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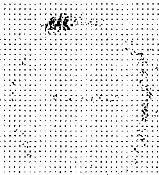
SHIFTS IN POLICY ON WOMEN'S HEALTH IN INDIA WITH A FOCUS ON REPRODUCTIVE HEALTH

DISSERTATION SUBMITTED TO THE JAWAHARLAL NEHRU UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF

MASTER OF PHILOSOPHY



vi, 126p + tables

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CERTIFICATE

This is to certify that this dissertation entitled, "SHIFTS IN POLICY ON WOMEN'S HEALTH IN INDIA WITH A FOCUS ON REPRODUCTIVE HEALTH", submitted by Manju Dhasmana is in partial fulfilment of six credits for the degree of **MASTER OF PHILISOPHY** of this University. It has not been previously submitted in part or full for any other degree or diploma of this or any other University.

We recommend that this dissertation be placed before the examiners for evaluation.

Mohan Rao 21st July '98.

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ACKNOWLEDGEMENTS

I am an author of this work only in the sense that I have put the material together. In many ways it is my way of thanking all those people who were there with me through all my trials and tribulations through a difficult time.

It is only fitting that I begin by thanking my Supervisor, Prof. Imrana Qadeer who helped me in clarifying my thoughts and organizing my work. I am aware that I was a disappointment to her but for me the experience of working under her has provided an opportunity to learn about the importance of conceptualization, clarity and objectivity. It is this learning that would stay with me for a long time.

My special thanks are due to Mrs. M.D.Rastogi and Mrs. Krishna Bhatia who went out of their way to help me.

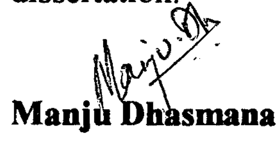
My sincere thanks to the staff of the CWDS library and also the documentation officer at UNDP.

Anita, Rinju, Raafe and Tara - thank you for being there when I needed you.

I will always remember Dr. Rama Baru to whom I owe a great deal for her unshakeable confidence in me and Dr. Nayyar for his moral support at a crucial juncture.

This acknowledgement will be incomplete without mentioning the unquestioning support of my family. Above all, I would be forever thankful to Vivek for helping me in the awesome task of typing and to Mohan who bore all my tantrums and bouts of depressions with the patience of a saint.

Finally, I alone am responsible for the errors and drawbacks of this dissertation.



Manju Dhasmana

INTRODUCTION

Before joining Jawaharlal Nehru University, I worked with three Non-governmental organisations and their experience in each of them brought me in touch with some aspect of women's health in some way or other. My first experience was with a resource support organisation which worked very closely with grass root organisations in UP. It's founding members had been involved with the women's activists group, Jagori. While working with them I had an opportunity to prepare some material for raising awareness about the injectable contraceptive, Depo-provera. What struck me about that particular experience was that even though my organisation took a stand against the contraceptive itself, it refused to get into any kind of debate about the Government's policies which promoted it.

My second brush with reproductive health was when I helped in designing and conducting a survey to assess the status of reproductive health and child survival in one of the slum colonies of South Delhi. When I joined the team, my assumption was that this was one of the efforts of the organisation to take an assessment of the needs of the community before framing a programme to address the needs. To my subsequent surprise and horror, I discovered that the organisation had already received heavy funding from MacArthur foundation to initiate a reproductive health project (along with suggested interventions by the funding agency). One wondered where was the point in conducting the survey.... it seems only to help the organisation in gaining an entry into the community and making it's intentions known to the community.

My last assignment was with an organisation which was acting as a 'Mother Unit' for the Family Planning schemes of the Government of India. The work involved

very close work with personnel of the Ministry of Health and Family Welfare. It was at this juncture that target free approach was introduced and close on it's heels came the reproductive and reproductive and child health approach. Approach papers were circulating freely at that time but the officials knew almost nothing about the operationalisation of the approach. What struck one very forcibly at that time was that even though the government papers talk freely of people's needs, this finds no place in the process of policy formulation and subsequent implementation. Even most of the officials were not aware of the reasons and rationale behind the new approach. What was apparent however was the influence of World Bank's literature - the approach paper was almost a copy of all the literature being taken out by the WB on the new approach(including the language). The new approach generated a lot of debate among colleagues but mostly centred around the contents of the approach. With very few actually questioning or debating the Government's reasons for introducing the new approach when the 'target free approach itself had not been fully understood at the primary level.

As early as my first experience with women's health issue it was very clear that any attempt to understand the women's health issue must take into account the policies of the government and trying to separate the rhetoric from the reality, a need that I felt greatly in the later years of my work. Added to this was the growing emphasis on RH which seemed out of place given the problems in the field. The present study intends to analyse the shifts in policies on women's health that have taken place in post-independent India; with a closer look at the new reproductive and child health approach. The study is based on secondary dta which has been obtained from three sources:-

- Government literature viz, Plan documents, various Committee reports, country statements for international conferences and National Level Surveys looking at the morbidity, mortality and health services utilisation pattern.
- Literature of organisations active in the area of population control and Reproductive Health like UNFPA, Ford Foundation, Population Council.
- Literature of Non-Governmental Organisations active in the field of Health like Voluntary Health Association of India and material brought out by academicians and writers in the area of women's health.

The dissertation has been divided into five chapters.

Chapter I traces the evolution of Maternity and Child health Services from the Bhore Committee recommendations, through various committee reports and plan documents. The emphasis is on analysing the changing priority of MCH services in the realm of Health Planning.

Chapter II takes a look at the definition and evolution of the concept of Reproductive Health within the framework of three different ideological leanings of the women's movement, population establishment and the environment/ecological establishment. Attempt has also been made to trace the dominant actors in the of reproductive health at the centre-stage.

Chapter III, 'Integrating reproductive Health in India's health Planning' focuses on the developments in the country, linked to developments in the international arena, which led to adoption of the reproductive and Child Health Approach to Family Planning.

Chapter IV is a review of national level date on the morbidity, mortality and medical care utilisation by women.

Chapter V concentrates on discussing the various shifts in the evolution of MCH till the introduction of the new strategy of reproductive Health. One section of this chapter looks at the political economy of the RH approach with special emphasis on SAP and research as an instrument of rationalising the new approach.

One is aware that this study is very limited as it is only based on secondary data and for any comprehensive study it is important to incorporate experiences from the field. Another important limitation of this study has been that I have only looked at developments in the post- independence phase; the study would have benefited if I had been able to incorporate the policy perspective in the colonial phase.

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Chapter I

Women's health in Indian Planning

"Social policy is a reflection of the state's concern for it's citizens. Changes in policy therefore reflect the ideological shifts that a state undergoes in order to maintain it's legitimacy in civil society. Thus variations in policies with regard to the health of women has much to do with the society's delineation of women's social roles and women's attempts to challenge and change these roles" (1).

Planning in health has not always been helped by epidemiological considerations . It has often been political considerations which have determined the prioritisation of health problems and selection of interventions(2). It is therefore important that one looks for the nature of planning for women's health in our country. I have attempted to look at the direction and evolution of Healthcare services vis-a- vis the women in the post independence phase.

At independence there were two important documents, which later influenced the five year plan documents in health planning. The first report was the recommendations of the National health and Development Committee, more commonly known as the Bhore Committee. The other report was the recommendations of the National Planning Committee, also known as the Sokhey Committee (3).

Bhore Committee was appointed by the Government of India (GOI) in 1943 to make a broad survey of the then present position in regard to health conditions and health organisations in British India and recommend for future development. This committee made far reaching recommendations guided by two overriding principles.

3First, the provision of healthcare services was the responsibility of the state. Second, comprehensive healthcare should be available to people irrespective of their ability to pay (4).

The Committee presented their report in 1948 where they attempted to present a brief picture of health conditions and statistics of ill health present at that time. The report quoted the conclusions of the Special Committee appointed by the Central Advisory Board of Health to report on maternity and child welfare work in India. The Committee reported " maternal mortality rate for the country as a whole is probably somewhere near 20 per 1000 live births." The Bhore committee concerned by the high incidence of morbidity and mortality among mothers and children, recommended measures directed towards the reduction of these ills by setting a high priority on preventive, promotive and curative care in maternal and child health (5).

Bhore Committee visualised maternity and child welfare organisation to be an integral part of the General Health Service and to provide domicilliary and institutional health protection for expectant and nursing mothers as well as for infants and children. The Committee proposed both long term (stretching over 20-40 years) and short term recommendations. The short term recommendations covered a time span of two five year periods. As part of their short term recommendations , the committee proposed a primary unit for a population of 40,000 with one woman doctor , four public health nurses and four trained dais. They further suggested that the institutional service should consist of a dispensary at the headquarters of the unit and a hospital of 30 beds serving four such units together. At the dispensary , provision was to be made for four beds of which two was to be for maternity cases. At the 30 bed hospital , six were to be set aside for maternity and gynaecological cases (6).

The committee suggested the location of a medical officer at the headquarters of each primary unit and in the places where 30 bed hospitals were located . With maternity beds provided along with the services of the public health nurse , midwife and trained dai , it was possible to organise a maternity and child welfare centre, the range of activity of which could be expanded as and when more trained personnel and funds became available and communications improve (GOI 1972-73). " the maternity and child care centres should form the focus from which the health care of mothers and children will radiate into the homes of people."(7)

As part of it's long term programme the committee evolved a 3 tier organisational setup: the smallest unit of administration being the Primary unit serving a population of 10,000 - 20,000. A number of such primary units (15-25) would together constitute a secondary unit and about 3-5 of these would form the district health unit. Each primary unit would be served by three women doctors, one of whom would be in charge of the maternity and gynaecological ward in the hospital.The other two would provide domiciliary service which would also include the treatment of all forms of sickness in women and children. There would be provision for six midwives, four public health nurses and two women doctors for domiciliary services (8).

The committee also emphasised on the training of the required health personnel. To fill the deficiency in the training of health personnel they recommended certain periods of field training before the personnel became qualified. They emphasised the importance of providing facilities for specialisation in maternity and child welfare in the programmes of post graduate education. Such specialisation was to include obstetrics, gynaecology and paediatrics in order to

provide specialists whose services would be essential for the development of an efficient health organisation for mothers and children.

National Planning Committee (Sokhey Committee) appointed in 1938, began it's work in early 1939. Twenty nine subcommittees, formed into eight groups were set up with special terms of reference to deal with all parts and aspects of national life and work in accordance with a pre determined plan. One of the subcommittees was the Subcommittee on National Health ,headed by Colonel S. S. Sokhey. This committee underlined the dimensions of the health problems of mother and children in India. The committee report contained a graphic account of the volume of mortality among women and children and suggestions of ways and means of reducing such mortality by Lakshmibhai Rajwade (9).

The Sokhey Committee recommended a permanent statutory body for the protection of motherhood and childhood under the Ministry of Health and entitled to a major portion of the resources of the Health Ministry and also to a reasonably large portion of the Central Budget. " As far as one can see public health will always be a provincial subject ; but in the case of the problem of motherhood and childhood , co-ordination, research on a large scale, planning general supervision and financial assistance will necessarily have to be the function of a Central Institute or Department. A Director or Directress assisted by a committee of experts chosen mainly to represent the provinces will be in charge. He or she will be responsible to the Minister of Public Health" (10).

Sokhey Committee placed maternity and child welfare services over any other aspect of public health, "motherhood and childhood are very largely helpless and dependent conditions and are fundamental to the future of the race, and for their protection the state has therefore to step in " (11). They drew out separate

plans for urban and rural sectors for provision of maternity and child welfare services. For the urban sector they envisaged a primary unit covering a population of 5-7 thousand. Each unit will comprise a maternity home organised as a section of health station with a pre-natal and post-natal clinic ; and an institute centre called the Matra Seva Mandir . Each health station was to be serviced by a specialist in maternity and gynaecology and child welfare work. Maternity home was to have provision for two beds per thousand of population and have three midwives attached to it.

Committee suggested that maternity services in rural areas would be organised in two sections - provision of two maternity beds in charge of a midwife - health visitor for every thousand people and a travelling health unit. Travelling unit was to do all the pre-natal and post-natal examination and treatment . Every one of these travelling units would have the services of a doctor with a general degree; a woman doctor or nurse trained for special maternity and child health work and a compounder (12).

The committee also laid emphasis on a compulsory and comprehensive system of birth and death registration to provide accurate information and statistics on maternal and infant mortality. They stressed the importance of training the local dai who were to register with local authorities for obtaining the certificate of competence in order to practice their profession. The Committee recognised women's economic roles and expressed concern for their health in relation to the environment at their place of work.. They therefore recommended that , in addition to Factory Act of 1934 , regulating the hours of work for women and employment of expectant or nursing mothers , establishment of creches must be made compulsory in all the factories which employ nursing mothers. Another

one of the Committee's recommendations was to bring all the provinces under the Maternity Benefit Act (13).

The first Five Year Plan (1951- 56) was initiated in India based on Bhore Committee's recommendations for a three tier organisational structure for maternal health at the district level. Priority accorded to MCH in the First Plan continued in the **Second Plan (1956-61).** Special attention was given to improving institutional facilities. 4500/2100 maternal and child welfare centres became an integral part of General Health Services in the rural areas, with missionary and charitable institutions continuing to supplement the extension programmes of these centres. At the end of the Plan each of such centres was serving a population of 10,000 to 25,000 (15).

The Third Plan (1961-66) aimed at expansion of health services, to bring about progressive improvement in the health of the people by ensuring a certain minimum of physical wellbeing. Increased emphasis was laid on preventive public health service. The Third Plan proposal, " to link up the maternity and child health services associated with the primary health units with extended facilities in referral and district hospitals. Short orientation courses would be arranged at these hospitals for personnel engaged in maternity and child health work" (16). This Plan period also saw some important developments which also had their bearing upon the development of maternal and child health care as part of general health services.:-

- The Plan accorded a very high priority to Family Planning. As against a provision of Rs.5crores in Second Plan, the Third Plan approved a total outlay of Rs50crores for the programme of Family Planning. The Third Plan was the beginning of the domination of the idea of population growth and control in the health planning services (17).

- The operational strategy for the Family Planning Programme over the first two Plan periods was the clinic approach. The 1961 census revealed an increasing rate of population growth than had been anticipated. This led to a rejection of the Clinic Approach in favour of the Extension Education Approach in what was called the Reorganised Programme for family Planning. It was this which gave a fillip to the development of family Planning infrastructure in the country (18). Extension Approach to Family Planning programme was an extremely technocentric programme with great emphasis on achievement of targets. The approach necessitated the establishment of full fledged FP Bureau at the district and state level, with corresponding strengthening of the Family Planning Organisation at the directorate General of Health Services(DGHS) at the centre. DGHS of that period , in a special report, recommended the addition of 4-6 ANMs, 4 Family Planning Assistants and 1 Block extension Educator at the PHC, who were to work only for the FPP (19).
- The GOI, Ministry of Health , set up a committee in June 1959 to review the development that had taken place during the late 1940s and 1950s. The committee , known as the Health survey and Planning Committee (Mudaliar Committee) submitted it's report in October 1961. This committee recommended that expansion of services should be stopped and the existing PHCs should be strengthened. It further suggested that the existing PHCs could be strengthened with a larger number of doctors and public health nurses who were to man even the subcentres. It proposed mobile dispensaries to cover the areas where the PHCs did not exist. The committee found the quality of services provided by the PHCs as inadequate with urban areas being better than rural areas. It therefore suggested that the work should be systematically organised, at least in urban areas, so as to serve as demonstration projects. Another recommendation of the Committee was the

establishment of specialist services including paediatric and maternity hospitals in the urban areas (20).

- in 1962, GOI invited a UN mission to chart out steps to be taken for greater acceptance of small family norms by the population. The committee submitted it's report in 1964 and recommended that MCH and Nutrition be delinked from FPP. The reason given was " the programme may be otherwise used in some states to expand the much needed and neglected maternity and child welfare services. ANMs were thus to be 'relieved' of other responsibilities such as maternal and child health and nutrition in order to concentrate their efforts on family planning.'(21).

During the year 1966 -69, GOI had **Annual Plans** instead of Five year Plans. These Annual Plans paid special attention to FPP. The recommendations of the UN mission were considered by a committee appointed by GOI . IN 1966, the Programme Evaluation Organisation of the Planning Commission studied some aspects of the implementation of the FPP and made recommendations concerning the organisation of the programmes at the central level. As part of these recommendations , family planning was withdrawn from the purview of the DGHS and constituted into a separate Department of FP in the Ministry of Health in April 1966. Based on the recommendations of the UN mission , the extension Approach to FP was replaced by a Reinforced Programme emphasising IUCDs. FPP was accepted as a vertical programme with it's own separate workers. Targets were set for the FPP, reinforced with threats and penalties affecting the employment and security of the ANMs (22).

There was a growing recognition that a close linkage between MCH and Family Planning exists. Relationship between infant mortality and acceptance of small family norms was also being observed. Recognition of these linkages and " with

a view to giving a broader base to FP ", it was decided in 1967 that MCH be integrated with FPP (23). This integration was codified in the **Fourth Plan (1969-74)** which noted "The programme of family planning is likely to be more effective and acceptable if maternity and child health services are integrated with family planning. This has now been done. The scheme of immunisation of infants and pre school children with DPT, immunisation of expectant mothers against tetanus, prophylaxis, against nutritional anaemia for mothers and children and nutritional programme for control of blindness caused by Vitamin A deficiency among children will be implemented through family welfare planning centres. Family planning will be effectively integrated with the general health services of primary health centres and subcentres" (24).

In the beginning of this Plan period there were targets set for family planning along with penalties for failing to met these targets . However no targets were set for MCH work. The MCH Advisory Committee noted that this had led to ANMs favouring family planning work over MCH. The Committee recommended setting of targets for MCH work which were put into operation at the end of the Fourth Plan. Targets were set for immunisation of pregnant mothers against tetanus, and also for the prophylaxis programme against nutritional anaemia. However there were no penalties for not reaching the targets (25).

On 20th September , 1970, the first meting of the Executive Committee of the Central Family Planning Council was held. The Committee recommended that steps should be taken for the integration of medical , public health and family planning services at the peripheral level. On the recommendations of this committee , GOI constituted a Committee in October 1972 on ' **Multipurpose Workers under Health and Family Planning**' under the chairmanship of

Kartar Singh, the then Additional secretary , Ministry of Health, GOI. The Committee submitted it's report in September 1973. The Committee recommended the Multipurpose Health Workers Scheme which was considered as a significant development featuring grass root level integration of several vertical health programmes (26).

Launching the Multipurpose Scheme in 1974 is considered by many as an important milestone in the field of maternal and child health work in India. Following were the important recommendations of the Committee:

- Male and female Multipurpose workers (designated as Male/Female Health worker) would work as a team. "FHW will be the present ANM while the MHW would be the present Day Basic Health Worker, Malaria Surveillance Workers , Vaccinators, Health Education Assistants and the Family Planning Health Assistants" (27).
- the programme would be first introduced only in areas were malaria is in the maintenance phase , small pox has been controlled.
- for proper coverage there should be one PHC for a population of 80,000 , with each PHC divided into 16 subcentres each having a population of 3000-3500.
- FHW was to provide 100% ante-natal and post-natal coverage to a population of 3-4 thousand and about 50% coverage for intra natal care. They were also to provide infant care, nutrition work, family planning work , training of dais, health education programme, provide care for minor ailments, provide first aid and refer cases to the nearest dispensary. FHW was to look after a population of 10- 12 thousand. This population was to be divided into 2 zones - one intensive area of 3-4 thousand or an area of not more than 5 km radius from her place of stay, where she will be responsible for maternity and child health work and Family Planning services ; the other

was the area of less intensive work (also termed as twilight area) where services were to be available for partial coverage on request only (28).

- **In the fifth Plan (1974-79)** there was a shift towards a broad based developmental perspective. It paid considerable attention to MCH and sought to integrate FPP, MCH and nutrition services and highlight the problems of malnutrition and anaemia and their implications for MCH. It noted that 'the primary objective is to provide minimum health facilities integrated with family planning and nutrition for vulnerable groups'(29).The Fifth Plan also paid considerable attention to rural urban disparities in health care services. A Minimum Needs Programme (MNP) was launched with the aim of providing for the needs of the poor. The package provided elements of health, family planning , nutrition , environmental improvement and water supply. During this Plan period the number of doctors serving the PHCs were increased considerably, as also the number of PHCs and subcentres.

The World Population Conference was held in 1974 in Bucharest where the shift in planning towards a developmental perspective was reflected in the address of the then Union Minister of Health who asserted " Population Policy, is thus, one of the several vital instruments for securing comprehensive social developments and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of high fertility. It has truly been said that the best contraceptive is development."(30) This policy was also strongly endorsed at the National Population Conference held at New Delhi in December 1974. The conference considered various aspects of population programmes and policies. " The prospects of the reduction of birth rate are closely linked with the prospect of economic development. Without the attainment of a level of economic and

social development supplying at least the minimum needs of the masses , it is unrealistic to expect a rapid reduction in the birth rate ".(31).

The Fifth Plan was prematurely terminated in 1975 when emergency was declared which facilitated the passage of the **National Population Policy of 1976** which called for a 'direct assault' on the problem of population. The Policy accepted 'birth control' as a vital means to the attainment of the goal of 'health for all , in the shortest possible time.' A host of anti-natalist measures were introduced (32).

The Policy document talked of female education and raising the age of marriage to reduce birth rates. 'Raising the age of marriage will not only have a demonstrable demographic impact, but will also lead to more responsible parenthood and help to safeguard the health of mother and child '(33). It further goes on to say, 'wherever female literacy improves, it has been seen that fertility drops almost automatically . It is therefore necessary that special measures be taken to raise the levels of female education , particularly above the middle level for girls as well as non-formal education plans for young women especially in certain backward states where the family planning programme so far has been unimpressive' (34).

The government was swept out of power in 1977. The new government announced a family planning programme on a wholly voluntary basis, as an integral part of a comprehensive policy covering education , health, MCH and nutrition. The programme was renamed Family welfare Programme. There was an emphasis on 'peoples health in peoples hands' and a need for community participation was felt by the Planners. As part of this thinking the **Community Health Volunteers Scheme** was inaugurated in 1977. The idea was to bypass

the medical establishment and go directly to the people. This represented a basic shift in the approach to health services. In this sense it was a landmark (35).

In 1978, WHO- UNICEF organised a conference at Alma Ata to launch a movement of ' Health for All through Primary Health Care '. This conference was organised as a reaction to widespread international disillusionment with vertical programmes, recognition of a need to provide sufficient coverage to rural populations, and the faltering integration of preventive and promotive programmes achieved so far. In 1981, a global strategy for this programme was adopted by WHO, which was later endorsed by the United Nations Central Assembly. India was a signatory to these declarations. To achieve the goal of ' Health for All by the year 2000 A.D', the Ministry of Health and Family Welfare, GOI convened a national conference. The Planning Commission appointed a working group on 'Health for All' to suggest and monitor the progress of this programme on a regular basis. The working group submitted it's report in 1981.

In 1980 was published an important study conducted by a group set up jointly by the ICSSR and the ICMR with Dr. Ramalingaswamy as the Chairman entitled ' **Health for All : An Alternative Strategy**'. The report suggested certain steps for restructuring the health care service infrastructure based on the principle of promoting the preventive and curative aspects of health. They also made recommendations for health services for women and children (36). The report stressed ,' MCH services are after all a part of the health care system; and if the health services themselves fail at the periphery, it is idle to expect MCH services to reach the under privileged groups. The first step needed therefore is to take general health services to the people' (37). The report recommended that

community approach should determine the MCH strategy which would aim at total coverage of all women and children.

They stressed that MCH services should be largely domiciliary in the community approach and the dai and the female Community Health Volunteers must be utilised for this purpose. The report also laid stress on training of traditional birth attendants, dais and female Community Health volunteers in early diagnosis and management through simple and safe procedures and utilising them for MCH work. They must be supported by excellent referral backing by the female MPWs (health workers) at the subcentre level. The sub-centre should undertake difficult deliveries , intravenous rehydration. tubectomies, vasectomies and emergency treatment for all. The community hospital should be the apex referral institution within the community for MCH problems . The district hospital level and above should handle only the more complex surgical and medical problems of women and children. The report commented that nutritional surveillance should form the core of both ante- natal and post-natal care. Immunisation of mothers and children was prioritised over Family Planning.

Working Group on Population Policy was appointed by the Planning Commission in October, 1978 and submitted its report in 1980. In their view, ' population policy and the general development strategy are two sides of the same coin.' They recommended a long-term demographic goal of Net Reproductive Rate of 1 implying that for a given set of conditions of mortality and fertility, on an average, a woman will be replaced by just one daughter and 2-child family will be normative pattern in the society by 2001 AD. The report recognized regional differences and divided the country into 3 regions with different objectives. They emphasized demand generation as a function of

socio-economic development. Emphasized on female education and health care as having the most motivational impact (40).

The group emphasized the role of women in fertility reduction, 'women are the best votaries of family welfare programme. The reason are obvious. They have to bear the brunt not only of pregnancy but in a significant number of cases of maternal care and rearing of children. We, therefore, recommend that the family welfare programme for the immediate future be increasingly centred around women.' They further added, ' we are convinced that to the extend developmental efforts are oriented towards women and children in the short run, the greater would be the felt need for family planning services' (41).

The sixth plan (1980-85) tried to codify the Primary Health Care Approach and proposed to view health in totality as a part of the strategy of human development. " The approach of the plan is to treat all health services such as health, hygiene, education, prevention and control of diseases, curative and rehabilitative facilities, both as a package in itself and as a part of the overall programme of social services which include nutrition, safe drinking water, maternity and child health, intensive rural development, adult education, housing etc " (38).

The plan emphasized infrastructure development and integration of services at the PHC level. The plan emphasized improved health and nutritional status through various extension programmes for immunisation, prophylaxis against nutritional anaemia. Family Welfare Programme continued to receive a very high priority. States with weak infrastructure and having high birth, high infant and/ or high infant mortality rates continued to receive highest priority in the provision of family welfare services. The Plan says, ' since acceptance of small

family norms have direct relationship with the prevailing infant mortality rates, maternity and child health services, which include the Expanded Programme of Immunization would be carried out in a major way and the small family norm would also be promoted through the adult literacy programmes.' (39)

The sixth plan accepted many of the Group's recommendations. The augmenting of rural infrastructure under the MNP received some impetus. In keeping with the suggestions of the group, there was an increasing emphasis during the Plan period on the sterilization of women, often at laprascopic camps 42).

In the 80s interesting shifts took place in the areas of health strategies. Considering the difficulties of cost and personnel in the attainment of 'Health for all by 2000 AD'. A shift from Primary Health Care to Selective Primary Health Care was accepted. The approach was targeting of certain diseases. **In 1983, Child Survival Development Revolution (CSDR)** was launched by UNICEF and Child Survival Strategies were enumerated. As part of this approach the MCH component was translated into GOBI-FFF approach (growth monitoring, oral rehydration, breast feeding, immunization - Family Planning. Feeding Programmes and female literacy). It was also the first time that the concept of social marketing was introduced to promote the immunization programme(44).

The Seventh Plan (1985-90) observed that, ' the performance of the MCH programme during the sixth plan, particularly in the field of immunization and ante-natal care is far from satisfactory. Measures for strengthening the programme and increasing the child survival rate are essential for the success of the programme' (45). Plan emphasized the Governments commitment to the

achievement of 'two-child' norm and recommended Child Survival Strategies to enhance Child Survival rate. The Plan Document outlined the major thrust areas for MCH in the Plan period. One of its thrust areas was to support voluntary organisations, NGOs, village health Committees, women's organisations and traditional birth attendants. In the implementation of MCH Services it was emphasized that MCH services would be provided on the basis of the 'high risk' approach.

Seventh Plan emphasized the provision of Medical Termination of Pregnancy (MTP) services in the realm of MCH Programme. The reason given was the improvement of health of the mother. I quote, " the health of mothers, and, in particular maternal mortality, is significantly affected by induced abortions performed by unqualified persons under unhygienic conditions. The MTP Act (1971) is a legislative measure for improving maternal health through the stipulation of conditions under which pregnancies may be terminated.; By the end of Seventh Plan period, it is anticipated that MTP Services would be provided at all primary health centres. In urban areas it would be available in all maternity homes and centres. MTP Services would be an integral part of MCH Services and would be closely linked with MCH Programme "(46). 1985). During this plan period the Expanded Programme of Immunization was modified into Universal Programme of Immunization for Women and Children.

The Eighth Plan (1992-97) document states that containing of population growth was one of the most important objectives of the Plan. It talked of convergence of services provided by various social services sectors, 'based on a holistic approach to social development and population control, integrated programmes for raising female literacy, female employment, status of women, nutrition and reduction of infant and maternal mortality will be evolved and

implemented' (47). During this Plan Period, Child Survival and Safe Motherhood Programme, which was launched in 1992 was emphasized, 'setting up of Regional Maternal and Child Survival and Safe Motherhood initiatives will be vigorously pursued. These initiatives will include a) strengthening of UIP b) greater emphasis on Diarrhoea Control Programme and effective implementation of ORT Programme c) Acute Respiratory Infections Control Programme d) Anaemia Management Programme and not just Anaemia Prophylaxis e) Safe Motherhood Programme with high risk pregnancy approach f) intensified effort for training of birth attendants (48).

This Plan Period also saw the coming forth of recommendations of **Draft National Population Policy in May 1994**. The documents criticized the trend of women bearing the entire responsibility for family limitations. The document recommends, ' holistic and comprehensive approach in health would be identified and implemented beyond maternal and child health care and FP Services to cater to gynaecological and sexual problems, safe abortion services and reproductive health education'(49). The report recommended abandoning of targets for specific methods and discontinuation of incentives in cash or kind for the acceptors of contraceptives as well as to motivators and service providers. The Report recommended that there should be as wide a range as possible of methods of limiting the family.

The report mentioned that identification of Family Welfare Programme with contraceptive and sterilisation had created a negative image and it should be substituted with a positive image by emphasizing on measures like higher age at marriage, literacy, education, reduction of Infant Mortality Rate, management of infertility and desirability of having a planned family (50).

The Ninth Plan (1997-2002) talks about assessing the needs for reproductive and child health (RCH) at PHC level and undertaking areas specific micro planning to provide need-based, client-centred, demand driven, high quality, integrated reproductive and child health care. Another important objective is to reduce infant and maternal mortality and morbidity so that there is a reduction in the desired level of fertility (51). In other words despite its claim at broadening the approach towards FPP, RCH continues to pursue the narrow goals pertaining to one biological system among women through hi-tech without looking at the other determinants of women's health.

From the above described recommendations of various committees and plan documents it comes across strongly that the focus of women's health has been rather narrow and that there have been some important shifts in the way in which planners have perceived and contextualised women's health in planning process. Bhore Committee and Sokhey Committee, concerned with high maternal mortality present at that time, envisaged a health programme related to motherhood. Both the Committees urged a high priority for MCH Services in the development of Health Services and this prioritization was reflected in their recommendations. When primary health centres were first established in 1952, maternal and child health services were almost the only ones among their activities which reached out to the population at large.

The priority given to MCH was also reflected in the Ist and IInd Five Year Plans where the MCH centres were an integral part of the General health Services. However, this emphasis was not translated into infrastructure development as the staff that was recommended by Planning Commission (a total staff of 20) was much less than what the Bhore Committee had suggested. In actual functioning the number was even smaller (11), only 50% of whom

were responsible for MCH. Even in purely quantitative sense, this was inadequate when seen in terms of ANM's workload i.e., attending to over 800 births in 40 villages each year.

The Third Plan saw the strong preoccupation with Family Planning. Though this programme was part of Health Sector it was felt that it was to be kept away from MCH and should have its own staff, with an aim to protect its resources being utilized by MCH programme. However, the Fourth Plan saw a shift in strategy when MCH was integrated with FP. The intention was to provide a broad base to the FPP. This was an important watershed in the realm of development of health services for women's health. However given the framework of population control people's well being and their conscious action never acquired centrality and MCH became the carrot for the iron rod of FPP ; women's well being remained outside its scope.

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Health is a dynamic concept which has social, economic and political dimensions and is not merely an individual or personal, biological or physical phenomenon whose problems are to be solved at the individual level through medical technology. It does follows that sustained improvement in the health status of a population is not possible merely through interventions in the health sector. Bhore Committee recognised this and noted that, " the health of people depends primarily upon the social and environmental conditions under which people live in work, upon security against fear and want, upon nutritional standards, upon educational facilities and upon facilities for exercise and leisure". It, therefore, followed that specific programme of health like MCH would have limited impact.

Even within this narrow focus on woman's motherhood role it was possible to effect some impact on her health status, but instead of providing better and safer contraceptive, reducing maternal mortality rate, and controlling anaemias and infections, the focus was shifted to less frequent morbidities like RTIs. Even abortion services remained peripheral in the wake of concerns like AIDS. Integration of MCH with FPP and separation of MCH from General Health Services gradually saw MCH Programme being completely overshadowed by demographic goals.

It was originally visualised that in integrating the two programmes, family planning work should become part of MCH work. But in actual practice, it turned out that the MCH work became a part of family planning work(52) . This had serious consequences for MCH activities. As the pressure to intensify family planning work increased, the MCH work of ANMs was increasingly neglected. While there were targets for FPP, there were none for MCH leading to lopsided functioning of ANMs where they favoured family planning.

With the ensuing Plan Periods, domination of FPP kept increasing. Strategies in MCH were often chosen with the aim to reduce fertility and with very little concern for women's health. For example, the Post Partum Programme was introduced in 1969-70 for women who came for deliveries with an eye to enhance acceptance of female sterilization ; Intensive District Programmes were initiated to cover the 'most populous' States alone ; and contraceptive projects introduced in 1967 focused on female contraception. The Population Policy Document of 1975 talked of female education and raising the age of marriage to reduce birth rates but not about women's health. Medical Termination of Pregnancy was introduced as a strategy of MCH in the Seventh Plan with an aim to introduce abortion as a strategy of population control. These thrusts

ensured that services developed in the name of maternity care would benefit FPP more than the women themselves. The Working Group on Population Policy asserted that women were the best votaries of FPP and thereafter Family Welfare Strategies must centre around women. In accordance with this recommendation, Sixth Plan Period emphasized on sterilization of women.In the 80s the emphasis shifted to Child Survival Strategies to reduce Infant Mortality Rate as part of the recognition among Planners that there was a close relationship between infant mortality rate and birth rate. The official emphasis was on ' creation of demand for family planning' by reducing IMR. These strategies remained devoid of any steps to lower maternal mortality. The emphasis on maternity in the integrated FPP came last through the safe Motherhood Scheme introduced in 1992-93.

The most recent trend in policy for women's health is linked with the requirements of Structural Adjustment Programme of Population Control - the two main priorities of international funding agencies. At both the international conferences at Cairo and Beijing in 1994 and 1995, questions of defining development and assessing state strategies for it, were not open to debate. Women's welfare was considered within the framework of SAP. The new strategy that was advocated is the 'Reproductive and Child Health Approach.' This new approach is being promoted as a comprehensive broad based strategy for women's development. This preoccupation with achieving population control completely undermined and neglected the past-experience and its analysis that shows that while a comprehensive view of women's health remains a distant dream, within the domain of health sector planning, even the impact of Communicable Disease Control Programmes, nutrition and sanitation services has not been considered seriously while RCH is being projected as the key to women's health problems.

Chapter II

Reproductive Health - Evolution and Definition

The concept of Reproductive Health has been variously interpreted and defined by different groups based on their respective ideological leanings. In this chapter I look at three major actors - Women's movements which is by no means a homogeneous group; Population Establishment and the Environmental /Ecological Establishment- and see how each one has defined Reproductive Health and also describe the meetings and conferences where the concept got crystallised.

Women's Movement

Reproductive rights has been for along time on the agenda of feminists movements across the globe. The birth control movement which emerged in the late 19th century and gained momentum in the early 20th century was essentially a protest movement of women. In 1918, The National Union of women's Suffrage Societies in England expanded it's objectives to include legislative reforms in various fields like divorce and legitimacy and also pressed for both voluntary and public birth control provisions. The radical feminist of that period emphasised on women's right to control their own destinies and bodies and the right to access to birth control became a part of their larger struggle for democratic rights. Many women's organisations in England, including women workers' organisations supported the movement because they were concerned with the high rates of maternal mortality and wanted to free women from the bondage of unwanted pregnancies. Demand for free access to contraceptives found a space in the concerns raised by socialists as the assumption was that repeated pregnancies were harmful to the health of working women and were in contradiction with capitalist interest as they provided unlimited supply of cheap labour. In 1915, Emma Goldman and Margaret Sanger deliberately defied obscenity laws in the US by distributing pamphlets on birth control, and initiated the movement there. And even earlier in 1908, Alexandra Kollontai in her 'Social Bases of the Human

Question' claimed not only women's rights to fulfilling work but also their rights to sexual freedom and control over their own fertility. [53,54].

There was a resurgence of the Reproductive Rights movement in the early 1970's in the West. The international women's health movement started challenging the rationale on which population polices were based - viz, that population control in the social interest has precedence over individual well being and individual rights. The movement strongly criticised the prevailing emphasis on narrowly construed 'family planning programme's' as the main way of fertility reduction. It also questioned the safety of modern contraceptive technologies both intrinsically and as actually delivered, the poor quality of services, the failure of governments to address women's health and empowerment more broadly, and the economic policies that jeopardise social services and promote growth over human welfare.(55)

A central tenet of the international women's health movement is that women's health and rights, not macro demographic objectives, are of paramount concern. In general, the movement argues that policies and programmes should ensure better quality nd provide more holistic approaches to women's health services, particularly in the area of reproductive health. The movement also places great importance on the issue of sexuality and gender relations. Policies and programmes should include women's representative at all levels of decision making; promote increased responsibility among men for their own reproductive behaviour, for prevention of Sexually Transmitted Diseases(STDs), and for the health and well-being of their partners and children they father; provide equal opportunity for women in all aspects of social, economic and political life, for it's own sake, not simply as a means to reduce fertility; and pursue sustainable approaches to development that invest directly in people's well - being.(56).

Like all social movements the women's health movement is shaped by many political, cultural and socio-economic factors, and by it's interactions with other social movements. The women's movement, therefore has developed differently in different regions, with varying levels of political awareness and involvement. It is important therefore to highlight the differences in the nature of demands that women made in different parts of the world. For instance, in the West , by the 70s, the social and economic conditions were ripe for women to assert their rights over their bodies, to demand the right of aborting a foetus, and be the sole decision maker in the matter of having or not having a baby. On the other hand, the women's movements in the Third world were linked with nationalist struggles against powerful political and economic forces. They asserted their entitlement rights, and the right to equal wages and work. Though influenced by western movements, even in the post 70s movement, they focused on marginalisation of women in the work force, the dwindling health and educational facilities of the public sector, rising prices and sexual exploitation of women. Guided by the expressed demands of women, these movements concentrated on empowering women economically, politically and socially before they could question the deep rooted assumption of both women and men about reproductive rights.(51)

Evolution of the Reproductive Health Framework within Women's Movement

The universal human rights was first ratified in the United Nation's Charter of 1945. The UN Universal declaration of Human rights in 1948 affirmed equality among sexes as a basic principle, but only in 1975 was women's conditions seriously examined by an international body, when the United Nations' sponsored meetings launching the women's decade. At the 1975 International Women's Year Conference in Mexico, women activists denounced coercive practices in contraceptive research and services as human rights abuse and were instrumental in asserting that the conference 'grounded it's assertion of the right to reproductive

choice on a notion of bodily integrity and control'. The key result of the Decade for Women was an international legal instrument, the Convention for the Elimination of All Forms of Discrimination against women (CEDAW), ratified in 1979. CEDAW however failed to specify a number of women's reproductive rights, except to affirm women's rights to family planning information, counselling and services and to have equal rights with men to decide on the number and spacing of their children.(58).

The International Campaign on Abortion, Sterilisation and Contraception (ICASC), founded in Europe in 1978 to counter pro-natalist and anti-natalist movements, may have been the first to formalise a concept that many women's organisations had come to recognise as reproductive rights: 'Women's right to decide whether, when and how to have children - regardless of nationality, class, race, age, religion, disability sexuality or marital status - in the social, economic and political conditions that make such decisions possible.'(59). In 1978 ICASC convened their first global conference in Amsterdam which was attended by a large number of women's health activists. The Amsterdam conference is often cited as the birth event of the International Reproductive Health and Rights Movement, bringing together individuals representing initiatives taken throughout the world . On that occasion the campaign changed it's name to Women's Global Network for Reproductive Rights (WGNRR), under pressure from Southern activists who felt that an explicit reference to reproductive rights would more appropriately encompass Southern women's health agenda. One underlying principle formed the basis for communication among the profusion of diverse women's groups: the belief that women should be seen as subjects and not objects of population policies (60,61).

In 1984, the International Women's Health Coalition, based in New York expanded their networks and activities. At about the same time, southern women

researchers and activists created an international south-south network, Development Alternatives with Women for a New ERA (DAWN), which promoted development from a feminist perspective (62). Throughout 1992 and 1993, DAWN, WGNRR, IWHC and the Women's Environment and Development Organisation (WEDO), among others, organised a series of regional meetings and preparatory committees to articulate and co-ordinate women's inputs into the UN Process. A key product of this process was the Declaration of the Reproductive Health and Justice International conference which was delivered to Heads of State and drafters of ICPD Programme of Action. The document stresses that:

- inequitable development models and strategies had led to marginalisation opf women and these have severe consequences for women, specially when they are in conjunction with economic programmes for structural adjustment.
- there was a need to design social development strategies starting from the concerns and priorities of women which include redistribution of resources, restoration of basic services eroded by macro-economic policies, provision of comprehensive health services addressing the reproductive health need s of women and men, strengthening of women's participation in political and policy making process.
- reproductive rights are human rights which are inalienable and inseparable from basic rights such as right to food, shelter, health, security etc.
- women are entitled to bodily integrity and therefore, violence against harmful practices must be recognised as a major reproductive rights and health issue.
- better health services are one element of women's rights. In addition, sexuality and gender power relationships must be addressed as a central aspect of reproductive rights.

Abortion; A Rights and Health Issue

The campaign for legal abortion may be considered to have inaugurated the contemporary feminist movement for reproductive rights and freedom (65). Despite women's activism, the UN conference documents are not explicit about abortion rights. When abortion is discussed, it is framed as an epidemiological problem and mentioned as a recommended measure to reduce high levels of maternal mortality and morbidity associated with clandestine procedures, Participants have been otherwise reluctant to endorse publicly the legalisation of abortion and the expansion of safe and accessible services as a solution.

Women advocacy strategies for abortion rights have not been uniform within or across regions, but they have developed around two major axes in both the North and south : the health rationale, which denounces the illegality of abortion rights as a major contributing factor to women's mortality around the world; and the rights rationale, which asserts that a woman's right to terminate pregnancy is a fundamental right and inalienable one protected by fundamental principles of individual human rights. However the strategies of these two principles have not been mutually exclusive and have been used simultaneously by women activists (64). However even within the advocates of rights rationale there are two groups. One of the groups asserts that human rights entitlements are not just morally defined in abstract, but must be grounded in cultural, political and social conditions. They therefore suggest that women's activist need to define advocacy strategies applicable to diverse cultural and political contexts and advocate alliances with the other side. The other group claims that independent of an absolute concept of individual rights the rationale run's the risk of effecting a definition of rights that is mutable, subject to changes as a consequence of historical developments and may be then applied to relativise all human rights demands/violations as culturally defined. In many settings the women's

movements have opted to pursue the health rationale, viewing it as more morally compelling than the rights argument in their particular context and have built alliances with international maternal mortality and safe motherhood campaigns. This has also been prompted by recognition by many that the health rationale may be more compelling to a broad public.(65).

There have been two very different reactions among western feminists to the basic difference in the content of women's movement in the different parts of the world. One trend locates it in the political economy of health itself, rejects crude universalism, and attempts to seek explanations of women's reproductive and sexual health problems within their specific social situations. It recognises the differences of approach within the feminist movement and emphasises the significance of links between health and reproductive health as well as structural adjustment programmes and women's empowerment. This view point was the one stressed by Committee on Women, Population and Environment, a loose alliance of women activists, environmentalists, community organisers, health practitioners. The Committee asserted that national governments, international agencies and other social institutions must provide resources such as fair and equitable wages, land rights, appropriate technology, education along with affordable, culturally appropriate and comprehensive healthcare and access to safe, voluntary contraception as part of broader reproductive health services. They demanded an end to structural adjustment programmes which sacrificed human dignity and basic needs for food, health and education to debt repayment and free market, male dominated models of unsustainable development(67). Women activists working with this approach strongly oppose population policies and consider current population policies to be against women's interests and believe that action should be directed towards dismantling population policies, rather than towards modifying them to meet women's needs. Collaboration with the establishment is thought to lead inevitably to co-optation and is therefore rejected (68). Despite all

the rhetoric to the contrary, the conventional population paradigm is deeply anti-ethical to the rights of women and poor communities, since it fails to recognise the fundamental power relationships at the root of gender and class oppression. The demographic imperatives also undermine the delivery of decent health and family planning services. It is time to put family planning where it has always belonged: in the context of broader health services and sexuality education"(69).

The other trend highlights factors of commonality in different women's movements in different regions, and emphasises strategies which place reproductive health centrally in dealing with women's health, both at the policv level as well as within the women's movement(70). The essential premise on which they operate is that population policies would continue in the foreseeable future and therefore work in collaboration with the establishment to transform population policies, contraceptive research, and family planning programmes to ensure women's reproductive health and rights. I reproduce here some of the extracts of their reasoning:

"there would seem very little scope to include reproductive health in the mandate of current family planning programmes. If, on the other hand, population policy is redefined to include concern with the reduction of morbidity and mortality, then reproductive health has a legitimate place in that policy, whether reproductive health services are offered on their own vertical programmes or are integrated with the provisicn of fertility reduction or other health services. Similarly, the broadest interpretation of population policy- which is not so different from a thoughtful development and human welfare policy- would naturally embrace reproductive health as an important goal. Our long term vision is one in which population policy is similar to development policies attentive to reducing class, ethnic, and gender disparities. Good social and economic development policy and just population policy would become indistinguishable. Family planning would be subsumed within the reproductive health which in turn would be subsumed within

health. This goal , despite being highly desirable, is unlikely to be pragmatic in the near future. Therefore, we propose a transitional strategy for the next 10-15 years , the 1994 strategy. It focuses primarily on fertility reduction (77).

In the recent years, the women's movement has been troubled by a number of conceptual and ideological debates as well as weaknesses in organising strategies. Women's movement has been criticised for it's focus on 'reproductive health' which is construed as being narrow and taking away the emphasis from 'women's health'. Within women's organisations questions are being raised about focusing the debate so closely on reproduction, there is also a debate proposing improvement in Comprehensive Health Services or that specific Women's Reproductive Health Services should be the primary focus. Proponents of the former position argued that better services for everyone will benefit women as well, while those arguing for women's services fear that women will get left out if they are not specifically targeted. Others point out that in many regions of the world, the only health services available to the poor are family planning and maternal-child health services; if they are eliminated in favour of an ideal constellation of comprehensive services, the result may be no services at all (72).

Another discontent being articulated, especially in southern women's movement, is that enough attention has not been paid to diversity - of national identity, race, ethnicity and class, "our diversity is real, but perhaps because of the fear that acknowledging differences could divide our forces, our discourse and practice have not reflected that reality".(73).

Women's movement has also been voicing concerns about the movement's language being appropriated and manipulated by the population establishment. Controversy exists within the movement about the values and risks of the exchanges with population establishment. Some activists are concerned that the

result will be small changes at the margin but no real transformation of policy. Many fear that they will be co-opted in the establishment.

More recently the debate has developed over the universal applicability of the concept of reproductive rights. There is no denying the fact that the suppression of reproductive health and right issues in the third world is rooted in women's oppression under the exploitative patriarchal structure of the family that functions as the basic unit of the capitalist system. However, this reality is not sufficient to argue that reproductive health and rights issues of the first and third world women can be treated at par (74).

Population Establishment

The population establishment is made up of a wide spectrum of organizations and individuals pursuing different and sometimes conflicting activities and goals. Yet they are loosely joined together by a common sense of purpose and often more tightly by a common source of funds. Following are the major agencies involved in population activities :

1.The US Agency for International Development (USAID). USAID population assistance takes mainly two forms :

- bilateral assistance to country-level programs, which accounts for about half of the population budget. In 1993 USAID made the policy decision to target assistance on two types of countries : " countries that contribute the most to global population and health problems " and " countries where population and health conditions impede sustainable development," which include places where growth rates " threaten the environment."
- the other half of USAID's population budget goes primarily to co-operating agencies, which include non-profit groups, private firms, and universities.

USAID's new " Sustainable Development Strategy " identifies population growth as a key " strategic threat " which " consumes all other economic gains, drives environmental damage, exacerbates poverty, and impedes democratic governance." ( ). Population control is one of USAID's four main areas of concentration and although population programs will have health care and female education components, family planning will continue to receive the most resources as AID believes it is the most effective means to reduce population growth. It is evident that USAID will support health and education only to extend that they serve its population control objectives.

2. The U.N. Fund for Population Activities (UNFPA). With a budget of close to $ 220 millions a year, UNFPA is the largest multilateral member of the population establishment. Although in history UNFPA is supposed to support a wide spectrum of population related activities, in practice its main emphasis is on funding family planning programmes. This emphasis on family planning is no accident. According to a UNFPA official interviewed in 1984, "USAID which provides about a quarter of our funds, puts pressure on us to focus on family planning ."( ).officially, the UNFPA is committed to the principle of voluntarism and must abide by the U.N. Human Rights Charter but in effect the organisation does not do what people want but what governments want and this can often conflict with voluntarism especially if it involves pushing population control. UNFPA has often played a negative role regarding coercion and has given awards to the population field's worst human rights violators and has often actively co-operated with them. It has also produced extensive and expensive propaganda promoting population alarmism,. It is also playing an active role in orchestrating the new population " consensus." However, not all UNFPA sponsored programs are oriented towards population control and it funds some positive initiatives in the field of women's health but it's institutional ethos continues to be strongly neo-Malthusian. Between 1969 and 1991, for example, the UNFPA devoted only 1.6%

dialogues with senior government officials, and by arranging the co-financing of large population projects with other donors, which gives the Bank a greater power in its role as a co-ordinator.

In the 80's the Bank increased its leverage by making the release of structural adjustment loans contingent upon adoption of population control policies in a number of countries. While the Bank tried to free market forces through its privatisation strategies, it tried ever more tightly to control population growth by robbing health budgets and using incentives and disincentives. This shift in the Bank ideology from a more liberal view point that poverty alleviation through social and economic development being the main key to fertility decline has been analysed by many analysts. According to Peter Gibbon, this shift was prompted by the Bank's belief that population problem could no longer wait for socio-economic development to solve them ; this urgency was increased by the threat of ecological imbalance and by the necessity to succeed with the structural adjustment effort( ). Despite the differences within the Bank, a greater importance began to be attached to population than to poverty. Gibbon maintains that this shift reflects a fundamental change in the North's strategy of stabilising and dominating the South. In the 70's the international community was awash with petro-dollars, donors and lenders competed to give assistance to Southern countries based on the optimistic faith that investment would spur modernisation and that poverty reduction programs would succeed in bringing political stability. In the 80's, with the international economic recession and decline of Eastern Bloc, Northern concern shifted from making loans to recovering them, from buying alliances with Southern elite to forcing them to comply with the austerity -programs. The North became more interested in "direct political stabilisation" of the New World Order through selected U.S. military interventions, co-option of international NGOs and reduction of population growth. According to Gibbon, this created the paradox of weakened emphasis on poverty while poverty was increasing and a renewed emphasis on population control while population growth was actually slowing.

Gibbon believes that in the 90's the liberal approach seems to be creeping back though it is too early to tell whether this transformation is real or rhetorical. Belatedly the Bank is beginning to criticise family planning programs that use demographic targets and incentives: " the point is to provide fertility regulation as a reproductive health and not a population control measure."

4. Foundations- Ford Foundation, MacArthur Foundation. The most powerful of the Foundations has been the Ford Foundation who played a major role in the early designs of the family planning programs, greatly influencing, and by many accounts distorting, the structure and goals of India's family planning programme. Some of it's early population specialists considered coercion a viable option . Ford, however , transformed its population program into a reproductive health program in the mid-1980's and is now an important source of support for many women's health initiatives.

The MacArthur Foundation increasingly active in the population field has a similar philosophy and is also a key funder of more progressive research and advocacy organisations with a focus on Brazil, India, Mexico and Nigeria.

Pressure Groups and Publicists. Public support for population control is vital in order to lubricate the wheel with regular applications of funds. Thus pressure groups and publicists perform an important role in building a U.S. population control constituency, lobbying Congress and influencing the media. They tend to take an extreme view - believing that overpopulation is the second greatest hazard in the world next to nuclear war. In the 1990's their strategy has been to appropriate the language of women's rights in order to make the population message more palatable. Population agencies have vigorously courted mainstream environmental groups because they see interest in the environment as a way to attract a broader constituency and expand U.S. funding for family planning programs. Of all the pressure groups, the Population Action International is the most influential. It exercises leverage by using prominent

retired military, government, and business leaders to press its case not only on the U.S. public and Congress, but on the senior Third World officials. It would be mistaken, however , to view this process as simply the Western population establishment putting pressure on recalcitrant Third World leaders, for many are more than willing to co-operate. This is because there is often a more common interest between the population agencies and Third World elite. Money helps to lubricate the relationship between the population establishment and the Third World elite. Although these material rewards help to cement the alliance, the identity of interest between foreign agencies and Third World elite go far beyond the perks. Both are part of the new class of world managers, which has begun to transcend differences in culture. They define most issues as " management problems " rather than as moral dilemmas, failing to question their own values and assumptions and to confront the frequent incompatibility between population control and respect for human rights. Bringing the birth rates down is an enterprise that befits their managerial talents, whereas attacking poverty and inequality head on would jeopardize their privileged position in the hierarchy of politics and power.

The International Planned Parenthood Federation (IPPF). The IPPF is the largest international private agency funding family planning services. Major contributors include the government of Japan, Denmark, Canada, United Kingdom. IPPF promotes family planning as a basic human right, it uses overpopulation rhetoric to build support for its programs and takes an incautious attitude to contraceptive safety.

The Population Council. Since its inception in 1952 the council has played a key role in the design and introduction of family planning programs, the training of the Third World personnel, and the transformation of population studies into a respectable discipline. The main funding source is the U.S. government. Despite its professed commitment to quality of care and freedom of choice, the Council has actively promoted the mass introduction of easily

abusable contraceptive technologies into already abusive population control programs with its Centre for Biomedical Research developing new contraceptives, such as Norplant, often designed to play a major role in reducing population growth. The council's credentials among the upper echelons of population establishment have given population control a legitimacy it might otherwise lack.

After three decades of intensive investment, the poor outcomes of demographically oriented population policies led to major actors in the international arena to adopt a concept of reproductive health and integrate it into population discourse, such as in ford and MacArthur Foundations' Reproductive Health Programmes and the 'quality of care' framework adopted by the population council and the world Bank's 'Reproductive and Child Health Approach' to Family Planning. One needs top look at some of the important conferences that led to this strategy being included in the population discourse.

In 1970 the UN General Assembly designated 1974 as World Population Year and began preparations for the World Population Conference to be held in Bucharest, 1974. During the conference the World Population Plan of Action which had set specific targets for world population stabilisation was rejected by third world leaders who saw a focus on population growth as a way to avoid addressing deeper causes of under development, such as inequalities in international relations. Women movement activists, demographers also added their voices to the critique of population control. The World Population Flan of Action was substantially revised - explicit targets were dropped and population growth was placed within the broader context of socio-economic transfonnation.

In August 1984, was organised the International Conference on Population in Mexico City. Population Establishment, wanting to avoid the strong reaction

shown at the Bucharest Conference, kept the discussion carefully circumcised and within the bounds of an emerging population control consensus. The official US Policy statement of the Reagan Administration launched a full scale attack on abortion rights. Ironically the policy statement served to legitimise the position of population establishment by casting it in the role of defender of reproductive rights as the extremism of Reagan position made the population control lobby seem moderate by comparison (76).

The International Conference on Population and Development held in Cairo in September 1994 defined reproductive health as, "physical, mental and social well-being (not just the absence of disease), and the ability to exercise one's human sexuality without health risks. Sexual health is defined as the integration of physical, emotional, intellectual and social aspects of sexual being, and the objective of sexual health services should be to encourage personal relationships and individual development, not just the treatment of reproductive health problems and sexually transmitted diseases". Based on this conceptualisation of reproductive health, different agencies have operationalised it differently. The Population Council experts for instance define it as "prevention and management of unwanted pregnancies, services to promote safe motherhood and child survival ,nutrition services for vulnerable groups, prevention and treatment of RTIs and STIs, reproductive health services for adolescence, health sexuality and gender information, education and counselling, establishment of efficient referral system." It has been argued that this operationalisation transforms reproductive health in \to a gamut of services based on technology and reduces the scope of reproductive health to contraception, maternal and child health, nutrition, services for RTIs and STIs, AIDS, abortions and sterility. (77).

Population lobby appropriated the concept of reproductive health and have adopted it as their new strategy to expand the scope of fertility reduction

activities and yet appear to have shifted out of the umbrella of the well recognised strategies of population control.

As with sections of Women's Organisations, population lobby also frames reproductive health within the constraints imposed by structural adjustment programmes. Beyond a few reforms suggested here and there, transforming economic relations is not central to population establishments agenda. Reproductive health is pushed centre-stage in the name of women's liberation irrespective of class and gender roles and entitlement, health, employment, and educational status of women (78). Gender becomes a way for population agencies to bypass politically sensitive issues of class, race and inequalities between developed and developing nations.

Environmental/Ecological Establishment

Population and Development field have in the recent years been characterised by appropriation of language from the women's movement promote their own concerns of fertility reduction in the Third World. More recent trend that has been observed is the appropriation of environmental concerns. As part of this new development and analysis, 'women, population and environment' have become formally linked, "a holy trinity in the consensus cosmology" (77).

Today, in many quarters, family planning is also viewed as the technological fix for the ecological crisis. This belief threatens to capture public imagination the West, erode women's right and steer the environmental movement way off course. According to this logic, the provision of modern contraceptive will help liberate women and concurrently reduce the birth rate, thus considerably reducing the pressure on the environment and economy, and ultimately making everyone on the planet, rich and poor, better of. The UN Fund for Population Activities (UNFPA) has done the most to articulate and promote this view. This is An important element of the new strategy to obscure class, gender and race

inequalities in a grand consensus in which everyone's interests are ostensibly served simultaneously (78).

Genesis of the Approach

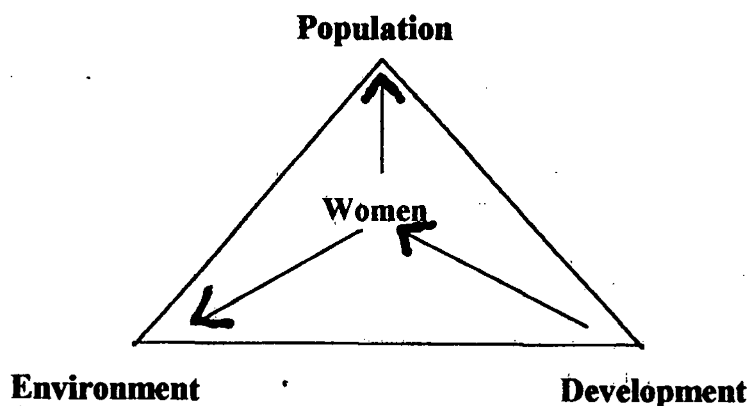
In the late 1960s Malthusian undercurrents in the environmental movement rose to surface with the first big wave of population paranoia. In 1968, the Sierra Club published Paul Ehrlich's 'The Population Bomb' which represented the alarmist concerns in the ecological movement. Paul Ehrlich's work has played the most important [part uin legitimising and popularising the belief that overpopulation is the main cause of environmental crisis. Ehrlich employs the concept of 'carrying capacity' of earth and proposed that if humans multiply beyond the carrying capacity of the environment then nature may end the population explosion by way of famine and AIDS. Ehrlich suggests that it is the women's fertility that is out of control and this control; must be exercised through family planning programmes. Ehrlich's work represented the ideas of white middle class elite. The book was criticised for it's alarmist viewpoint.

In 1968, an informal international group was established called the Club of Rome which published it's first report 'Limits to Growth' in 1972. The report looked at various variables like size of population, inductrial production and consumption, malnutrition, environmental degradation etc. and applying a system's analysis, attempted to link these variables in a global model. The report further talked of Global equilibrium which could be achieved only through control of population and cutting down consumption. The criticism of this report was along these line - it looked at environmental problem from the developed countries' perspective and the scholars of the Third World found both it's analysis and prescriptions unrelated to problems faced by their countries; by taking a global viewpoint it did not take into account regional diversities and social divisions; it also did not consider the possibility of discovery of new sources of resources (79).

In 1974, the Sierra Club hired it's first population programme Director, and the National Audubon Society launched it's own programme in 1979. In 1981 Audubon sponsored the National conference on Population, which became a springboard for the Global Tomorrow Coalition. The coalition, a network of about 100 population and environmental groups, was the first major effort to bring those two constituencies together (National Audubon Society and Population Crisis Committee). This coalition presaged, and helped to generate, the new wave of population paranoia at the end of the 1980s. many mainstream environmental organisations, especially in the west, became a part of this thinking.

Links Between Population - Environment Agencies

The 1990s population control consensus finds institutional expression in gretare inter-agency co-operation and coalition building with mainstream environmental groups. UNFPA has been the most prominent example of this nexus. The UNFPA explicitly acknowledges the importance of women in the relationship between population and the environment, which it expresses as:



Women are at the very centre of the triangle and according to UNFPA, " the interaction between these four sectors creates a powerful synergy that can either enhance or retard the achievement of a more balanced style of development" (80). The role and status of women are supposed to affect each

point of the triangle and are in turn affected by them. Women influence the environment through their daily task of fetching water, collecting wood etc. and their management of family resources. Women affect population through their reproductive behaviour. Development gets influenced through women's economic and political roles in family and society. According to UNFPA, poverty is the most important factor that influences and intensifies the positive or negative nature of this web o f relationships and the answer to the problem of poverty is located in the population growth and the onus for this firmly placed on women, "improving women's status feeds fertility decline, thus reducing considerably the overall negative impact fo population on environment and development" (UNFPA, 1992). In addition to enabling women to regulate their fertility, the UNFPA believes that the other key way to incorporate them into population, environment and development programme is to improve and enhance women's role as resource managers.

With this conceptualisation of women being at the core of population, development and environment relationship has some serious blind spots and lacunae. In advocating this approach UNFPA fails to recognise the role played by inequitable access to resources, debt crisis, structural adjustment programmes which have maintained and deepened crisis in the Third World, As in case of reproductive health rhetoric there is an attempt to focus on gender issues to side-step the more important role of socio-economic and political factors.

Another argument against this conceptualisation is that women presented in the triangle are shown to be an undifferentiated mass without any recognition of the profound differences in how they react to their environment. Also, "this view of improving women's status as a means to an end, rather than an end by itself objectifies women, targeting their wombs and turning them into the mechanical components of yet another exercise in misconceived social engineering"(81).

The growing identity of both ideology and interests between the population establishment and environmental mainstream was evident in their joint planning for the UN Conference on Environment and Development (UNCED), or Earth Summit, held the Rio De Janeiro, Brazil in June 1992. Among their initiatives were the circulation and signing of a 'priority statement on population' within the population and environment committees. It states, "because of it's pervasive and detrimental impact on global ecological systems, population growth threatens to overwhelm any possible gains made in improving living conditions"

Another joint effort was the formation of the Campaign on Population and the Environment "COPE" in 1990. COPE was a collaborative effort of the Audubon Society, the National Wildlife Federation, The Planned Parenthood Federation of America, Population Action International and the Sierra Club. It's major objective was to, "to expand public awareness of the link between population growth, environmental degradation and the resulting human suffering, and to translate into public policy" (82).

The ultimate example of the merger between the population establishment and the environment mainstream was the transformation of IPPF's autonomous magazine 'People' into an inter-agency venture called 'People and Planet' sponsored by IPPF, UNFPA in partnership with a host of other population and environmental groups.

During the Rio conference the Population/ Environment lobby was opposed by many southern nations during formal inter-governmental negotiations when they refused to put population on the UNCED agenda because they felt that it would divert attention from Northern responsibility for the environmental crisis. At the same time the non-governmental Women's Action Agenda condemned the idea that women's fertility rates are to blame for environmental

degradation. Women's activists drafted the NGO treaty on population and environment , which strongly came out in support of women's access to safe, voluntary contraception and abortion as a basic right - not as tools of population control. They identified structural adjustment, militarism, wasteful and unjust production and consumption patterns as the key culprits in environmental degradation.

In 1991, the Committee on Women, Population and Environment was formed comprising of a loose alliance of women activists, environmentalists, community organisers etc. The committee released a statement outlining an alternative approach to the women, population and environment issue. It represents a consensus very different from that of mainstream. I quote, " people who want tot see improvements in the reationshiop between the human population and natural environment should work for the full range of women's rights; global demilitarisation; redistribution of resources and wealth between and within nations; reduction of consumption rates of polluting products and processes and of non-renewable resources; reduction of chemical dependency in agriculture; and environmentally responsible technology. They should support local, national and international initiatives for democracy, social justice and human rights"(83).

Chapter III

Integrating Reproductive Health in Health Planning in India

Towards the end of the Seventh Five Year Plan it was reluctantly being agreed upon and being accepted that the family planning programme in India had reached a dead end. **The Eighth Plan** document in it's review of the Family Welfare Programme during the Seventh Plan noted " inspite of massive efforts in the form of budgetary support and infrastructure development , the performance of the Family Welfare Programme has not been commensurate with the inputs. Right from the beginning the achievement of the set goals has been unsatisfactory, resulting in the resetting of targets.... While the Seventh Plan target of achieving Couple Protection Rate of 42% was achieved, this was not matched by a commensurate decline in the birth rate, possibly because of improper selection of cases" (84).

Eighth Plan document listed Population control as one of it's six most important objectives. The approach to strategic interventions during the Plan period was to constitute an inter-sectoral interaction, supported by political commitment and a popular mass movement. The following strategies were enunciated in the **Eighth Plan Directional Paper** for achieving the goals of Family Welfare during the Eighth Plan period :

1. convergence of services provided by various social services sector e.g. welfare, nutrition etc. Based on a holistic approach to social development and population control, integrated programmes for raising female literacy, female employment, status of women, nutrition and reduction of maternal and infant mortality were to be evolved and implemented.
2. emphasis on area specific planning at the district , the sub-district and the panchayat level based on critical and in-depth desegregated analysis of a constellation of socio-biological indices and demographic determinants.
3. Panchayati Raj institutions were to play a significant role in planning, implementing and administering the programme with the role of the centre

to be limited to general policy, planning and co-ordination, providing technological inputs where required.

4. Child Survival and Safe Motherhood initiatives would be vigorously pursued.
5. Amount of funds channelled through voluntary organisations, for promoting and incorporating family planning as a major objective, was to be substantially increased.

To sum up, the base and the basis of the population control programme was to be decentralised, area specific microplanning , within the general directional framework of a national policy aimed at generating a people's movement with the total and committed involvement of community leaders, irrespective of their denominational affiliations and linking population control with the programmes of female literacy, women's employment, social security, access to health services and mother and child care (85).

Along with the growing realisation that the Family Planning Programme was a failure, there was also pressure from the women's groups and health groups in the country who were criticising the emphasis on women in the programme and bringing into focus the morbidity burden of the programme. These groups called for a radical reconsideration of the programme's goals and strategies. The programme also had some discrepancies e.g. there was no relationship between success of the programme and financial investment (139th report of the Public Accounts Committee noted that despite financial investment of mammoth level there was no significant change in Birth Rate); no relationship had been established between Couple Protection Rate (CPR) and Birth rate; no co-relation between CPR and Rate of Population Growth e.g. Gujarat and Maharashtra had high CPR and high Rate of Population Growth while Kerala had relatively low CPR but it's Growth Rate was lowest in the country.

At the heels of these realisations and questions, there was also a need to prepare for the Third Decennial International Conference on Population and development.(ICPD) at Cairo in 1994. All these factors together led to the formation of an Expert Group in 1992, under the chairmanship of **M S Swaminathan**, to chart out a new population policy. The Committee submitted it's report in 1994. The recommendations of the Committee must be contextualised within the above mentioned concerns.

The report noted that identification of the Family welfare Programme with sterilisation and contraceptives had given it a bad name and created a negative image . The report emphasised that this must be substituted by a positive image by emphasising on measures like higher age at marriage, literacy, education, reduction of IMR, increasing birth spacing, management of infertility and the desirability of having a planned family (86). The report also incorporated all the strategies of Family Planning that were enumerated in the Eighth Plan - area/region specific planning strategies, decentralised action, important roles to be played by Panchayats, and Nagarpalikas. Some of their suggestions are :-

A) replace the vertically structured Family Planning Programme with decentralised democratic planning Some of the proposed changes within this were to be :

- MCH and Family Planning to be merged with Health.
- No targets for specific contraceptive methods except the goal of National average of Total fertility Rate of 2.1 by 2010 AD.
- Incentives for acceptors, motivators and service providers to be discontinued.
- End discrimination against women and emphasis on special care for girl child and adolescent girl.

- increase involvement of voluntary organisations.
- monitoring and evaluation on the basis of sustainable human indicators.

The report stressed that the ' current trend of shifting the entire responsibility for family limitation to women will be checked and the culture of joint responsibility will be emphasised.' The committee suggested the establishment of a professionally manage statutory body - Population and Social Development Commission - at the national, state and district level with a fund of it's own , for achieving the twin goals of population stabilisation and promotion of integrated quality of life improvement measures .

The Report talked of a new orientation that was pro-women and pro-poor but it was criticised for the 'manifest disjunction between it's policy perspective and the policy recommendations that followed' (87). One example of this disjunction was the recommendation of a statutory body at the district , state and national level. This is in contradiction to the perspective of integration of Family Planning and MCH into health. Where was the need for restructuring the organisation if there was to be an integration?

There is also an attempt to pacify the Women's movement and health movement activists by incorporating their concerns e.g. stressing that gender equity is vital for achieving population goals and for better life; and emphasising the culture of joint responsibility for limitation of family. However in their specific recommendations they only talk about a ' reemphasis on male sterilisation and spacing methods'. It however makes no mention of how the gender equity was to be achieved and how could such a complex

multidimensional problem be resolved within the framework of family planning.

The criticism aside, the report also had a lot of positive elements : it talked of land entitlement rights for women but the persistent criticism led them to rethink the strategies and therefore the Statement on National Population Policy brought out in December 1996 does not mention these original recommendations. At best this report can said to be a prelude to the Cairo Conference where the Government of India wanted to show an ' international ' face to the Aid givers.

For the **International Conference on Population and Development** held in **Cairo** in September 1994 in Cairo, Egypt, Government of India formulated a **Country Statement**. This document had two major parts - the first dealt with ' Demographic Context' of the country and the other looked at 'Population Policy, Planning and Programme framework' (88). The document maintained that ' bringing women into the mainstream of development has been a national concern since independence' and asserted that the projection of a positive image of the girl child and a social movement to raise the age of marriage of girls were important interventions as part of the concern for development of women.

The document talked about the transition in economy that the country was going through and about the policies of government directed at both the macro-economic stabilisation and fundamental structural reform. These policies were aimed at imparting greater dynamism to the economy. The document also talks about special efforts initiated to provide a safety net to the poor who were likely to be affected during the initial stages of economic reforms. There is also

a mention of sensitising the quality and pattern of growth to the social imperatives. However it does not go into any details about what these steps to form a safety net are and how was the growth to be made sensitive.

The document details the key features of a New Action Plan to impart dynamism to the country's Family Welfare Programme. These key features are along the lines of the Draft National Population Policy and the strategies enumerated in the Eighth Plan. The Fourth section in the document reflects the National Action Plan for future which begins by listing some of the emerging and priority concerns - fulfilling the minimum needs of the people in the context of the population programme e.g. provision of safe drinking water leading to reduction of morbidity and mortality, eradication of illiteracy , particularly among females with special emphasis on adolescent girls; greater attention to he problem of child labour; creating more employment opportunities by stepping up economic growth with the hope that this can be achieved through economic reforms (again there is no mention of operational aspects).

The document devotes one subsection on the relevance of the World Population Plan of Action adopted at the World Population Conference at Bucharest in 1974. It exhorts the global community to address the issues of global development and seek to harness the vast potential of human and natural resources of developing countries to impart a new element of sustainable dynamism, to the world economy. The document talks about greater attention to be paid to research for new and safer contraceptives. This subsection is concluded by, " in the final analysis, what people want is the same as the health administrators , health providers and reproductive health researchers want, ' a happy and healthy life for men and women without fear of disease or unwanted pregnancy"(89). This section thus exemplifies the attempt of the Government to

present a 'contemporary' and 'international' picture of the policy and planning process to the Conference. The language is a reflection of the thoughts and ideas of the population lobby who constituted important aid givers to the country.

During the ICPD, Cairo a Programme of Action (POA) was formulated which advocated a new approach to population policy. This new approach was not to be demographically driven but instead attempted to emphasise on the empowerment of women and reproductive health care and reproductive needs of the individual. To achieve the objective of universal access to reproductive health services, all participating countries were urged to make reproductive health services available through the country's primary health care system. The Indian Government was one of the signatories and committed itself to introducing reproductive health in it's family welfare programme. It is in this context that the World Bank brought out it document titled, " **India's Family Welfare Programme : Towards a Reproductive and Child Health Approach** " in June 1995 (90).

The objective of the report was to identify, in collaboration with the Ministry of Health and Family Welfare (MOHFW), the specific constraints that stood in the way of re-orienting the FWP towards a reproductive health approach , and to spell out feasible actions that could be taken to overcome them. The report encompassed child health, in addition to reproductive health , because child health was an integral part of India's FWP. The report focused mainly on public provision of RCH services, while also examining the potential for expansion of the private sector role, which is supported by GOI. By it's own admission the WB states that the scope of the report was limited, ' while the report considers links between family welfare and other aspects of social policy

and poverty reduction, it does not address the full array of population policy issues that the GOI is considering....... While consideration of the broader issues is warranted and is being undertaken by the Indian authorities , the focus of the report is practical guidance to strengthen the FWP' (91).

The report recommended some measures to re-orient the FWP :-

a) Overall recommendation - re-orient the family welfare programme as quickly as possible, to a reproductive and child health approach that meets individual client health needs and provides high quality services.

b) policy recommendations - Eliminate method specific contraceptive targets and incentives . Replace them with broad reproductive child health goals and measures. Increase the emphasis on male contraceptive methods and broaden the contraceptive method mix.

c) Public Sector Recommendations - Improve access to RCH services; respond more effectively to client needs; increase support for front line workers for e.g. by enhancing the quality of training and providing adequate supplies ; improve the referral system especially for obstetric care, by strengthening the Primary Health Centres and First Referral Units.

d) Private Sector Recommendations- increase the role of private sector, especially by : revitalising the social marketing program and adding health and nutrition products ; expanding the use of private medical practitioners in the provision of RCH services; continuing to encourage experimentation with an expanding role of private sector in implementing publicly funded programmes; monitoring the experiments and identifying best practice for dissemination system wide.

e) Finance Recommendations - Increase the budget for RCH to meet staffing and other critical gaps, to enhance service quality and offer an essential reproductive health package ; and use funding as a performance incentive to re-orient the programme towards a RCH approach by taking steps to improve state level finances.

The report devoted one section to discuss which reproductive and child health services should be made available through health and family welfare programmes. The report recommended that an essential service package be made available nation-wide over a five to ten year period and additional services on a more restricted basis where the delivery package exists.

Recommended RCH Services

S.No	Essential Package Nation-wide	Additional Services in selected districts
1	Family Planning	Growth monitoring, nutrition education and food supplementation for children under six and pregnant and lactating women (through ICDS).
2	Safe Abortion	Reproductive Health Services for adolescents.
3	Safe Motherhood	Diagnosis and treatment of cervical cancer
4	Prevention and management of reproductive tract and sexually transmitted infection.	Advanced diagnosis and treatment of reproductive tract and sexually transmitted infection
5	Child survival	
6	Health ,sexuality and gender information, education and counselling.	
7	Referral services for all the above interventions	

(WB 1995 , III ; 12: 45)

The report goes on to suggest that the priority targets for the essential service package should be all couples of reproductive age , with a special emphasis on those at highest risk i.e. women who are pregnant or have an infant , the very poor and high risk adolescents.

Within each of the above mentioned strategies the report gave further recommendations.

1. Family Planning - the report emphasised on additional reversible methods to be added to the choice of contraceptives and more stress on male contraceptives. Safety being an important issue for contraceptive methods, greater attention must be paid to informed choice and screening for contraindications .
2. Expanding reproductive Tract and Sexually Transmitted Infections - these services must be made available at lower levels of health system. This service, recommended the report, was to be made mandatory wherever services for inserting Intra-uterine device were available.
3. Safe Abortion- the report lamented the lack of these services at the PHC level and suggested that provision of equipment and training along with IEC were important to strengthen the programme at district hospitals and Community health Centres.
4. Safe Motherhood
   - all deliveries to be attended by someone trained in hygienic delivery and recognition of complications.
   - provision of post-partum services which would include early detection and management of infection and haemorrhage and counselling in breast feeding, health nutrition and family planning.
   - Expand the coverage of antenatal and postnatal care services .

- strengthening the training programmes for ANMs to identify and refer the highest risk pregnancies; refresher training for TBAs to ensure that they can recognise the signs of complicated deliveries.
- strengthen the referral system.

5. Child Survival - the child survival component of CSSM must be expanded to include interventions needed to reduce perinatal and neonatal mortality like treatment of birth asphyxia and prevention of genococcal eye infection.
6. IEC and other action on sexuality and gender- The report emphasised on a need for sensitising the providers of health care to gender issues and also to involve a larger number of female doctors in the health and family welfare programme.
7. Improvement of Referral Services - to ensure that referrals are completed in a timely manner , pregnant women and dais need to learn the early signs of complications and communities need to learn to mobilise transport to referral units.

The report also talks about gender concerns in reproductive programme. It suggested that women's poor access to health and family welfare services must be addressed by action on both demand and supply side.

For the **World Conference on Women of the United Nations** , held at **Beijing** in September 1995, Government of India prepared a **Country Paper**. The paper emphasises on "women's pivotal role in the quest for sustainable development and population stabilisation"(92). The Country Statement talks of increasing women's education, age of marriage and employment along with economic betterment of households , improvement in the distribution of health related resources such as food, medical care, adequate housing, health education and

information, increased opportunity costs of raising children and old age security arrangements as an attempt towards declining fertility.

It suggests that to increase the utilisation of contraceptives it was important to change the circumstances in which women make decisions about contraception. The barriers to increasing utilisation are localised in women's lives - their low decision making powers in the early ages of marriage , poor health and pregnancy wastage , social pressure against contraception before completion of the desired family size, general son preference, secondary infertility because of RTIs etc. The Statement therefore stresses that women need control over their sexuality and life situation.

The Approach Paper to the Ninth Plan brought out by the Planning Commission laid down the suggested strategies for the Ninth Plan period as :

- to assess the need for reproductive and child health at the primary health centre level and undertake area specific micro planning.
- to provide need based, client centred, demand driven, high quality, integrated RCH care.

As part of this attempt, department of family welfare (Ministry of Health and family welfare, GOI) detailed a programme for providing RCH services which I reproduce here. (93)

The RCH programme will incorporate the components covered under the CSSM programme and will include two additional components, one related to Sexually Transmitted Diseases (STDs) and other relating to Reproductive Tract Infections (RTIs). The main highlights of the RCH programme:

- The programme integrates all interventions of fertility regulation, maternal and child health with reproductive health of both men and women;

- the services to be provided will be client centred, demand driven, high quality and based on the needs of the community arrived at through decentralised participatory planning and the target free approach;
- the programme envisages upgradation of the level of facilities for providing various interventions and quality of care. The First Referral Units (FRUs) being set up at sub-centre level will provide comprehensive obstetric and new born care. Similarly RCH facilities in Primary Health Centres will be substantially upgraded;
- the programme will improve access of the community to various services which are commonly required. It is proposed to provide facilities for MTP at the primary health centres, counselling and IUD insertion at sub-centres in a phased manner and
- the programme aims at improving the outreach of services particularly for the vulnerable groups of the population who have till now substantially been left out of the planning process e.g.

⇒ special programmes will be taken up for urban slums, tribal population and adolescents.

⇒ Non Governmental organisations will be involved in a much larger way to improve out reach and make it a people's programme.

⇒ skills of practitioners of Indian System of Medicine (ISM) will be upgraded by training and research and development in ISM will be supported to improve the image of RCH services and

⇒ Panchayati Raj system will have a greater role in planning , implementation and assessment of client satisfaction.

Programme Interventions

The programme will be based on a differential approach with the inputs varying depending on the capability of the health system in the district. Districts are

categorised as A, B and C on the basis of Crude Birth Rate and Female Literacy Rate which the programme says reasonably reflect the RCH status of the district. Some interventions are however, nationally uniform.

A Interventions available in all Districts

- Child Survival interventions (as available under CSSM programme).
- Safe Motherhood interventions (as available under CSSM programme).
- Facilitation for operationalisation of Target Free Approach.
- Institutional development.
- Integrated training package.
- Modified Management Information System
- IEC activities and counselling on health, sexuality and gender.
- Urban and Tribal areas RCH package.
- District sub-projects under Local Capacity Enhancement.
- RTI/STI clinics at District Hospitals (where not available).
- Facility for safe abortion at primary health centres by providing equipment, contractual doctors etc.
- Enhanced community participation through Panchayats, Women's groups and Non Governmental Organisations.
- minor civil works.
- Provision for lab technicians for laboratory diagnosis of RTI/STI emergency obstetric care.
- Adolescent health and reproductive hygiene.

B. Interventions in selected States/Districts.

- Screening and treatment of RTI/STI.
- Emergency obstetric care at selected First Referral Units (FRUs) by providing drugs.

- Essential obstetric care by providing drugs and staff nurse at primary health centres
- Additional ANMs at sub-centres in the selected districts for ensuring maternal and child health care.
- Improved delivery services and emergency care by providing equipment kits, IUD insertions and ANM kits at sub-centres.
- rental to contractual Primary health Nurses/ANMs , not provided government accommodation.
- Facility of referral transport of women during emergency to the nearest referral centre.

(94).

The Approach Paper goes on to say that the Government of India had come to the conclusion that contraceptive targets and cash incentives had resulted in the inflation of performance statistics and progressive deterioration in the quality of services. The practice of fixing targets from above had been therefore, stopped as it was proving counterproductive.

The approach Paper, however, cautions that the target free approach did not mean a license to do no work as the population goals remain the same as before as the health workers must arrive at the requirements in consultation with the local community and families, and these requirements would then constitute the targets for ANM for the year. (95).

It appears that even though there would be no obvious targets set down the indirect targeting would still continue as the demographic goals still remain. If one looks closely at the above mentioned documents, one realised that these documents have been largely congruent with the developments at the

international level, whether it's the Cairo Conference or Beijing Summit or the World Bank report. The process of our policies and programmes being influenced and in many cases being initiated at the behest of International Bodies and Donor Agencies continues till date with the acceptance and vigorous implementation of Reproductive and Child Health Approach to Family Planning as detailed by international pressures.

According to many critics this approach is like ' old wine in new bottle ' as the goals of women's health seem to be subservient to 'broad social policy' and 'demographic objectives'. " The new consensus recognizes that an important goal of reproductive health programs should be to reduce unwanted fertility safely, thereby responding to the needs of the individuals for high quality services, as well as to demographic objectives". "While fertility reduction concerns can be addressed at the level of broad social policy, the design and management of reproductive health programs need to be directed primarily at the needs of the actual and potential clients". In the Bank's RH recommendations, under the guise of addressing women's concerns the agenda of RH is seen as a method of attaining objectives set by faceless financial institutions and governments (96).

The Bank's proposal considers anaemia to be a problem for women only when they are pregnant or lactating. This needs to be viewed in the context that 80% women in India are anaemic, one of the highest in the world. Anaemia in women is not just a consequence of reproductive ill-health- it is a function of diverse factors including discrimination of the girl child, undernutrition and a myriad of culturally and economically determined factors. (97)

Budget estimates show that MCH component is only a small part of the FPP. Bank's document notes that MCH spending is far below WB's

recommendations. By the Bank's calculations MCH should be to the tune of 83% of the total expenditure on family planning and MCH. However' India has been spending only 30% of the total expenditure on family welfare. By the Bank's own calculations, India should be spending 25 times more on MCH. Yet the estimates for increased investments do not reflect this, with a modest increase of 40%-60% of current levels being projected. If this is the level of evaluation of the existing MCH component of the family planning programme, there is every reason to doubt the good intentions of the Bank in promoting the RCH approach (98).

According to many commentators, the recommendations of the WB are in no way a departure from the past practices of the FPP in India. At best it is an attempt to legitimise the Bank's concerns for population control and demographic objectives. The concept of RH arose out of feminist movement's concerns for women's needs but it has been transplanted in completely different circumstances. The document also represents continuity in the present approach of pursuing family planning goals to the detriment of general health care. " spending on the disease control programs is increasing, and the workload of these programs threatens to cut into the time both ANM's and the MMPW's can spend on reproductive and child health work. A review of ANM's and MMPW's work loads should be carried out as a basis for policy decisions on the future strength of the MMPW cadre, and rationalization of the ANM's role in other programs." (emphasis added) The report, therefore, recommends drawing away resources from the general health services. The Bank has borrowed heavily from the feminist terminology but the concerns are Bank's own (99).

These documents also share their emphasis on being 'pro-women' at the rhetoric level. They talk of a paradigm shift whereby the earlier coercive elements of family planning programme would be eliminated and be replaced with a target free approach with greater emphasis on empowerment of women. These however, never got translated into action . The document talks of 'empowerment' but when it comes to recommendations they limit themselves to talking about certain discrete , manipulatable elements like need for women literacy, employment or male sterilisation. Even this narrow focus on women empowerment is kept subservient to the more important demographic goals.

India's country statement for ICPD, Cairo spoke of being pro-poor and pro-women but at the same breath also talked of poor being most affected during the initial phases of the country's structural reforms. However these reforms are non-negotiable and the solutions recommended is provision of safety nets 'sensitising the quality and pattern of growth to social imperatives' but as usual there are no details about these noble intentions.

Chapter IV

Review of National Level Data on Morbidity, Mortality and Medical Care Utilisation for Women

In India, only a few national level morbidity/health Surveys which can throw light on the health status of the people are available. There are some disease specific Surveys available such as Goitre Surveys which were conducted in a specific population for the surveillance and detection of specific diseases. Besides these, there has been area specific health surveys which have covered a particular area or region. At the national level, National Sample Survey Organisation (NSSO) has been the only source of data on health problems based on a large sample. National Council for Applied Economic Research (NCAER) has been another organization conducting national surveys since 1986 to establish market structures for a variety of consumer goods. Data collected by these two agencies has been used to look at morbidity and health care utilisation by women (100)

NCAER conducted its **Second Round of Household Survey of Health Care Utilisation and Expenditure** in 1993 which collected information on the prevalence of illness, utilisation of health services and expenditure associated with each episode of illness. Data was collected based on household interviews carried out with a detailed questionnaire. The reference period for the study was one month preceding the date of interview. It was a one-time survey and does not reflect the seasonal variations in morbidity pattern. The universe for the study comprised both rural and urban areas of the country. Sample consisted of 18, 6?3 households.

NCAER Survey was based on lay reporting of illness and not on clinical examination. The interviewers were asked to note down the symptoms as described by the household. At the editing stage, the symptoms were classified/grouped under different illnesses using the WHO's Manual on Lay reporting of Health information. The survey included both treated and untreated illnesses, the reason for not seeking treatment was also ascertained from the respondent. The Survey had scope for including

NSSO's 42nd Round of Survey mainly concentrated on social consumption ; the objective being to make an assessment of the benefits derived by various sections fo society from public expenditure incurred data pertaining to the year 1986-87 and provided both all-India and State level data. The Survey covered whole of Indian Union except Ladakh and Kargil districts of J&K and rural areas of Nagaland. The reference period for the study was thirty days prior to the date of interview (101).

I Prevalence Rate was defined by NSSO Survey as proportion of persons with ailments which prevailed for any length of time during the reference period preceding the date of survey. Table I shows the prevalence rate by sex for the country.

Table - I : Prevalence Rate of Illness (All India Level) by Sex.
per 1,000 population

	RURAL			URBAN		
	Male	Female	Total	Male	Female	Total
NCAER	105.5	108.1	106.7	98.2	108.4	103.0
NSSO	64	63	64	30	33	31

Source: working paper no.53, second round of household survey, NCAER 1992

- NSSO's 42nd round ,report no.364,Morbidity and utilisation of medical services, MOHFW,GOI, 1987

At the all-India level prevalence rates (total) are higher for rural areas as compared to urban areas but these differences are much more marked in the case of NSSO Survey. However, both the surveys indicate **no significant sex differentials**. The NCAER Survey reports that the prevalence rates in this second round of survey were higher than the first round of survey. These were partly attributed to an increase of reference period in the 2nd round (30 days as compared to 2 weeks in the

Ist round) ; and partly to improvements in the interview technique which could have resulted in the reporting error coming down considerably resulting in better accounting.

Table II - Prevalence Rate of Illness (All India) by Sex and Age Groups

per 1,000 population

Age Groups	RURAL		URBAN	
	Male	Female	Male	Female
<= 5	131.4	125.0	143.5	122.7
6 - 14	86.5	72.9	76.0	67.2
15 - 59	99.5	110.4	90.2	110.5
>= 60	214.6	192.2	219.7	215.9

Source: working paper no.53, second round of household survey, NCAER 1992

Data indicates that except in the age group 15-59 years the reported morbidity rates are much lower for the females as compared to males for both rural and urban areas. These results are at a variance with majority of nutritional studies which have found higher rates of malnutrition for women and girls (Sen and Sengupta 1983)(102) One, therefore, expected the morbidity to be considerably higher for females. This raises questions about reporting and memory lag.

One also wonders about the need to club the 15-49 years age group together. The other age groups that the study has used comprise of 15 years span. It would have been much more useful if this age span was further divided into three separate categories e.g. 15-30, 31-45, and 46-59. This analysis would have been more helpful in deciphering a relationship between age and prevalence rates.

<u>Prevalence of Disease by Nature of Illness</u> - In the NCAER survey, the symptoms recorded by the interviewers were grouped under the 4 broad categories of illness for the purpose of this analysis :-

1. Serious Communicable Diseases which includes Typhoid, Malaria, Cholera, T.B., Acute Gastro-enteritis, Jaundice, Mumps and Chickenpox.
2. Acute Illnesses - Diarrhoeal diseases, Respiratory infections, Non-Specific Fever, Skin Diseases, Eye/Ear problems, Headache, Bodyache, Backache and Stomach problems including indigestion, gas, acidity and constipation.
3. Chronic Illnesses - Aches and pains (arthritis and rheumatism), cardio-vascular diseases, diabetes, kidney problems, cancer, breathing problems/asthma, weakness/anaemia/dizziness, mental and psychological disorders and others.
4. Accident/injuries.

Table III and Table IV look at the distribution of illness by the nature of illnesses for adults and children and for rural and urban sectors respectively.

Table III - Prevalence rate of Illness by Nature of Illness for Adults and Children - Rural

per 1,000 population

Nature of Illness	Adults		Children		Total
	Male	Female	Male	Female	
Typhoid, malaria, cholerae, acute gastro-enteritis and jaundice	12.4	10.4	16.3	13.5	12.6
Mumps, measles, chickenpox, TB	5.1	2.6	0.9	0.4	2.9
Diarrhoeal diseases	4.9	5.5	12.0	11.8	7.4
Respiratory infections	9.1	9.3	15.0	16.6	11.3
Non specific fever	30.0	31.5	39.3	32.8	32.5
Eye/ear problem	6.8	7.0	3.7	2.2	5.6
Headache, bodyache, backache	4.1	9.0	1.6	1.6	4.8
Stomach problems - indigestion, gas, acidity, constipation	6.9	11.5	3.1	3.8	7.2
Others	2.6	7.2	1.4	0.9	3.5
Accident and injuries	4.3	1.1	1.7	0.4	2.3
Skin diseases	3.7	1.7	3.1	5.0	3.2
Aches and pains - arthritis, rheumatism	2.2	2.0	0.0	0.0	1.4
Cardiovascular diseases	4.5	3.1	0.4	0.0	2.6
Diabetes, kidney problem	1.2	1.3	0.1	0.0	0.9
Breathing Problems/ Asthma	2.8	4.1	0.1	0.0	2.3
Cancer	0.8	1.0	0.3	0.0	0.7
Weakness, dizziness, anaemia	2.7	5.1	0.6	1.0	2.8
Mental/ psychological disorders	0.8	0.2	0.0	0.1	0.4
Others	3.0	3.0	0.4	0.3	2.1
All Illnesses.	108.0	116.6	100.3	90.4	106.6

Source : working paper no. 53, 2nd round of household survey, NCAER.

Table IV - Prevalence rate of Illness by Nature of Illness for Adults and Children - Urban

per 1,000 population

Nature of Illness	Adults		Children		Total
	Male	Female	Male	Female	
Typhoid, malaria, cholerae, acute gastro-enteritis and jaundice	11.4	11.2	15.7	11.3	11.8
Mumps, measles, chickenpox, TB	2.7	2.2	0.7	0.6	1.9
Diarrhoeal diseases	5.0	6.8	11.7	10.3	7.6
Respiratory infections	10.1	12.3	16.6	17.0	12.8
Non specific fever	21.7	26.1	32.2	29.8	25.9
Eye/ear problem	4.9	6.1	3.8	3.3	4.9
Headache, bodyache, backache	4.3	7.5	1.1	2.4	4.6
Stomach problems - indigestion, gas, acidity, constipation	5.7	8.8	2.9	2.3	5.8
Others	2.1	7.6	0.7	0.6	3.7
Accident and injuries	5.0	1.5	2.7	0.8	2.9
Skin diseases	2.9	3.1	2.9	1.8	2.8
Aches and pains - arthritis, rheumatism	2.3	3.1	0.0	0.0	1.9
Cardiovascular diseases	9.0	7.7	0.3	1.0	6.1
Diabetes, kidney problem	3.3	2.7	0.0	0.1	2.2
Breathing Problems/ Asthma	3.7	3.2	0.7	0.5	2.3
Cancer	0.5	0.7	0.1	0.0	0.4
Weakness, dizziness, anaemia	3.4	4.6	1.3	1.3	3.2
Mental/ psychological disorders	0.8	1.3	0.2	0.0	0.8
Others	1.9	1.5	1.4	0.6	1.5
All Illnesses.	99.7	118.0	95.0	83.7	103.1

Source: working paper no.53, 2nd round of household survey, NCAER.

The distribution of reported illnesses by nature of illness shows that among the various types of illnesses, 'fever' which included viral fever, flu and other non-specific fevers, seems to be the most common illness among both adults and children. Fever accounted for 30% of reported illnesses in the rural areas and about 1/4th of the reported illnesses in the urban areas. The data indicates that communicable Diseases account for a high proportion of reported illnesses. The Serious Communicable Diseases accounted for 14.5% of all reported illness episodes in the rural areas and 13.3% in all urban areas. For Women (adults & children) the Serious Communicable diseases accounted for 12.54% in urban areas and 13% in rural areas. Another fact that emerges is that there are no notable sex differentials observed in the pattern of illnesses suffered by males and females - in both children and adults category.

Another aspect that both these surveys look at is the utilisation of health services and access to health services. Both these have been looked at under the categories of Males and Females and in both rural and urban sector. The NCAER Survey shows the " Percentage Distribution of Untreatd Illness by Duration of Illness ".

Table V - Percentage distribution of Untreated Illness by duration of Illness

Duration	RURAL			URBAN		
	Male	Female	Total	Male	Female	Total
1 day	8.0	6.3	7.2	13.2	15.2	14.3
2 - 3 days	44.3	43.3	43.8	38.2	39.9	39.1
4 - 7 days	23.4	23.2	23.3	31.4	27.0	29.0
> 7 days	24.4	27.3	25.7	17.1	18.0	17.6
All	100.0	100.0	100.0	100.0	100.0	100.0

Source: working paper no.53, second round of household survey, NCAER 1992

The percentage of untreated illness was least when the illness lasted only one day for both males and females and is true for both rural and urban sectors. Sex

differentials are again not very marked except in the categories of 1 day and 4-7 days. For illnesses lasting only one day percentage of untreated illnesses the males have a slight edge over females in both rural and urban sectors. This is suggestive of restricted access to health care services for women as it indicates that women's ailments are ignored at initial sages and medical aid is sought only when the illness becomes more serious. In case of urban sector we find that for the category 4-7 days percentage of untreated illnesses is higher for males. The NSSO Survey has looked at " proportion (per 100,000 population) of persons treatd to total persons with ailments ". The figures are, 82,760 and 80,196 for males and females respectively in rural areas and 90,186 and 88,112 respectively for males and females in urban areas. The percentage of untreated illnesses is more for females than for males.

Both the NSSO and the NCAER have also looked at the cases of hospitalisations.

Table VI - Percentage distribution of Hospitalisation cases - All India

per 1,000 population

	RURAL			URBAN		
	Male	Female	Total	Male	Female	Total
NCAER	8.4	5.5	7.2	10.9	8.4	9.7
NSSO	--	--	2.8	--	--	1.7

Source: working paper no.53, second round of household survey, NCAER 1992

- NSSO's 42nd round ,report no.364,Morbidity and utilisation of medical services, MOHFW,GOI, 1987

Though in overall reporting of illness one did not observe any significant sex differentials, but the number of hospitalisation cases per 1,000 population have worked out to be lower for females in the NCAER Survey. The NSSO Survey reports that the male -female ration in both urban and rural areas worked out to be

reports that the male -female ration in both urban and rural areas worked out to be 56:44 which is also consistent with the trend noticed in NCAER Survey. This low hospitalisation rate is consistent in all States, being very marked in some cases, with the exception of Kerala which has rates of hospitalisation in favour of females in rural areas but the rates are lower for females in urban areas. This trend has been seen in both the surveys.

As I have already mentioned it was the emphasis on maternity health that focussed attention on women's health issues. In the initial years of post-independence maternity and child health received attention but it was later diluted as focus shifted more and more to Family Planning Programme. Even with MCH there has been a tendency to focus more on child health and increasingly the maternal health was being promoted as an aim to decrease infant and child mortality which would lead, it was hoped, to a decline in fertility. Maternal health did find its way into the planning with the CSSM Programme but this did not last long as soon the new rhetoric in international and national documents was the RCH approach to family planning. Within this context we lock at 2 survey which have looked at the utilisation pattern of women of MCH Services :- National Family Health Survey (NFHS), 1992-93 and NSSO 42nd Round of Survey - Report NO. 368, Utilisation of Child and Maternity Care Services.

NFHS covered the population in 24 States and NCT of Delhi containing 99% of population. Its a household survey with an overall sample size of 89,777 ever married women in the age group 13-49 years. The main objective of the survey was to collect reliable and up-to-date information on fertility, family planning, mortality and maternal and child health. The Survey used three types of questionnaires : Household, woman's and the village questionnaire(103).

NFHS provides data for Ante-natal care utilisation in terms of " Percentage Distribution of Live Births in the Four Years Preceding the Survey by ANC ". The figures show that at the all-India level, for 62 per cent of births mothers received ANC while for 37 per cent of live births mothers did not receive any ANC. However the total figure of 62% was contributed to by the figure for urban sector (81%) which was considerably higher than the rural sector (37%). NSSO has looked at " Percentage of Mothers Registered for Pre-Natal Care" which was 21% for rural area and 47% for urban areas (104). The NSSO Survey also looked at the utilization of post-natal care which was found to be considerably lower than ANC and keeping in the line with the trend for ANC, is much lower for rural areas (13%) as compared to urban areas (24%). NCAER also looked at " percentage of mothers received ANC relative to the age group" which showed that utilization of ANC decreased with the age of the mother. Coverage of ANC was greatest, 64%, among births to young mothers below age 20 years and lowest, 42% among births to mothers aged 35 and over.

Percentage of Live births Taking Place at Home are 81% for rural sector and 47% for urban sector (Source : NSSO). Within this group 1/3rd of births taking place at home in rural sector are without any assistance and only 27% were attended by Non-governmental nurses or mid-wives. In urban sector, 26% are without any assistance and 35% are attended by midwives or nurses, 51% of births taking place at home cited their own preferences for doing so while 4% in urban and 20% in rural sector listed non-availability of services as their reasons. An important component of MCH Services is the Distribution of Iron and Folic Acid Tablets. Information was also collected on whether the mothers received tablets during each pregnancy resulting in a live birth during the preceding 4 years (NFHS). Data shows that only 51% of mothers received tablets with the figure being 45% for rural areas and 69% for urban areas. However this percentage is much lower for NSSO Survey (10% for rural sector and 19% for urban areas). The figures for Mothers who received Tetanus Toxoid Vaccination (NFHS) were equally dismal - 54% of

births were to mothers who had received 2 or more doses of TT Vaccine 7% received only one dose and 39% did not receive any. The receipt of 2 doses was higher in urban areas (74%) than in rural areas (48%).

Mortality

While morbidity loads reveal their pattern in NCAER and NSSO data, the analysis of the Model Registration Scheme of the Government of India (which was quoted in, " Rights and Reproductive Health - a Public Health Perspective" by Qadeer, I. 1996) (105) further highlights the problem of Women's Health.

Table VII shows the " Total Female Deaths in India Over the Decade 1982-93".The table highlights the very high proportion of mortality in 0-4 years of age (22-28%) as compared to the 5-14 years age group (4.7 - 5.4%). Deaths in age > 15 years constitutes the highest per cent of total deaths (ranging from 66.78% to 72.47%).

Table VIII looks at the " Main Causes of Death". Deaths due to a child birth constitute 2.1 to 2.9 per cent of the total female deaths. The main causes of death remain respiratory diseases, causes peculiar to infancy, diseases of the circulatory system (which include anaemias), fevers and digestive disorders. The notable trend is a lack of decline in proportions of those causes for which specific programmes exists i.e., Maternal and Child Health (106).

In Table IX, specific communicable diseases (cholera, gastro-enteritis, T.B., pneumonia, dysentery, whooping cough, meningitis, jaundice, tetanus, measles, chicken pox and poliomyelitis) have been clubbed together to look at three specific groups of causes of death - communicable diseases, maternal deaths (deaths related to pregnancy and child birth) and anaemia. The table presents age specific death rates for these three groups. Table IX shows that in all age groups communicable diseases cause the highest proportion of deaths. In the 15-44 years of age group

these deaths are more than double the deaths caused by maternity causes. Another alarming trend one notices is that maternity deaths and deaths due to general anaemias have been contributing more towards the total female deaths while the percentage contribution of communicable diseases has declined. We take a closer look at this in Table X (107).

Table X gives the " Distribution of Communicable Diseases Over All Age Groups". Communicable diseases is the largest cause of deaths in the age group 0-4 years. 47-53% of all communicable diseases deaths occur in young girls > 14 years. In the category 15-44 years old, communicable diseases account for 12-24% of the total deaths. The proportion of deaths due to communicable diseases in the reproductive age group has n fact increased after the initial decline. As a result the age-specific death rates for communicable diseases are much higher than the overall proportional distribution of deaths due to communicable diseases (30 : 24 for 1993) in this age group. This proportion reverses to 40:49 in the younger group and to 12:35 in older women for 1993.

Table XI looks at "Females Deaths Due to Child Birth". The reproductive age group (15-44 years) has been sub-divided into age groups of 15-24 years, 25-34 years and 35-44 years. In this > 15 years age group we find that deaths due to child birth

Age Groups	1982	1983	1984	1985	1986	19 87	1988	1989	1990	1991	1992	1993
0 - 4	2000 (28.05)	2065 (26.62)	2113 (26.74)	2080 (27.01)	2155 (26.32)		2546 (24.76)	2309 (24.32)	2055 (22.39)	2274 (22.68)	2680 (23.56)	3258 (24.51)
5 - 14	368 (5.16)	392 (5.05)	412 (5.21)	391 (5.08)	426 (5.20)		510 (4.96)	452 (4.76)	472 (5.14)	544 (5.43)	551 (4.84)	654 (4.92)
15 - 44	1168 (16.38)	1340 (17.27)	1300 (16.45)	1319 (17.12)	1414 (17.27)		1603 (15.59)	1724 (18.16)	1660 (18.09)	1770 (17.66)	2144 (18.85)	2543 (19.13)
> = 45	3593 (50.40)	3961 (51.06)	4077 (51.59)	3912 (50.79)	4192 (51.20)		5624 (54.69)	5009 (52.76)	4992 (54.38)	5437 (54.23)	5998 (52.74)	6836 (51.43)
Total	7129	7758	7902	7702	8187		10283	9494	9180	10025	11373	13291
Total deaths in Age >= 15 yrs	4761	5301	5377	5231	5606		7223	6733	6653	7207	8142	9379
% of total deaths	66.78	68.33	68.04	67.91	68.47		70.28	70.92	72.47	71.89	71.59	70.56

Source : survey of causes of death (rural), RGI Vital Statistics Division.

Table VII - Total Female Deaths in India , 1982 - 93

constitute not more than 17-19% of the deaths due to communicable diseases except in 1993 when it is 24%. This increase over time is perhaps due to complications of pregnancy related to rising communicable diseases (table X) and improved recording of maternal mortality.

Table XI(A) looks at " Relative Proportion of Maternal and Communicable Disease Deaths in 15-44 Years Age Group ". Data shows that communicable diseases continue to cause twice the number of deaths compared to maternal mortality, even in the reproductive age group (15-44 years). Put together, obstetric deaths constitute 1.7 - 2.9% of all deaths in the 15-44 years age group and communicable diseases contribute 5.1 to 5.8% of all deaths between 1988-93(108).

Table XII takes a look at, " Deaths Due to Anaemia With and Without Pregnancy Among Women Aged 15-44 Years". Data indicates that as a complication of pregnancy it has declined as its share in the total deaths due to anaemia has come down from 3.4% to 1.02% over 1982-93. However, general anaemia (without pregnancy) continue to be a serious threat to women's lives. Even if the 1993 figures are treated wit caution, the rising contribution of general anaemic to deaths cannot be denied

Cumulative data on deaths due to toxaemia, haemorrhage, complications of pregnancy, sepsis, abortion and post-natal complications is clubbed together with maternal (obstetric) deaths with associated medical conditions such as T.B., anaemia, dysentery and small pox. A majority of these were certified by doctors but some were not. This data is shown in Table XIII. Among the total registered maternal deaths, up to 16.39% mortality is caused by complications due to associated causes. Given that all deaths were not certified by medical personnel, and complications such as cerebro-vascular diseases, diabetes, etc., have not been considered, the detection of associated causes can only be an under-estimate.

Better diagnosis and services alone can help such women adequately. In other words the underestimation of the underlying ill health of pregnant women is a major issue (109). It has been pointed out that this very insightful data has not been presented for the later years.

A number of studies have been shown a direct relationship between mortality and malnutrition. A longitudinal study conducted by the National Institution of Nutrition shows a good correlation between the nutritional status of adults (as measured by Body Mass Index) and mortality during the subsequent 10 years period (1979-89). The mortality rate of men with a normal BMI was 12 and those with severe undernutrition (BMI < 16) had a mortality rate of 32. Coupled with this information is data showing that "anaemia" continues to contribute a large share to maternal deaths, this has a great deal of importance for any programme that seeks to reduce maternal mortality (110). Nutrition trend in India show that when BMI is used to assess the nutritional status of adults, only 50% of adults had normal nutritional status while the rest suffered from different degrees of chronic energy deficiency (CED). This was true for both males and females.

Data on dietary energy intake shows a great deal of inter-state comparison. The average dietary energy intake for the whole of the country is 2,200 Kcal, close to the recommended dietary intake (RDI) laid out by ICMR but this is contributed to in a large part by States of Punjab, Madhya Pradesh, Orissa, West Bengal and karnataka where the intake is above or at par with RDI. However, States of Andhra Pradesh and Gujarat have shown marginal deficits. In the remaining States, the average intake is much less than 2,400 Kcal /CU - the minimum level suggested to define poverty. If we look at the average intake of different nutrients, at the aggregate level, expressed as a percentage of the RDI for the two periods 1975-79 and 1988-90 we find that all nutrients, except Vitamin-C, have recorded a deficit with the maximum deficit being observed for Vitamin-A and Energy (111).

Accepting the analysis of the data from the above surveys it must be emphasised that these surveys have their own limitations as they have been conducted through non-medical investigators, using symptoms as a means of diagnosing and grouping the illnesses under different categories. In this chapter, we hae looked at data on morbidity and mortality for women and utilisation of medical care facilities for women. From the data we can draw the following emphasises :-

Morbidity

Looking at NCAER and NSSO data it emerges that there are no significant sex differentials in the prevalence rate of illnesses. Even for the pattern of illnesses in terms of type of illnesses there are no differentials observed. Both males and females in both rural and urban sector suffer most commonly from 'fever' with 'communicable diseases' forming a high proportion of reported illnesses for males and females.

Utilisation of Medical Care Facilities

Though in overall reporting of illness significant sex differentials were not mated, the number of hospitalisation cases per 1,000 population have worked out to be lower for females in both NCAER and NSSO Surveys. Looking specifically at the maternity and child health services it emerges that though the coverage /utilisation of ANC services is average (62%) at the all-India level it worked out to be much lower for rural areas. It was also indicated that the utilisation of PNC ws much lower than ANC. The number of institutional deliveries continue to be low, especially for rural areas. It was also indicated that the utilisation of PNC was much lower than ANC. The number of institutional deliveries continue to be low, especially for rural areas and even within domiciliary deliveries majority are without any assistance. The percentages of pregnant women who received Iron & Folic Tablets and Tetanus Toxoid Vaccination was equally dismal with the figure being as low as 10% for NSSO data. Another significant fact that emerged from

NFHS data was that proportion of mothers who received ANC in the 1st trimester was also low (24% - country as a whole, 39% for urban areas and 20% for rural).

Mortality

Model Registration data on mortality of females revealed that girls of under 15 years of age bear the highest load of mortality and the major cause of death in this group as well as the reproductive age group of 15-45 years are the communicable diseases. Maternal mortality due to child birth forms 12.3% of major causes of death in the reproductive age group and even in this category 4%-6% of deaths are not directly related to child births but to the complications caused by associated causes like infectious diseases, anaemia and malnutrition (112).

Nutrition

The dates indicates that the protein, energy and other nutrients adequacy of households has shown a marginal decline over the last 10 years which is particularly marked in states such as Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra. This has serious implications for any programme that seeks to address the concerns of women's health.

According to many observers, the focus on women's health through maternity services and motherhood roles is essentially flawed as it completely negates the other aspects of their lives. Women's health problems become important only when they are pregnant. Apart from maternity care, health services to little to contribute to overall health of women. Any strategy that is devised within this maternity care oriented framework is bound for failure as it leaves untouched many parameters of women's lives which impinge upon their health. Such policy misses the composite nature of health problem and the interdependence of its various dimensions. However, it would be churlish to deny that even this narrow

interpretation of women's health had the potential of bringing forth key issues of women's health into national consciousness.

The emphasis over various plan periods should have been on widening this narrow focus and having a more composite and comprehensive focus whereby women's total health became the central concern for health planning. This, sadly, never happened. In the name of benefiting women's health, women's reproductive role got more and more focus. By emphasizing women's 'biological vulnerability' (GOI 1995), the importance of social conditions and stratification was further undermined. Even when the reproductive health concept was used to broaden official approach to women's health only areas such as menopause and menarche were talked of and malnutrition and Communicable disease remained out of focus.

In this context data which indicates women's health status helps us in understanding and reviewing policies. Even within the narrow focus of RH, there was scope to improve women's health status and there access to health services/medical care if the linkages of RH with General Health and Nutritional Status were adequately appreciated and it was realised that younger women carry their burden into older age groups and add to the problems of that age.

Sr. No.	Major Causes	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
1	Accidents and Injuries	4.4	4.6	4.9	5.1	6.0	5.5	6.4	7.5	7.7	7.1	6.82
2	Child Birth and pregnancy	2.4	2.6	2.2	2.7	2.1	1.8	2.1	2.3	2.5	2.4	2.93
3	Fever	10.4	10.8	10.7	9.6	11.0	8.8	8.2	8.2	7.9	8.5	7.35
4	Digestive disorders	7.4	17.8	7.8	7.6	7.7	6.8	6.9	6.8	6.7	6.9	7.22
5	Cough(disorders of Respiratory System)	17.2	18.0	18.2	18.8	17.6	18.6	18.3	16.3	16.3	17.2	16.15
6	Disorders of the Central Nervous System	3.5	4.5	3.9	3.9	3.9	4.6	4.6	4.3	4.4	4.3	4.25
7	Diseases of Circulatory System	7.4	8.5	9.1	9.1	8.3	8.4	9.8	9.7	9.8	9.3	9.67
8	Other clear symptoms	8.2	7.4	7.6	8.8	8.8	8.7	8.0	8.0	7.9	7.9	8.26
9	Causes peculiar to infancy	12.4	11.2	10.8	10.7	10.2	10.1	9.8	9.9	10.7	10.2	11.74
10	Senility	24.8	24.2	24.2	23.4	24.4	26.1	26.0	27.1	26.1	26.2	25.61

(Source : Survey of Causes of Death)

Table VIII - Percentage of deaths among major cause - group by female (1982 - 93)

Age Group		1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
0 - 4	Communicable Diseases	10.79 (45.46)	1112 (45.26)	1201 (47.56)	1151 (46.58)	1236 (47.89)	1478 (48.36)	1286 (46.55)	1076 (42.58)	1185 (42.05)	1223 (37.85)	1600 (40.90)
	Maternal Deaths	1	--	--	--	--	--	--	--	--	--	--
	General Anaemia	34 (1.44)	96 (3.11)	98 (3.88)	117 (4.73)	132 (5.11)	151 (4.94)	125 (4.52)	148 (5.85)	137 (4.86)	152 (4.70)	198 (5.06)
	Total female deaths in age group	2368	2457	2525	2471	2581	3056	2761	2527	2818	3231	3912
15 - 44	Communicable Diseases	443 (37.93)	489 (36049)	470 (36015)	473 (35.86)	504 (35.64)	532 (33.19)	545 (31.61)	490 (29.50)	497 (28.08)	624 (29.10)	775 (30.48)
	Maternal Deaths	161 (13.78)	200 (14.93)	175 (13.46)	241 (18.21)	176 (12.45)	182 (11.35)	202 (11.72)	209 (12.58)	251 (14.18)	270 (12.59)	384 (15 10)
	General Anaemia	24 (2.05)	52 (3.88)	56 (5.15)	44 (93.44)	49 (3.47)	69 (4.30)	75 (4.35)	58 (3.49)	69 (3.90)	95 (4.43)	135 (5.31)
	Total female deaths in age group	1168	1340	1300	1319	1414	1603	1724	1661	1770	2114	2543
45 +	Communicable Diseases	486 (13.52)	615 (15.53)	576 (14.13)	601 (15.36)	611 (14.58)	726 (12.91)	553 (11.04)	517 (11.96)	680 (12.50)	732 (12.20)	820 (12.00)
	Maternal Deaths	6	6	4	--	--	--	--	--	--	--	--
	General Anaemia	143 (3.98)	172 (4.35)	196 (4.8)	162 (4.14)	129 (3.08)	145 (2.58)	168 (3.35)	148 (2.96)	159 (2.92)	149 (2.48)	181 (2.65)
	Total female deaths in age group	3593	3961	4077	3912	4192	5664	5009	5992	5437	5998	6836

(Source: Survey of Causes of death, GOI Reports)

Table IX: Age specific Deaths(female) due to Specific causes

Figures in parenthesis represent % of age specific deaths due to that cause.

Age Groups	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
0 - 4	43.22 (868)	38.74 (860)	42.90 (964)	42.06 (936)	41.59 (978)	42.10 (1152)	43.28 (1032)	38.0 (823)	37.0 (874)	38.69 (994)	38.94 (1244)
5 - 14	10.50 (211)	11.35 (252)	10.54 (237)	19.66 (215)	10.97 (258)	11.91 (326)	10.65 (254)	11.70 (253)	13.16 (311)	8.92 (229)	11.14 (356)
15 - 44	22.06 (443)	22.03 (489)	20.91 (470)	21.25 (473)	21.43 (504)	19.44 (532)	22.86 (545)	22.65 (490)	21.04 (497)	24.29 (624)	24.26 (775)
> = 45	24.20 (496)	27.70 (615)	25.63 (576)	27.01 (601)	25.98 (611)	26.53 (726)	23.19 (553)	27.6 (597)	28.78 (680)	28.50 (732)	25.67 (820)
*Total Deaths	2008 (28.1)	2216 (28.5)	2247 (28.4)	2225 (28.8)	2351 (28.7)	2736 (26.6)	2384 (25.1)	2163 (23.6)	2362 (23.5)	2569 (22.5)	3195 (24.0)

Source: survey of causes of death - rural, GOI, 1982 -93.

Table X - Percentage Distribution of Female Deaths due to Communicable Diseases (1982-93)

Figures in parenthesis represent deaths in absolute number

**Figures in parenthesis represent the percentage of total deaths*

Age Groups	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
15 - 24	56 (6.03)	95 (8.57)	66 (5.96)	70 (6052)	79 (7.09)	68 (5.0)	72 (6056)	92 (8.46)	87 (7.39)	112 (8.32)	128 (8.02)
25 - 34	70 (7.53)	66 (5.96)	79 (7.12	76 (7.07)	67 (6.01)	84 (6.68)	96 (8.74)	95 (8.74)	106 (9.01)	114 (8.47)	187 (11.72)
35 - 44	35 (3.77)	39 (3.5)	30 ()4.71)	54 (5.03)	30 (2.69)	30 *(2.38)	34 (3.1)	24 (1.93)	58 (4.93)	43 (3.19)	69 (4.31)
>= 45	6 (0.65)	6 (0.54)	1 (0.09)	8 (0.74)	--	--	--	2 (0.18)	--	--	--
Total	167 (17.98)	206 (18.59)	176 (15.88)	208 (19.37)	176 (15.78)	182 (14.47)	202 (18.40)	210 (19.32)	251 (21.32)	269 (19.59)	384 (24.08)
Total deaths due to major comm. Diseases in age grp. 15 yrs	929	1108	1046	1074	1115	1258	1098	1087	1177	1346	1595

(source : Survey of Causes of Deaths, GOI, 1982 - 83)

Table XI : Female Deaths due to Child birth in India

Figures in parenthesis are death as percentages of deaths due to communicable diseases in 15 years.

	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
Maternal Mortality	161 (2.24)	200 (2.57)	175 (2.21)	200 (2.59)	176 (2.15)	182 (1.77)	202 (2.13)	208)2.26)	251 (2.50)	269 (2.36)	384 (2.89)
Communicable Diseases	443 (6.21)	489 (6.30)	470 (5.95)	473 (6.14)	504 (6.16)	532 (5.17)	545 (5.74)	490 (5.34)	497 (4.96)	624 (5.49)	775 (5.83)
Total Female Deaths	7129	7758	7902	7702	8187	10283	9494	9180	10025	11373	13291

(Source : Survey of causes o death (rural), RGI, GOI.)

Table XI(A) : Relative proportion of Maternity and Communicable Disease Deaths in 15 - 44 yrs Age group

Figures in parenthesis represent percentages of total death

	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
Anaemia with pregnancy	40 (3.42)	37 (2.46)	41 (3.15)	42 (3.18)	30 (2.12)	31 (1.93)	41 (2.38)	41 (2.46)	50 (2.82)	53 (2.47)	26 (1.02)
General Anaemia	24 (2.05)	52 (3.88)	67 (5.13)	44 (3.34)	49 (3.46)	69 (4.30)	75 (4.35)	58 (3.49)	69 (3.90)	95 (4.43)	135 (5.31)
Total	64	89	108	86	79	100	116	99	119	148	161

(Source: survey of causes of death, GOI, 1982-93)

Table XII : Distribution of Deaths due to Anaemia with or without pregnancy among Women aged 15 - 44 yrs

Figures in parenthesis are percentages

Year	Direct Obstetric Mortality			Indirect Obstetric Mortality			
	Certified by Doctor	Not Certified by Doctor	Total	Certified by Doctor	Not Certified by Doctor	Total	Grand Total
1966	49672 (92.79)	3858 (7.2)	53530 (89.17)	5898 (90.69)	605 (9.3)	6503 (10.83)	60033
1967	51925 (94.08)	3265 (5.91)	55190 (87.30)	7658 (95.37)	371 (4.62)	8029 (12.70)	63219
1968	44680 (96.96)	1397 (3.03)	46077 (83.61)	8599 (95.17)	436 (4.82)	9035 (16.39)	55112

(Source: Health statistics of India, 1966 to 1970,Director General of Health Services, Ministry of Health and Family Planning, Government of India)

Table XIII : Distribution of Maternal deaths by Obstetric Causes, direct and associated with General Disease

Figures in parenthesis indicate percentages

Chapter 5
Discussion and Conclusion

Historically, the state through its emphasis on maternity health focused attention on women's health issues. Both the Sokhey Committee and Bhore Committee underlined the enormous dimensions of the health problems of mothers and children and urged a high priority for maternal and child health services in the development of health services in the country. This high priority accorded to MCH continued during the 1950s. Its integration with the General Health Services laid a sound ground for catering to maternal health. However, this emphasis got diluted over the various plan periods when MCH was first denied resource allocation in favour of Family Planning and later usurped by the family planning programme as a tool for getting 'cases' rather than an objective by itself. In other words, even the narrow concern for maternal health was half-hearted and more an instrument of family planning rather than a reflection of concern for women's health.

The fact of subjugation of MCH emerges much more clearly in the pattern of Central Government expenditure which is clearly tilted towards family planning activities - the budgets of family planning programme have risen by 30 per cent to 40 per cent over the years but the comparative investment into MCH over 1982-93 have declined in proportion (113). Inputs into supportive programmes such as Post Partum Programmes and Community Health guide schemes have remained static or have actually declined (114).

Even within MCH the critical emphasis was on child survival and most targets were set for nutritional and immunization programme. The official emphasis has been on creation of demand for family planning by reducing the Infant Mortality Rate. The child survival strategies remained devoid of any steps to lower maternal mortality for a long time and even when focus was provided by safe motherhood programme, the goal was to reduce infant mortality with a view to reduce fertility.

In the 90s the concept of 'reproductive health' gained entry into the folds of health planning for women. Rhetoric aside, the introduction of reproductive health was not prompted by the government's concern for women's health but was another reflection of its commitment to the goals of fertility reduction. The attempt was to refurbish the family planning programme and give a new lease of life to it.

A major consequence of this development has been the current reformulation of FPP strategies. Along with pressures of achievements from population lobby, the protest from women's and health groups in the country about the morbidity and human rights violation associated with contraception, growing realization that FPP had reached a dead end, the fear of AIDS, the knowledge of links between AIDS and RTI, availability of new contraceptives such as injectables - all acted together to create conditions for the acceptance of a reproductive health strategy within the national FPP. It is in this context that the WB brought out its document entitled, "India's Family Welfare Programme : Towards a Reproductive and Child Health Approach".

Though important reproductive diseases are not the only health problems of women. In a milieu where we are talking of cutbacks in social sector and reduction of State's investment, it becomes very important to prioritize and target interventions which are multi-pronged with mutually supportable strategies and appropriate for a large population. It is in this context that the **incorporation of RH in the health planning for women poses problems :-**

Epidemiological Prioritization

It has become a common argument that looking at deaths is not sufficient (116)

morbidity with high death rates is not necessarily indicative of good health. Therefore, when resources are limited, a judicious handling of two with a focus on handling those problems first which lead to mortality is a accepted methodology (117).

Mortality data obtained from the Model Registration Scheme of Government of India indicates that of all the deaths among women, 65 per cent are caused by disease groups predominantly infectious in nature, and a mere 2.3 per cent are related to child birth. If women in the reproductive age group are looked at exclusively, deaths due to child birth increase to 12.5 per cent. Even in this per cent about 4-6 per cent deaths are due to complications arising out of associated causes and not due to the process of child birth alone. Deaths purely due to major infectious disease constitute 28.6 per cent of death in this age group. Another significant fact that emerges from the mortality data is that majority load of mortality is borne by girls under 15 years. These girls, therefore, enter reproductive age with a disadvantage and are not likely to be healthy mothers.

This data raises serious doubts about the appropriateness of identifying reproductive age groups for intervention when communicable diseases, anaemias and malnutrition are the major killers and they are problems common to all age groups. It also suggests that it is imperative to deal with health problems of under 15 years old girls who bear the highest load of mortality. From a Public Health perspective the data highlights the importance questioning an approach that handles a mere 2.5 per cent of deaths at the cost of 65 per cent of others.

Narrow Interpretation

There is a very real fear that with the population agencies being obsessed with the demographic objectives, the concept of reproductive health will get transformed into a package of "reproductive and sexual health services" and

even within this only those interventions will be targeted which lead to fertility reduction. One can see a reflection of the same when the Population Council in their transitional strategy for the next decade propose that the FPP "pay attention to those aspects of reproductive health that interact directly with the avoidance of unwanted fertility" and the list is limited to safe abortion, treatment of pre-existing conditions that would make particular contraceptive methods unhealthy, and treatment of contraceptive side effects. This technological fix has been further narrowed down by the World Bank which sees FPP alone as a necessary input to improve women's health.

Technocentricity of RH Approach

One major aspect of ground level reality affecting reproductive health in the country is the problem of technology, specially the contraceptive technology which has been the most complex issue in the entire complex of population policy issues. Women's groups have been concerned about its potential for abuse of long acting , provider controlled contraceptive technologies within a family planning programme that has been vertically driven by an excessive emphasis on meeting method-specific targets. Lack of transparency and general openness about test results and methods by those in authority tends to aggravate the problem further. There is lack of adequate technical information among policy makers, programme implementers and health activists. Information about the stage of development of particular technologies is not only hard to come by but also difficult to interpret (117).

In the WB report the technical integrity of the programme in seen as sacrosanct and not open to negotiations. " The MOHFW recommended in the action plan that injectables(hormonal contraceptives) be introduced under the program, initially under controlled conditions and gradually on a wider scale...Given the need for safe, effective and convenient reversible methods mentioned above, there seems every reason to phase this method into the programme, with the necessary training, surveillance and monitoring by the ICMR and the medical

college engaged in research and demonstration efforts regarding contraceptive methods...In order to give a wider choice of contraceptives to the acceptors, new contraceptives such as Norplant-6 and injectables shall be introduced under the programme, initially under controlled conditions and gradually on the wider scale". In keeping with its stated objectives of providing more choices the report's recommendations for new technologies to be adopted relies heavily on long acting hormonal contraceptive methods. Such programs are, by their very nature, provider dependent. More so, in an environment where women have very little access to information and health services.

The proponents of the method claim that risk-benefit assessment favoured these technologies in populations where maternal mortality is high and contraceptive prevalence low. These arguments assume that maternal mortality is caused primarily by unwanted pregnancies which contraception would avert. However they miss out that a large proportion of maternal deaths occur in women with wanted pregnancies. Causes due to reproduction account for two percent of deaths among women in India. Even in the reproductive age group they account for 12% of deaths. These percentages cannot account for the high maternal mortality ; the vast majority of these deaths are primarily due to diseases of poverty- undernutrition, anaemia, infectious diseases and lack of access to health care facilities in the event of complications of pregnancy. Contraception or sterilisation alone, thus, has an extremely limited role to play in declines of maternal mortality.

The approach ignores the social determinants of RH and reduces the concept to some discrete, maniputable package of services which are not rooted in the socio-economic realities of the women's lives and are not epidemiologically prioritized.

Interlinkages between RH and General Health Services.

A policy focus on reproductive health isolated from broader public and primary health care may be of doubtful efficacy because of the interactions between reproduction and other health problems. For e.g. treatment of anaemia by iron-folic acid supplementation has limited effectiveness in the presence of untreated hookworm and malarial infection. Similarly, management of a number of reproductive tract infections and STD's is difficult in the absence of clean water and sanitation. There is a growing evidence of problems of Uterine Prolapse in women who have had as few as 2 or 3 children resulting from the fact that their poverty and the lack of easy physical access to firewood, fodder and water means that they are forced to return to bearing heavy weights soon after child birth (118).

Good reproductive health care is, therefore, predicated on adequate primary and public health facilities, including easy access to water and sanitation. This synergy between RH on one hand and primary and public health on the other hand is rendered more critical by deteriorating health infrastructure and the resurgence of diseases such as malaria in other virulent forms. A major dilemma is, therefore, how can women's reproductive health needs be addressed when the primary health care infrastructure is in the appalling conditions that it is, and when budgetary finances for health have been cut in the post 1990's fiscal environment.

Instead of focusing on maternal mortality and its causes, the term, reproductive health, diffuses the focus. It highlights contraceptive technologies, abortions, sterility and RTIs without locating them in the overall social, economic and

epidemiological context of Indian women (119). An already weakened infrastructure is further burdened by a host of new activities (with an emphasis on fertility reduction). It argued that the term 'RH' shifts emphasis from maternity to reproduction when the MMR is still high and preventable infectious diseases continue to be the most critical threat to life (120).

It appears from the above analysis that the integration of RH into the health planning for women in India has not been based on any epidemiological prioritisation and is likely to erode any remaining scope for a comprehensive strategy for women's health. The Rights rhetoric aside, the onslaught on women through contraceptive technologies, in guise of providing a wider choice, will continue and be intensified. The RH approach will be in continuum with the existing FPP of GOI. The question, therefore, that one needs to ask is **why was there a need felt to introduce RH ?**

The next logical step is to look at possible factors, explanations or motivations that could have contributed to the introduction of RH in health policy and planning.

Let us look at rationale that were employed to justify RH :-

Conceptualisation of Maternal Health was very narrow

An argument provided for the substitution of 'maternal health' with 'reproductive health' was that the definition of maternal and child health was limited and there was a need to broaden the scope by adopting a reproductive and child health. This argument does not hold true if we look at the original definition of maternal health. WHO conceived of maternity health in the fifties as , "In the narrow sense it is the care of pregnant women, her safe delivery, her post natal examination, the care of her newly born infant and the maintenance

of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well being of the young people who are potential parents, and to help them develop the right approach to family life and to the place of the family in the community. It should also include guidance in parent craft and in problems associated with infertility and family planning". In other words the definition carried with it the potential of growing into a much wider concept covering issues of ill-health, family planning, attitudes towards and perceptions of sexuality, family, and society (121).

Till the sixties the integrated nature of maternity health was fully recognised by WHO. Infectious processes were rightly understood to harm the foetus if the mother was exposed. This broad-based perception of maternity continued through the seventies. In 1976, though Primary Health Care and education of mothers was added to the core of services, 'unplanned reproduction' and the need to regulate fertility acquired importance. Later, the term maternity health was incorporated into the broader terminology of reproductive health that WHO adopted. Other than maternity this covered abortion, contraception, HIV, AIDS, RTIs and Sterility Services. It is not clear as to why could the reproductive health needs be not met within the scope of maternity care ? Looking at the elements of this new approach it is not very clear how it broadens the scope as the original definition of maternity care by WHO had adequately included the additional dimensions of RCH which are being promoted as new.

Failure of MCH Programme

Different Documents and plan periods have emphasised that the performance of MCH programme has not been satisfactory or that the targets for ante-natal care or immunization have not been met adequately. This was advanced as a reason to review strategy of MCH approach and finally resulted in being used to

justify that MCH approach was too narrow, inadequate and in essence a failure. Subsequently, Reproductive Health was suggested as a more comprehensive, broad-based strategy towards women's health. However, an analysis of policies and plan documents reveal that the problem lies more with the implementation of the programme and the mismatch between recommendations and reality that continue in health planning.

Bhore Committee had envisaged MCH services as firmly grounded in a strong general health services. However, after its evolution MCH got completely overshadowed by the objectives of population control. This situation got further compounded when in the name of integration the general health services became sub-ordinate to the family planning programme and the sole criteria for assessing performance was reduced to couple protection rate. The shortage of women doctors in peripheral institutions, non-functioning PHCs, poor referral services, lack of supplies of drugs, and the absence of electricity at the PHCs, together with indifference of senior health officials responsible for supervisory activities at the district level, limited the possibilities even for comprehensive strategy towards adequate maternity care.

Political considerations

It appears from the above analysis that the move towards RH was :

- not prompted by the government's concern for women's health.
- in continuation with the existing policy of advocating population control at the cost of women's health.
- it is going to overload an already burdened and weakened structure instead of strenghtening the General Health Services.

Therefore it leads one to look for the basis of shifts in strategy towards RH was political and lies outside the realm of health system. The answer to the question of 'why Reproductive Health?' lies in the **'Aid Conditionalities of Structural Adjustment Programme and the influence wielded by Population Lobby'.**

A very large number of developing countries have in the last decade and half, incurred heavy international indebtedness owing to balance of payments problems and have been obliged to implement 'structural adjustment policies as laid down by International Monetary Fund (IMF) and the World Bank as a condition for obtaining loans. These policies are ostensibly designed to correct external payments imbalance(stabilisation) and restructure the economy(adjustment) by imposing deflationary contraction on the economies concerned (121).The preoccupation is with economic growth per se and represents a retraction from any marginal move in the 1970s towards a Basic Needs Approach to development. In the context of adjustment, education, health and other social services which were considered basic rights and needs are increasingly seen as commodities for purchase. Non Governmental Organisations are encouraged to play a greater role in providing services for 'vulnerable' and 'underprivileged' groups. 'Trickle-Down' approach is relied upon to improve the standards of living of the majority inspite of previous experiences that demonstrated that this does not work.

Literature available on the impact of SAP on the impact of SAP in Latin America and Africa which implemented the programme before India show that it has led to widespread miseries(122) which has had great implications for women's health.

It is important to look more closely at these implications to fully appreciate the importance of introducing RH into the health planning. When we consider the implications of Sap, it appears that it would have both direct and indirect effects on health care. Indirect effects arise primarily from the macroeconomic changes that lower income or cause a rise in prices.. Objectives that aim at decreasing demand and employment, rising prices, and reducing government services and rely on the development of the private sector have the potential to increase morbidity and mortality and thus, affect health status.

SAP and Marginalisation of Female Workers.

Female marginalisation in its generic form contends that the process of industrialisation and economic development are accompanied by marginalisation of women in the production process. It can mean exclusion of women from the productive employment either as decline in overall work participation rates or diminishing share in wage and salaried employment (122). It can also mean the segregation of women workers in certain specific jobs which are low in occupational hierarchy, less rewarding and low in status (123). It may also mean economic inequality reflected through gender wage differentials and 'casualisation' of female labour force.

Research and studies during the last two decades show that though the share of agriculture and allied activities in GDP has declined from 54.91% in 1951-52 to 1955-56 to 38.82% in 1985-86 to 1989-90, it is still the largest component of GDP. Two-thirds of India's work force and 80% of all economically active women are engaged in agriculture and allied activities. As part of SAP, government has initiated a series of policy reforms in agriculture comprising of removal of input subsidies on fertilisers, irrigation, electricity and credit over time; realigning domestic prices with international prices by removing all trade restrictions; unification of prices so that dual markets in food grains and other

agricultural commodities are eliminated; removal of restriction on production and marketing choices and incentives for the expansion of agribusiness. With increased emphasis on export earnings, there is a likelihood of cropping pattern shifting in favour of cash/export crops which implies a change in the form of payment and nature of employment. For e.g. in Kerala shifts to crops such as rubber and coconut has severely limited the employment opportunities for women (124). Implications for women from small peasant households would be more complex as in cash crop cultivation they are primarily involved as unpaid labour. Increase I cash crop output will put pressure on women ti increase their labour contribution without resulting in any greater control of income. There will also be a shift in the nature of payment eg. in Tamil Nadu the practice of partial payment of wages in food grains has declined implying a decline in real household income(125).

The impact of SAP in the industrial sector would be greater. Disinvestment of the public sector and reduction in public expenditure will necessarily imply a reduction in employment in the organised public sector. this will have a negative impact on women as public sector is the leading employer of women in the organised sector. Women may be the first to be retrenched as they occupy lower hierarchies. In India between 1991 and 1992 growth in female employment in the public sector has decelerated to 2.7% per annum from the level of 8% per annum in the eighties.(126)

The Indian rupee has been devalued to enhance it's export competitiveness and this may increase employment of women in the export oriented industries. However much would depend on the nature of the market and how India is able to compete. Another aspect of these industries is that they employ young girls. Their exploitation in pie-rate work in export oriented garment industries is well documented. This would further reduce her access

to education as he would have to share a great burden of substantiating house hold income.(127)

Introduction of modern technology will increase the demand for skilled and increase productivity per labourer to maintain competitiveness with international firms who are being encouraged to invest in India. Since women have fewer skills as compared to men it is likely they will be pushed out from the production process in this labour restructuring. Many of the agro-processing units are facing crisis due to removal of subsidies. Many of these units in these industries will either shift to household enterprise or mechanise. It is again primarily female labour which will be retrenched considering the bias of the employer, the social constraints and their obligatory domestic responsibilities.

In many developing countries implemented SAP has led to informal sector flooded with unemployed and retrenched. Based on census data it shows that employment grew in unorganised sector at 2.61% between 1981 and 1991 compared to a growth of 0.1 % in the organised sector. However even in informal and self employed sectors women may not be able to compete with men. They are relegated to the bottom of informal sector in jobs such as petty vending and domestic services. If most labour legislation, specially the ones protecting the rights of women are dismantled, female labour may appear disadvantageous given the possibility of disruption in work due to demands of maternity and child care. This may also lead to significant out-migration of women into such sectors as "sex tourism".

SAP and Access to Food

from the point of view of food security in today's under-developed nations, the most important feature of the colonial experience was the displacement of domestic foodgrains production by exportable productions for metropolitan markets. During 1893 to 1947, food grain outputs in British India virtually stagnated at a 0.11% annual growth rate while non-food crops for export grew at an over 10 times faster rate of 1.31% annually. This led to a substantial decline in the per capita availability and absorption of foodgrains ranging from as much as 35% in the inter-war period to nearly 20% even in the most prosperous states. The subsequent shock of the large deficit-financed war expenditures after 1940, concentrated in Bengal, led to a rapid rise in food prices and precipitated a large scale famine claiming 3 million lives.

Uniformed experience of less developed countries, which have opened their agricultural sector to the forces of international demand as part of SAP, has been a fall in their per head production of basic food grains for their own population and a rise in the per head production of exportables - an experience similar to the Colonial period. A number of countries in sub-Saharan Africa have faced the alternatives of either letting their population starve or of incurring further indebtedness for food imports.

Policy changes required under India's SAP include the phased scrapping of food subsidy, curtailment of government procurement operations and eventual restoration of free market in foodgrains; including opening up to the international market. This has led to accelerated inflation. By May 1994 the increase in wholesale prices was recorded at 11.1% which was significantly higher than the rate of 8.5% recorded in 1993-94. There have been two disturbing aspects of increase in prices- food prices have accelerated more sharply than the general price index; and vulnerable the highest increase in

prices. A recent study found that top decile in rural areas suffered 12% inflation rate while the bottom decile suffered 18% inflation rate(131).

Another recent study has shown that there has been an increase in the number of poor between 1990-91 and 1991-92 by 8.1 million in rural areas and 2.6 million in urban areas. High rates of inflation adversely affect women who shoulder the burden of provisioning for the family as they often cutback on their own consumption to manage resources. Daily reproductive work also increases as there is a tendency to curtail expenditure on items which could be produced by her own labour. Pickling, servicing, repairing etc. become increasingly important time consuming activities substituting for commodities available the market. During adjustment programme women's monetary contribution to the household economy becomes critical but the policies diminished this income by creating unemployment in the formal sector in lower paid' less skilled job where women are concentrated and secondly by forcing them into informal sectors where falling demand due to lower real incomes increase competition and the time to produce a surplus. There is increasing evidence that the poor (132) women are having to increase their activities to generate income at the same time as having fewer resources to support them in the work which is seen as their primary responsibility - child rearing and a whole range of domestic tasks to maintain the family.

Women constitute a significant section of the poor. Two-thirds of women agricultural labourers are below the poverty line according to the NSS. Female headed households constitute about 35% of the poor households. Iot would not be wrong to assume that women would constitute a majority of the increasing poor in the period of stabilisation. According to Human Development Report, 1990 (UNDP), "a large proportion of poor households are headed by women. Female members of the household are worse off than male members because of

gender based differences in the distribution of food and other entitlements within the family. SAP has, does, reinforce the phenomenon of growing and deepening 'feminisation' of poverty.

There are two important features of food economy and Public Distribution System - the fragility of food self-sufficiency achieved by the country and the implications of a very high degree of regional concentration of food output and procurement. This imparts an important dimension of urgency, to the continuation of the PDS because the free market cannot and will not respond to the consumption needs of the rural and urban poor and will not re-channel food supplies within the country where they are needed the most. However the trend has been to reduce the size and scope of PDS and price-hike in cereals distributed through PDS. This is very serious in the context of declining per capita monthly consumption of cereals.

SAP has effected a contraction in expenditures on special programmes that provide income support to the poor. There has been real reduction in expenditure on both IRDP and JRY between 1991 and 1994. In case of JRY the number of person days of employment generated has declined from 864 to 778 million person days in the same period. Similarly families assisted annually under IRDP has declined from 3.35 million to 2 million between 1989-93. One can expect an increase in morbidity rates among women with decreasing consumption and an increasing work burden.

- Decline in wages and employment mean that there is less family income for spending on health care as more money needs to be spent on food due to increasing food prices.

- Increase in foodgrain prices mean that women would cut back on their own consumption which would have deleterious effect on her nutritional status.
- Economic attack on women's health are reflected in the health of children. Undernourished mothers working upto 16 hours a day have little chances of maintaining a healthy pregnancy. Even if pregnancy comes to term, chances of survival of the child and mother are low.

The most visible impact of SAP is aimed at restructuring the health service system. The key elements of the new strategy are:-

- Primary health care centres are to restrict their activities to prevention of communicable diseases and promotion of family welfare.
- Encouragement of private sector and restriction of curative care to this sector.
- NGOs to be encouraged in health sector.
- User fees to be introduced in public hospitals.
- Reforms under SAP have involved withdrawai in India's commitment to health sector development. Centra; grants as a proportion of the state's total medical health expenditure feel sharply. In the case of centrally sponsored disease control programmes, the share of central grants declined from 41% in 1984-85 to 29% in 1988-89 and declined significantly to 18.5% in 1992-93. Real expenditures declined even more sharply. States which are dependent on central funds(most of which are poorer in terms of socio-economic indicators) suffer more. This implies disparities in provision of health facilities across states. Given that the poor depend to a greater degree on health facilities provided by the government, a reduction in the per capita health expenditures is bound to a lead to a further deterioration in the quantum as well as quality of services rendered in the public sector. The

reduction in the relative share of public health is particularly alarming as several communi9cable diseases have shown a resurgence in recent times.

- Cost recovery programmes, such as user fees may lead to reduced utilisation by the poor, and among them women specially who are likely to delay medical care so as to minimise health cost. It will also mean that gender differentials in health care among children and adults will widen greatly.
- Prioritisation of health services is likely to adversely affect the maintenance cost of the health of the poor. Los of subsidies will have direct effect on import of essential medicines. This will also result in medical care for each episode of illness. There will be drug shortages and resultant morbidity and mortality. As the poor are likely to face the situation of depressed real incomes thereby limiting their demand for health services. As majority of the poor are women they are likely to suffer the most on account of their unequal health status.

Population Control measures are part of the WB - IMF aid conditionalities.

At both the international conferences at Cairo and Beijing in 1994 and 1995, questions of defining development and assessing state strategies for it were not open to debate. Women's welfare was considered within the framework of SAP. One can therefore see that in order to fulfil the aid conditionalities, Indian Government had two obligations - to cut down on the state's investment in welfare, and yet retain it's electoral majority; and to control population growth in such a manner that evokes no protest from any quarter. 'Reproductive Health', therefore, becomes the new strategy of the state. The state continues through this new strategy to pursue it's goal of fertility reduction and yet appear as if it is shedding it's earlier dogmatic and technocentric stance. By appropriating the language of women's movement, the state appears to be truly concerned about women's welfare. Also by centering the debate around gender

issues it is able to obfuscate the more important and pertinent issues related to economic policies being pursued by the government and its consequences of increased marginalisation of people.

An important part of this effort is the greater inter-agency co-operation and coalition building for population control consensus. The chain of engineering consensus begins with the most powerful population donors, the WB, USAID and UNFPA, co-ordinating their pressure on governments to implement population control policies. In a candid article about shaping population policy, two Bank officials described the process in Senegal- the Bank and UNFPA carried out a joint sector mission to document the importance of population, while USAID funded presentations were given to leaders from ten regions of Senegal demonstrating the impact of rapid population growth on development potential. Then the Bank regional staff spoke about population with high level officials when discussing terms for a structural adjustment loan. As a result, preparation of a Population Policy Statement and Action Plan by the Government became an 'agreed condition' of the loan (123)

An important element of pushing this agenda has been the role played by the national and international NGOs in the implementation of the reproductive health strategy for population control. NGOs dependence on donor agencies limit their scope of action and ability to be critical . A critical instrument in the pushing of this agenda and in 'selling' this strategy has been to rationalise it through research and literature.

Research

There has been a spurt of activity to emphasise reproductive health. Huge funds are being invested by funding agencies to generate data on reproductive

health. Organisations such as Ford Foundation and Mac Arthur Foundations are supporting social science research and interventive strategies to improve the reproductive health of women. Ford Foundation in its strategy paper proposes to propagate RH research not only through social science and bio-medical institutions but also through non-governmental community based organisations. The latter are seen as a means of direct intervention to promote RH. This thrust of the funding agencies has led to a perceptible shift from activism to research among the NGO sector. More and more of them are getting involved in training programmes for reproductive health. Guided by the funding agencies professional experts, the participating NGOs often adopt their given methodologies and conceptual framework. The consequence is that RH research does not arise either out of the perceived needs in women's lives or epidemiological priorities. A case in point is the Amar Jesani and Neha Madhiwalla's study funded by Mac Arthur Foundation, " Morbidity Among Women in Mumbai City - Impact of Work and Environment".

The study is based on a household survey of 430 households, selected from five different clusters, all located within an area of one square mile, on the basis of their 'class character' which was ascertained using certain indicators such as the occupation of its residents, condition and size of their house etc. These households were classified into categories of 'slum' and 'non-slum', the slum being defined on the basis of the degradation of the immediate environment observed by the researchers. The study purports to modify earlier studies on morbidity by using a probe list of 14 questions probing specific symptoms to elicit more information on women's health and by using women respondents only who had been trained to make them more sensitive to women's health problems and the difficulties that women face in articulating these. Exclusive female respondents were used for interviewing. In the interview, the woman respondent was asked about all episodes of illness experiences by all family members in the month of June 1996. Following this,

specific symptoms were probed for all women above the age 11 years. The resultant data on morbidity was then analysed. Symptoms were coded into eight types of illnesses based on physiological system. However they included categories such as 'pains, aches, injuries' and 'weakness.'(124)

The study reported 'dramatic gender differences' with female morbidity being higher than male morbidity in all age groups. Female morbidity was reported as twice as higher than males prior to probing and increased to three-and-a-half times after probing. Male morbidity was found to adhere to a U-shaped curve with morbidity at both ends of the life span being very high while in females the morbidity was found to rise with age till they reach the age of 45 years, after which they decline to a small extend. The study also reports that cohabiting and ever married women reported a much higher morbidity than never married women. They further found that high morbidity rates among women were complemented by the high prevalence of specific type of illnesses with the reproductive illnesses forming the largest group of problems related to menstruation and child bearing (28 : 2 :1). Taken together, reproductive health problems, aches, pains and injuries and weaknesses all of which are interrelated and form a complex of gender related health problems, form 51.69% of all illness reporting among women. The study goes on to state that, "married cohabiting women with children in the reproductive age group who live in the slum environment are the most vulnerable to ill health and the possible explanation of the high morbidity in slums is the degradation of the physical environment".

There are some methodological problems with the study :-

1. In its concluding remarks the study mentions that, 'this study indicates the gender-blindness of household level health surveys. When no importance is attached to gender of the respondent and interviewer, the levels of morbidity

reported for both males and females are almost similar.' I feel that this is a sweeping generalisation specially when you consider that this is based on a very small sample for a pilot study. It can be conceded that national level household surveys suffer on account of not having trained investigators but it is not necessary that all large surveys must always use sex-matched investigators.

2. In their opening remarks they mention that both categories - one which can clinically be defined as illness and may not be experienced so by the women for whom it may be a natural part and conversely, a complaint made by a woman and not clinically established - must be part of women's morbidity. "Unless we are prepared to accept and observe both these categories of problems, that part of women's morbidity will not emerge. It is a case of not seeing what we are not prepared to observe in the first place". However, I feel that this study is more a case of, 'seeing what we want to and are prepared to see in the first place' which is exemplified by probing for specific symptoms. The study does not make a mention of what questions were used for specific probing for reproductive morbidity of women and why probes for other complaints were not used.

3. The researchers talk a great deal about gender-sensitivity and how it was important to consider what women considered as a health problem (such as weakness, pains, aches and injuries) even though they are not strictly clinical classification of morbidity. This gender-sensitivity was to be increased by using women respondents and interviewers. However, I am not so sure about justification for using female respondents to gauge male morbidity. Is not what they perceive as illness equally important to assess male morbidity in order to make any fair judgement on gender-differentials in morbidity? What about probing for specific male problems?

4. The study mentions that women in the reproductive age group suffer from very high morbidity in terms of illnesses for which this study examines. This

exercise would have been much more fruitful if other illness categories eg., communicable diseases were also included.

The above study is an example of how international funding agencies influence the researchers to provide justification for the reproductive health programme, thus providing an "objective" and "scientific" base to their own agenda of population control through reproductive health. Similar studies have also been conducted by WB and UNFPA. For eg. the WB report on Policy and Finance Strategies for Strenghtening Primary Health Care mentions that the women in the main years of child bearing bear the greatest load of excess mortality, a fact that is not borne out by data.

Illness and death from reproduction related causes are significant for women, however, a concern for women's health needs to look beyond the sphere of reproductive health per se. Even if we accept the RH approach within the health planning it is imperative to define priorities within it which must be reflected in appropriate resource allocations.

At present, there is a lack of reliable data which can help in identifying relevant policy interventions. In such cases the choice of interventions gets defined by the availability of the technology or other factors not linked to desirable health outcomes. The intervention chosen then makes little difference to the profile of morbidity and mortality and represent a waste of scarce community resources. There is therefore need to stress RH research that is a consequence of the perceived needs in the women's lives or the epidemiological priorities.

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