health Statistics in India*.

2. Births and deaths are among the most important events of the human life. There is a close relationship between these vital events and the pattern of life. Besides births and deaths, the incidence of diseases by age and sex and disabilities resulting therefrom need to be correctly and faithfully recorded, as they are required for planning health services. Government have made laws that births and deaths should be reported with necessary details as and when they occur. If reporting is complete and basic records are correctly maintained, the changes in numbers recorded by the Census every ten years should tally with the sum total of births and deaths during the same period, leaving a small margin for net balance of migration. The existence of compulsory registration laws does not mean that the vital events specified therein are completely registered. Nor does it indicate the ability to produce adequate statistics on births, deaths and marriages. Registration of births and deaths is defective to such an extent that almost no reliance can be placed on the registered data.

3. As observed by Coale and Hoover, 'High birth rates result from social beliefs and customs that necessarily grow up if a high death-rate community is to continue in existence.'¹ High birth rates and high death rates which are specialties of an agrarian low-income society are effected by economic changes and alterations in the mode of living. In an urban society children are more of a burden than in a rural setting. In India, however, the differential fertility between city and rural areas is slight or even non-existent. Urbanization alone will not be sufficient to bring about reduction in the birth rate. Nor is it by any means certain that small changes in the economic pattern or a slight rise in per capita income will reduce fertility.

4. In Uttar Pradesh growth rate as derived from registered birth and death rates tallied more or less with the mean decennial growth rate obtained from Census data up to 1941, but it fell appreciably behind in 1941-50 and far too short of it in 1951-60, as the following Table will show:

Table 1.1: Registered and Census (Gross and Mean Decennial) Growth Rates for Uttar Pradesh

Decade (Regd.)	Natural Increase Rate Per Cent	Growth Rate (Census) Per Cent	Mean Decennial Growth Rate (Census) Per Cent
1901-10	2.2	(—) 1.0	(—) 1.0
1911-20	2.1	(—) 3.1	(—) 3.1
1921-30	8.4	6.7	6.4
1931-40	12.3	13.6	12.7
1941-50	8.3	11.8	11.2
1951-60	6.7	16.7	15.4

The above Table indicates that at present there is gross under-registration of both births and deaths, but more so of births than of deaths and also that the extent of under-registration is growing.

5. Before 1921, population growth in all parts of the country, including Uttar Pradesh, was erratic. It was only after 1921 that it assumed a definite trend. The decrease of population during 1901-10 is attributed to famine, malaria, and the plague. The next decade 1911-20 witnessed the severe influenza epidemic, and consequently the population declined in most parts of the country. Mr. Edye in his Census Report of 1921 attributed the variation in population "to disease, relatively to which all other influences are insignificant to some extent to plague, cholera and malaria but overwhelmingly to the influenza epidemic". The registered data, however, show a slight increase in the population during these two decades. This is due to under-registration of deaths which had occurred in large numbers in that period. There was noticeable improvement in the next decade, and then a period of unprecedented growth commenced. Mr. Turner observed, "the outstanding feature of the decade 1921-30 has been its freedom from epidemics in a serious form and the rela-

tively high general standard of public health". During the decade 1931-40 growth rate experienced acceleration. On the whole, the decade was healthy, and the State was relatively free from serious epidemics. The incidence of cholera, plague and small-pox had fallen, and anti-malaria schemes had been put in force. The decade 1941-50, though free from famine conditions and severe epidemics, was a troubled period. It saw the ravage of the Second World War, scarcity, short supplies, political unrest, attainment of Independence, and communal disturbances. The first half of the decade was not healthy, but the conditions improved in the latter half. The result of all these was to slow down the growth of population to some extent. The next decade 1951-60 saw settled times. Incidence of disease was further brought under control. The birth rate increased, and the decennial growth reached an all time high mean rate of 15.4, not surpassed in any previous decennium. The registered data, on the other hand, have shown a continuous sharp fall in growth rate obviously on account of gross under-registration of births.

2. Births and Deaths correlated to Growth of Population

6. There is an obvious relationship between births, deaths and the growth of population. The following Table gives the registered birth and death rates in Uttar Pradesh for each decade since 1901 (computed rates from Census data given within brackets). Registered birth and death rates from 1901 to 1950 have been taken from the U. P. Census Report, 1951 pp. 73 and 83 and from 1951 to 1960 from the data obtained from the Director of Medical and Health Services. The computed birth rates for the period from 1901 to 1940 have been taken from page 74 of the U. P. Census Report. Those of the period from 1941 to 1960 are based on the calculations of Shri S. P. Jain.

Table 1.2 : Birth and Death Rates (Regd.) in Uttar Pradesh (1901-60)

Decade	Decennial Birth Rate	Decennial Death Rate	Decennial Natural Increase Rate
1901-10	41.7 (41.7)	39.5 (42.7)	2.2 (—1.0)
1911-20	42.9 (44.0)	40.8 (47.1)	2.1 (—3.1)
1921-30	34.0 (39.9)	25.6 (33.5)	8.4 (6.4)
1931-40	34.2 (38.8)	21.9 (26.1)	12.3 (12.7)
1941-50	24.8 (38.6)	16.5 (27.2)	8.3 (11.4)
1951-60	15.9 (41.5)	9.2 (24.9)	6.7 (16.6)

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The above Table reveals that between 1901-20 both birth and death rates were high, the latter being higher. The margin of error was small. The quality of registration deteriorated after 1921 mainly due to the reduction of a large number of village *chaukidars* in 1922. Taking the birth rate as 40 approximately, the death rate during 1921-30 was about 34. The quality of registration improved to some extent during the next decade. The birth rate for 1931-40 is believed to have been 39, hence the death rate should be near-about 26. A very sudden drop in the death rate occurred during 1921-30 and a further drop of considerable magnitude in 1931-40. The excess of births over deaths in 1921-30 and 1931-40 resulted in a large growth of population. The registered data erroneously show that the birth rate commenced to fall steeply from 1941 onwards, and both the birth rate and the death rate have come down almost to the level of materially advanced countries of the West! The birth rate continued to be the same during 1941-50; the death rate showed a slight rise increasing to 27. During 1951-60 the birth rate manifested an upward trend, but the death rate has come down to 25 resulting in a natural growth.

7. The variation in population was nominal during 1901-20, appreciable in 1921-30, high in 1931-40, registering a slight recession in 1941-50 and a steep rise in 1951-60. The birth rate has not shown very great fluctuation except for a significant fall in 1921-30, probably as an after-effect of the influenza epidemic which changed the age composition of the population. Variation in the death rate has so far been the principal determining factor in the population growth. The loss of population till 1921 was due to famines and epidemics. The decline in death rate since then has been due to better distribution of foodgrains in times of scarcity and the progress made in medicine and public health in combating disease and scourges like the plague, cholera and small-pox. Infants who were victims of respiratory diseases could now be fortunately saved with new drugs. The widening gulf between the birth rate and death rate is mainly responsible for the phenomenal rise in the State growth rate between 1931 and 60.

3. Registration of Births and Deaths

8. Before the integration of the princely states the registration area in Uttar Pradesh covered the whole of the State excluding the former States of Tehri Garhwal, Rampur and Banaras and small enclaves comprising 5.6 per cent of the total area of this State and 2.4 per cent of the total population in 1941. The registration area has since been extended to these territories also and at present it comprises the whole of the Uttar Pradesh. But previous data are available for the former registration area only. Since, however, the parts which were not under

¹ *Population Growth and Economic Development in Low-Income Countries* by Coale and Hoover, page 10.

registration or for which vital statistics are not available covered a small area, and were in all respects similar to the neighbouring districts of this State, it can be safely assumed that the birth and death rates of the registration area are representative of the entire State for the earlier period also.

Though vital statistics for different periods are not quantitatively comparable on account of the vagaries of registration, the data of the same period can be made to yield some qualitative results.

4. The Birth Rate

Birth Rates by Sex

9. The distribution of births by sex and year and their rates for Uttar Pradesh during various decades from 1921 are given in the Appendix. There has always been a greater number of births of males than of females, as is the case everywhere else, as the following Table will show :

Table 1.3: Birth (Registered) by Sex in Uttar Pradesh (1921-30 to 1951-60)

Decade	Number of Births		
	Persons	Males	Females
1921-30	15,921,016	8,411,956	7,509,060
1931-40	17,667,306	9,372,753	8,294,553
1941-50	14,479,317	7,792,842	6,686,475
1951-60	10,919,788	5,965,681	4,954,107

10. The Appendix further shows that during 1951-60 the maximum birth rate was in 1951, which continued to show a downward trend till 1957, whereafter there was slight rise. In fact, this downward trend does not represent the true state of affairs. It is the result of further deterioration in the registration of births, particularly in the rural areas, as would appear from the difference of the actual mean decennial growth rate of population and the growth rate thrown up by registered data.

11. Examining the birth rate for each year separately from 1951-60, it would again appear that the male birth rate is every time higher than the female birth rate, which fits in with the universal law. The following Table gives the birth rates (registered) of each sex from 1951-60:

Table 1.4: Birth Rate (Registered) by Sex in Uttar Pradesh (1951 to 1960)

Year	Male	Female
1951	10.77	8.96
1952	9.50	7.92
1953	9.46	7.82
1954	9.09	7.58
1955	8.35	7.06
1956	8.43	6.99
1957	8.14	6.68
1958	8.67	7.16
1959	8.30	6.90
1960	9.08	7.53

Thus the gap between male and female birth rates is about 1.5 per thousand. Multiplying this by 2.6, which is the ratio between the number of births estimated from Life and adjusted Age Tables and registered births, the gap between male and female births is of the order of 3.9 per thousand.

Birth Rates by Natural Divisions

12. Uttar Pradesh can be divided into 5 natural divisions. Names of districts in each natural division are given as under:—

Himalayan: Uttar Kashi, Chamoli, Pithoragarh, Tehri Garhwal, Garhwal, Almora, Naini Tal and Dehra Dun.

West Plain: Bijnor, Moradabad, Budaun, Rampur, Bareilly, Pilibhit, Shahjahanpur, Saharanpur, Muzaffarnagar, Meerut, Bulandshahr, Aligarh, Mathura, Agra, Etah, Mainpuri, Farrukhabad, Etawah and Kheri.

Central Plain: Kanpur, Fatehpur, Allahabad, Sitapur, Hardoi, Unnao, Lucknow, Rae Bareilly, Bara Banki, Faizabad, Sultanpur and Pratapgarh.

East Plain: Bahraich, Gonda, Basti, Gorakhpur, Deoria, Azamgarh, Jaunpur, Ballia, Ghazipur and Varanasi.

Hills and Plateau: Jhansi, Jalaun, Hamirpur, Banda and Mirzapur.

13. The mean decennial birth rates for the State and the natural divisions for the decades 1901-10 to 1951-60 are given in the following Table:—

Table 1.5: Mean Decennial Birth Rates (Registered) in Uttar Pradesh and Natural Divisions (1901-10 to 1951-60)

Decade	Uttar Pradesh	Himalayan	West Plain	Central Plain	East Plain	Hills and Plateau
1901-10	41.7	37.1	44.3	41.4	38.6	42.7
1911-20	42.9	35.9	45.1	43.2	40.1	45.5
1921-30	34.0	34.7	38.9	30.8	30.0	36.2
1931-40	34.2	36.5	39.3	30.0	30.4	38.3
1941-50	24.8	29.3	29.5	20.2	21.8	27.6
1951-60	15.9	23.9	19.6	13.4	12.6	16.7

14. The above Table shows that generally the birth rate is in this descending order: West Plain, Vindhyan Hills and Plateau, Himalayan Hills, Central Plain and East Plain. Contrary to the general belief, the eastern districts have a lower birth rate which might be due either to lower fertility prevailing there or greater extent of under-registration in that area or both.

Birth Rates—Rural and Urban

15. Decennial birth rates for 1921-30 and onwards are given below with rural and urban breakdown:

Table 1.6: Mean Decennial Birth Rates (Registered) for Rural and Urban Areas (1921-30 to 1951-60)

Decade	Birth Rate (Registered)		Decade	Birth Rate (Registered)	
1921-30	T	34.0	1941-50	T	24.8
	R	33.4		R	23.5
	U	41.9		U	32.9
1931-40	T	34.2	1951-60	T	15.9
	R	34.0		R	13.7
	U	35.6		U	30.7

It may be mentioned at the outset that areas treated as urban in the Annual Reports of the Director of Medical and Health Services, are not identical with areas recognized as urban at the Census, there being some differences. This requires to be borne in mind while studying the data.

16. The above Table shows that the rural birth rate is consistently lower than the urban birth rate, which goes against the accepted notion. The reason for higher birth rates in urban areas is chiefly due to a more efficient system of registration. As urban data are more reliable, inter-decade analysis of urban birth rates can be hazarded. The mean decennial birth rate in urban population has been showing a continuously downward trend. It dropped by 6.3 per thousand during 1931-40, by 2.7 during 1941-50 and further 2.2 during 1951-60. The total drop during 30 years has been 11.2 per thousand. Despite all this fall, the birth rate is still high. It is nearly double the rates obtaining in the countries of North, West and Central Europe and in the United States and Canada.

Birth Rate in Cities (Population 100,000 and above)

17. As has been indicated earlier, the recorded birth rate in urban areas is generally higher than in the rural areas, because of a more satisfactory system of registration. In cities generally the registration machinery is even more efficient and there are no large omissions. The birth rate is further augmented as many women of neighbouring areas come to cities for confinement on account of better medical facilities available. Birth rates for the 17 cities of Uttar Pradesh are given in the following Table:—

Table 1.7: Mean Decennial Birth Rates (Registered) for Cities of U. P. (1921-30 to 1951-60)

Cities in order of	1951-60	1941-50	1931-40	1921-30
Population				
1. Kanpur	26.3	27.0	35.2	32.7
2. Lucknow	30.0	34.3	40.4	38.7
3. Varanasi	40.3	39.5	49.3	48.7
4. Agra	46.9	48.7	51.3	48.9
5. Allahabad	26.2	29.0	37.3	38.0
6. Bareilly	18.3	34.2	40.0	31.5
7. Meerut	29.4	32.0	29.1	22.3
8. Saharanpur	35.4	35.8	43.0	47.5
9. Aligarh	20.2	24.4	36.9	43.7
10. Gorakhpur	25.9	25.6	33.1	35.8
11. Moradabad	33.4	40.6	46.3	47.9
12. Jhansi	33.6	42.3	40.5	36.3
13. Rampur	6.1	N.A.	N.A.	N.A.
14. Dehra Dun	22.9	24.0	32.2	23.2
15. Mathura	39.6	39.0	45.3	43.8
16. Shahjahanpur	32.0	30.7	32.5	40.1
17. Mirzapur-cum-Vindhyachal	31.1	34.2	42.5	44.5

N.A.=Not Available

18. The above Table shows that the birth rate of cities generally showed a very slight increase in 1931-40 from 1921-30, and since then it is steadily coming down. Cities which have manifested an increase during 1951-60 as compared with the previous decade are Varanasi, Gorakhpur, Mathura and Shahjahanpur. While the data are more trustworthy than for rural area, too much reliance should not be placed when making comparisons from decade to decade. Among the cities considering all the 4 decades together, Agra has the highest birth rate followed by Varanasi, and Dehra Dun the lowest, followed by Meerut. For Rampur, figures for the previous decades are not available, and that for 1951-60 is too low.

5. Mortality

General Considerations

19. The study of mortality is of extreme service for determining the factors which contribute to the well-being of the society. In the words of William Farr, 'There is a definite task before us to determine from observation the source of health and the direct causes of death in the two sexes at different ages and under different conditions. The exact determination of evils is the first step towards their remedies'. Unfortunately, the registration of deaths and their causes suffers from grave defects. Mortality statistics can serve a useful purpose only when the total number of deaths is classified by causes and also by age, sex, occupation and community. The correctness of causes of death is obviously dependent upon medical diagnosis. The

basis of mortality statistics should be residence, but they are usually compiled according to the place of death. On account of hospital facilities provided by cities and towns, quite many births and deaths occur therein, which would otherwise have taken place in villages where the persons concerned usually reside. Owing to the operation of this factor, mortality statistics of small areas get vitiated and fail to serve as a true index of health conditions of those areas. Age reporting is defective to such an extent that the precise estimate of death rates by ages becomes very difficult. The greatest difficulty is encountered in estimating the death rate among infants and children.

20. The level of mortality varies from one demographic group to another. Mortality indices partly depend on biological factors, such as sex, age and physical health of individuals and partly on social and environmental factors, such as locality, occupation, social and economic position, and marital status. These two kinds of factors are operating all the time. Mortality among males, as a rule, is higher than among females throughout the entire span of life, such being the law of nature for which no universally accepted reason exists. Perhaps it is due to the difference in the constitutional structure of the two sexes—the male suffering from deficiency of one chromosome which might make him more vulnerable to illness and death. But in India the female death rate is high, particularly in the reproductive period. The result is that in large parts of the country males outnumber females in every age-group, except the very highest. Age also plays an important part in deaths. Mortality is invariably higher in the youngest age-groups and age-groups of 50 years and above than in the middle age-groups. This is a universal pattern, which holds true irrespective of all other considerations.

Social and Environmental Factors

21. The level of education, sanitation and general living, social consciousness, and the availability of preventive and curative measures against diseases all play a very important role in the health of a nation. The position with regard to India has been given in the Report of the Health Survey and Development Committee, 1946, as follows:

'The maintenance of the public health requires the fulfilment of certain fundamental conditions, which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection to all members of the community, irrespective of their ability to pay for it, and the active co-operation of the people in the maintenance of their own health. The large amount of preventible suffering and mortality in the

country is mainly the result of an inadequacy of provision in respect of these fundamental factors. Environmental sanitation is at a low level in most parts of the country, malnutrition and under nutrition reduce the vitality and power of resistance of an appreciable section of the population, and the existing health services are altogether inadequate to meet the needs of the people, while lack of general education and health education add materially to the difficulty of overcoming the indifference and apathy with which the people tolerate the insanitary conditions around them and the large amount of sickness that prevails'.

22. Climate has a profound effect on the general health of the community. A cool and fairly dry climate is good for health, while hot and moist climate is detrimental. Many diseases of tropical countries do not exist in cold climates. Malaria, for instance, requires a moderately high temperature for effective multiplication of mosquitoes which are carriers of infection. The seasons too have their influence on public health. Quite a number of diseases are seasonal in character, appearing in certain seasons. The cold season in the country is particularly healthy.

23. Except for better preventive and curative devices existing in them, cities are less healthy than villages where the air, water and food are fresh and clean. The air of the cities is polluted by the large number of people constantly breathing therein and by contamination with smoke and industrial gases. Close living and overcrowding lead to rapid spread of infection. Housing conditions have a direct effect on the health of inmates. Ill-constructed and congested houses are not conducive to health and increase the incidence of infectious diseases. The larger the number of persons per room, the greater the chances of infection spreading. Apart from these, the city life has certain other dangers as well to health. The nature of work, more often than not, is indoor and sedentary, devoid of physical exercise. There is continuous din and bustle and constant hurry. Life moves so fast that its strain gets beyond endurance, resulting in high blood pressure and diseases of the nervous system and the heart. Moreover, owing to the continuous stream of fast vehicles on the road and fastworking machinery there is an added danger to life and limb. From all these considerations the cities are more deadly than villages.

24. Occupation too has an effect on a person's health. Some occupations are more hazardous than others and claim a higher mortality. Sedentary occupations, such as officework apparently carries the least hazard, but in the long run are ruinous to health.

25. Marital status too has its own effect on health and mortality. Unfortunately, reliable data of mortality by marital status are not available in this country. But this subject has been studied by some western authors such as Benjamin², Hauser and Duncan³, and others. They have observed that in married males mortality is lighter than in single and widowed persons at all ages, and in married females at younger ages. In older women it is much the same for all marital conditions. The differentials are usually larger for men than for women. They arise from differences in the habits and living conditions of the married and unmarried. However, married women are subject to certain diseases to a greater extent, such as cancer of the uterus and the breast, apart from the risks in child-bearing. Where maternal mortality is high, the death rate of young married women is higher than that of single woman. These observations it must be added, apply to happily married couples. An unhappy marriage leads to morbidity and shortening of life through tension, but perhaps unhappy marriages are for fewer than happy, or at least placid marriages.

26. Economic status and standard of living have a direct influence on mortality. People with good sources of income can afford to live in better houses, eat better food, and obtain better medical care than those who are not so fortunately placed. On the whole they and their families live a healthier life, and the visits of death are less frequent. Infant mortality is visibly lowered and the child survival index goes up. Differences in the survival rate between one income group and the other are considerable. The figures clearly bring home the heavy toll of life that poverty and filth claim among the children in lower income classes and how the survival rate increases with the rise in income which brings relatively improved amenities of sanitation and health.⁴

Death Rates by Natural Divisions and Rural/Urban

27. The mean decennial death rates for the State and the natural divisions are given in the following Table since 1901:

Table 1.8: Mean Decennial Death Rates (Registered) in Uttar Pradesh and Natural Divisions (1901-60)

Decade	Uttar Pradesh	Himalayan	West Plain	Central Plain	East Plain	Hills and Plateau
1901-10	39.5	29.3	42.8	41.3	35.0	37.5
1911-20	40.8	34.5	44.5	42.2	35.5	41.4
1921-30	25.6	27.5	28.9	30.7	22.3	28.1
1931-40	21.9	24.6	25.1	19.6	19.3	23.9
1941-50	16.5	19.3	18.7	13.8	15.3	19.2
1951-60	9.2	13.3	10.9	8.5	7.6	18.9

² B. Benjamin, *Elements of Vital Statistics*.

³ Hauser and Duncan, *The Study of Population*.

⁴ D. N. Majumdar, *Social Contours of an Industrial City*.

It will be seen that the death rate of the State registered a rise till 1920, after which it declined very rapidly. In reality the decline was not so rapid as indicated. The steep fall is due to a certain amount of under-registration. If necessary corrections are applied the computed death rates for the decade 1921-30 would be 33.5 and for successive decades 26.1, 27.4 and 26.1 respectively. The greatest improvement took place during 1921-30 followed by the next decade 1931-40.

28. The Table shows that the death rate differs widely from one natural division to the other. On the whole, the West Plain manifests the highest death rate. Other natural divisions in the descending order are the Hills and Plateau, the Central Plain, the Himalayan Hills, and the East Plain. Contrary to the general belief the eastern districts appear to have a lower death rate which may be a fact or may be due to greater extent of under-registration in those areas. Comparison of birth and death rates in natural divisions shows that those with a high birth rate have a high death rate, and those with a low birth rate have low death rate.

29. Decennial death rates from 1921-30 onwards are given in the following Table for total, rural and urban:

Table 1.9 Mean Decennial Death Rates (Registered), for Rural and Urban Areas (1921-60)

Decade	Death Rate (Registered)	Decade	Death Rate (Registered)
1921-30 T	25.6	1941-50 T	16.5
R	24.8	R	15.6
U	35.9	U	22.5
1931-40 T	21.9	1951-60 T	9.2
R	21.5	R	8.5
U	24.8	U	13.9

Comparing the rural and urban death rates for the same decade, it becomes apparent that the urban death rate is higher than the rural. To some extent this is correct, but partly it is also due to better recording of vital statistics in urban areas. However, the extent of under-registration of deaths in towns appears to be somewhat greater than that of births. The registered urban birth rate for the decade 1951-60 is 30.7 while the registered death rate is only 13.9.

30. Nevertheless, the reduction of deaths has been going on at a faster rate in the urban areas than in the rural, owing to the advancements made in medical science

and improvement in sanitation. The urban population receives better medical aid, as more medical facilities exist in cities and towns. The struggle against death and disease has borne better fruit in towns than in villages.

Death Rate in Cities (Population 100,000 and above)

31. The death rates for the cities of the State are given in the following Table :

Table 1.10: Mean Decennial Death Rates (Registered) for Cities of U.P. (1921-1960)

Cities in order of Population	1951-60	1941-50	1931-40	1921-30
1. Kanpur	19.7	23.2	29.9	40.0
2. Lucknow	13.0	22.2	28.6	38.3
3. Agra	12.8	28.5	32.6	34.9
4. Varanasi	22.9	42.4	47.6	53.1
5. Allahabad	9.3	19.5	24.1	28.6
6. Meerut	6.6	15.2	15.8	15.6
7. Bareilly	6.5	22.2	23.6	21.4
8. Moradabad	15.6	23.9	29.2	37.2
9. Saharanpur	12.6	26.2	36.1	43.1
10. Dehra Dun	4.3	13.6	22.8	20.6
11. Aligarh	8.4	15.0	21.8	35.7
12. Rampur	3.0	N. A.	N. A.	N. A.
13. Gorakhpur	9.7	18.6	25.6	27.4
14. Jhansi	12.2	29.4	28.3	27.8
15. Mathura	12.3	24.4	32.0	38.4
16. Shahjahanpur	12.5	21.2	20.4	29.8
17. Mirzapur-cum-Vindhyachal	12.8	20.8	24.5	26.6

N. A.=Not Available

The above Table reveals that the death rate in cities as well has been falling steadily and the steepest decline has occurred between 1951-60. The death rate of cities is undoubtedly higher than that of villages, but in respect of epidemic control they are more fortunate. It takes much less time to stem the tide of an epidemic in a city by concerted municipal and public health efforts than in the rural area. Among the 17 cities, Varanasi has the highest death rate for which special reasons exist. Hindus from far and near prefer to pass their last days at Varanasi wishing to die there, because according to a religious belief people dying in that holy city attain salvation. Saharanpur, Kanpur and Agra are next in descending order. Saharanpur has a humid Tarai climate and Kanpur and Agra are large congested cities. The lowest death rate has been reported from Meerut and the next lowest from Dehra Dun. As regards Rampur the figures for earlier decades are not available, and those for 1951-60 do not appear to be too reliable.

32. There seems to be a definite connexion between high birth and high death rates and low birth and low death rates. Agra and Varanasi both have high birth and high death rates and Dehra Dun and Meerut both have low birth and low death rates.

Deaths by Causes

33. In certain advanced countries the medical practitioner who attends to a person in his illness is required in the case of death to give a certificate stating the cause of death. Such a certificate is of great utility in the statistical classification of causes of mortality.

34. The plague, cholera, small-pox and malaria used to take a heavy toll in the past wiping out large populations. Improvement in sanitation, destruction of carriers, and the introduction of preventive measures such as vaccination and inoculation have brought these diseases under control. The largest number of deaths is ascribed to fevers, a general term including typhoid, malaria, influenza and all diseases in which the body temperature rises above the normal. Apart from the plague, cholera and small-pox, the diseases next in importance to fevers are respiratory diseases, the chief ones being pneumonia and pulmonary tuberculosis. Then come water-borne diseases, such as dysentery and diarrhoea. Deaths from other causes include deaths from injuries, snake-bites, etc. The following Table gives the percentage of deaths from major causes of six decades. Registration for the plague, cholera and small-pox can be deemed to have reached a fair standard of accuracy, but for fever it is most faulty. Among fevers the heaviest mortality is from malaria.

Table 1.11 : Percentage Distribution of Deaths from Major Causes (1901-60)

Decade	Per cent Deaths due to			
	Fever	Plague	Cholera	Small-pox
1901-10	71.7	7.0	3.4	0.7
1911-20	73.9	5.9	3.1	0.3
1921-30	75.4	3.6	3.5	0.5
1931-40	77.1	1.9	2.0	0.9
1941-50	77.5	1.6	3.8	1.2
1951-60	66.6	N	1.1	2.7

N=Negligible

The plague which used to be a mass killer in the past has been almost totally eradicated. During the decade 1951-60 the total number of deaths from this disease has been 17,506 of which 16,768 have been reported from rural and 738 from urban areas. The years 1959 and 1960 were completely free from deaths due to the plague. In 1958 too the number was only 4, though in the opening years of the decade it was considerable. However, the incidence of small-pox has increased from 1.2 per cent to 2.7 per cent during the decade.

35. The following Table gives the actual number of deaths from the plague, cholera and small-pox :—

Table 1.12 : Number of Deaths from Plague, Cholera and Small-pox (1901-1960)

Decade	Total Deaths	No. of Deaths from		
		Plague	Cholera	Small-pox
1901-10	18,747,113	1,305,474	634,537	140,801
1911-20	18,819,255	1,112,380	582,819	56,775
1921-30	11,993,248	429,136	420,891	60,247
1931-40	11,333,226	211,413	222,669	105,353
1941-50	9,668,671	156,521	363,194	112,820
1951-60	6,318,738	17,506	71,647	168,900

36. After 1920 the plague seems to have lost its former virulence. Anti-rat campaign by trapping, baiting and cyano-gassing, anti-flea measures with D. D. T. and anti-plague inoculation effectively reduced the incidence of this disease.

37. Progress in the control of cholera has been relatively slow, the disease flaring up again and again in an epidemic form but during 1951-60 there has been considerable improvement. Sterilization of drinking water, prohibition of exposed food for sale, and anti-cholera inoculations are resorted to whenever this disease raises its head. Rigorous enforcement of anti-cholera measures in important *melas* has made them safer to attend, and they are no longer held in dread.

38. Small-pox has, however, been persisting. Its eradication is now being done with the help of the World Health Organization. The Government of India appointed an Expert Committee in 1958, as a result of which pilot projects were started. In Uttar Pradesh the project is located at Sultanpur. Inaugurating the Anti-Small-pox Week in September, 1963, the late Prime Minister, Pt. Jawahar Lal Nehru observed, "The countries that had systematic campaigns had now completely eradicated small-pox, but in our country, in spite of vaccination having been in vogue for more than one hundred years, small-pox epidemics have been recurring with periodic cyclicity every five to seven years claiming a heavy toll of life". Small-pox, besides taking a heavy toll of life, also causes blindness and disfigurement in many. It has been completely eradicated in many advanced countries of the world, where people adhered to a rigid system of vaccination. In this country due to superstitious beliefs, people are not enthusiastic about vaccination. India and Pakistan are the biggest reservoirs of small-pox in the world. Due to its easy communicability it is a source of danger to us as well as to those countries which conquered it long ago.

39. The highest mortality in Uttar Pradesh is from fevers. Of this malaria takes the largest toll. It not only causes a large number of deaths, but also saps the vitality of the people. It is now yielding to the world-wide campaign against it, which is saving two million lives every year. The recent decline in Uttar Pradesh is due to the large-scale measures taken in this regard. As a result of special precautions taken by the malaria control units large tracts of the Tarai have now become habitable. Malaria incidence is greater in those areas where there is damp climate, water-logging, and bad sanitation. Water-logging breeds mosquitoes the anopheles species of which acts as the carrier of the disease. Mosquito breeding can be controlled by prevention of water-logging, pouring of mineral oil on the surface of pools, and the use of insecticides. Considerable success has already been achieved in this direction.

40. Of the remaining causes of death, tuberculosis is the greatest threat. Many of the deaths occurring from pulmonary tuberculosis are confused with deaths from respiratory diseases. With increasing industrialization and congestion in urban areas, incidence of this disease and consequent deaths therefrom have gone up. Poor state of health, unsatisfactory living conditions, and absence of proper nutrition increase susceptibility to tuberculosis. Kanpur, the industrial metropolis of this State, has the largest incidence of tuberculosis. Work on the cause and prevention of this disease is being carried on at several clinics aided by the Uttar Pradesh Tuberculosis Association. In order to reduce its incidence a large-scale campaign for B. C. G. vaccination as an anti-tubercular measure has been undertaken. The impact of mass vaccination will be visible after 1966, when the vaccinated persons will belong to the age-group 15-30 years, the period at which tuberculosis causes the highest mortality.

41. Diarrhoea and dysentery, epidemic dropsy, deficiency diseases and many others are responsible for quite a large number of deaths. For the control of beriberi and epidemic dropsy which are more prevalent in the rice-eating eastern districts of the State, *argemone mexicana* used for the adulteration of mustard oil has been declared as poisonous and action is taken under the Uttar Pradesh Prevention of Adulteration Act.

42. Cancer, though it does not claim a large number of lives, is now growing into a formidable enemy. Since it is difficult to diagnose the disease in its initial stage, cure at a late stage becomes difficult. It is hoped that researches into the causes and cure of cancer will bear fruit, and this fell disease will cease to be a great menace which it happens to be at present.

43. Maternal mortality should be a rare occurrence, because in course of nature child-birth need not cause the death of the mother at all. Pre-natal and post-natal maternal care and qualified medical attendance at the time of birth will certainly lead to fewer maternal deaths. In all under-developed countries including India incidence from maternal deaths is sufficiently high. During 1921-30 maternity and child welfare work was introduced in this State on an organized basis. The prohibition on child marriage has also helped in the decline of maternal mortality.

44. The following Table gives the maternal death rate for the 17 cities of this State for the years 1951, 1955 and 1960 :

City	Maternal Deaths per 1,000		
	1951	1955	1960
1 Kanpur	11.8	10.8	11.8
2 Lucknow	1.4	1.5	0.2
3 Varanasi	4.7	0.7	0.5
4 Agra	1.8	0.1	N.A.
5 Allahabad	2.5	3.2	1.4
6 Bareilly	1.8	3.1	5.7
7 Meerut	2.6	N.A.	6.2
8 Saharanpur	1.8	2.1	0.7
9 Aligarh	4.4	4.7	4.2
10 Gorakhpur	2.2	N.A.	1.8
11 Moradabad	4.1	2.8	2.3
12 Jhansi	N.A.	N.A.	N.A.
13 Rampur	5.7	4.0	1.1
14 Dehra Dun	3.8	2.1	0.3
15 Mathura	1.7	1.7	5.1
16 Shahjahanpur	3.8	1.5	1.6
17 Mirzapur-cum-Vindhyachal	1.9	N.A.	2.1

N. A. = Not Available

Kanpur has the highest mortality rate followed by Aligarh. However, exact comparability on account of different standards of registration is difficult.

Mortality by Age and Sex

45. Mortality is highest in infancy and early childhood for both sexes, then the risk of death appreciably lessens. It again increases after a certain age. In every country more boys are born than girls, but the balance is soon restored by nature which kills off more males than females at each successive stage, though, as said earlier, the death rate here among females in certain age-groups is so high that the balancing effect of nature does not become operative except at a considerably advanced age.

46. It is proposed to take up two decades for the study of the age and sex pattern of mortality. The first decade is 1921-30 and the other, 1951-60. The figures of deaths have been taken from the Annual Reports and the mean decennial population of the respective age-groups has been worked out from the Tables of the 1921, 1931, 1951 and 1961 Censuses. The ratio of deaths to the mean decennial population in a particular age-group gives a rough indication of the death rate in that age-group. The age and sex pattern of mortality for 1921-30 is given in the following Table :—

Table 1.14: Age & Sex Pattern of Death in U. P. (1921-30)

Age in Completed Years	Male Deaths	Female Deaths	Percentage of Deaths to Mean Population	
			Males	Females
0 (Infants under one year)	1,542,394	1,292,589	206.1	177.3
1—4	1,205,272	1,094,083	47.7	42.4
5—9	344,709	300,166	10.2	10.0
10—14	231,333	195,859	7.7	8.2
15—19	188,810	188,749	8.5	10.1
20—29	467,960	501,804	10.7	12.3
30—39	496,737	458,250	13.7	13.9
40—49	521,096	395,048	19.9	16.9
50—59	581,235	424,414	36.9	29.6
60 +	854,439	749,302	77.3	65.5
Total	6,393,985	5,599,283	25.4	24.5

The undermentioned conclusions follow from the above Table :—

(1) Mortality continuously declined till the age of 15 in both sexes after which it showed a tendency to rise with advancing age. After 50 years of age the rate rose steeply for both sexes.

(2) The male death rate was higher than the female death rate at all ages, with the exception noted in the next subpara.

(3) The death rate of females exceeded that of males in the ages 10-39, the greatest difference being in the age-groups 15-29. Thus women in the reproductive age-groups are more exposed to the risk of death. The factors responsible are the loss of vitality from repeated child-bearing and indoor household duties in overcrowded and ill-ventilated houses.

47. Similar data for 1951-60 are given in the following Table :—

Table 1.15: Age and Sex Pattern of Death in U. P. (1951-60)

Age in Completed Years	Male Deaths	Female Deaths	Percentage of Deaths to Mean Population	
			Males	Females
0 (Infants under one year)	650,483	525,888	50.3	41.5
1—4	619,861	515,573	15.5	13.7
5—9	253,459	206,822	5.6	4.9
10—14	179,555	149,095	4.5	4.1
15—19	168,046	149,149	4.7	4.7
20—29	223,147	216,268	3.8	4.1
30—39	255,366	218,369	5.4	5.2
40—49	305,200	231,476	8.6	7.5
50—59	348,090	257,715	14.5	12.5
60 +	480,623	364,553	25.9	19.5
Total	3,483,830	2,834,908	9.7	8.7

The above Table gives a far smaller number of deaths for the decade than for the decade considered previously, but that is not the chief point, because to a very large extent the difference is due to under-registration. The same tendencies as exhibited by the decade 1921-30 are more or less in evidence in this decade, but the age-groups are substantially different, as will appear from the following.

(1) Mortality has shown a continuous decline till the age of 15 in both sexes as before.

(2) There has been a rise in the mortality rate in the age-group 15-19.

(3) Mortality has again declined in the next age-group 20-29. In fact, the age-group 20-29 has the lowest mortality rate in both sexes.

(4) From the age of 30 the mortality rate progressively increases with advancing age. After 50 years of age the rate rises steeply for both sexes.

(5) The male death rate is higher than the female death rate at all ages, with the exception noted in the next subpara.

(6) The death rate of females exceeds that of males only in the age-group 20-29, but the gap is now much smaller.

48. The comparison of the two sets of figures shows that apart from the general decrease in the death rate, the mean age of the population and the expectation of life have made a substantial improvement during the last 30 years and that females are no longer subject to the same

high rate of mortality during their reproductive years as used to be the case in the past, on account of the general improvement in health and better attention paid at the time of confinement.

6. Infant Mortality

General Causes

49. For demographic and statistical purposes, all children under one year of age are considered infants, hence *infant mortality* refers to deaths of children of less than one year. Infant death rate may be defined as the number of infant deaths that occur per thousand live births in any population in one calendar year. Thus, infant mortality ignores both foetal deaths or still births and takes into account only live births and infant deaths.

50. The largest number of children die in their first year. Even in infants the risk of death decreases as time passes. About 50 per cent of infant deaths occur in the first month and 30 per cent between the second and the sixth months. Thus four-fifths of deaths occur during the first half-year and one-fifth during the second half. It further shows that the infant faces the greatest risk in the first few weeks of his life. Deaths in early infancy are to a great extent due to such causes as birth injuries, congenital malformation etc., while in later years to infection and parasitic diseases.

51. The importance of infant mortality cannot be overemphasized. The infant death rate is perhaps the most sensitive index of health conditions as the first year continues to remain as the most vulnerable period of life even in advanced countries. A high infant death rate shows poor and insanitary environment. A precise study of infant mortality requires adequate information regarding the physical condition of the mother, her age, the order of birth, interval between successive birth, age of the infant at the time of death, medical aid rendered, and various social and economic factors. While data on the above items may be considered as almost the barest minimum, information on many is not available. Data on causes of death in infancy and early childhood as well as on causes of foetal deaths are extremely deficient on account of poor diagnosis or inadequate reporting of the correct cause. Diagnosis of infant diseases is particularly difficult. In the words of Dr. F. J. W. Miller the difficulty of diagnosing diseases in infancy is so great that sometimes no opinion can be given even by experienced physicians. In these circumstances it becomes difficult to investigate the causes of infant mortality scientifically.

52. Many causes of infant mortality can be traced directly to the mother. The general health of the mother comes first. It is well known that a woman in a poor

state of health cannot give birth to healthy offspring. The age of the mother and the order of birth also play a great part. Infant death rates are higher when the mother is either too young or old enough to be on the verge of menopause. The chance of the survival of the first baby is too remote if the mother is very young. Repeated pregnancies without proper spacing lessen the chances of survival. Birth order also assumes significance after a few births. 'Too many births to the same mother lessen the chances of survival for the children born last. The lowest mortality rates usually occur among second children. Although the risk of death does not increase substantially until the fifth birth, it then rises sharply, so that tenth or late children have only half as much a chance of survival as do second children.'

53. Deaths of new-born infants are often the result of causes which come into operation long before the birth, sometimes as far back as the time when existence was in the shape of merely a fertilized ovum. As a consequence, the child is born with certain handicaps which render it unfit to carry on the struggle of existence. Premature birth also renders a child prone to sickness and death. It is caused by the poor health of the mother, weakness of the uterus, injury, shock, and formation of excessive fluid. Death of the mother as a result of confinement or from any other cause in the early life of the infants also puts him under a disadvantage in his fight for life.

54. Besides the above certain cultural and social factors are also responsible for infant mortality. The condition of the lying-in-room where the expectant mother is usually kept is mostly far from hygienic. It is often dark and dingy, ill-ventilated and devoid of fresh air. Frequently it is near to the privy. Under these conditions the mother and the infant are exposed to any and every kind of infection. The other important cause of high infant mortality is the time-honoured custom to call in an unqualified *dai* ignorant of the nature of her work and of the elementary rules of hygiene. These factors create circumstances which cause not only a large number of infant deaths, but also a large number of maternal deaths.

55. Faulty feeding and malnutrition due to ignorance, carelessness or lack of means also are important contributory factors. Other deaths can be traced to ailments, such as fever, convulsions, diphtheria, respiratory diseases, bowel complaints, and to serious infectious diseases appearing in an epidemic form.

56. Other factors remaining the same, poverty is an important cause for the high incidence of infant mortality. Income plays an important part in determining where a family should live in reasonably clean locality or in a disreputable slum. The poorer sections can also ill-afford proper nutrition and medical aid in the event of sickness. Titmus has established from official data in England that infant mortality rates gradually increase as one goes down in income. In the family planning enquiry conducted by D. N. Majumdar's team at Kanpur 1,525 married women, mostly of lower income groups were interviewed. It was established that the economic level has a profound effect on mortality and survival of children as the following Table would illustrate :—

Table 1-16: Loss and Survival Index in Relation to Income Level

Income	Percentage of	
	Loss	Survival
Below Rs. 50	44.5	55.5
Rs. 51-100	39.9	60.1
Rs. 101-200	30.2	69.8
Over Rs. 200	24.9	75.1

Infant Death Rates

57. The computed infant death rate is 186 per thousand for Uttar Pradesh which is the highest in India. The registered infant death rate of Uttar Pradesh has ranged between 85 and 129 during 1948-60 as the following Table will show :—

Table 1.17: Infant Death Rates in U. P.

Year	Rates	Year	Rates
1948	109	1955	99
1949	95	1956	105
1950	104	1957	97
1951	129	1958	103
1952	129	1959	85
1953	122	1960	92
1954	110		

This Table shows that the registered infant rate which was 129 in 1951 came down to 92 by 1960. Though infant mortality has shown some improvement over the years,

yet to quite a large extent the fall is due to progressive under-registration. The infant death rate has fluctuated a good deal, the years 1951 and 1952 being the worst years.

58. Analysing the infant death rate by rural/urban it will be evident that the rate is higher in urban areas than in the rural. Partly, it is because of better registration and, partly, because of unhealthy surroundings and overcrowding found in urban areas.

Table 1-18: Infant Death Rates by Rural and Urban in U. P. (1948-60)

Year	Infant Death Rates		Year	Infant Death Rates	
	Rural	Urban		Rural	Urban
1948	93.0	169.0	1954	105.0	128.0
1949	80.0	158.0	1955	94.0	111.0
1950	92.0	151.0	1956	102.5	112.5
1951	129.0	130.0	1957	95.9	100.8
1952	125.0	144.0	1958	99.5	113.3
1953	118.0	134.0	1959	83.0	91.2
			1960	90.8	94.6

59. An analysis of the infant death rates for cities shows that a wide divergence exists among them. The following Table gives the infant death rates for the years 1956 to 1960 for the 17 cities of the State :—

Table 1.19: Infant Death Rates for Cities of U. P. (1956-60)

Cities (Corporation/ Municipalities)	Infant Death Rates				
	1956	1957	1958	1959	1960
1. Kanpur	215.6	223.9	190.6	142.6	165.0
2. Lucknow	95.8	96.5	141.2	101.8	88.0
3. Varanasi	160.8	124.8	127.4	115.6	112.0
4. Agra	92.9	52.8	85.2	81.4	60.0
5. Allahabad	92.5	84.0	73.0	64.7	73.0
6. Bareilly	103.8	75.7	95.7	78.1	82.0
7. Meerut	54.7	48.1	56.0	44.9	44.0
8. Saharanpur	120.5	115.6	124.8	108.1	100.0
9. Aligarh	101.7	89.1	149.8	75.8	101.0
10. Gorakhpur	90.9	68.0	82.8	70.1	61.0
11. Moradabad	116.4	149.6	96.0	118.7	94.0
12. Jhansi	114.1	126.2	112.5	90.8	108.0
13. Rampur	34.8	46.5	23.7	37.5	18.0
14. Dehra Dun	62.3	77.9	67.4	45.6	56.0
15. Mathura	83.9	62.1	77.3	59.9	76.0
16. Shahjahanpur	114.2	77.1	102.8	92.0	100.0
17. Mirzapur-cum-Vindhyachal	142.0	98.8	108.4	105.7	93.0

60. The low infant death rates of certain cities might be due to under-registration. Kanpur has the highest infant death rate due to overcrowding and the pollution of air by smoke. A large number of families of mill labourers dwell in congested localities and occupy sub-standard houses beyond the reach of the sun and fresh air.

CHAPTER II

HOSPITAL MATERNITIES

1. Nature & Scope of Study

India has a high birth rate. This is to a very large extent due to marriages taking place at a comparatively younger age and being almost universal and to the conjugal habits of the people. For the study of important characteristics of the fertility pattern and the family-building habits of the people, data were collected from the hospitals of Kanpur, Lucknow, Agra, Varanasi, Allahabad, Meerut, Bareilly, Gorakhpur, Dehra Dun and Faizabad on especially prepared cards. The scheme was to investigate 5,000 cases, but only 2,515 filled-up cards (excluding those of still births and multiple births) were received. The results presented are consequently based on a limited number of cases; for certain characteristics only a few cards, sometimes even a single card, supply the basis. This circumstance imposes severe restrictions on the study undertaken in this chapter.

2. The advantage of maternity services even in large cities accrues only to a small fraction of population. First, hospital maternity is not yet popular, secondly, even for those who would like to go to hospitals there are not enough beds. Generally maternity cases coming to the hospitals are of selected type. The earlier orders of births have a weightage, particularly the first. Among Hindus the trading classes are more hospital-minded than others, and among Muslims, craftsmen and unskilled workers. Thus hospital maternity data do not yield an objective picture of the fertility pattern of even the urban population. These limitations are required to be kept in view while interpreting them.

3. Maternity cards elicited information about (a) the sex of the child, (b) birth order, (c) age of the mother at each child-birth, (d) number of children alive and dead, and (e) religion, occupation, and income. Since the population from which these cases come is not known, the data do not furnish material for working out birth rates.

4. A study of birth statistics for the period 1946-48 by order of births had been under taken by Shri S. P. Jain, now Deputy Registrar General Vital Statistics, in 1950 and data relating to 684,925 births for the period 1946-48 were collected from 30 municipal towns of India including the first ten towns of Uttar Pradesh namely,

Kanpur, Lucknow, Agra, Varanasi, Allahabad, Meerut, Bareilly, Moradabad, Saharanpur and Aligarh. The percentages of births in each birth order as they appeared in that investigation and those obtained from hospital maternity data in 1961 are compared in the following Table :

Table 2.1: Percentages of Births in each Birth Order in Hospital Maternities and 30 Municipal Towns

Birth Order	Hospital Maternities	30 Municipal
	1961	Towns 1946-48 ¹
	Per cent	Per cent
1st	27.7	21.0
2nd	18.9	19.6
3rd	14.8	16.7
4th	12.7	13.1
5th	10.4	9.4
6th	6.1	6.9
7th	4.0	4.8
8th	2.6	3.3
Higher Orders	2.8	5.2
All Births	100.0	100.0

The two sets of percentages differ. The proportion of first births in the data obtained from hospital maternities is much higher and of the births of the 9th and higher orders much lower than in the statistics collected from 30 municipal towns 15 years earlier.

5. The age at first maternity is not the same for all countries. From the birth statistics collected in the aforesaid investigation and those published for the U. S. A., Australia, and England & Wales for 1946 it appeared that the average for India was 21.9 years, for U. S. A. 24.4, for Australia 25.8, and for England & Wales 26.7. The average maternity age for 'all birth orders' also differed. For India and the U. S. A. it was 27.2 years, for Australia 28.4, and for England & Wales 29.5². From these data two conclusions can be drawn: (1) child-bearing in the materially advanced countries of the West commences at a comparatively later age and (2) there are more births of higher orders in India, which raise the average age of 'all birth orders' bringing it at par with the average for the U. S. A.

2. Average Maternity Ages for various Types of Mothers

6. The most important factor affecting fertility is the span of child-bearing age. The data collected through maternity cards reveal that the upper limit is 47 years and the lower 12 years. These are only the maximum and the minimum of maternity ages. What is more important is the average age of maternity for various characteristics for each order of birth. An analysable trait is the degree of fertility from which point of view mothers can be classed into four categories—those who have produced (1) 10 or more children—the most fertile, (2) 7-9 children—again very fertile, (3) 4-6 children, and (4) 1-3 children. The third and fourth categories comprise mothers of all types, as the limit of fertility has not been reached in their case and some of them may eventually have a large number of children. It would be convenient to choose some birth orders, say the 1st, 4th, 7th and 10th and to work out averages for these orders of births for the four categories of mothers as in the following Table :

Table 2.2: Average Maternity Ages (years) at selected Birth Orders for various Categories of Mothers

Birth Order	All Mothers	Mothers having Children			
		10 +	7-9	4-6	1-3
1st	19.4	17.2	18.0	18.5	20.0
4th	25.8	22.5	24.6	26.3	..
7th	30.9	27.8	31.4	..	..
10th	34.2	34.2	..	..	..

The average age for each birth order is the lowest in mothers of the highest fertility, and it progressively increases as we proceed to those who have given fewer births. The average maternity age of women coming for their first confinement is 20.4 years. They represent those who have entered the field of maternity most recently and exhibit a welcome trend towards later age at the first child-birth.

3. Average Maternity Ages by Communities

7. Data collected through maternity cards were analysed for such characteristics as community, occupation and income and average maternity ages worked out for each order of birth. Only current births were taken into account. Table 2.3 gives the average maternity age for each birth order by communities, which can be regarded as the age at which maternity of a given order of birth is concentrated. The corresponding number of cards in each case is given within brackets.

Table 2.3: Average Maternity Ages for each Birth Order by Communities

Birth Order	Average Maternity Age (years) for				
	All Communities	Hindus	Muslims	Christians	Others
1st	20.4 (697)	20.4 (615)	20.1 (71)	20.0 (2)	23.1 (9)
2nd	22.5 (476)	22.6 (417)	22.3 (53)	20.7 (3)	24.7 (3)
3rd	25.4 (371)	25.2 (332)	25.9 (32)	26.0 (2)	24.6 (5)
4th	27.1 (321)	27.1 (286)	27.0 (29)	25.7 (3)	27.3 (3)
5th	29.0 (261)	29.1 (232)	28.0 (24)	24.0 (1)	25.3 (4)
6th	30.4 (154)	30.5 (142)	30.4 (10)	..	26.0 (2)
7th	31.9 (100)	32.1 (88)	30.1 (10)	..	31.0 (2)
8th	34.2 (65)	34.2 (59)	34.0 (5)	38.0 (1)	..
Higher Orders	35.5 (70)	35.4 (64)	36.7 (4)	..	33.5 (2)
All Orders	25.1 (2,515)	25.2 (2,235)	24.5 (238)	24.5 (12)	25.6 (30)

8. The difference between the average age at first maternity and the average age for 'all birth orders' is 4.7 years in the general case, and the percentage of births of the 4th and higher orders is 38.6. The average age of Hindu mothers at first maternity is 20.4 years, of Muslim 20.1, and of Christian 20.0. The slightly later age among Hindus at the birth of the first child is probably due to (1) the *gauna* taking place sometime after the marriage in certain sections of the Hindu society and (2) the existence of a greater proportion of higher income groups among hospital-confined Hindu mothers. The average age should normally go up with the order of birth, but there are certain deviations as would be apparent from the Table. They have been caused by (1) the sample not being representative, (2) the study being confined to current births alone, and (3) the availability of only a small number of cases for certain birth orders.

Hindus

9. Hindu mothers whose cases came up for study belong to all income groups, the largest number to the income-group Rs. 75-150. The average age at first maternity from hospital data is higher in Hindus than in Muslims and Christians for almost every birth order up to the 8th. The differences between the ages at

¹ S. P. Jain, *A Study in Birth Order Statistics of India*.

² *Ibid.*

successive births do not appear to follow any definite pattern. They wax and wane in an erratic manner. The difference is greatest between the 2nd and 3rd birth orders and smallest between the 5th and the 6th. Being numerically the largest community the averages of maternity ages for Hindu mothers for the various birth orders correspond most closely with the averages for all communities taken together. The difference between the average age for the 1st maternity and for 'all births' is 4.8 years. The percentage of births of the 4th and higher orders is 39.0 which is slightly greater than the percentage of 38.6 in the general case. This may perhaps be due to the greater preference shown by the Hindu community for hospital maternity in births of higher orders.

Muslims

10. Muslim mothers whose cases have been studied mostly belong to the lowest income group, i.e. to families having monthly income below Rs. 75. The age at first maternity is earlier in Muslims than in the general case and the difference between the averages for the first birth order and 'all birth orders' is also smaller, i.e. 4.4 years. The interval between the average ages at the 2nd and 3rd birth orders is very considerable—3.6 years and that between the 4th and 5th orders only one year. The number of cards after the 5th birth order is, however, too small to yield any reliable result. In the cases which came up for study the percentage of births of the

4th and higher orders is 34.5 which is less than in the case of Hindus. Perhaps there is less preference among Muslims for hospital confinement where births of higher orders are concerned.

Christians and Others

11. Only 12 cases of Christians were reported. Half of them belonged to the income group of below Rs. 75 and half to the income group Rs. 75-150. The age at first maternity according to hospital data is the lowest in Christians as compared to Hindus and Muslims. The average age for the second order of birth is only 0.7 years more than for the first. This is on account of a very small number of cases of Christians coming to the hospital for confinement during the period of study, those coming for their second confinement happening to be those who started their maternity career earlier. The number of cases in respect of Christians is so small that no valid conclusions can be drawn. The cases of 'Others' were 30. Of them 9 belonged to the Sikh religion and the religion of 21 was by mistake not recorded. No discussion regarding them is possible.

4. Average Maternity Ages by Occupation

12. Occupation of the husband plays some part in the family-building pattern. Table 2.4 gives data on average maternity ages according to occupations. The number of cards in each case has been given within brackets.

Table 2.4: Average Maternity Ages at each Birth Order by Occupation of Husband
Average Maternity Age (years)

Birth Order	Average Maternity Age (years)								
	All Occupations	I Professional and Technical	II Administrative, Executive and Managerial	III Clerical	IV Sales	V Farmers	VI Craftsmen, Production Process Workers	VII Unskilled Workers	VIII Others
1st	20.4 (697)	20.4 (74)	21.7 (23)	20.6 (133)	20.4 (132)	21.7 (63)	19.5 (108)	20.2 (36)	20.3 (128)
2nd	22.5 (476)	23.3 (57)	24.4 (17)	22.0 (112)	22.4 (94)	23.7 (35)	22.0 (75)	23.5 (17)	22.1 (69)
3rd	25.4 (371)	24.7 (45)	27.3 (12)	25.6 (76)	24.9 (101)	26.7 (20)	25.1 (61)	25.7 (17)	26.6 (39)
4th	27.1 (321)	27.0 (25)	28.2 (9)	26.8 (53)	26.5 (77)	28.1 (27)	27.1 (71)	26.8 (20)	27.5 (39)
5th	29.0 (261)	30.1 (24)	27.2 (6)	28.7 (52)	28.5 (68)	28.7 (19)	29.5 (47)	28.8 (13)	29.1 (32)
6th	30.4 (154)	30.4 (12)	31.0 (5)	30.8 (25)	30.3 (49)	30.1 (12)	30.6 (32)	32.0 (4)	29.9 (15)
7th	31.9 (100)	30.4 (14)	31.8 (5)	31.3 (10)	32.1 (31)	33.7 (8)	32.4 (12)	31.0 (4)	32.2 (16)
8th	34.2 (65)	35.8 (6)	35.5 (2)	31.8 (5)	34.4 (13)	30.7 (7)	35.1 (14)	34.0 (7)	35.2 (11)
Higher Orders	35.5 (70)	41.0 (2)	37.0 (3)	34.0 (9)	35.2 (22)	35.3 (11)	35.7 (13)	33.0 (1)	35.8 (9)
All Orders	25.1 (2,515)	24.8 (259)	26.3 (82)	24.4 (475)	25.5 (587)	26.1 (202)	25.2 (433)	25.2 (119)	24.7 (358)

The above Table reveals that the lowest age (19.5 years) for first maternity falls in Occupational Group VI—Craftsmen and Production Process Workers and the highest (21.7 years) in Occupational Groups II and V. The lowest age for 'all birth orders' is in Occupational Group III—Clerical, and the highest (26.3) in Occupational Group II—Administrative, Executive and Managerial.

Occupational Group I—Professional, Technical and Related Workers

13. The average age for the 1st birth order is the same as for 'all occupations', but that for 'all birth orders' is 24.8 years which is earlier. This group does not represent professions of any particular class, but a motley crowd. Most of the mothers belong to families of income group Rs. 75-150. The difference between the age for 1st maternity and for 'all birth orders' is 4.4 years which is less than in the general case. The percentage of births of the 4th and higher orders is the smallest among all groups. These two things suggest some conscious effort at family planning.

Occupational Group II—Administrative, Executive and Managerial Workers, etc.

14. This is the smallest of all occupational groups the majority of families belonging to the middle class having a monthly income of Rs. 150-300. The average age at the first child-birth is 21.7 years which is highest. Marriages in families of this occupational group are usually late. The difference between the averages for the 1st birth order and 'all birth orders' is 4.6 years, and the proportion of births of the 4th and higher orders is 36.6, both of which are only slightly lower than in the general case. Thus though marriages are late there is no indication of appreciably lower fertility. Only the average maternity ages for certain birth orders, especially the earlier ones, are higher than the rest which raises the average for 'all birth orders' to 26.3 years—the highest among all groups.

Occupational Group III—Clerical and Related Workers

15. Most of the mothers belong to families having a monthly income of Rs. 75-150. This group has almost the same average age for the 1st birth 'as all occupations' taken together. The difference between the first birth order and the average for 'all birth orders' is only 3.8 years which is the smallest and the proportion of births of 4th and higher orders the second smallest. For the highest birth orders the ages are comparatively younger. There appears to be some conscious effort at family planning in this group also.

Occupational Group IV—Sales Workers

16. This group has the largest representation in hospital maternities, and about half of the families of this group have a monthly income of Rs. 75-150. The real income of this occupational group may be actually higher. The average age at first maternity is the same as for 'all occupations', but the average for 'all birth orders' is slightly different being 5.1 years, appreciably greater than in the general case. The proportion of births of the 4th and higher orders is 44.3 per cent, the highest among all groups, which shows that mothers belonging to this group have the greatest fertility. Alternatively, confinements of higher orders in the hospital may be more popular in the business community.

Occupational Group V—Farmers

17. This group is made of well-to-do hospital-minded farmers. The largest proportion of mothers belong to families with a monthly income of Rs. 75-150. The age at first maternity is as high as in the case of the second group, which suggests late marriage. The average age for 'all birth orders' is the second highest. The difference is 4.4 years which is smaller than in the general case. The percentage of births of the 4th and higher orders is 41.6 which is greater. Though marriages are late in this group, child-bearing is quick and the number of births large. There seem reason to believe that the total fertility in the cultivating class is high.

Occupational Group VI—Craftsmen and Production Process Workers

18. As stated earlier the youngest age for first maternity falls in this group. More than half of the families belong to the lowest income group and have an income of less than Rs. 75/-per month. Marriages in this occupational group take place much earlier than in others. The difference between the average age at the first birth and at 'all births' is 5.7 years, the greatest among all groups, and the percentage of births of the 4th and higher orders 43.6, both greater than found in the general case. This proves that productivity in this group not only starts earlier, but more children are born, the degree of fertility being the second highest. However, unlike the previous group intervals between successive births are not too short.

Occupational Group VII—Unskilled Workers of all Kinds (Domestic Servants, etc.)

19. This is the poorest occupational group, most of the families earning less than Rs. 75 in a month. The average age at first maternity in this group is slightly lower than in the general case and the average age for

'all birth orders' slightly higher. The difference is 5.0 years. The percentage of births of the 4th and higher orders is 41.2. Both figures are higher than the corresponding figures in the general case. Women in this occupational group have a greater fertility than the average.

Occupational Group VIII—Others

20. This comprises heterogeneous elements which cannot be assigned to a particular group. The average for the first order of birth is more or less the same as in the general case, but lower for 'all birth orders'. The proportion of births of the 4th and higher orders is also smaller. As this group does not represent any occupation in particular, detailed analysis is not attempted.

Table 2.5: Average Maternity Ages at each Birth Order by Income

Birth Order	Average Maternity Age (years)					
	All Incomes	Below Rs. 75	75—150	150—300	300—600	600—1,000
		A	B	C	D	E
1st	20.4 (697)	20.1 (301)	20.4 (303)	21.6 (83)	21.1 (10)	..
2nd	22.5 (476)	22.2 (196)	22.7 (190)	22.2 (78)	26.2 (11)	26.0 (1)
3rd	25.4 (371)	24.8 (149)	25.7 (165)	25.8 (48)	25.1 (9)	..
4th	27.1 (321)	26.8 (143)	27.4 (135)	26.9 (35)	26.5 (6)	28.5 (2)
5th	29.0 (261)	29.5 (114)	29.1 (114)	29.1 (27)	27.0 (5)	23.0 (1)
6th	30.4 (154)	30.1 (57)	30.5 (77)	30.9 (19)	..	33.0 (1)
7th	31.9 (100)	31.8 (42)	32.0 (41)	32.1 (16)	32.0 (1)	..
8th	34.2 (65)	35.2 (34)	33.7 (23)	31.4 (8)	..	..
Higher Orders	35.5 (70)	35.6 (33)	35.4 (32)	32.7 (3)	38.5 (2)	..
All Orders	25.1 (2,515)	24.9 (1,069)	25.3 (1,080)	25.1 (317)	25.6 (44)	27.8 (5)

Five income groups have been shown in the above Table. Income group F, i.e., Rs. 1,000 per month and above was not represented in the cards received. The percentage of births of the 4th and higher orders for the income group A of Rs. 75 per month or less is 39.6, for the Rs. 75-150 income group B 39.1, for the Rs. 150-300 income group C 34.1, and for the Rs. 300-600 income group D 31.8. For the income group Rs. 600-1,000 no cards of the 1st birth order are available, hence the percentage cannot be given. The difference between the average ages for the 1st birth order and all birth orders for the

5. Average Maternity Ages by Income

21. Income plays an important part in the number of children born as well as the average age of the mother for all orders of birth. In the lowest income groups marriages take place earlier and births of higher orders more frequent. In higher income groups marriages usually take place later and consequently the age at first maternity advances. The reasons are socio-economic. For higher income groups with monthly incomes of Rs. 600 and above the number of available cards is so small that no valid conclusion can be drawn. These facts will be apparent from the data given in Table 2.5. The number of cards in each case is given within brackets.

group A is 4.8 years, for B 4.9 years, for C 3.5 years and for D 4.5 years. As the percentage of higher births progressively falls this difference should also gradually decline, if the spacing remains constant. The figures given here show that birth intervals have appreciably increased from the income group A to B, but exhibit a sudden shortening when we proceed from group B to C. Perhaps this is largely due to the under-reporting of incomes. If half of the cards are transferred from group B to group C and a few from group C to D the figures would be smoothed and the only striking jump

in birth intervals would be from group A to group B. The decline in the percentage of higher birth orders from the group A to group D would be more gradual. However, an attempt will be made to analyse the data as they are presented in the Table.

Income Groups A and B—Income below Rs. 150

22. These groups cover 85 per cent of the cases studied. The occupational group most largely represented is of sales workers. The average age for the first maternity is considerably lower than in the next two groups of higher incomes. Maternal activity starts earlier. The percentage of births of the 4th and higher orders is greater than in the general case. Spacing between successive births in the income group B is better than in the income group A for earlier birth orders. The low average for the first maternity is due to early marriages. It is only 20.1 years in the income group A. In the other group the average is slightly better.

Income Group C—Income Rs. 150-300

23. This group covers about 13 per cent of the cases under study. The two occupational groups most largely represented are clerical workers and sales workers. It has a higher average for the first maternity than the groups considered earlier, which points towards late marriages. The percentage of births of the 4th and higher orders is much lower than in the general which indicates exercise of some check on unlimited family expansion. Spacing between successive births is much smaller than in the groups considered above. It may partly be due to the reasons explained in paragraph 21 and partly due to early fertility terminal after a few births following each other in quick succession.

Income Group D—Income Rs. 300-600

24. Only 2 per cent cases belong to this group. The two occupational groups most largely represented are sales workers and professional and technical workers. The average age for the first maternity is slightly lower than in the previous income group, which may mean that the age of marriage is a little earlier. Or this may have been caused by wrong reporting of incomes. The percentage of births of the 4th and higher orders is still smaller, i.e. 31.8. There is an obvious consciousness for having a small family. Intervals between consecutive births are smaller in this income group also than in the general case.

Income Groups E and F—Income Rs. 600 & above

25. The number of cards received were only five, three of which belonged to families engaged in administrative, executive and managerial work, the fourth to a family in professional and technical work and the fifth to an agricultural family. The data being scanty are not capable of any detailed interpretation. There was no case of the first or third maternity. However, there was one of second maternity, two of the fourth, and one each of the fifth and the sixth. Except in one instance, all show higher ages for 'all birth orders' than in the case of all incomes considered together.

6. Children born previously for various Maternal Age Periods

26. The following Table gives the distribution of new maternities among families of different attained sizes. The average number of previous children born plus the new child is not necessarily identical with the average number of children amongst married women of these ages.

Table 2.6: Average Number of Previous Children in Maternal Age-Groups

Age-Group	Previous Children born	Difference
Below 17	0.08	..
18—22	0.60	0.52
23—27	2.15	1.55
28—32	3.83	1.68
33—37	5.34	1.51
38—42	6.20	0.86
43—47	7.00	0.80
48 & Above	N. A.	N. A.

The previous births in the age-group below 17 years can be neglected. No data are available for age-group 48 and above. The difference rises steadily with age and then declines in a similar manner. The greatest difference is between the age-group 23-27 and 28-32. The largest number of children are acquired in the age-group 23-27. Thereafter the number begins to decrease. The power to produce children in young women goes on waxing till a certain age after which it commences to wane. The peak of maternity force has its seat not far off from the year 27. The reproductive activity slows down considerably after 37 years of age. Cases of maternity after this age occur only in the very fertile section of women.

CHAPTER III

FERTILITY—MEASURES AND TRENDS

1. General

"Data on fertility, that is the frequency of births in a population, form an almost indispensable basis for studying the prospects of population growth in a country, the probable development of its age structure, the possible effects on population growth of economic and social changes, public health measures and other factors. Knowledge of the fertility of different groups of the population, such as religious or ethnic groups, makes it possible to assess likely changes in the composition of the population. The study of the fertility of different groups also throws light on the conditions which influence fertility. Information on fertility is important in many different scientific fields (sociology, anthropology, genetics, etc.)"¹.

2. Growth of population is the result of gains from births (natality) and losses from deaths (mortality) and migration. In fact, natality measures the rate at which the population is added by births and is ordinarily assessed by the number of births to the size of the population or a section thereof. Birth rate depends on the age-sex distribution of the population. General fertility rate is defined as the number of births occurring to 1,000 women in the reproductive age-group 15-44. It does not take into account the effect of the proportion of women in reproductive age-group. What is more important is the number of married women of child-bearing ages in a given population which determines its potential fertility, though to some extent this is dependent upon intention and willingness. Nuptial fertility rate is defined as the number of births per 1,000 ever-married women in the reproductive age-group 15-44. It takes into account both marriage and capacity for child-bearing. Only married women need be considered, as in this country the percentage of births occurring outside wedlock is negligible.

3. Many factors influence the fertility of married women. The chief factors are (1) age at marriage, (2) duration of marriage, (3) attained age—this, in fact, is the sum of the foregoing, (4) order of birth, and (5) period elapsed since the previous birth. Other factors are incidence of foetal loss, marital habits, sexual taboos, breast-feeding, etc. Indirect factors are religion, education, and social and economic status.

4. As India has adopted an official policy of family limitation, it becomes necessary to study factors which can bring about decline in fertility. Only isolated data on fertility were available so far. Surveys undertaken lately have gone a long way to fill up the gap and have resulted in the collection of a fair amount of statistical information. Fertility enquiries, however, suffer from severe limitations such as unsatisfactory approach on the part of the field worker and the hesitation and reluctance on the part of respondents in furnishing information of a rather intimate nature. However, they can form the basis of qualitative appreciation, though for a quantitative judgement they may not be very reliable.

5. In India marriage is an institution bordering on universality and unlike western countries the proportion of girls and women who get married is overwhelmingly large. In Uttar Pradesh the percentage of married women in the reproductive age-group of 15-44 is 91.4 and of widowed, divorced, etc., 4.5. The percentage of women in the married state is the highest in the age-group 20-34 when the reproductive power is also at the peak. This results in a high birth rate as fertility for all practical purposes is unregulated. Circumstantial curbs on fertility, such as prolonged stay of the wife with her parents, enforced absence of the husband for long periods away from home in connexion with work, illness, accidental injury, etc., do not imply 'birth control'. Birth control means modification of fertility by intentional employment of methods for avoiding unwanted births to restrict the family size or to ensure adequate spacing. Uncontrolled fertility may be defined as fertility not restricted by birth control.

2. The Fertility Survey of Ever-Married Women, 1961-62

6. A Sample Fertility Survey of Ever-Married Women was carried out throughout India in 1961-62 by the Registrar General, which included all women in the married state as well as those who had been in this state at any time of their life, and their fertility differentials by various characteristics were studied. The object of this survey was to collect information on the fertility pattern of Indian women. In the fertility surveys conducted earlier only still-married women were taken

into consideration, and the study of fertility differentials was confined only to the wife of the head of the household.

7. The data for the present survey were collected by canvassing all households in randomly selected blocks covering between one and two per cent of the total population. The sample blocks were the same as selected for the Post-Enumeration Check carried out in March, 1961. Information was collected on the number of inmates along with details about their age, sex and marital status. In the case of ever-married women, i.e., women who had married at any time of their life, further information was collected about the age at marriage, duration of married life, children born during the whole lifetime and during the past 12 months. Duration was counted from effective marriage, i.e., the time when husband and wife commenced to live together. The age of the mother at successive birth was computed from the ages of children. In the case of children still alive their present ages were considered and in that of dead children from their ages at death and the period gone by since. Two schedules, viz., (1) the Household Schedule and (2) the Fertility Slip were designed for this purpose. The Household Schedule had three Sections. Section 1 was intended to obtain particulars of all persons (including visitors) in the household as regards relationship to the head of household, sex, age and marital status. Section 2 elicited information about married widows or divorced women, and Section 3 about the number of workers above 10 years of age and their employment activity during the past 15 days. The Fertility Slip was designed for every woman married at any time and had 14 questions to collect information on religion, education, marital status, age at marriage, present age, duration of married life, years of widowhood or divorce in the case of widows and divorcees, particulars of births and details of children born alive, husband's occupation, industry and education.

8. Before attempting an analysis of the various Tables, the various concepts need to be explained:

(i) *Nuptial Age-Specific Fertility Rate*—Annual number of live births to 1,000 ever-married women in the specified age-group.

(ii) *Parity*—The total number of live children born to a woman during her entire reproductive span, e.g., a woman of parity 4 is one who ceased child-bearing after 4 children were born. Only women past the child-bearing age, i.e., aged 45 years are considered for parity.

(iii) *Parity progression ratio for birth of Order 'n'*—The percentage of women who having borne *n* children already get the next child, e.g., parity progression ratio of 80 for the 3rd birth means that out of 100 women who have already 3 children, only 80 get the fourth child.

9. Fertility Slips were sorted out by rural and urban, and further subdivided into four groups as follows:

- A—Women married only once and still in the married state;
- B—Women married only once, but now widowed or divorced;
- C—Women married more than once, but in married state now; and
- D—Women married more than once, but now widowed or divorced.

10. The Survey took in its stride 102,944 ever-married women. Out of them 88,102 belonged to the A Group, 12,988 to the B Group, 1,638 to the C Group and 216 to the D Group. Their numbers by marital status and rural/urban are given in the following Table:

Table 3.1: Ever-Married Women in Rural and Urban Areas by Marital Status

Groups	No. of Women		Percentage	
	Rural	Urban	Rural	Urban
All Groups	74,715	28,229	100.0	100.0
A	63,222	24,880	84.6	88.1
B	9,881	3,107	13.2	11.0
C	1,421	217	1.9	0.8
D	191	25	0.3	0.1

It will appear from the above that the percentage of ever-married women in the married state (A+C) is 86.5 in the rural area and 88.9 in the urban and of those widowed or divorced 13.5 in the rural and 11.1 in the urban. It has been observed that in a few cases of A-type women the data relating to number of children born in the marriage duration 1-4 seem to be defective.

11. The percentage distribution of the ever-married women in the various age-groups of the reproductive period is given below:—

Table 3.2: Percentage Distribution of Ever-Married Women by Attained Ages (all women)

Attained Age	Per cent	
	Rural	Urban
12 & below	1.7	0.4
13-17	5.3	3.9
18-22	14.9	15.7
23-27	13.5	15.3
28-32	15.8	17.3
33-37	9.5	10.4
38-42	11.1	11.4
43-47	6.9	6.7
48+	21.3	18.9

¹ *Fertility Data in Population Censuses*—United Nations—Population Studies No. 6, page 3.

About 45 per cent of ever-married women are aged between 18 and 32. The very small number in the age-group 33-37 may be due to misreporting of ages.

12. The following Table gives the percentage of women by the number of times married:—

Table 3.3: Percentage of Ever-Married Women in each Age-Group by the Number of Times Married

Age Group	Rural			Urban		
	Once	Twice	Thrice or more	Once	Twice	Thrice or more
All Ages	97.8	1.9	0.3	99.2	0.7	0.1
13—17	99.6	0.4	0.0	99.7	0.3	..
18—22	99.1	0.8	0.1	99.7	0.3	0.0
23—27	98.6	1.2	0.2	99.6	0.3	0.1
28—32	97.7	2.0	0.3	99.0	0.8	0.2
33—37	97.0	2.6	0.4	98.8	0.9	0.3
38—42	96.7	2.9	0.4	99.0	0.8	0.2
43—47	96.8	2.7	0.5	98.2	1.5	0.3
48+	97.3	2.4	0.3	98.8	1.0	0.2

The percentage of women married more than once is very low both in rural and urban areas as widow remarriage is not yet a prevalent custom. As between rural and urban the proportion is lower in urban areas. As would be naturally expected, the proportion gradually rises with age, but after the age of 40 years begins to fall.

Children by Attained Ages of Mothers

13. Difficulties arise in interpreting data relating to children born to women married more than once, as there is always an interval, often quite long, between successive marriages or children born to women in the married state who are now widowed or divorced. It will, therefore, be more convenient to consider only women married once and still in the married state, in other words to confine discussion only to A-type women. Current fertility can be measured by the crude birth rate or age-specific fertility rates. Life-time fertility is measured by the average number of children born to a woman in the whole reproductive span. Considering married women of all ages still in the married state the average number of children born to them is given in the following Table:—

Table 3.4: Average No. of Children by Attained Ages of Mothers (A—Type Women)

Age-Group	Rural		Urban	
	No. of Children	Difference	No. of Children	Difference
Below 13	0.0	..	0.0	..
13—17	0.1	0.1	0.2	0.2
18—22	0.9	0.8	1.1	0.9
23—27	2.1	1.2	2.4	1.3
28—32	3.0	0.9	3.4	1.0
33—37	3.8	0.8	4.2	0.8
38—42	4.1	0.3	4.5	0.3
43—47	4.3	0.2	4.6	0.1
48 and Over	4.2	X	4.3	X
All Ages	2.8	..	3.1	..

The difference at first rises steeply and then progressively falls. The greatest difference is found between the age-groups 18-22 and 23-27. The highest productive power is concentrated around the year 25.

Nuptial Age-Specific Fertility Rates

14. The same thing can be studied in a different form by considering the number of children born in a year to 1,000 married women in specific age-groups as in the following Table:—

Table 3.5: Age-Specific Nuptial Fertility Rates (A—Type Women)

	Age-Group			
	13—17	18—22	23—27	28—32
Rural	66.9	216.1	247.4	213.1
Urban	100.6	237.4	243.8	198.3

	Age-Group			
	33—37	38—42	43—47	48 & Over
Rural	167.4	114.2	67.1	20.2
Urban	138.5	98.6	52.9	17.7

The nuptial fertility rate at first increases with age attaining its maximum during the ages 23-27 and then begins to fall. After 37 years of age the reproductive power falls below half of the maximum and progressively goes on lessening. Even women of 48 years and over who have not yet reached menopause are capable of having children, though the probability in its favour cannot be rated high. The low fertility rate below 18 indicates a type of sub-fecundity. It appears that a girl does not become fully mature immediately after the commencement of menstruation. The capacity to conceive and bear children is acquired slowly. The proportion of women able to conceive rises by gradual acceleration, until it reaches a point of inflexion beyond which it levels off. This point is somewhere near 18 years, though its location may differ from one demographic group to another. Certain circumstances also lead to low fertility in the earlier years of marriage, such as the wife living with her parents or the husband living elsewhere for education or employment.

15. The Fertility Survey gives the nuptial fertility rate for all ages as 179.3 for rural and 178.6 for urban areas which are less than the computed rate of 221.6. Similarly, it gives birth rates of 36.8 and 32.7 for rural and urban areas respectively which again are slightly lower than the computed rate. The lower rates of Fertility Survey are possibly on account of omissions in the recording of the number of births, particularly in the case of deceased children.

Age at Marriage

16. The effect of age at marriage on the fertility performance of woman can be studied in relation to the average number of children born, average completed family size, age-specific fertility rates, parity progression ratio, average number of children contributed by each birth order, expectations of fertile life, childlessness and sterility. For this purpose three marriage age-groups, viz., below 18, 18-22 and 23 and above have been selected. Since a very large majority of marriages take place below the age of 18 years, the proportion of women who marry between the ages 18-22 is small and of those who marry above the age of 23 very small. This reduces the number of women marrying in higher age-groups to such an extent that the data suffer in value. This has especially to be kept in view in studying the fertility behaviour of women married at the age of 23 or later.

17. The Fertility Survey data show that the average number of children born to A—type mothers of completed fertility is 4.22 in rural and 4.40 in urban areas. These figures are lower than the computed family size (no. of children) of 5.51 owing to possible omissions in recording the number of births. The slightly smaller number

of children born to women in rural areas may be reporting error or may to some extent be due to different living conditions of married couples. On the whole, the average family size is almost the same for both areas. Differentiating the average family size by the three marriage age-groups, the following pattern emerges:

Table 3.6: Average No. of Children born to Women of Completed Fertility by Age at Marriage (A—Type Women)

	Marriage Age			
	Below 18	18—22	23 and Above	All Ages
Rural	4.22	4.04	3.68	4.22
Urban	4.52	3.99	3.65	4.40

It is apparent that there are fewer children as marriage age advances. Early marriages are more fertile except when some physical impairment takes place in the early years of marriage. Reduction becomes significant in rural areas after the age of 22, and in urban areas even after the age of 18.

Contribution of Birth Orders to Family Size

18. All birth orders are not equally important in the building-up of a family. In fact, the importance of each birth decreases with increasing birth order as the following Table will show:

Table 3.7: Percentage of Children contributed by each Birth Order to Family Size of Women of Completed Fertility (A—Type Women)

		Order of Birth									
		1	2	3	4	5	6	7	8	9	10+
All Ages at Marriage	Rural	22.3	20.4	17.0	14.0	10.4	6.9	4.3	2.4	1.2	0.7
	Urban	21.1	19.1	16.6	14.1	10.7	7.7	5.0	2.7	1.6	1.4
Below 18	Rural	22.3	20.4	17.0	14.0	10.4	6.9	4.3	2.4	1.2	0.7
	Urban	20.8	18.8	16.6	13.9	10.8	8.0	5.1	3.1	1.8	1.1
18—22	Rural	23.0	20.8	17.8	14.1	10.4	6.4	4.0	2.0	1.0	0.5
	Urban	22.8	19.3	17.0	14.3	10.3	7.3	4.3	2.5	1.5	0.7
23 and Above	Rural	25.5	22.8	19.0	14.4	9.5	5.7	2.2	0.6	0.3	..
	Urban	24.4	22.5	17.8	13.7	9.9	6.0	3.6	1.9	0.2	..

The average contribution of each birth order gets less and less. This aspect can be further studied by the age at marriage which tells the same tale. However, the importance of the first birth increases with the age at marriage and the fall in the contribution of successive births much quicker. This is as expected, as the percentage contribution of the first birth should go up with lowering fertility and of very high orders should go down.

Parity Strains

19. Table 3.8 shows the percentage of mothers of completed fertility by the number of children born to them. The percentage rises gradually with parity and then starts falling. There seems to be a common belief that parity and spacing are governed by a woman's personal equation. The largest number of women are of parity 4, both in rural and urban areas. Women

of parity 0, i.e., childless women, are 5.7 per cent in rural areas and 6.7 per cent in urban, but the picture changes for higher birth orders. For example, in rural areas women of parity 10 and above are 2.0 per cent and in urban 4.0 per cent. In interpreting results the observations made in para 17 require to be kept in view.

Table 3.8: Percentage of Families of different Sizes for Mothers of Completed Fertility (A—Type Women)

		Percentage of families having number of children										
		0	1	2	3	4	5	6	7	8	9	10+
All Ages at Marriage	Rural	5.7	8.8	11.4	15.2	15.2	14.5	11.5	8.0	5.0	2.7	2.0
	Urban	6.7	9.7	10.2	11.9	14.7	13.1	12.2	9.2	5.0	3.3	4.0
Below 18	Rural	6.1	9.0	11.0	15.1	15.1	14.2	11.2	8.0	5.1	2.9	2.3
	Urban	6.2	8.8	10.3	12.1	13.7	13.2	12.8	9.2	5.9	3.2	4.6
18—22	Rural	7.3	9.1	11.9	14.6	15.3	15.7	10.3	8.0	3.9	2.4	1.5
	Urban	9.2	13.6	9.2	11.1	15.9	11.7	11.8	7.9	3.7	2.8	3.1
23 and Above	Rural	6.4	9.2	14.3	17.4	17.5	14.1	12.6	6.0	1.5	0.8	0.2
	Urban	10.7	7.8	16.5	14.5	14.1	14.6	8.7	6.3	5.3	1.0	0.5

20. Analysing the data further by age at marriage, it appears that the percentage of childless mothers generally increases with the age at marriage. In rural areas out of the women married below the age of 18 and those married between 18 and 22 the largest number have 4 to 5 children; while among those married above the age of 23 the largest number have 3 to 4 children. Among the women of urban areas married below 18 years the largest number have 4 to 5 children, among those married between 18 and 22 years 4 children, while among

those married above 23 years of age the largest number have 2 children and the next largest 5 children. Considering that some omissions have occurred in reporting the number of children the peak in the above Table would shift slightly to the right.

Parity Progression Ratio

21. The pattern of parity progression for different birth orders is indicated by the following Table (three sets of ratios for the different marriage age-groups are presented):

Table 3.9: Parity Progression Ratio, i.e., Pro portions of Women who get $n+1$ st Child, n Children having been born (A—Type Women)

		n	0	1	2	3	4	5	6	7	8	9
All Ages at Marriage	Rural		94.3	90.7	86.7	79.5	74.3	66.8	60.6	54.9	49.2	59.8
	Urban		93.3	89.6	87.8	83.9	76.1	72.0	63.9	57.5	59.2	77.7
Below 18	Rural		93.9	90.4	87.1	79.6	74.3	67.4	62.1	56.5	50.3	45.2
	Urban		93.8	90.6	87.9	83.7	78.2	73.0	64.1	59.8	57.3	59.3
18—22	Rural		92.7	90.1	85.8	79.7	73.2	62.5	60.5	49.4	50.0	38.8
	Urban		90.8	85.0	88.1	83.7	72.0	71.4	59.5	54.8	61.6	52.8
23 and Above	Rural		93.6	90.1	83.0	75.3	66.8	59.9	40.2	28.9	38.5	20.0
	Urban		89.3	91.3	79.8	77.6	72.1	60.0	60.0	51.9	21.4	33.3

The above Table shows that the parity progression ratios are generally higher for women married below 18 as compared to those married between 18-22, and the latter in their turn are greater than for women married at 23 years or later. This trend is found both in rural and urban areas. The figures further indicate that the ratios generally decline with the order of birth. In other words, a larger percentage of women cease to reproduce at each birth except in the case of very high

birth orders, but that is due to the small number of cases of very high birth orders coming up for study. The ratio shows a sudden fall after the fourth birth in the rural and after the fifth in urban areas.

Expectation of Fertile Life at Various Ages

22. The following Table gives the expectation of fertile life in various age groups:

Table 3.10: Expectation of Fertile Life at Various Ages (A—Type Women)

Ages	Years of Fertile Life	
	Rural	Urban
15—19	20.25	19.97
20—24	15.52	15.32
25—29	11.29	11.05
30—34	7.38	7.33
35—39	4.41	4.35
40—42	2.80	2.80

It appears from the above Table that the expectation of fertile life in the youngest age-group is higher for the rural areas than for the urban, but later on it becomes the same in both. It gradually declines, until it is 2.80 years in the age-group 40—42. As would appear from the figures of the youngest age-groups fertility in the majority of women is expected to cease at 37 years of age, except in the highly fertile section in which reproduction goes on till a later age. Fertile period is not identical with the interval between the commencement of menstruation and menopause. It may begin much later and end much earlier.

Duration of Marriage

23. Table 3.11 gives the percentage distribution of women by age at marriage in different durations of marriage.

Table 3.11: Percentage Distribution of Women in different Durations of Marriage by Age at Marriage (A—Type Women)

Rural			Marriage Duration (in years)	Urban		
Age at Marriage				Age at Marriage		
23+	18—22	—18		—18	18—22	23+
0·4	13·8	85·8		0	63·4	35·0
3·6	22·1	74·3	1—4	64·4	32·7	2·9
2·7	19·9	77·4	5—9	69·7	28·3	2·0
2·2	19·2	78·6	10—14	75·2	23·4	1·4
2·0	20·7	77·3	15—29	72·9	25·7	1·4
1·3	21·1	77·6	30+	72·9	24·7	2·4
2·2	20·4	77·4	All Durations	71·5	26·7	1·8

The above Table shows that both in rural and in urban areas a very large majority of marriages takes place below the age of 18 years. The percentage of such marriages is higher in villages than in towns. In rural areas while it is more or less constant for all marriage durations, it is particularly high in the marriage duration of

less than one year. To some extent this might be due to a relatively large number of young marriages in that particular year. It may at the same time be indicative of high mortality in villages among girls married before the age of 18 in the second or third year of marriage. The percentage of marriages above 23 years of age is very small, but of those in the age-group 18-22 is quite considerable particularly in urban areas on account of the differences in social systems and levels of education between villages and towns. The average age of girls at marriage is 16.2 years in rural areas and 17.0 years in urban at present.

24. Fertility performance of women married at different ages can be compared for the same duration of married life by expressing the average number of children born to one group as a ratio of those born to another group which may be taken to be the base. This ratio is called the index of performance. The indices of performance for various durations are given in the following Table expressed as per cent of fertility performance of women married between 18-22 years:

Table 3.12 Fertility Performance of Women married in various Age-Groups by Duration of Marriage (A—Type Women)

Duration of Marriage	Age at Marriage			
	Rural		Urban	
	—18	23+	—18	23+
1—4	140	140	117	100
5—9	113	147	106	83
10—14	104	112	103	83
15—29	105	100	110	90
30+	105	93	113	95
All Durations	108	93	118	86

A study of the above Table shows that as compared to the marriage age-group of 18-22 the marriage age-group of below 18 has generally a higher fertility for all marriage durations in both rural and urban areas. In rural areas as marriage duration exceeds 9 years fertility performance ratio becomes steady. In the case of marriages at 23 years and later, the position is different. The performance is higher than the base up to the marriage duration of 14 years, at par in 15-29 and less later on. It appears that child-bearing in women married after the age of 23 is quicker in all marriage durations especially in 5-9 years. In urban areas it is at par in the duration 1—4, and thereafter much less showing that child-bearing is much slower in women married after the age of 23. This may be the effect of social environments and education. For all marriage durations both in rural and in urban areas total fertility decreases with the age at marriage.

Duration of marriage is much more important than attained age as duration is the dominant characteristic. Age-specific fertility rates are, however, more common as they are easier to obtain, but duration-specific rates are more useful.

Sterility

25. Nuptial age-specific fertility rate is governed by the proportion of ever married women in the age-group concerned and their fecundity. Child-bearing comes to a

stop after the menopause, which usually occurs between 45-50. However, there are some women who suffer from primary sterility and cannot conceive. There is also secondary sterility which may occur after one or more births due to natural or pathological causes or as a result of accident at confinement or some other time.

26. The ratios of Table 3.9 can be looked at in another way by subtracting each from 100 and calling it the sterility ratio. The sterility ratios of women of completed fertility are given below:

Table 3.13: Sterility Ratio, i.e., Proportion of Women who cease Reproduction after getting *n*th Child (A—Type Women)

<i>n</i>		0	1	2	3	4	5	6	7	8	9
All Ages at Marriage	Rural	5.7	9.3	13.3	20.5	25.7	33.3	39.4	45.1	50.8	40.2
	Urban	6.7	10.2	12.2	16.1	23.9	28.0	36.1	42.6	40.8	22.3
Below 18	Rural	6.1	9.6	12.9	20.4	25.7	32.6	37.9	43.5	49.7	54.8
	Urban	6.2	9.4	12.1	16.3	21.8	27.0	35.9	40.2	42.7	40.7
18—22	Rural	7.3	9.9	14.2	20.3	26.8	37.5	39.5	50.6	50.0	61.2
	Urban	9.2	15.0	11.9	16.3	28.0	28.6	40.5	45.2	38.4	47.2
23 and Above	Rural	6.4	9.9	17.0	24.7	33.2	40.1	59.8	71.1	61.5	80.0
	Urban	10.7	8.7	20.2	22.4	27.9	40.0	40.0	48.1	78.6	66.7

It appears from the above Table that primary sterility occurs in 5.7 per cent unions in rural and in 6.7 per cent in urban areas and it increases with the age at marriage. Secondary sterility increases with each birth order and also with the age at marriage. After the first birth the sterility ratio is higher in rural areas than in urban.

27. Data were collected on the age of the youngest child born to A—Type women in the age-group 38—47. This excluded women suffering from primary sterility. There was, however, one drawback. If the last-born did not survive it was left out of consideration. With this limitation, the age of the mother at which she ceased child-bearing was calculated. The following Table gives the rate of sterility per 1,000 women by quinquennial age-groups:

Table 3.14: Percentage Rate of Sterility by Quinquennial Age-Groups (A—Type Women)

Ages	Rural	Urban
15—19	0.3	0.4
20—24	1.1	1.1
25—29	2.4	2.8
30—34	6.9	6.9
35—39	18.8	19.3
40—42	30.0	27.5

The above Table shows that the sterility rate suddenly becomes quite high both in rural and in urban areas in the age-group 35-39 for which the mean age can be taken as

37. After 41 years of age the onset of sterility is very quick.

28. The two Tables show that sterility increases with birth orders as well as with age. There are two ways of looking at this phenomenon. According to one view sterility increases with age. According to another, it increases after each birth the rate of increase undergoing acceleration after a few births.

Still Births

29. The following Table gives the number of still births per 100 births (all births including still births) (i) after six months of gestation and (ii) within six months of gestation:

Table 3.15: Still Births per 100 Births (both live and still) (A and C—Type Women)

Attained Age		After six months of gestation	Within six months of gestation
13—17	Rural	6.2	2.4
	Urban	..	6.0
18—22	Rural	6.0	0.2
	Urban	3.1	3.4
23—27	Rural	6.1	0.2
	Urban	2.8	3.3
28—32	Rural	6.3	2.4
	Urban	4.2	2.3
33—37	Rural	5.5	3.9
	Urban	2.9	2.7
38—42	Rural	7.8	3.6
	Urban	3.3	2.0
43—47	Rural	6.9	3.5
	Urban	9.1	1.0
All Ages (13—47)	Rural	6.2	2.7
	Urban	3.4	3.0

The above Table shows that the still-birth rate after six months of gestation in respect of all ages (13—47) for rural areas is 6.2 and for urban 3.4, while within six months of gestation it is 2.7 for rural and 3.0 for urban. The still-birth rate after six months of gestation in rural areas is highest for women in the ages 38-42 and in urban areas in the ages 43-47. In the case of still birth rates within six months of gestation, the rate for rural areas is the highest in the ages 33-37, and for urban in the ages 13-17 after which there is a continuous decline.

Multiple Births

30. The following Table gives the percentage of multiple births to total births:

Table 3.16: Multiple Births per 100 Births (A and C—Type Women)

Attained Age	Per cent contribution	
	Rural	Urban
13—17	0.8	1.8
18—22	0.4	0.2
23—27	0.2	1.2
28—32	0.5	0.4
33—37	1.6	..
38—42	0.7	..
43—47	1.4	..
48+	..	16.7
All Ages (13—47)	0.6	0.8

The data given in the above Table relate only to twins, as no case of other multiple births was reported. Out of a total of 9,916 and 3,963 current births in the rural and urban areas, only 56 in the rural and 30 in the urban areas were twin births. The percentage contribution of twin births to total births thus comes to 0.6 in the rural and 0.8 in the urban. In the attained age 48+ the contribution of twin births in urban areas is as high as 16.7 per cent, and appears to be a sample bias. Leaving it out, the contribution of twin births in rural areas is greater than one per cent in the ages 33—37 and 43—47, while in urban it is so in the ages 13—17 and 23—27.

Summary of Results

31. The following gives a resume of results arrived at in the foregoing paragraphs 11-29:

- (1) Marriage in women is almost universal in this country. The largest proportion of married women is in the fertile age-group of 18-32. Remarriage of widows is not common.

(2) Fertility is low in ages below 18 years as the capacity to conceive and bear children is acquired slowly and reaches maturity about the year 18.

(3) Age-specific fertility after the year 18 rises with age and reaches its peak in the age-group 23-27 after which it begins to fall.

(4) About 6 per cent unions are completely barren. In others sterility increases with age after the year 25, slowly at first but rapidly from the year 37. After 41, the onset of sterility is very quick.

(5) The normal expectation of fertile life is from the age of 18 to the age of 37, though in highly fertile women reproduction goes on till a much later age.

(6) The period of fertile life is not identical with the entire span of menstrual cycles. Usually it starts later and ends earlier.

(7) Considering a multitude of women, each succeeding birth order contributes lesser and lesser children. The largest number of children born are of the 1st birth order, next largest of the 2nd birth order and so on. A greater and greater proportion of women cease to reproduce at successive birth orders. Sterility increases with age as well as the order of birth.

(8) The age at marriage has a profound effect on the fertility pattern. Married women have been divided into 3 categories by their age at marriage—(1) those married before 18 years of age, (2) those married between 18-22 years and (3) those married at 23 years or later. A woman of the first category builds up the largest family and of the third the smallest. The extent of childlessness is also more pronounced in the third category than in the first or second.

3. Acknowledgement

32. In the writing of this chapter the paper *Indian Fertility—Our Knowledge and Gaps* issued by the office of Registrar General has been of great help. The debt owed to it is gratefully acknowledged.

CHAPTER IV

COMPUTED BIRTH RATES, DEATH RATES ETC. AND
EXTENT OF UNDER-REGISTRATION

1. Methodology of Estimating Birth and Death Rates

As stated earlier, the registration of births and deaths in India is so seriously at fault that the data can not be used with any reliance. It becomes, therefore, essential to calculate birth rates and death rates from Census data. The birth and death rates so obtained indirectly are called computed birth and death rates. As Indian Census data are notoriously defective in regard to the reporting of age, age-statistics have first got to be smoothed before they can be put to use.

2. There is a direct relationship of the rates of growth and migration with the levels of birth and death rates. Difficulty is encountered in obtaining reliable migration data, but at the 1961 Census this information has been obtained on a reliable footing. Migration had not been given its due importance before 1951 in computation of birth and death rates, because its effect was deemed to be negligible. For a proper appraisal, this factor has got to be taken into account. Estimates of births and deaths are made by two methods—(1) *Differencing* and (2) *Reverse Survival*. By the Differencing method the death rate is first estimated and the birth rate is worked out from it. The observed growth rate is split up into the rate of natural increase which is the excess of births over deaths and the net rate of gain or loss by migration. On the other hand the Reverse Survival method makes a direct estimate of the birth rate.

Differencing Method

3. *Natural population* at any Census is defined as the enumerated population from which immigrants have been excluded and to which emigrants have been added. *Mean Population* for any decade is the arithmetic mean of the enumerated population at the beginning and at the end of the decade. *Mean Natural Population* is the arithmetic mean of the natural population at the commencement and the conclusion of the decade. Thus, if N_1 is the natural population at the beginning and N_2 at the end of any decade, then $\frac{1}{2}(N_1+N_2)$ is the mean natural population for that decade.

4. The population aged 10 and above in 1961 gives the survivors of 1951 population. The difference denotes deaths during the decade 1951-61 in the 1951 popula-

tion. It can be shown that the number of deaths during the decade in the 1951 population is equal to the total number of deaths during the decade in the current population aged 5 years and above. A simple proof of the same is given below:—

Deaths in 1951-52 = Deaths in the 1946-47 population + Deaths of children under 5 years

Deaths in 1952-53 = Deaths in the 1947-48 population + Deaths of children under 5 years

Deaths in 1959-60 = Deaths in the 1954-55 population + Deaths of children under 5 years

Deaths in 1960-61 = Deaths in the 1955-56 population + Deaths of children under 5 years

All deaths during the decade 1951-61 = All deaths in the 1951 population during the decade + All deaths of children under 5 years during the decade

As the population was slowly and continuously growing the mean of the 1946-47 and 1955-56 populations will be approximately the 1951 population.

Transposing the terms of the equation,

All deaths in the 1951 population during 1951-61 = All deaths during the decade 1951-61 minus Deaths of children under 5 years

= Number of deaths during the decade of persons aged 5 years and above.

5. For the above calculation natural population only should be considered which excludes the effect of migration. If P_1 stands for the enumerated population, E_1 , the number of emigrants and I_1 , that of immigrants

in 1951; and P_2 , E_2 and I_2 the corresponding figures for 1961, then

$$N_1 = P_1 + E_1 - I_1$$

$$N_2 = P_2 + E_2 - I_2$$

Where N_1 and N_2 are the natural populations of 1951 and 1961 respectively. Let $N_2(10+)$ and $P_2(10+)$ represent the number of persons aged 10 years and above in the mean population and the enumerated population of 1961. If the number of deaths at ages 5 and above in the current population during 1951-61 be represented by d , then

$$d = N_1 - N_2(10+) = P_1 - P_2(10+) + (E_1 - I_1) - (E_2 - I_2)$$

The expression $(E_1 - I_1) - (E_2 - I_2)$ stands for the change by 1961 in the 1951 Census migrant population. It may be called the *migration change*. It requires to be stressed that the formula is approximate and not too exact; but, on the whole, it may be taken to be reasonably correct.

6. Applying the 1951 and 1961 data of U. P. in these formulae, we have

1951 Population	= P_1	= 63,215,742
1961 Population of persons 10 years and above (adjusted)	= $P_2(10+)$	= 52,161,900
1961 Immigrants	= I_2	= 1,651,554
1951 Immigrants	= I_1	= 1,388,103
1961 Emigrants (Migrants outside India estimated as 5 lakhs)	= E_2	= 3,083,879
1951 Emigrants (Emigrants outside India estimated as 7 lakhs)	= E_1	= 2,234,876

Therefore, the number of deaths during the decade among persons aged 5 years and above = $d = P_1 - P_2(10+) + (E_1 - I_1) - (E_2 - I_2) = 10,468,290$

The magnitude of the migration change is -585,552 and of $E_2 - I_2 = 1,432,325$.

7. For estimating the total number of deaths from the figures of deaths of 5 years and above we have to take recourse to registered data for whatever they are worth. It is assumed for the purposes of calculation that the ratio between the two will be approximately the same as in registered vital statistics. The registered number of deaths of 5 years and above for the decade is 4,006,933 and their registered total number

is 6,318,738. The ratio may be taken as 1.6. If the computed total number of deaths is denoted by D , then $D = 10,468,290 \times 1.6 = 16,749,640$

The 1951 natural population $N_1 = P_1 + E_1 - I_1 = 64,062,515$ and the 1961 natural population $N_2 = P_2 + E_2 - I_2$ (where P_2 is the enumerated population of 1961) = 75,178,726. Hence the mean natural population of the decade 1951-61

$$= \frac{1}{2}(N_1 + N_2) = 69,620,620$$

The mean annual death rate for the decade will, therefore, work out as

$$\frac{D}{\frac{1}{2}(N_1 + N_2)} \times \frac{1000}{10} = \frac{16,749,640}{69,620,620} \times 100 = 24.06 \text{ per thousand}$$

The recording of deaths of infants and young children of 0-4 is generally poorer than at older ages which gives a lower ratio than actual of total deaths to deaths at ages 5 and above. The actual death rate should be slightly greater.

8. It is now necessary to make an allowance for deaths among migrants to obtain fresh migration. The changing migrant population can be represented by the mean migrant population at the mid-censal point to which an over-all death rate of 22 per thousand may be applied for a period of half a decade. Fresh migration may be, therefore, deemed to be = migration change -0.22 of $(E_2 - I_2) - \frac{1}{2} \times 0.22$ of migration change = 0.89 of migration change -0.22 of $(E_2 - I_2)$. As stated before the migration change = -585,552 and $E_2 - I_2 = 1,432,325$.

Substituting these figures in the above formula, Fresh Migration = -836,253

The fresh migration rate can be obtained by dividing the above by the mean enumerated population 68,481,072:— Fresh Migration Rate = -1.22 per thousand

9. Birth rate can be calculated from the growth rate, death rate and the fresh migration rate according to the following formula:—

$$\text{Mean Birth Rate} = \text{Mean Death Rate} + \text{Mean Growth Rate} - \text{Mean Fresh Migration Rate}$$

The mean death rate is 24.06, the mean growth rate 15.38, and the mean fresh migration rate is -1.22. The mean birth rate is therefore,

$$= 40.66 \text{ per thousand.}$$

The actual birth rate can be slightly higher than this figure for reasons already given in the estimation of death rate.

10. *A simple formula for Birth Rate*—If extreme fineness in calculation is not aimed at, migrants can be ignored altogether in comparison with the total population of the State and only the enumerated population may be considered as in the following working :

- (1) 1951 Population $=P_1=63,215,742$
- (2) 1961 Population of persons 10 years and above (adjusted age data) $=P_2(10+)=52,161,900$
- (3) 1961 Population $=P_2=73,746,401$
- (4) Mean Population of 1951-61 $=\frac{1}{2}(P_1+P_2)=68,481,072$

The number of deaths among persons of 5 years and above is (1)-(2) which is equal to 11,053,842. The total number of deaths during the decade can be obtained by multiplying this by the ratio 1·6. Their number works out as 17,686,147. Dividing by the mean population the death rate comes to 25·83.

$$\begin{aligned}\text{Mean Birth Rate} &= \text{Mean Death Rate} + \text{Mean Growth Rate} \\ &= 25\cdot83 + 15\cdot38 \\ &= 41\cdot21 \text{ per thousand}\end{aligned}$$

which differs only slightly from the figure worked out in the preceding paragraph.

Reverse Survival Method

11. Birth rate can be calculated from *Age Tables* and *Life Tables* prepared at the Census. Children of less than 10 years of age, i.e., belonging to the age-group 0-9 are the survivors of those born in the intercensal period. The *Life Table* gives the survivors of one lakh births at each age. The *Age Table* gives the population at each age. For this purpose, the adjusted Age Table should be employed. Suppose the number of survivors at age x is L_x . Then the ratio of the number born to the number existing is $\frac{100,000}{L_x}$. If the actual number of

persons at that age is P_x , the number of births from which these persons have survived is $=100,000 \times \frac{P_x}{L_x}$. Putting $x=0,1,2,\dots,9$ we can get the number of births in each year and their sum will give the total number of births in the decade. Expressing this symbolically,

$$\text{Total number of births in the decade} = 100,000 \times \sum_{x=0}^9 \frac{P_x}{L_x}$$

Division of the number of births by the mean population of the decade will give the mean birth rate.

12. The estimate of birth rate obtained by the above method also has its limitations. Infant and child mortality are liable to changes and the risk to which an

infant was exposed may not be the same in 1951 and 1961. But if all births during the decade are combined for the purpose of calculation, as in the above case, the chances of mistake are reduced. Besides, there is practical difficulty in consulting the *Life Tables*. They have been prepared for males and females separately and there is no Table for persons of both sexes taken together. The number of survivors is obtained by taking the arithmetic mean of the figures given in the separate Tables which can vitiate the result. Secondly, separate Tables for Uttar Pradesh have not been prepared at this Census. This State has been combined with Madhya Pradesh in the Table for the Central Zone. With these limitations the number of births in each year of the decade by the age of survivors is worked out below :

Age	Survivors of One Lakh Births	Actual Survivors in 1961	Number of Births
x	L_x	P_x	One Lakh $\times \frac{P_x}{L_x}$
0	86,018	3,031,800	3,524,611
1	79,383	2,559,300	3,223,990
2	77,178	2,318,600	3,004,224
3	75,581	2,175,000	2,877,707
4	74,244	2,082,300	2,804,671
5	73,639	2,003,100	2,720,161
6	72,865	1,934,700	2,655,184
7	72,302	1,875,700	2,594,257
8	71,889	1,824,100	2,537,384
9	71,577	1,779,900	2,486,692
			28,428,881

Dividing this by the mean population of the decade 68,481,072 the

Mean Birth Rate = 41·51 per thousand.

$$\begin{aligned}\text{Mean Death Rate} &= \text{Mean Birth Rate} - \text{Mean Growth Rate} + \text{Mean Migration Rate} \\ &= 41\cdot51 - 15\cdot38 - 0\cdot86 \\ &= 25\cdot27 \text{ per thousand}\end{aligned}$$

The mean migration rate has been calculated from the migration change. The expectation of life is a shade higher in Madhya Pradesh during this decade than in Uttar Pradesh. This would make L_x for this State smaller and would slightly raise the birth rate of Uttar Pradesh. Looking at the figures from year to year it will be observed that the birth rate has progressively increased during the decade and is now well over 45.

Computation of Birth Rates and Death Rates by the Registrar General, India

13. Deputy Registrar General (Vital Statistics) has calculated the birth rates and death rates for all States in India taking into consideration all factors

involved and fitting them in the all-India picture. He has given the following rates for the decade 1951-61:

Uttar Pradesh	(a) Birth Rate	41·5
1951-61	(b) Death Rate	24·9

The corresponding figures given by him for the previous decade 1941-51 are—

Uttar Pradesh	(a) Birth Rate	38·6
1941-51	(b) Death Rate	27·2

Table 4·1: Computed Birth and Death Rates for States in India, 1941-51 and 1951-61

1941-51					1951-61				
India and States			Birth Rate	Death Rate	India and States			Birth Rate	Death Rate
INDIA	..	..	39·9	27·4	INDIA	..	..	41·7	22·8
1. Hyderabad	..	..	43·1	29·5	1. Andhra Pradesh	..	..	39·7	25·2
2. Madras	..	..	35·7	22·8	2. Madras	..	..	34·9	22·5
3. Uttar Pradesh	..	..	38·6	27·2	3. Uttar Pradesh	..	..	41·5	24·9
4. Assam	..	..	46·7	31·8	4. Assam	..	..	49·3	26·9
5. Bihar	..	..	39·0	26·6	5. Bihar	..	..	43·4	26·1
6. Madhya Pradesh	..	..	46·1	38·5	6. Madhya Pradesh	..	..	43·2	23·2
7. Orissa	..	..	37·2	29·9	7. Orissa	..	..	40·4	22·9
8. Saurashtra	..	..	42·2	24·9	8. Gujarat	..	..	45·7	23·5
9. Travancore Cochin	..	..	37·4	18·0	9. Kerala	..	..	38·9	16·1
10. Rajasthan	..	..	42·5	27·2	10. Rajasthan	..	..	42·7	19·4
11. Bombay	..	..	41·0	24·9	11. Maharashtra	..	..	41·2	19·8
12. Mysore	..	..	36·9	18·9	12. Mysore	..	..	41·6	22·2
13. Punjab	..	..	41·2	26·3	13. Punjab	..	..	44·7	18·9
14. West Bengal	..	..	35·4	28·6	14. West Bengal	..	..	42·9	20·5

On account of the reorganisation of States the data for the two decades are not exactly comparable, the territorial jurisdiction having changed meanwhile. In the case of Uttar Pradesh, however, there has been no change in jurisdiction and exact comparisons are possible. In the majority of areas the birth rate has shown an upward trend from 1941-51 to 1951-61, and in all areas except Mysore the death rate has gone down. The All-India picture is also the same. The over-all birth rate has gone up from 39·9 to 41·7 and the over-all death rate has shrunk from 27·4 to 22·8. The gap from 12·5 has widened to 18·9. During 1941-51 the lowest birth rate obtained in West Bengal on account of the depredation caused by the Great Famine. Assam continues to have the highest birth rate, the figure for 1951-61 being as

A comparison of the two sets of figures shows that the birth rate has further increased and the death rate has further decreased making the gap between them still wider.

2. Computed Birth and Death Rates for States

14. Birth and death rates computed by the Deputy Registrar General (Vital Statistics) from Census data for the two decades since 1941 are given in the following

Table :

high as 49·3. The States which have birth rates exceeding that of Uttar Pradesh in 1951-61 taken in descending order are Assam, Gujarat, Punjab, Bihar, Madhya Pradesh, West Bengal, Rajasthan and Mysore—all except the last in North India. The States which have birth rates below 40·0 in ascending order are Madras, Kerala and Andhra Pradesh—all in South India. Only Assam, Bihar and Andhra Pradesh have higher death rates than Uttar Pradesh. Kerala, Punjab, Rajasthan and Maharashtra have now death rates well below 20·0.

15. The exponential growth rate net of migration (birth rate minus death rate) is 18·9 for India and 16·6 for Uttar Pradesh. These rates are given in the following Table :

Table 4-9: Birth and Fertility Rates in States, 1951-61

State	Birth Rate	General Fertility Rate	Nuptial Fertility Rate	Completed Family Size (No. of Children)
1 Andhra Pradesh	39.7	183	213	5.23
2 Madras	34.9	153	196	4.57
3 Uttar Pradesh	41.5	204	222	5.51
4 Assam	49.3	254	317	6.79
5 Bihar	43.4	205	229	5.82
6 Madhya Pradesh	43.2	203	224	5.78
7 Orissa	40.4	183	215	5.35
8 Gujarat	45.7	220	259	6.17
9 Kerala	38.9	182	265	5.10
10 Rajasthan	42.7	209	229	5.70
11 Maharashtra	41.2	195	227	5.47
12 Mysore	41.6	201	242	5.53
13 Punjab	44.7	235	278	6.03
14 West Bengal	42.9	215	258	5.74

23. The above Table makes out a certain relationship among the three rates and the average number of children born to a women of completed fertility. All the figures are the highest in the case of Assam and the lowest in the case of Madras. An Assamese woman has on the average 6.8 children, a Gujarati woman 6.2, and a Punjabi woman 6.0. On the other hand a Madras woman has 4.6 children, a Kerala woman 5.1, and an Andhra woman 5.2. The average number of children born to a woman in Uttar Pradesh in the whole reproductive span is 5.5. The States in which the completed family size exceeds 5.50 in descending order are Assam, Gujarat, Punjab, Bihar, Madhya Pradesh, West Bengal, Rajas-

Table 4-11: Registered and Computed Birth and Death Rates in India and States, 1941-51 and 1951-61

1941-51					1951-61				
India/States	Registered		Computed		India/States	Registered		Computed	
INDIA	..	..	(a) 27.2	(a) 39.9	INDIA	..	..	(a) 27.1	(a) 41.7
Madras	..	..	(b) 19.4	(b) 27.4	Madras	..	..	(b) 13.2	(b) 22.8
Uttar Pradesh	..	..	(a) 30.8	(a) 35.7	Uttar Pradesh	..	..	(a) 28.1	(a) 34.9
Assam	..	..	(b) 20.6	(b) 22.8	Assam	..	..	(b) 14.5	(b) 22.5
Bihar	..	..	(a) 24.8	(a) 38.6	Bihar	..	..	(a) 15.9	(a) 41.5
Madhya Pradesh	..	..	(b) 16.5	(b) 27.2	Madhya Pradesh	..	..	(b) 9.2	(b) 24.9
Orissa	..	..	(a) 16.8	(a) 46.7	Orissa	..	..	(a) 9.7	(a) 49.3
Travancore-Cochin	..	..	(b) 11.4	(b) 31.8	Travancore-Cochin	..	..	(b) 4.4	(b) 26.9
Bombay	..	..	(a) 21.9	(a) 39.0	Bombay	..	..	(a) 15.0	(a) 43.4
Mysore	..	..	(b) 16.1	(b) 26.6	Mysore	..	..	(b) 7.9	(b) 26.1
Punjab	..	..	(a) 37.0	(a) 46.1	Punjab	..	..	(a) 19.7	(a) 43.2
West Bengal	..	..	(b) 30.3	(b) 38.5	West Bengal	..	..	(b) 12.3	(b) 23.2
			(a) 28.2	(a) 37.2				(a) 24.7	(a) 40.4
			(b) 26.0	(b) 29.9				(b) 15.5	(b) 22.9
			(a) 20.3	(a) 37.4				(a) N. A.	(a) 38.9
			(b) 9.4	(b) 18.0				(b) N. A.	(b) 16.1
			(a) 32.9	(a) 41.0				(a) 30.6	(a) 41.2
			(b) 22.6	(b) 24.9				(b) 16.4	(b) 19.8
			(a) 16.2	(a) 36.9				(a) 25.0	(a) 41.6
			(b) 11.6	(b) 18.9				(b) N. A.	(b) 22.2
			(a) 39.5	(a) 41.2				(a) 38.7	(a) 44.7
			(b) 23.9	(b) 26.3				(b) 14.2	(b) 18.9
			(a) 20.5	(a) 35.4				(a) 21.5	(a) 42.9
			(b) 18.9	(b) 28.6				(b) 8.9	(b) 20.5

than, Mysore and Uttar Pradesh—all except Mysore located in North India. Generally speaking, a larger number of children per woman is born to the north of the 22° N latitude than to the south of it, Mysore being an exception.

7. Extent of Error in Registration Data

24. To have an idea of the extent of error through incompleteness of registration, the recorded and computed birth and death rates may be considered. The following Table indicates that in every decade there has been under-registration in both births and deaths.

Table 4-10: Recorded and Estimated Birth and Death Rates in India

Period	Birth Rate		Death Rate	
	Recorded	Estimated	Recorded	Estimated
1891-00	33	46	31	44
1901-10	37	49	33	43
1911-20	37	48	34	47
1921-30	34	46	25	36
1931-40	34	45	23	31
1941-50	27	40	19	27
1951-60*	27	42	13	23

*Excluding Assam, Bihar and U. P. where registration is grossly deficient.

The above Table reveals that in every decade there is an appreciable difference between the registered and computed birth and death rates which shows how deplorable the registration system is almost everywhere.

25. Table 4-11 exhibits the extent of under-registration of birth rates for some States during the decades 1941-51 and 1951-61. In this Table (a) means the birth rate and (b) the death rate.

The States for which figures are not available have been omitted from the above Table. It appears that in Assam, Bihar, Uttar Pradesh, Madhya Pradesh and West Bengal there is more than 50 per cent under-registration of births, and in Punjab and Madras less than 20 per cent during the decade 1951-61. The registration system of these two States only can be called fairly satisfactory.

26. The extent of under-registration in Uttar Pradesh is very high. Table 4-12 gives an idea about the extent in the total, rural and urban areas during the decade 1951-61. In this Table for dividing the birth between rural and urban areas the number of married women aged 15-44 in these areas have been taken into consideration. The distribution of deaths has been made proportionately between the two areas.

Table 4-12: Under-Registration of Vital Statistics in U. P. in 1951-61

Total/Rural/Urban	Estimated Births	Registered Births	Percentage Omission	Estimated Deaths	Registered Deaths	Percentage Omission
Total	..	..	..	28,419,640	10,919,788	61.6
Rural	..	..	..	17,051,790	6,318,738	63.0
Urban	..	..	..	25,173,860	8,155,661	67.6
				3,245,780	2,764,127	14.8
				2,192,000	1,258,514	42.6

A study of the above Table reveals that during this decade the total under-registration of births is 61.6 per cent, with 67.6 per cent in rural and 14.8 in urban areas. The total under-registration of deaths is 63.0 per cent with 66.0 per cent in rural and 42.6 per cent in urban areas. The percentage of under-registration of births in urban areas is less than 15, but that of deaths is surprisingly high. Even in urban areas the under-registration is considerable. Except in a few local bodies where it can be said that adequate steps have been taken to register every birth and death, the position is still unsatisfactory and much attention is needed in this direction.

tory and much attention is needed in this direction.

8. Acknowledgment

27. In the writing of this chapter the *Census of India, Paper No. 6 of 1954* containing an article on Computed Birth and Death Rates in India and States during 1941-50 and a paper on State Growth Rates and their components prepared by the Registrar General's office for the All-India Seminar on Population, 1964 sponsored by the Institute of Economic Growth have been of great help. The debt owed to them is gratefully acknowledged.

CHAPTER V

CONCLUSION

We have stressed earlier the amount of importance which should be attached to the correct registration of vital statistics. The statistics of natality by sex give the trend of births in a demographic group, and if they could also be collected by community, occupation, income, and mother's age they would furnish a wealth of material for the study of birth differentials by these characteristics. Reliable mortality statistics by sex, age and cause would provide a correct estimate of the risk of death to which every man or woman is exposed at a given age and also of further expectation of life at that age. Deaths by causes and by months in which they occur provide data on the incidence of particular diseases in the localities concerned and their seasonability, which enables the State to take up its public health programmes. The recording of deaths by community, occupation and income would further add to the utility of mortality statistics and furnish material for differential study by these factors. Though deaths are even now registered by causes, yet in the absence of proper classification a large number of deaths are ascribed to such vague terms as *fever* and the recording of age is anybody's guess.

2. Birth and death statistics even in respect of the characteristics for which they are collected, as noticed before, are grossly deficient. The system of registration was fairly satisfactory up to 1940, but it has progressively deteriorated since. During 1941-50 the under-registration in births was 35.8 per cent and in deaths 39.3 per cent. During 1951-60 the percentage of under-registration of births and deaths has been 67.6 and 66.0 respectively in rural areas, and 14.8 and 42.6 in urban areas. In the total population the under-registration of births and deaths has been 61.6 per cent and 63.0 per cent respectively. The deterioration set in during the years of the Second World War and has continued ever since. The improvement hoped for by the transfer of this work from *chaukidars* to village panchayats has unfortunately not materialized.

3. Earnest measures to improve the system of registration system require to be undertaken forthwith. Collection of vital statistics may be entrusted to an agency which has a literate village official operating for a group of villages, usually not exceeding 10 in number, who may gather this information during his visits to them in the course of his normal duties. If need be, a small honorarium, say 2 paise per entry, may be paid to

him. This will involve a modest expenditure of about Rs. one lakh per annum which is a small price to pay for the invaluable information so gained. It would be advisable to consolidate data at the district level in the district office of the same department which is entrusted with the all important duty of collection of this vital information, otherwise village and intermediate officials will not feel the requisite responsibility. Thereafter, the figures may be transmitted to the Director of Medical & Health Services for compilation at the State level. For the appraisal of the margin of error, periodical sample surveys may be undertaken by an independent agency, such as the Director of Economic Intelligence & Statistics.

4. In the absence of reliable data on Vital Statistics recourse of necessity has to be taken to compute birth and death rates from Census figures, but the latter can be used for the State as a whole and not for natural or administrative divisions or districts owing to the variable factor of migration and the non-availability of Life Tables and adjusted Age Tables for areas smaller than the State. The knowledge of the birth and death rates for the State as one unit is not sufficient, particularly in such a vast State as Uttar Pradesh which has seven distinct natural divisions with different climates, physical features, natural vegetation, soils and agricultural conditions. Where conditions vary to such an extent, the computed rates for the whole State do not serve the required useful purpose. This makes it all the more necessary to have dependable vital data, region by region, and district by district.

5. Several social and environmental factors have a bearing on health and consequently on diseases and deaths, such as climate, sanitation, housing condition, level of education, standard of living, nature of work, and marital status. Mortality statistics as well as computed data show that the death rate is steadily on the decline. It used to be over 40 per thousand before 1921. The mean death rate per thousand in the decade 1941-51 was 27.4 for India and 27.2 for Uttar Pradesh. For 1951-61 the corresponding figures are 22.8 and 24.9. With the fall in the death rate the expectation of life at birth has increased from 32.1 in 1941-51 to 41.2 in 1951-61 for India, and from 34.2 in 1941-51 to 38.9 in 1951-61 for Uttar Pradesh. Improvement in the case of Uttar Pradesh has been relatively less. The lowering of death

rate is due to the advancements achieved in prophylactic and curative medicine, effective control of dreaded diseases such as the plague, cholera, smallpox and malaria, and better system of distribution of subsistence in times of scarcity. Even now, our country has a higher death rate and a lower expectation of life than economically advanced countries as would appear from the following :

Table 5.1 : Death Rates and Expectation of Life in Uttar Pradesh, India and in certain Selected Countries

Territory or Country	Death Rate per 1,000	Expectation of Life in Years at Birth
Uttar Pradesh	24.9	38.9
INDIA	22.8	41.2
Japan	7.5	67.9
U. S. S. R.	7.5	68.1
Australia	8.7	70.0
United States	9.5	70.3
France	11.5	71.2
United Kingdom	11.9	70.9

These figures have been worked out from Tables 4.6 and 4.7 of Chapter IV. Death rate of Uttar Pradesh is still higher and expectation of life lower than obtaining in the country generally. The chief cause of the high death rate in this country is the greater incidence of infant and child mortality. Table 5.2 gives the number of survivors at each age out of 1,000 children born for India and the Central Zone in which Uttar Pradesh is located.

Table 5.2 : Survivors at Ages up to 5 years out of 1,000 Births in India and Central Zone (Uttar Pradesh and Madhya Pradesh)

Exact Age	Survivors in	
	India	Central Zone (U. P. and M.P.)
At Birth	1,000	1,000
1 year	855	819
2 years	826	791
3 years	805	769
4 years	788	753
5 years	776	741

These figures have been worked out from the Life Tables for 1951-60. As many as 14.5 per cent infants in India and 18.1 per cent in the Central Zone do not live to see the second year of life, and as many as 22.4 per cent in India and 25.9 per cent in Uttar Pradesh become casualties before their fifth year is out. Thus about a quarter of the children born are not destined to see more than five summers. About 50 per cent of infant mortality cases

occur in the first month, 30 per cent from one to six months, i.e. more than three-fourths in the first half-year of life. The remaining one-fourth occur in the second half of the year.

6. Here, as elsewhere in the world, the number of males at birth is greater than that of females, but in advanced countries a higher rate of mortality affects the former which reduces the number of males to less than that of females at a comparatively early stage. In India (and in certain other countries) the mortality rate among males is slightly higher only up to the age of 4 years, and in Uttar Pradesh up to the age of 2 years, after which females die in relatively greater numbers. *This results in a larger number of males than of females at every age.* However, infant mortality is far greater among males than females. Table 5.3 gives the survivors of 1,000 males and 1,000 females at each age up to 5 years for India and the Central Zone.

Table 5.3 : Survivors by Sex up to 5 years out of 1,000 Male and 1,000 Female Births in India and Central Zone. (Uttar Pradesh and Madhya Pradesh)

Exact Age	Survivors in			
	India		Central Zone	
	M	F	M	F
At Birth	1,000	1,000	1,000	1,000
1 year	847	862	816	822
2 years	821	831	790	792
3 years	802	807	770	769
4 years	787	789	755	751
5 years	776	775	744	738

These data too have been obtained from the Life Tables for 1951-60. In Uttar Pradesh female mortality as compared with male mortality rises rapidly from the age of 10 and is very high in the ages 15-24 after which it gradually comes to level. Thus there is a great decimation of female lives during the early reproductive period, maternity taking a heavy toll.

7. Apart from improvements in public sanitation and further intensification of preventive and curative measures the following steps are indicated for reduction of the death rate :

- (1) Better medical attendance at child-birth and better pre-natal and post-natal care of mothers. There are at present far more deaths of females during the reproductive ages than warranted.
- (2) Better care of infants. A large number of infants die within 24 hours of their being

born. This again calls for trained attendance at birth. Child mortality is profoundly affected by (i) the age of mother at the time of effective marriage, (ii) the number of children born, (iii) the income level of the family, and (iv) environmental factors. The child-loss index rises sharply if the age of the mother at effective marriage is below 15, or the woman gives a large number of births or if the income of the family is low. Early marriages need to be discouraged and frequent pregnancies avoided, if improvement in child mortality is desired. At the same time efforts to raise the standard of living require to be continued. As survival rates of newborn children improve, birth rates will tend to fall, as the necessity of having an extra child as a matter of precaution will cease.

8. It can be assumed that the death rate will come down still further in course of time, which will make the already wide gap between the birth rate and the death rate wider still wider. The present birth and death rates in their own stride will lead to a quick natural increase of population, but a declining death rate and an increasing birth rate will inevitably lead to a mighty population explosion in no distant future, unless the former is substantially reduced. The mean birth rate per thousand in the decade 1941-51 for India and Uttar Pradesh was 39.9 and 38.6 respectively. For 1951-61 the corresponding figures are 41.7 and 41.5. There has been an appreciable increase in the birth rate of the country, the rise in Uttar Pradesh being comparatively greater. A glance at Table 4.6 of Chapter IV will reveal that the birth rate of the economically advanced countries lies between the values 17.0 and 22.5 per thousand, which is nearly half that of India and Uttar Pradesh. In those countries both the birth and the death rates are low and the expectation of life high. Only countries which have a low birth and a low death rate can provide conditions for a normal expectation of a long and healthy life.

9. For arresting the spiral growth of population, no one in his senses would suggest pushing up the death rate. The solution of the population problem lies in the drastic curtailment of the birth rate. A concerted effort is needed not only to put a curb on the rising birth rate, but also to reverse its trend. To achieve this end repeated studies in the fertility pattern will require to be undertaken. Some investigations have been made, but more are needed to study fertility behaviour by various differentials. However, the investigations made so far have yielded some positive conclusions. They have been

discussed in Chapters II and III and a brief mention of them here will be sufficient.

10. From Hospital Maternities data it appears that the upper limit of age for child-birth is 47 years and the lower 12. Other important conclusions are as under:

(1) The average age for each birth order is the lowest in mothers of the highest fertility, and it progressively increases as one proceeds to mothers of lower parity.

(2) There are welcome indications that the average age at the first child-birth has shown an upward trend during the last few years. The average age for the first confinement is 20.4 years at present.

(3) The proportion of births goes down as the birth order goes up. The highest proportion obtains in the case of the first births, and decreases progressively thereafter.

(4) The bride's age at marriage is the lowest in families belonging to the Craftsmen and Production Process Workers occupational group and Managerial Workers and of enlightened hospital-minded Farmers. The average age at first maternity in the first-mentioned occupational group is only 19.5 years and in the other two, 21.7 years.

(5) The proportion of births of the 4th and higher orders is the smallest in the occupational group of Professional and Technical Workers followed by that of Clerical Workers. In these occupational groups some indirect evidence of family planning seems to exist. On the other hand, though marriages are late in the occupational group of Administrative, Executive and Managerial Workers and in that of Farmers there is no indication of any appreciably lower fertility. The proportion of births of higher orders is the greatest in the occupational group of Sales Workers followed by those of Craftsmen and Production Workers, Farmers and Unskilled Workers. Mothers coming from families belonging to these occupational groups have a large number of children and evidence of family planning in them is scarce. In the families of Farmers who visit the hospital, while marriages are late, child-bearing is in quick succession.

(6) Income also plays its part in marriage and family-building pattern. The age at marriage is the youngest in the lowest income group and as a rule progressively rises with income. This is reflected by the average ages at first maternity. In the income group of below Rs. 75 per month the average is 20.1 years; in that of Rs. 75-150, 20.4 years; in that of Rs. 151-300, 21.6 years and in that of above Rs. 300, 21.1 years. The deviation in the last-mentioned case seems to be due to sample bias.

(7) The proportion of births of the 4th and higher orders progressively falls with the rise in income. Admittedly, it is the poorest class which has the largest number of children, and it is also the class which can least afford to have them. Evidence of consciousness of family planning is given by upper income levels. What is needed is to make the lowest-income groups conscious of the same.

(8) There seems to be reason to believe that fertility differentials by occupations or incomes are not the effect of a particular occupation or standard of living—as uncontrolled fertility in this country is not much affected by social and economic factors—but are due to awareness in certain classes for deliberate birth control.

(9) Analysis of the ages of mothers by the number of previous births shows that the largest number of children are acquired during the ages 23-27 in which age-group the reproductive power seems to be at its peak. Very few children are born before the age of 17 years. The average number born in each quinquennial age-group rises steadily with the age of the mother, reaches the maximum as mentioned above, and then commences to decline. Considerable slowing down in reproduction occurs after the age of 37 years.

11. The Fertility Survey of Ever-Married Women conducted in 1961-62 yielded the following conclusions:

(1) There is universality of marriage among females and the largest proportion of married women is between the ages 18-32 which is the most fertile period. Women married once only need be considered for discussion as the percentage of women married more than once is only 2.2 in rural and 0.9 in urban areas. Widow remarriage though in existence is not common.

(2) In rural areas more than three-fourths of the marriages of girls take place below the age of 18 years, and in urban areas about two-thirds. Less than one-fourth girls in rural areas and less than one-third in urban are married at ages 18-22. The number of girls married at 23 years and above is only 2 per cent.

(3) The percentage of mothers by parity rises at first, reaches the maximum nearabout four and then declines. The largest number of mothers of completed fertility have 4 children.

(4) Each succeeding birth order brings less children than its preceding order. The 1st order of birth contributes the largest proportion of children. This result was noticed in hospital maternity cases also. A larger and larger proportion of mothers quit the arena of reproduction at each birth.

(5) The period of fertile life is usually from 18 to 37 years of age, except in the case of highly fertile women

where it continues for a longer duration.

(6) A study of age-specific fertility indicates that

(i) the fertility is low under the age of 18 years, since the capacity to conceive and bear children is acquired slowly and reaches maturity about the 18th year,

(ii) thereafter, the age-specific fertility rate rises with age acquiring the maximum value in the age-group 23-27,

(iii) then it begins to decline, dwindling to half of the maximum immediately after the age of 37 years. In the age-group 43-47 it is as low as in that of under 18.

All these facts have already been noticed in the course of analysis of hospital maternity data.

(7) About 6 per cent marriages are barren. In the remainder onset of sterility commences from the age of 30 and is very well marked from the age of 37. After the age 41, sterility sets in apace.

(8) The investigation of the fertility pattern by the age at marriage reveals that

(i) Women married under the age of 18 have the largest number of children and those married at 23 or later the smallest. In other words, the more advanced the age of a woman at marriage, the lower her parity,

(ii) the contribution of the 1st order of birth to the total family size advances with the age at marriage and the parity progression ratio diminishes more quickly—these are corollaries of (i),

(iii) childlessness and secondary sterility increase as the age at marriage advances.

12. Though fertility varies from one geographical region to another, e.g., fertility is higher to the north of 22° N latitude than to its south (Mysore being an exception). The chief causes of high birth rate in this country are:

(1) Universality of marriage among females.

(2) Low age of girls at marriage.

(3) Absence of deliberate birth control measures in an overwhelming majority of married couples.

These three causes will now be taken up one by one.

13. *Universality of Marriage*—In India marriage is almost universal for females unlike western countries which have between 25 and 30 per cent of girls and women aged 15 years and above in the unmarried state. Among males the institution of marriage cannot be that

much universal, as they are appreciably in larger numbers. In Uttar Pradesh only 1.4 per cent of girls and women of 15 years and above in rural and 4.7 in urban are in the never-married state—all else being married. The following Table shows for All-India and Uttar Pradesh the percentage of married women in various age-groups from 15 years up to 44 years :

Table 5.4 : Percentage of Married Females in India and Uttar Pradesh by Rural and Urban, 1961

Age-group	India		Uttar Pradesh	
	Rural	Urban	Rural	Urban
10-14	22	7	34	10
15-19	74	52	86	59
20-24	93	86	98	91
25-29	95	93	97	96
30-34	92	91	95	95
35-39	87	87	92	92
40-44	78	77	84	85

The above Table shows that the proportion is highest in the age-group 25-29 after which it begins to fall on account of occurring cases of widowhood. Considering several age-groups of high percentages together, the largest proportion of married women is found in the ages 20-34 which incidentally are the most fertile. In India, with some exceptions, marriage is practically the only career open to girls, unlike the case in western countries where a fair percentage is in employment. Experience of those countries suggests that women's advancement in general is likely to be accompanied by a fall in marriage rate. The increasing employment of women in industries and offices in those countries have resulted in a decrease of marriages and consequent fall in the birth rate. In our urban areas some educated women have begun taking to careers, but at present not much change can be expected in rural areas in this direction. Even the employment of married women will have some effect on the birth rate. It has been ascertained that generally women in employment have lesser number of children than those engaged in domestic duties only.

14. *Low Age at Marriage*—Table 5.4 given in the previous paragraph reveals the prevalence of marriage below the age of 14 years despite the provision of the Child Marriage Restraint Act, 1929. Child-marriages are prevalent in Uttar Pradesh to a greater extent. The current mean age of marriage for rural area is 16.2 years

and for urban 17.0. By the age of 19 as many as 86 per cent girls in rural and 59 per cent in urban get married. To reduce fertility it appears desirable to raise the age of marriage for both sexes. As observed in the study of ever-married women the number of children is reduced by 0.35 when the marriage age is advanced from under 18 years to 20 years and further reduced by another 0.35 if it is advanced to 23 years. Thus there is a net reduction of 0.70 child per family if the age of girls at marriage is raised to 23 years. According to A.J. Coale and C.Y. Tye, immediate temporary reduction in birth rate can be achieved, even when completed family size is not reduced, by advancing the age of marriage which would curtail the reproductive period exposed to pregnancy. In the opinion of these authorities, there are two reasons why a younger pattern of fertility results in a faster growth. One is that on account of low age of marriage some births take place which would be avoided if the girl fails to live up to the proper marriage age in a later-marriage-age society. The other is that there is less spacing between births, leading to a higher rate of growth per annum.

15. *Absence of Deliberate Birth Control Measures*—Despite economic difficulties the desire to limit the family size is conspicuous by its absence in a very large percentage of married couples. They consider children as gifts from heaven and leave the question of shelter, food and clothing to Providence absolving themselves of all responsibility in that matter. Even among those who recognise the necessity of having fewer children, a large majority is ignorant of the mechanism of conception and of the methods for avoiding the same, and quite many of those who know are on many occasions careless enough to neglect them, fondly trusting that they would be spared just for once—and lo and behold, an unwanted pregnancy is in the offing.¹

16. A survey of attitude towards restricting the number of births was conducted in 1955 by D. N. Majumdar's team in lower-income areas of Kanpur city. The team interviewed 1,525 married women, of whom 760 expressed themselves in favour of family limitation, 506 were positively against and the remaining 259 indifferent. Thus the percentage of those who were in favour was not even 50. In rural areas it is feared to be still less. The attitudes were further analysed by differentials of community, income, education and age. The results achieved are summarised below :

Table 5.5 : Percentages of Women desiring to restrict Births, by Community, Income, Education and Age¹

Community	Per cent	Income Group	Per Cent	Education of Mother	Per cent	Age of Mother	Per Cent
All Communities	49.9	All Incomes	49.9	All Education Levels	49.9	All Ages	49.9
Hindus	44.8	Below Rs. 50	48.0	Illiterates	44.5	15-24	47.4
Muslims	70.9	Rs. 50-100	48.8	Primary	69.1	25-34	52.8
Sikhs	58.3	Rs. 101-200	56.4	Secondary and	72.6	35-44	60.0
Christians	100.0	Above Rs. 200	53.3	College	..	45 and over	26.1

¹ Prepared from Tables V to VIII on pp. 191-2 of *Social Centours of an Industrial City* by D. N. Majumdar.

The existence of the desire to limit the family is well known among Christians. The high percentage of such women among Muslims can be readily understood against the background of large families. Higher income and education increase the awareness of the need to restrict the family. Differentials by mother's age make an interesting reading. Those of 45 and over belong to the older school and the same time have passed the stage of child-bearing. Their negative attitude is easily understandable. But that of the age-group 15-24 requires explaining. Perhaps that is due to imperfect realisation at that age of the horrors of a large family. Out of the 760 women who favoured family planning 668 were entirely ignorant of the methods, 54 were aware of certain methods but had not used them, 36 had used them on occasions and 2 preferred not to answer². *This highlights the infinitesimal extent of the practice of contraception in this country.*

17. It is of utmost essence that the people should be made conscious of the need of restricting the family, if the nation is to survive. Considering the question from the national angle, a common limit for all cases may be suggested. The concept of *improvident maternity* has come to stay. It was defined by the Census Commissioner of 1951 as a child-birth occurring to a mother who had already given birth to three or more children of whom at least one was alive. Avoidance of improvident maternity will make the population maintain itself at a reasonably stationary level. 'Consistently with this approach it is immaterial if, in a particular case, the pecuniary circumstances of the family or the state of health of the mother are such that further maternity may be allowed to occur and the offspring supported without much difficulty. Whether or not an individual can afford it, the nation cannot—and hence it is 'improvident maternity' all the same³. This consciousness has to be inculcated universally in all strata of the society,

educated or uneducated, rich or poor. This will remove the stock argument advanced against birth control that it is practised by the better and the more educated classes of people who will further diminish in numbers, while the illiterate masses or communities not practising birth control will continue to grow.

18. Mere arousal of awareness will not be enough. Scientific knowledge of the necessary amount of human physiology relevant for the purpose and of the mechanism of conception is most necessary. Besides, mechanical and chemical contraceptives for localised use and oral contraceptives for taking by mouth—if any reliable efficacy can be discovered—should be made available in sufficient quantity at suitable centres at cheap rates, well within the reach of the masses. These centres should also be used for giving training to married couples in the use of contraceptives. The task is tremendous and no single department of Government can hope to cope with it. The energies of all departments of Government require to be pooled for this purpose and the help of all non-official organisations which are prepared to co-operate sought. For approaching rural womenfolk the services of wives of village officials will be invaluable—of such of them as are prepared to lend a willing hand in this national programme. The approach has to be human. Love, esteem and confidence have to be won before the people can be made to listen. Extensive publicity (not smacking of propaganda) will be indispensable for the proper education of the public with regard to the need for family planning and its know-how.

19. A reduction in the birth rate will indirectly induce a fall in the death rate to some extent by effecting an improvement in the health of the mother, children and the family generally. There is all the more reason why a drastic cut in births is desirable, if the population is to be kept within reasonable limits.

² *Ibid.*

³ Census of India, 1951, Part IA-Report, p. 218.

A NOTE ON THE PHYSIOLOGY OF CONCEPTION AND BIRTH CONTROL MEASURES

1. Physiology of Conception

The basis of sexual reproduction in nature is the union of the male and female germ cells, i.e., the sperms and the ova. The spermatozoa are formed in the two testes, that is, male sex glands and are collected in the epididymis where they undergo a maturing process. From there they travel up a duct called the *vas* which opens into the back part of the urethra. Here the secretions of seminal vesicles and the prostate gland mix with the sperms at the time of ejaculation. An average ejaculation contains two to five hundred million sperms. Nature has shown extreme extravagance in the supply of male sex cells. Each sperm measures only about 1/600 of an inch in length and can be seen only with the help of a microscope. In shape it resembles a minute long tadpole with a round head, a small middle, and a long tail. The lashing of the tail from side to side propels it forward.

2. Corresponding to the testes, the two ovaries are the sex glands in the female. They are located inside the body in the lower part of the abdomen and are not visible from outside. They develop the female germ cells called the ova, of which each ovary contains a very large number. The ripening process starts with puberty and goes on slowly. Only three to five hundred develop in the entire reproductive span, and the rest degenerate. In 28 days or so, several of the cells increase in size and one of them gets more enlarged than others. As it grows, it reaches the surface of the ovary and is eventually pushed out. This extrusion of the mature ovum is called *ovulation*. It is round in shape, about 1/200 inch in diameter, just visible to the naked eye, being of the size of a small dot, and is entirely devoid of the power of locomotion. In the matter of female germ cells nature appears to be very niggardly, as only one ovum is discharged in a month. As the ovum is extruded from the ovary it is drawn into the fallopian tube which propels it slowly towards the uterus in about 3 to 4 days' time. It stays there a few days and then disintegrates or passes out. The ejection of the ovum is an independent process and is not in the least connected with the sexual act, unlike the case in males. Ovulation generally occurs about midway between two menstrual periods, i.e., 14 to 16 days before the next menstruation and its occurrence is not felt. As a matter of fact, the release of the ovum generally sets the pace for the next menstrual cycle.

3. Sperms ejaculated in a sexual contact gain their way into the uterus very quickly and continue their journey up the fallopian tubes. If an ovum is present in one of the tubes at this juncture, they swarm round it until one of them enters it. A special biological mechanism prevents the entry of any further sperm. This union is called fertilization or conception. The fertilised ovum travels towards the uterus and attaches itself to its wall. It remains in the uterus during the whole period of pregnancy and then finally emerges as a new-born infant. Ovulation is suspended at the commencement of pregnancy and is resumed some months after delivery.

2. Birth Control Measures

The 'Safe Period'

Birth control consists in preventing the fertilization of the ovum by a sperm. As we have seen, only one ovum is released each month and it retains its vitality for a short time only, which according to Potter is less than 48 hours. The sperms themselves do not survive for very long. They lose their vitality in about 48 hours after their entry into the fallopian tubes. Thus conception can take place only about the ovulation time. During the remaining part of the month fertilization is unlikely, because there is no ovum to receive the sperm and the sperms cannot hope to live till the next ovulation takes place. Thus it is possible to determine the infertile period during which the probability of conception is nil or infinitesimal. This infertile period is usually referred to as the *safe period*. Ovulation occurs from 14 to 16 days before the beginning of the next menstrual period which brings in an amount of uncertainty; for in women of irregular periods the date of the next period cannot be exactly foretold. But some approximation is possible and a 'safe period' of smaller duration can be determined after allowing for the estimated margin of error. Calculation of the safe period may be illustrated by an example. Suppose the average period between the commencement of two consecutive menstruations in the case of woman is 24 days. Ovulation occurs between the 8th and 10th day from the start of the previous menstruation. (If the period varies from 24 to 27 days, the ovulation can occur from the 8th to the 13th day.) For the calculation of the 'unsafe period', 3 days are added on each side to eliminate the survival of the sperms or the ovum. In the example quoted, the 'unsafe period' would extend from the 5th

to the 13th day counted from the commencement of the last menstruation. The remainder of the days constitute the 'safe period'. It consists of two distinct parts—the pre-ovulation and the post-ovulation. The latter is considered to be safer. A more accurate method to determine the time of ovulation is by observing changes in the body temperature. The oral temperature taken immediately on waking continues to be low during the initial days of the menstrual cycle. Then it shows a drop of about one-third of a degree, after which it rises by about one degree and stays constant at that level for the rest of the menstrual cycle. The changeover from low to high is usually a fortnight before the commencement of the next menses and can be presumed to coincide with ovulation.

2. Birth control by safe periods is the cheapest method, as it costs nothing. Even if it fails in some individual cases, it is likely to be generally effective when applied to a very large population. It is most suited to a low-income country like India and deserves to be given a fair trial, at least in those cases where the people cannot afford or are positively averse to other modes of contraception.

Mechanical and Chemical Contraceptives

3. The main problem is to prevent the fertilization of the ovum by a sperm. This can be done in three ways (1) by avoiding to deposit sperms in the female genital tract, (2) by putting an obstruction in their path, or (3) by employing some hostile substance for their destruction. The first includes such practices as *coitus interruptus* and *coitus reservatus*, both considered unsatisfactory from the biological and psychological points of view. The second envisages the use of mechanical contraceptives and the third of chemical.

4. For males the mechanical contraceptive is the condom also known by its other names—the sheath and the french-letter. This is used as a cover for the male part during the coitus. For females the most popular mechanical contraceptive is the check pessary which covers the neck of the uterus. There are some intra-uterine appliances too, but they are not considered too satisfactory.

5. For females another mechanical contraceptive called the "Intra Uterine Contraceptive Device" is being now advocated. It is a real technological break-through for the Family Planning Programme and gives a new hope

for quicker acceptance of family planning in India. The device is made up of a non-tissue reactive plastic material in the shape of a *loop*. There are several varieties of them, but the one commonly used in India is the *Lippes Loop*. It has to be inserted into the uterine cavity by a physician. It is safe, relatively effective, and highly acceptable being a "once for all" method. It is said to be good for both spacing and limiting the family size, and is said to be free from the usual disadvantages of other contraceptives. It is being manufactured in India now and will be available at all District Female Hospitals shortly.

6. Chemical contraceptives are for women only and may be of several kinds: douche, tablets, powders, suppositories, jellies and creams.

7. For details regarding the use of mechanical and chemical contraceptives some competent physician, or the local family planning clinic, or a standard treatise may be consulted, as they are outside the scope of this work.

Sterilization

8. Exposure of testes or ovaries to X-rays produces a temporary or permanent sterility depending on the strength of the X-ray and the period and number of exposures. Correct amount of dose is rather difficult to determine.

9. An easy surgical method, technically known as *vasectomy*, is now available for the sterilization of the male. It consists in blocking the *vas* which is a long duct carrying the sperms from the testes to the back of the urethra. If these ducts are severed or tied up, the passage of the sperms is obstructed and fertilization does not take place. Otherwise, no difference is caused to the sexual act. The operation is quite simple and only a few days' rest is all that is required.

10. A similar operation can be performed on the female and to it has been given the name of *salpingectomy*. In this the fallopian tubes are shut off, which prevents the ovum from reaching the uterus. But this operation requires an abdominal incision and is not so simple.

3. Acknowledgement

In the writing of this note Dr. Hannah Stone and Dr. Abraham Stone's book *A Marriage Manual* has been of great help and guidance and the writer acknowledges his indebtedness to these authors.

Table 1—Decennial Birth Rate, Death Rate, Growth Rate, Rate of Natural Increase and Per Cent Migration-cum-Registration Error in Uttar Pradesh during 1941-50 and 1951-60 decades

Decennium	Total Rural Urban	Mean Population of decade	Mean Population of decade for area under registration of birth and death	Registered births during the decade	Mean Decennial Birth Rate (Registered)	Registered Deaths during decade	Mean Decennial Death Rate (Registered)	Decennial Rate of Natural Increase	Mean Decennial Growth Rate	Per Cent Migration-cum-Registration Error
1	2	3	4	5	6	7	8	9	10	11
1941-50	T	59,873,795	58,473,509	14,479,317*	24.8	9,664,105*	16.5	8.3	11.2	2.9
	R	52,050,811	50,834,416	11,963,466	23.5	7,945,208	15.6	7.9	9.9	2.0
	U	7,822,984	7,639,093	2,515,851	32.9	1,718,897	22.5	10.4	20.0	9.6
1951-60	T	68,481,072	68,481,072	10,919,788	15.9	6,318,738	9.2	6.7	15.4	8.7
	R	59,428,275	59,428,275	8,155,661	13.7	5,060,224	8.5	5.2	16.3	11.1
	U	9,052,797	9,052,797	2,764,127	30.7	1,258,514	13.9	16.8	9.4	7.4

*Excludes figures of Tehri Garhwal and Rampur being not available.

Table 2—Registered Births, Deaths, and their Rates and Sex-ratio at birth and death from 1941 to 1960 in Uttar Pradesh

Years	Births			Deaths			Birth Rate			Death Rate			Fe-male births per 1,000 male births	Fe-male deaths per 1,000 male deaths
	Persons	Males	Females	Persons	Males	Females	Persons	Males	Fe-males	Persons	Males	Fe-males		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1941	1,771,957	945,232	826,725	1,064,908	575,476	489,432	32.2	17.2	15.0	19.3	19.9	18.7	875	850
1942	1,593,416	850,351	743,065	1,033,429	556,759	476,670	28.5	15.2	13.3	18.8	19.0	17.9	874	856
1943	1,397,513	749,907	647,606	1,087,445	589,156	498,289	24.6	13.2	11.4	19.8	19.8	18.5	864	846
1944	1,436,026	772,719	663,307	1,072,412	590,771	481,641	25.1	13.5	11.6	19.5	19.7	17.7	858	815
1945	1,580,961	850,074	730,887	1,096,985	601,762	495,223	27.4	14.7	12.7	19.9	19.9	18.0	860	823
1946	1,459,738	784,963	674,775	918,834	504,502	414,332	25.0	13.4	11.6	15.7	16.5	14.9	860	821
1947	1,356,209	733,213	622,996	970,172	527,889	442,283	22.9	12.4	10.5	16.4	17.0	15.7	850	838
1948	1,230,783	667,624	563,159	819,266	454,975	364,291	20.6	11.2	9.4	13.7	14.5	12.8	844	801
1949	1,351,209	732,531	618,678	766,044	426,651	339,393	22.4	12.1	10.3	12.7	13.5	11.8	845	795
1950	1,308,645	710,071	598,574	839,176	463,408	375,768	21.3	11.6	9.7	13.5	14.4	12.9	843	811
1941-50	*14,486,457	*7,796,685	*6,689,772	*9,668,671	*5,291,349	*4,377,922	25.1	13.5	11.6	16.5	17.4	15.9	858	827
1951	1,252,028	683,356	568,672	726,410	401,230	325,180	19.8	10.8	9.0	11.5	12.1	10.8	832	810
1952	1,117,139	609,268	507,871	685,979	378,673	307,306	17.4	9.5	7.9	10.8	11.3	10.1	834	812
1953	1,120,179	613,367	506,812	705,268	390,413	314,855	17.3	9.5	7.8	11.0	11.5	10.2	826	806
1954	1,092,282	595,514	496,768	647,265	358,743	288,522	16.7	9.1	7.6	10.0	10.5	9.2	834	804
1955	1,020,309	553,074	467,235	550,677	304,606	246,071	15.5	8.4	7.1	8.4	8.8	7.8	845	808
1956	1,031,500	563,952	467,548	573,384	315,525	257,859	15.4	8.4	7.0	8.6	9.0	8.1	829	817
1957	1,002,586	551,087	451,499	571,974	316,672	255,302	14.8	8.1	6.7	8.5	8.9	7.9	819	806
1958	1,080,769	592,106	488,663	660,470	363,182	297,288	15.9	8.7	7.2	9.7	10.2	9.1	825	819
1959	1,046,109	571,528	474,581	547,826	299,740	248,086	13.2	8.3	6.9	7.9	8.3	7.5	830	828
1960	1,156,887	632,429	524,458	649,485	355,046	294,439	16.6	9.1	7.5	9.3	9.8	8.9	829	829
1951-60	10,919,788	5,965,681	4,954,107	6,318,738	3,483,830	2,834,908	15.9	8.7	7.2	9.2	9.7	8.7	830	814

*Figures for registered birth and death were not available for Tehri-Garhwal and Rampur and a portion of Banaras district comprising the former Banaras State except the figures of Rampur for the year 1950.

Table 3—Registered Birth Rate by Sex in Uttar Pradesh and Natural Divisions—1951-60

Number of Births per 1,000 of total population												
Uttar Pradesh			Himalayan Division		East Plain Division		Central Plain Division		West Plain Division		Hills and Plateau Division	
Years	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
1	2	3	4	5	6	7	8	9	10	11	12	13
1951	10.8	9.0	12.8	12.1	8.7	7.2	9.7	8.1	12.9	10.6	12.9	10.7
1952	9.5	7.9	11.9	11.2	7.7	6.5	8.5	7.0	11.1	9.2	9.8	8.1
1953	9.5	7.8	11.7	10.7	8.1	6.6	8.0	6.6	11.0	9.1	9.6	8.0
1954	9.1	7.6	10.5	9.6	7.3	6.1	7.4	6.1	11.0	9.1	10.0	8.4
1955	8.4	7.1	9.2	8.5	6.8	5.5	6.8	6.0	10.0	8.3	9.2	7.5
1956	8.4	7.0	10.2	9.3	6.9	5.6	7.1	5.9	9.8	8.1	8.8	7.3
1957	8.1	6.7	9.6	8.7	6.3	5.1	6.7	5.5	9.4	8.0	8.1	6.7
1958	8.7	7.2	9.8	9.0	6.7	5.5	6.6	5.5	10.7	8.7	8.8	7.2
1959	8.3	6.9	9.1	8.4	6.2	5.2	6.6	5.4	10.1	8.3	8.2	6.9
1960	9.1	7.5	7.9	7.5	6.8	5.8	6.8	5.6	11.7	9.5	7.3	5.9
1951-60	8.7	7.2	10.1	9.3	7.1	5.5	7.3	6.1	10.8	8.8	9.1	7.6

Table 4—Registered Death Rate by Sex in Uttar Pradesh and Natural Divisions—1951-60

Number of Deaths per 1,000 of each sex of the population												
Uttar Pradesh			Himalayan Division		East Plain Division		Central Plain Division		West Plain Division		Hills and Plateau Division	
Years	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
1	2	3	4	5	6	7	8	9	10	11	12	13
1951	12.1	10.8	14.7	13.9	12.4	11.2	12.1	10.6	11.3	10.5	12.2	10.6
1952	11.3	10.1	12.8	12.5	10.7	8.8	10.6	9.1	11.9	11.4	11.7	10.4
1953	11.5	10.2	14.1	14.1	10.4	8.3	9.9	8.5	12.8	12.3	11.9	10.5
1954	10.5	9.2	11.8	11.5	9.1	7.2	8.6	7.4	12.2	11.6	11.0	9.7
1955	8.8	7.8	9.7	9.2	6.8	5.4	8.2	7.2	10.1	9.6	9.0	8.1
1956	9.0	8.1	11.1	10.9	8.1	6.6	8.2	7.1	9.6	9.3	7.8	7.0
1957	8.9	7.9	9.8	9.5	7.9	6.5	8.6	7.4	9.2	8.7	8.6	7.6
1958	10.2	9.1	10.1	9.6	7.8	6.7	8.4	7.3	12.3	11.7	8.6	8.5
1959	8.3	7.5	8.7	8.2	6.1	5.2	6.4	5.6	10.5	10.2	6.7	6.3
1960	9.8	8.9	7.9	7.4	7.3	6.4	7.0	6.1	12.7	12.3	7.4	6.6
1951-60	9.7	8.7	10.8	10.4	8.6	7.1	8.7	7.5	11.2	10.7	9.3	8.4

Table 5—Deaths by months from Cholera, Plague, Small Pox, Fever including Malaria and Dysentery and Diarrhoea in Uttar Pradesh during the decade—1951-60

Causes of Death					
Months	Cholera	Plague	Small Pox	Fever including Malaria	Dysentery and Diarrhoea
1	2	3	4	5	6
January ..	432	2,991	11,895	321,192	17,082
February ..	636	3,644	11,661	296,791	16,193
March ..	2,618	4,965	19,965	326,406	20,536
April ..	3,679	2,740	25,735	337,360	22,459
May ..	7,135	1,049	30,061	367,421	24,952
June ..	10,748	467	27,087	382,059	26,951
July ..	9,167	292	14,683	359,237	26,631
August ..	17,338	157	8,225	375,802	30,166
September ..	10,213	162	4,955	385,975	29,037
October ..	6,428	246	3,193	364,103	24,140
November ..	2,236	323	4,666	348,231	22,002
December ..	1,017	470	6,774	347,909	20,983
Total ..	71,647	17,506	168,900	4,212,486	281,132

Table 11—District wise Total Deaths by Age with

Sl. no.	District	Year	Rural Urban	Age-							
				Under 1 year		1		5		10	
				Males	Females	Males	Females	Males	Females	Males	Females
1	2	3	4	5	6	7	8	9	10	11	12
14. Shahjahanpur—(concl.)	1959	R		697	457	862	574	480	374	354	289
			U	260	206	154	156	33	37	21	19
	1960	R		948	641	1,035	773	516	400	358	250
			U	301	232	198	248	91	85	25	29
15. Dehra Dun	1957	R		141	94	55	51	20	26	24	15
			U	187	114	47	50	14	16	20	10
	1958										

Table 11—District wise Total Deaths by Age with

Sl. no.	District	Year	Rural Urban	Age-							
				Under 1 year		1		5		10	
				Males	Females	Males	Females	Males	Females	Males	Females
1	2	3	4	5	6	7	8	9	10	11	12
53.	Varanasi	1957	R	42	33	891	673	372	294	287	249
			U	1,075	933	999	1,139	244	267	125	124
		1958	R	468	416	1,180	1,099	572	434	281	222
			U	1,125	1,089	901	926	231	261	113	166
		1959	R	392	359	817	702	349	246	318	289
			U	916	905	607	744	165	184	81	105
		1960	R								

Table 13 Births, Deaths, Infant Deaths and Maternal Deaths in

Towns 1	1951				1952	1953
	Births	Deaths	Infant deaths	Maternal deaths	Maternal deaths	Maternal deaths
	2	3	4	5	6	7
35. Sitapur M. B.	1,390	578	181	..	..	..
36. Maunath Bhanjan M. B. ..	1,556	638	170	2	2	7
37. Chandausi M. B.	1,800	813	279	11	3	1
38. Bulandshahr M. B.	1,047	258	53	1	2	..
39. Gonda M. B.	781	377	92	4	16	10
40. Khurja M. B.	1,323	652	220	2	3	2
41. Agra Cantt.	871	281	43	..	..	..
42. Lucknow Cantt.	238	217	50	..	..	..
43. Basti M. B.	154	151	1	..	..	..
44. Ballia M. B.	562	402	63	..	..	2
45. Haldwani-cum-Kathgodam M. B. ..	868	244	88	..	..	..
46. Banda M. B.	747	261	69	2	..	..
47. Kasganj M. B.	898	308	67	4	3	1
48. Ghazipur M. B.	1,331	690	111	7	5	2
49. Hardoi M. B.	690	157	40	4	..	..
50. Najibabad M. B.	1,289	520	186	..	..	..
51. Bijnor M. B.	1,111	435	118	5	5	3
52. Roorkee M. B.	759	346	111	..	..	..
53. Mainpuri M. B.	684	246	74	..	..	..
54. Tanda M. B.	861	539	74	..	..	..
55. Azamgarh M. B.	772	442	N. A.	..	..	..
56. Lakhimpur M. B.	990	235	71	..	..	..
57. Balrampur M. B.	785	537	121	..	..	..
58. Nagina M. B.	1,198	465	113	..	..	..

Towns having Population 30,000 and above—1951 to 1960 contd.

Maternal deaths	Maternal deaths	1956				1957	
		Births	Deaths	Infant deaths	Maternal deaths	Births	Deaths
		10	11	12	13	14	15
8	9	1,204	326	90	..	1,105	325
..	..	1,415	768	230	2	1,280	497
3	2	2,014	855	304	3	1,529	718
10	8	500	133	12	..	559	138
3	1	626	183	35	..	489	148
5	3	2,592	619	174	..	1,115	460
..	6	1,328	185	34	..	1,168	160
..	..	1,154	178	44	..	1,036	171
..	..	235	130	N.A.	..	97	115
..	..	483	236	86	..	382	284
..	..	1,254	183	60	..	1,214	140
..	..	802	212	84	..	623	219
1	1	661	228	80	5	508	147
7	7	1,174	724	59	..	1,175	548
7	..	570	140	37	..	589	181
..	..	1,109	366	125	..	1,043	297
..	..	854	298	100	2	733	204
2	1	752	251	94	..	696	221
..	..	668	246	75	..	651	209
..	..	643	246	49	..	367	188
..	..	813	351	71	..	772	365
..	..	1,204	219	87	..	1,160	169
..	..	536	311	56	..	494	397
..	..	1,029	317	97	..	868	285
..	..	..	..	..	..	..	..

Table 13—Births, Deaths, Infant Deaths and Maternal Deaths in

Towns	1957—concl'd.		1958			
	Infant deaths	Maternal deaths	Births	Deaths	Infant deaths	Maternal deaths
	16	17	18	19	20	21
35. Sitapur M. B.	77	..	1,133	401	79	1
36. Maunath Bhanjan M. B. ..	114	2	1,466	484	129	3
37. Chandausi M. B.	229	3	1,777	1,115	372	3
38. Bulandshahr M. B.	16	..	596	172	45	1
39. Gonda M. B.	31	2	657	249	66	3
40. Khurja M. B.	129	4	1,126	937	208	..
41. Agra Cantt.	18	..	976	153	38	..
42. Lucknow Cantt.	26	..	647	213	42	..
43. Basti M. B.	N. A.	..	337	185	6	..
44. Ballia M. B.	69	1	392	268	54	..
45. Haldwani-cum-Kathgodam M. B. ..	39	..	1,177	283	72	..
46. Banda M. B.	69	..	612	236	59	..
47. Kasganj M. B.	38	1	443	177	25	..
48. Ghazipur M. B.	81	..	1,123	508	42	2
49. Hardoi M. B.	22	..	756	205	50	..
50. Najibabad M. B.	59	..	1,001	445	91	..
51. Bijnor M. B.	45	..	857	315	72	1
52. Roorkee M. B.	64	..	792	330	98	..
53. Mainpuri M. B.	59	..	678	290	83	..
54. Tanda M. B.	6	..	477	281	20	..
55. Azamgarh M. B.	44	..	842	372	84	..
56. Lakhimpur M. B.	57	..	1,284	201	79	..
57. Balrampur M. B.	53	..	454	430	61	..
58. Nagina M. B.	77	..	762	375	59	..

Note—(1) Data relating to Births, Deaths and Infant Deaths are not available from 1952 to 1955.
 (2) N. A. stands for Not Available.

Towns having Population 30,000 and above—1951 to 1960 concl'd.

1959				1960			
Births	Deaths	Infant deaths	Maternal deaths	Births	Deaths	Infant deaths	Maternal deaths
22	23	24	25	26	27	28	29
1,127	216	60	1	1,158	219	37	..
1,545	432	95	12	1,011	432	95	1
1,839	1,525	312	11	2,503	1,811	392	3
422	111	18	..	390	108	20	..
590	192	30	..	639	278	69	4
1,176	481	124	2	1,466	629	169	5
926	114	16	..	953	113	13	..
927	169	32	3	615	159	58	1
727	196	2	3	370	142	1	..
522	183	51	1	602	130	63	1
1,271	187	85	1	1,368	181	30	2
548	127	34	..	361	79	10	..
510	152	35	..	488	194	59	..
966	402	44	..	241	179	27	..
972	270	78	..	926	293	69	2
980	300	59	4	951	384	80	6
711	217	52	1	819	415	80	2
745	216	55	..	733	278	81	1
651	158	32	1	731	235	63	N. A.
495	210	17	..	545	384	39	..
823	414	86	1	689	421	76	2
1,248	146	61	5	1,608	182	69	14
588	331	60	1	585	320	74	N. A.
851	289	43	2	858	375	34	2

Table 15—Infant Deaths by Age in Towns having Population 30,000 and above—1957 to 1960

Towns	Year	Within 1st 24 hours after birth	After 24 hours to the end of the first week	From the beginning of the second week to end of 1st month	Total	During the second and third months	During the fourth to sixth months	During the seventh to twelfth months	Total	Grand Total
1	2	3	4	5	6	7	8	9	10	11
1. Kanpur M. C.	1957	1,169	531	578	2,278	535	636	942	2,113	4,391
	1958	916	469	522	1,907	643	692	964	2,299	4,206
	1959	674	336	417	1,427	571	466	613	1,650	3,077
	1960	763	302	472	1,537	604	540	772	1,916	3,453
2. Lucknow M. C.	1957	77	266	270	613	181	170	329	680	1,293
	1958	126	281	391	798	270	253	629	1,152	1,950
	1959	144	247	322	713	248	240	456	944	1,657
	1960	77	302	319	698	308	242	470	1,020	1,718
3. Varanasi M. C.	1957	89	266	408	763	365	345	527	1,237	2,000
	1958	105	272	492	869	457	373	491	1,321	2,190
	1959	56	243	415	714	375	304	428	1,107	1,821
	1960	95	373	512	980	460	363	504	1,327	2,307
4. Agra M. C.	1957	48	84	164	296	226	189	412	827	1,123
	1958	71	119	188	378	253	318	463	1,034	1,412
	1959	88	104	335	527	318	253	679	1,250	1,777
	1960	111	114	269	494	402	282	294	978	1,472

Table 15—Infant Deaths by Age in Towns having Population 30,000 and above—1957 to 1960—contd.

Town	Year	Within 1st 24 hours after birth	After 24 hours to the end of the first week	From the beginning of the second week to end of 1st month	Total	During the second and third months	During the fourth to sixth months	During the seventh to twelfth months	Total	Grand Total
1	2	3	4	5	6	7	8	9	10	11
27. Ghaziabad M. B.	1957	2	6	24	32	19	16	46	81	113
	1958	3	19	29	51	17	21	53	91	142
	1959	3	7	25	35	15	24	37	76	111
	1960	4	10	26	40	16	25	41	82	122
28. Jaunpur M. B.	1957	2	9	16	27	44	38	29	111	138
	1958	..	3	25	28	43	30	30	103	131
	1959	2	6	10	18	41	26	13	80	98
	1960	..	..	..	..	..	19	42	61	61
29. Budaun M. B.	1957	15	30	33	78	31	27	40	98	176
	1958	48	47	4	99	5	5	21	31	130
	1959	25	19	46	90	15	37	54	106	196
	1960	8	48	45	101	15	69	60	144	245
30. Hardwar M. B.	1957	20	35	38	93	43	34	95	172	265
	1958	27	49	45	121	73	41	91	205	326
	1959	24	41	59	124	52	26	78	156	280
	1960	6	22	34	62	37	49	53	139	201
31. Pilibhit M. B.	1957	6	16	40	62	29	21	38	88	150
	1958	4	25	46	75	35	37	58	130	205
	1959									

Table 15—*Infant Deaths by Age in Town having Population 30,000 and above—1957 to 1960—concl'd.*

Town	Year	Within 1st 24 hours after birth	After 24 hours to the end of the first week	From the beginning of the second week to end of 1st month	Total	During the second and third months	During the fourth to sixth months	During the seventh to twelfth months	Total	Grand Total
1	2	3	4	5	6	7	8	9	10	11
53. Mainpuri M. B.	1957	17	7	5	29	4	5	21	30	59
	1958	4	8	16	28	5	9	41	55	83
	1959	3	2	7	12	3	2	15	20	32
	1960	18	9	5	32	6	10	15	31	63
54. Tanda M. B.	1957	1	..	..	1	..	..	5	5	6
	1958	..	..	..	..	..	6	14	20	20
	1959	..	..	..	..	..	..	17	17	17
	1960	..	..	..	..	..	..	39	39	39
55. Azamgarh M. B.	1957	3	1	4	8	2	13	21	36	44
	1958	..	..	..	..	..	3	81	84	84
	1959	..	..	..	..	..	..	86	86	86
	1960	3	3	1	7	12	..	57	69	76
56. Lakhimpur M. B.	1957	2	11	14	27	8	9	13	30	57
	1958	4	27	12	43	7	13	16	36	79
	1959	1	17	12	30	9	4	18	31	61
	1960	7	20	9	36	12	6	15	33	69
57. Bal										

Table 16—Deaths and Death Rates from Certain causes in Cities

		Fevers							
		Malaria		Enteric fever		Measles			
Cities	Year	Deaths	Rate	Deaths	Rate	Deaths	Rate		
1	2	3	4	5	6	7	8		
1. Kanpur M. C.	1956	358	0.49	537	0.74	..	..		
	1957	417	0.56	477	0.64	..	..		
	1958	505	0.66	573	0.75	40	0.05		
	1959	339	0.43	127	0.16	..	..		
	1960	5	0.01	501	0.62	144	0.18		
2. Lucknow M. C.	1956	1	0.00	4	0.01	3	0.01		
	1957	..	..	7	0.01	5	0.01		
	1958	3	0.00	11	0.02	5	0.01		
	1959	100	0.19	7	0.01	2	0.00		
	1960	..	..	26	0.05	1	0.00		
3. Varanasi M. C.	1956	105	0.27	35	0.09	234	0.60		
	1957	70	0.18	22	0.05	31	0.08		

Table 16—Deaths and Death Rates from Certain causes in Cities

Cities	Year	Fevers (concl'd.)		Dysentery and Diarrhoea			
		Other fevers		Dysentery		Diarrhoea	
		Deaths	Rate	Deaths	Rate	Deaths	Rate
		21	22	23	24	25	26
1. Kanpur M. C.	1956	5,573	7.62	13	0.02	1,043	1.42
	1957	5,330	7.11	..	..	1,149	1.53
	1958	4,657	6.07	148	0.19	1,079	1.41
	1959	4,805	6.12	380	0.48	985	1.25
	1960	4,791	5.96	286	0.36	1,147	1.43
2. Lucknow M. C.	1956	1,132	2.30	163	0.33	329	0.67
	1957	1,137	2.27	103	0.20	391	0.78
	1958	1,664	3.26	211	0.41	420	0.82
	1959	1,218	2.34	97	0.19	268	0.51
	1960	1,071	2.02	134	0.25	262	0.49
3. Varanasi M. C.	1956	2,190	5.65	223	0.57	302	0.78
	1957	2,380	6.00	193	0.49	267	0.67
	1958	2,403	5.93	199	0.49	204	0.50
	1959	1,920	4.63	102	0.25	168	0.41
	1960	2,338	5.54	173	0.41	271</	

Table 16—Deaths and Death Rates from Certain causes in Cities

Other

Cities	Year	Diphtheria		Chicken pox		Mumps	
		Deaths	Rate	Deaths	Rate	Deaths	Rate
		39	40	41	42	43	44
1. Kanpur M. C.	1956	22	0.03	..	..	1	0.00
	1957	32	0.04	..	..	9	0.01
	1958	13	0.02	..	..	..	..
	1959	32	0.04	..	..	..	..
	1960	34	0.04	..	..	..	..
2. Lucknow M. C.	1956	12	0.02	1	0.00	..	..
	1957	12	0.02	2	0.00	2	0.00
	1958	39	0.08	6	0.01	..	..
	1959	48	0.09	1	0.00	9	0.02
	1960	66	0.12	9	0.02	..	..
3. Varanasi M. C.	1956	4	0.01	197	0.51	..	..
	1957	3	0.01	48	0.12	..	..
	1958	2	0.00	62	0.15	..	..
	1959	4	0.01	12	0.03	..	..
	1960	5	0.01	23	0.05	..	..
4. Agra M. C.	1956	12	0.03	..	..	..	..
	1957	7	0.01	..	..	..	..
	1958	49	0.10	..	..	..	

Table 16—Deaths and Death Rates from Certain causes in Cities

		Fevers							
		Malaria		Enteric fever		Measles			
Cities	Year	Deaths	Rate	Deaths	Rate	Deaths	Rate		
1	2	3	4	5	6	7	8		
12. Jhansi M. B.	1956	..	..	..	..	..	..		
	1957	..	..	..	..	..	..		
	1958	..	..	..	..	..	..		
	1959	..	..	..	..	..	..		
	1960	..	..	..	..	..	..		
13. Rampur M. B.	1956	..	..	..	..	3	0.02		
	1957	6	0.04	6	0.04	3	0.02		
	1958	4	0.02	4	0.02	3	0.02		
	1959	21	0.12	..	..	..	..		
	1960	3	0.02	..	..	..	..		
14. Dehra Dun M. B.	1956	18	0.12	5	0.03	5	0.03		
	1957	6	0.04	..					

Table 16—Deaths and Death Rates from Certain causes in Cities

Cities 1	Year 2	Fevers (concl.)		Dysentery and Diarrhoea			
		Other fevers		Dysentery		Diarrhoea	
		Deaths	Rate	Deaths	Rate	Deaths	Rate
		21	22	23	24	25	26
12. Jhansi M. B.	1956	1,123	9.15	12	0.10	59	0.48
	1957	1,148	9.12	8	0.06	2	0.01
	1958	1,106	8.58	15	0.12	30	0.23
	1959	967	7.33	8	0.06	39	0.29
	1960	1,158	8.58	8	0.06	2	0.01
13. Rampur M. B.	1956	109	0.69	7	0.04	3	0.02
	1957	106	0.65	12	0.07	1	0.01
	1958	71	0.42	14	0.08	1	0.00
	1959	98	0.57	9	0.05	..	..
	1960	90	0.51	9	0.05	..	..
14. Dehra Dun M. B.	1956	74	0.51	25	0.17	22	0.15
	1957	135	0.89	31	0.20	22	0.14
	1958	80	0.51	27	0.17	34	0.22

Table 16—Deaths and Death Rates from Certain causes in Cities

		Other Causes					
Cities	Year	Diphtheria		Chicken pox		Mumps	
		Deaths	Rate	Deaths	Rate	Deaths	Rate
1	2	39	40	41	42	43	44
12. Jhansi M. B.	1956	..	..	..	..	..	..
	1957	..	..	..	..	..	..
	1958	..	..	..	..	..	..
	1959	..	..	..	..	..	..
	1960	..	..	..	..	..	..
13. Rampur M. B.	1956	..	..	..	..	..	..
	1957	..	..	..	..	..	..
	1958	..	..	1	0.00	..	..
	1959	..	..	7	0.04	..	..
	1960	..	..	1	0.00	..	..
14. Dehra Dun M. B.	1956	1	0.01	4	0.03	..	..
	1957	..	..	..	..	..	..
	1958	4	0.02	..	..	..	..
	1959	6	0.03	3	0.02	..	..
	1960	..	..	5	0.03	3	0.02
15. Mathura M. B.	1956	1	0.01	..			

Table 17—Live Births by Birth Order during

Cities	Population (in 000)		Total Births	Birth		
	Census 1961	Estimated 1960		1st	2nd	3rd
	2	3	4	5	6	7
1						
Agra	509	500	24,706	2,541	2,008	2,128
Allahabad ..	431	424	10,566	2,136	1,646	1,416
Bareilly .. .	273	269	1,927	457	324	273
Dehra Dun ..	156	156	3,366	116	107	86
Gorakhpur ..	180	177	4,511	714	398	562
Jhansi .. .	170	167	4,475	1,136	1,048	950
Kanpur .. .	971	953	20,970	2,002	2,988	4,118
Aligarh .. .	185	182	2,624	527	497	567
Lucknow .. .	656	645	19,613	3,647	2,673	2,924
Mathura .. .	125	124	4,679	830	511	697
Meerut .. .	284	280	6,319	1,123	1,505	1,214
Moradabad ..	192	190	6,649	828	938	962
Rampur .. .	135	135	899	165	161	119
Saharanpur ..	185	183	5,923	1,336	1,089	822
Shahjahanpur ..	118	116	3,676	746</		

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