

Women's Health: Fifty Years of Independence

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Women's health is an outcome of their social existence. The Indian women, though they had participated overwhelmingly in the National Freedom Movement, suffered since various aspects of their lives including health were under the control of the patriarchal social norms. The discourses on women's health revolved around biological reproduction; and successful biological reproduction meant a son by a 'pure' mother. This was the fulfilment of any man's existence and the ideological justification of man's control over women (1). Similarly, in the history of health services in Independent India, the health of women has been perceived by the planners primarily in the context of 'motherhood'.

In the economic production processes, women specially those who had to migrate to the place of their work, were socially discriminated against and were not favoured. At that time, the International lobby for women's health offered the Indian working class women, 'maternity benefit and leave' only. The burdens of malnutrition and hard factory labour on women were recognized only in the context of motherhood, while they continued to suffer from problems of low wages and imminent unemployment (2).

Women started expressing their struggles, voice their resistance and protests against the adverse physical and social conditions, through their writings. Some of them formed the left-wing Progressive Writers' Association with men during the Freedom Movement in the 1930s. But with independence and the gain of a secular state with constitutional guarantee of equal rights of women and men in political and economic life, the wave of women's movement had temporarily settled down (3). The movement, however, got intensified since the seventies with wider understanding of and deeper insights into women's lives. Over time on various occasions / accounts, it has brought out the limitations of the narrow perception of 'motherhood' in health planning and in capturing the realities of women's health problems in Indian society. The implications of this for women's health is serious both ideologically and empirically.

Ideas at Independence

At the time of Independence we had two important documents, which later influenced the Five Year planning on health. One is the recommendations of the National Health and Development Committee (generally referred to as the Bhore Committee) 1946 (4); and the other is the report of the National Planning Committee (also known as the Sokhey Committee), which was published in 1948 (5). Both the committees expressed worries and were concerned about the high rates of mortality as well as morbidity prevailing among mothers and children of our country. The scenario of maternal mortality was depressing. Maternal mortality rate (MMR) in certain provinces was as high as 12.9/1000 live birth and fifty per cent of the maternal deaths were due to puerperal sepsis and anaemia(6).

The Bhore committee had accepted that "the health of the people depends primarily upon the social and environmental conditions under which people live and work, upon security against fear and wants, upon nutritional standards, upon educational facilities, and upon facilities for exercise and leisure"(7). Holding such a holistic understanding of people's health, it also recognized in a wider context that: 'A nation's health' is 'perhaps the most potent single factor in determining the character and extent of its development and progress'. Any investment/effort on improving the national health would yield 'immediate and steady returns in increased productive capacity' (8).

The Sokhey committee, on the other hand, categorically emphasized on the productive role of women in the Indian society. Recognizing women's economic role and expressing concern for their health in relation to the environment at the place of work, it had recommended "Legal Protection of Women's Labour in Factories". In addition to the Factory Act of 1934 (which regulated the hours of work for women and employment of expectant nursing mothers), it also recommended that establishment of 'creches' must be compulsory in all the factories which employed nursing mothers. There was yet another recommendation to bring all the provinces under the 'Maternity Benefit Act' (9).

These committees recommended state supported and integrated preventive, promotive, and curative health care services for pregnant and lactating women in a three tier organisational structure for maternal health at the district level (10, 11). With these, the Five Year health planning was initiated in India. Provision of health services to the entire population was adopted as one of the directive principles of state policy (12).

The Strategies in Planning

The strategies adopted in health planning have been shaped by the strategies of overall development at home as well as by the discourses in international development (13). The trend is also of shifting emphasis within health, differential investments and inadequate growth of infrastructure.

Between Poverty and Population

The wider debate whether poverty or population growth is the key issue in socioeconomic development, has influenced the Indian planning in health. Initially, Maternal and Child Health (MCH) received utmost importance in the first two Five Year plans which aimed at building a sound and healthy nation through socioeconomic development (14, 15). However, the idea of 'population growth against limited resources' made a dominant appearance in the Third Five Year plan and 'population control' became an important component in the overall development and health planning. As a consequence, the MCH that had to provide maternal health care, no longer could attract the planners as before. Family Planning came the major force. During the Fourth and Fifth Five Year plans, however, an alternate pro-rural and pro-poor perspective emerged in planning. There were promises following the Declaration of Alma Ata, to achieve 'Health For All by 2000 AD through community participation and intersectoral co-ordination through primary health care approach (16). Minimum public health facilities integrated with Family planning and nutrition for the vulnerable groups including pregnant and lactating mother was one such promise made (17). But despite these attempts for forming an alternate view in health planning, 'Population' prevailed over 'Poverty'. The population Policy of 1976 asserted that 'the process of development is not to be lopsided unless socioeconomic imbalances in the health services are removed speedily'. It accepted 'Birth Control' as vital means to the attainment of the goals of 'Health For All in the shortest time' (18).

Later, the Working Group on Population Policy, in 1980, clearly equated general developmental strategy and population policy as 'two sides of the same coin'. The emphasis in the Sixth Plan quite naturally was on 'population control' (19). The implications for MCH was obvious. It was treated as an appendage to the Family Planning Programme (FPP) (20).

Maternal Health : The Glory and Sacrifice!

The MCH was marginalised not only by overemphasis on the FPP while planning, but also due to unequal sharing within the MCH itself. During the 1980s when the strategy of 'Health For All by 2000 AD' was already accepted, the difficulties of cost and personnel became major obstacles in attaining the goals. There was a shift from 'Primary Health Care' to 'Selective' Primary Health Care. The latter, of their six components, contributed only a small proportion to maternal health (21)E The 'Child Survival' strategies adopted, by UNICEF, also had, little to do with mothers' health per se. The evolution of maternal health in 'health planning is very similar to the way women have been viewed in the patriarchal Indian society. The text and scriptures in ancient India reveal that 'human motherhood' was socially glorified by adding an additional 'divine' dimension to it. Thus glorified 'motherhood' allowed women only self-sacrifice and practice for the well-being of the 'father' and 'son'(22). One can perhaps find a simile in the history of Maternal health within MCH.

When maternal health was receiving less and less attention in the planning, the Working Group on Population Policy of 1980 had already proposed something different (23). It considered "Women as the best votaries of family welfare programme" and replaced the view of 'motherhood' by 'womanhood'. Through the Seventh Plan period, this has been extended to Women's upliftment and development in the Eighth Plan. These, however, took place following the international decade for women which ended in 1985.

On the other side, influenced by the Feminist ideas, the Indian Women's movement for women's right to health and development had come face to face with the population control establishment. The emergence of apparently similar concepts, however, had been associated with very different interests and concerns in the two. The reproductive health initiative that emerged in the international women's network for their reproductive rights were later appropriated and transformed into 'reproductive health' in the International, Conference on Population and Development in 1994 and received global acknowledgement (24). Simultaneously the international bankers and many other organizations expressed their 'concern' in the Indian development in various ways. The Draft National Population Policy of 1995 had emphasISEthe concept of reproductive health of women for a 'pro-nature, pro- poor and pro-women' policy towards equitable and sustainable development' of the nation (25). It was highly criticized by Indian women's organizations on various grounds. One of those was for the contradictory statements that 'development needs to be equitable for its sustainability', against, putting the blame for the environmental degradation on

'population and poverty' and the statement that access to food, education, health and work for all 'will remain illusory, without limiting population growth.

Investment in Health : Picture of Differences

In Independent India, the trend in investment in Health sector over the Five Year Plans has remained much below the recommended proportion (10%) of the total allocation on development. Within health sector, however, the proportion of investment in 'Family Welfare' has increased steadily over time with a constantly higher attention to the family planning programme as compared to MCH. This has existed simultaneously with the dominance of the 'Population establishment' in the overall socioeconomic development. In contrast, investment in the area that includes Communicable Disease Control programmes, experienced a slow but steady crunch till few years ago (26).

The Infrastructure : An Unfinished Agenda

The Indian Health Planning was initiated with the recommendations of the Bhore Committee. It suggested an infrastructure in health services that would have one woman doctor, four public health nurses, four midwives and four trained dais in a primary health unit, covering 20,000 population. However, @@@en in the 1960@s, each PHC had only one medical officer, a sanitary inspector, one health visitor, a compounder and four auxiliary nurse cum midwives (27). Later, adoption of 'Health For All by 2000 AD' led to a considerable increase in the number of PHCS, subcentres and doctors serving there. The new schemes brought in personnel like community health volunteers and trained dais who joined the PHC network to make services meaningful for the rural masses. The dai training programme was supposed to directly help the MCH work(28). The emphasis on improving infrastructure continued. The Seventh Plan recognized the large gap between the infrastructural requirements and availability and emphaSIZEon its development (29). This included not only construction of health centres but also training and employment of health workers. The Eighth Plan document though it continued to accept that there is a mismatch between the requirement and availability of health personnel in different categories, eventually the message was for 'consolidation and operationalisation rather than major expansion' of the PHC network 'so that, their performance is optimized' (30a & 30b).

Besides inadequate expansion, the health infrastructure was also affected by inconsistent recommendations by various evaluation and advisory committees, set up at different points 'in time. Such committees which looked into the functioning of Primary Health Care scheme, Health and Family Planning Services and MCH services

separately (31,32,33,34,35,36,37) Cargo had different objectives. The recommendations had mostly resulted in periodical integration and disintegration of the services of family planning and communicable disease control programmes with that of MCH. In the name of integration, the intermittent shuttling of workers between unipurpose and multipurpose roles at the primary level left the inadequately met infrastructure, weak. Delivered through such infrastructure, MCH became a merely target oriented programme wherein, maternal health revolved around immunisation and iron-folic acid supplementation to pregnant mothers against tetanus and anaemia respectively. Even within this, the performance has been repeatedly reported to be far from satisfactory (38,39).

Implications for Women's Health

Health planning in independent India has severe implications for the health of women, even within the narrow perception of 'motherhood'. Given the high priority to MCH in health planning during the Fifties, followed by its integration with the general health services created a lot of future possibilities in the beginning. But the task of providing health services to the mothers and children became complicated when MCH intermingled with other programmes at the PHC 90' level.

Since independence, though there has been improvement in maternal mortality (death of women due to complications of pregnancy and delivery) figures, it has remained nearly stagnant over the past two and half decades (40). Despite periodical planning, there is little improvement in the proportions of critical causes of maternal death like, puerperal sepsis and anaemia. While proportion of puerperal sepsis as a cause of maternal death has declined from 32 percent in 1936 to 10 percent in the beginning of the 1 990s, reduction in the proportions of anaemia as a cause of maternal mortality has been much less. It has gone down from 23 percent in 1936 to 19 percent only, over the same period of time. The decline in puerperal sepsis might be explained by better living conditions of people, a rise in consciousness and some increase in their access to health care services and introduction of trained dais in the unchanged scenario of home delivery. It might also be due to reduction in the virulence of causative agents. The slow improvement in the prevalence of anaemia in causation of maternal death, however, has been explained in the failure of the National Anaemia Prophylaxis programme(41). Above all, the declining sex ratio reflects not only the poor health status but also the subordinate social status that women have received in this country (42).

There is a need for understanding women's health in totality, embracing 'maternal health' as well as the general ill-health' of women together. Since the mid eighties,

'maternal health' has been supplemented by women's health care' in health planning. The discussion on bringing reproductive health services(covering more problems such as reproductive tract infection, sterility and abortion) to the community through the primary health care network (43), therefore, also needs a careful reflection on the abilities of the infrastructure to reach out to women. In fact, infrastructural facilities seem to be an important pre- requisite to any attempt of rendering health services to women. However, infrastructural development of government health services alone does not necessarily ensure 'treatment of illness' for the poor, as seeking treatment is mostly associated with their recognition of 'severity' (74.61 percent according to the government assessment of the utilization of health care service's in early 1990s), which is rooted in the material and cultural basis of life (44).

In the hierarchical structure of the Indian society, it is the dalits and the tribals who are placed at the low--' rung. They are not only socially discriminated but also economically deprived. Although the official surveys are yet to substantially capture the poor health status of Women in general, there is increasing evidence that in the families where there is a constant interplay of the constraints of poverty and other social forces, processes influencing health in poor households push women to a marginalised position. They often die more painful deaths as compared to their male counterparts. Even within few kilometres of subdivisional town in a state like West-Bengal, women who suffer from chronic ill-health, die with little or no attention from qualified medical practitioner. This, however, mostly goes unnoticed in the intellectual discourses of medical ethics (45).

In the family, women confront ill-health within the boundaries of restrictive social norms. These norms, internalized by the members of the family including women, create a situation where various complexities and limitations are accommodated and absorbed by the women at the cost of their own right to expression. Besides, they also provide emotional support and extra physical labour whenever their husband or other members of family fall ill. In addition, they 'practice 'self-denial' and continue to keep their ill-health to their own selves. The gender restrictive social norms act as critical factors in determining women's health at family level.

Thus, women's health no more remains limited to the discourses of planning and the development of health services only. Rather, it points at the larger issue of gender - which is socially constructed and internalized. In this context, women's social status and its objective reflections in areas other than health care, such as education or employment, become equally important in the discourses of improving women's health. It is worth while mentioning here that the current national documents on education clearly reflect on the disadvantageous position of women, specially in the scheduled

caste and tribal communities in the rural areas (46). Similarly, women are the worse hit when it comes to employment. They are under-represented in the work force (47), their marginal position pushes them into unorganized sector where they are denied their rights. Above all, specific occupation and the pressure of earning and household activities lead to poor nutrition and ill-health (48).

In conclusion, one may like to draw attention to the major trends that prevail in the philosophies of current health interventions. On the one hand, we have the international forces influencing the State health interventions, and on the other, we have attempts of bringing 'the people' and their social existence to the centre stage. At this juncture, the discussion on women's health since independence would remain incomplete, without locating it in the current context of globalizationE

The wave of globalization, imposed by the more developed world has started producing a crisis in the developing world. While some articulate it as 'cultural annihilation' (49), there are others who elaborate it further. Gorostiaga describes it as the predominance of 'geoculture' that aims at a top down homogenisation of culture from the 'Global Dreams and global images' set by the wealthy nations (50). Thus in the developing countries like India, people's health, which is partly the way of their life, is also at stake. Women, given their socially disadvantageous position, are specially vulnerable to such forces.

The attempts for change, however, move in two directions. Some believe in choosing options while floating along with the tides of 'adjustment' to the forces of globalization. Others, on the basis of the sub-human experiences in the developing world, reject it saying that it has helped only in maintaining 'status quo'. Instead, they offer an alternate view of 'Development', that would represent the perspective of the oppressed and the vulnerable (51). They talk of 'cultural rejuvenation' in a political agenda (52). They consider gender' as a major component in this, along with labour, nature, culture and identity (53). In this new equation of power, perhaps, the less wealthy nations would find a realistic direction in achieving women's health.

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