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Programmimg Reproduction? Maternal Health Services

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In the absence of a basic questioning of women's status and role in society, birth control, abortions-and even maternal health care end up merely replacing an old set of traditions with new ones. Do maternal and child health services as they exist today have the potential to emancipate a woman or to further bind to her traditional roles, albeit in subtler ways? This article contends that the entire primary health programme reflects social attitudes towards women that view them primarily as mothers or potential mothers.

It is no longer a disputed fact that working class women participate in production with men and, like men, are alienated from the means of production. What makes their position still worse is that women participate more actively in reproduction than men do, and yet, unfortunately, are alienated from the means of reproduction as well. Juliet Mitchell (1971) argues that as in capitalist production where the social product is confiscated by capitalists, in reproduction the child is snatched away from a woman. Perhaps this is not strictly so. In patriarchal societies, the child, a result of physiological and emotional interaction, is seen as property, and male property at that. Concepts of illegitimacy and patriarchal lineage are examples. A child, created so actively by a woman, grows up in a capitalist and sexist milieu, and alienation occurs through the conditioning and values that she or he absorbs from infancy. Physical alienation does not usually occur because both women and children are conditioned socially not to question or to rebel inside the family. When women do so, physical alienation does occur in the form of custody in divorce, since custody is more often than not in favour of the male.

The changing role of the family further determines the newer roles that a woman performs within and outside the family. The institution of marriage too, on the exterior, becomes destabilised, say for example through, a divorce or the voluntary rejection of marriage by a sexually involved couple. However, the psychological and sociological functions and the grip of the family remain the same --- they create the masculine and the feminine', resulting in a 'man's world' and a 'woman's world'. They also condition the newly born infant to-accept and appreciate the security and stability' that the bourgeois family has to offer.

The prescribed relationship between the husband, wife and child determines and influences the roles that men and women perform within and outside the family. As an example, one may quote the doctor-nurse-patient relationship as being analogous to the man-woman-child hierarchical familial triangle. Looking deeper these role models, by virtue of their predetermined status, define the extent of food, health facilities, education and employment opportunities that men and women will receive in relation to each other. Therefore, even though women do enter the production force with vigour and compulsion, they inevitably land up doing jobs that are qualitatively and thus economically inferior to those performed by men.

The wage system continues to be structured according to the assumption that a woman's wage is only supplementary. Women are thus seen as economic attachments to men, not as free labourers who participate equally (Rowbotham, 1973). Women are thus financially compelled to stay with their men even in the face of unmasked oppression. Separation, and consequently alone or with the children and without a man, often means a drastic drop in a woman's standard of living, if not abject impoverishment.

With enforced backwardness, it is also easier to push women out of the labour force than men, whether because of automation unemployment or omnipresent and omnipotent reproductive duties. Women thus become a reserve army, which will work, at half pay and who will-be re-absorbed by the family if there 'is' unemployment (Rowbotham, 1973). Underpaid outdoor work, invisible domestic labour and conjugal duties therefore leave a woman vulnerable to be doubly exploited. The condition of working class women is ideal for the creation of a powerful political force. Unfortunately their realisation of exploitation dissipates instead of being sharpened. The shunting from reproduction to production and back to reproduction acts as a safety valve to smoothen conflict.

The changing role of the family also determines the reproductive potential of the woman. The family in turn is governed by historical inevitability, market compulsions and often by the prevailing political will, where reproduction is concerned. In peasant households with considerable landholdings, it might be desirable to have as many extra pairs of hands as possible; similar may be the case in not so advanced capitalism, where the quantity of workers needs to be maintained at a high level so that their exploitation through underpayment is possible. However, with the decline of labour-intensive industry and with the emergence of capital-intensive industrialisation, the main economic task of the family would no longer be to produce a large number of children, since quality rather than quantity would be important in the labour market (Peggy Morton, quoted in Mitchell, 1971). The family adapts itself accordingly, and in turn

monitors the reproductive ability of the woman to suit the requirements of the contemporary wage market.

The woman, therefore, is only seemingly liberated to become a wage earner. In truth, however, she holds no real power in either structure; in fact, forces that are alien, incomprehensible and beyond her control monitor her, both inside and outside the family. In the existing context, birth control, abortion or even good maternal health cares, in the absence of the basic questioning of a woman's role in society, end up merely replacing an old set of traditions with new ones. Not only does the woman perform the necessary functions that the traditional orthodox set-up demands from her, but she also faces the 'consequence' of being the modern, sexually liberated, bohemian woman.

It is in the light of this framework that we have to view the ideology of maternal and child health (MCH) services, whether they do liberate a woman even marginally, say from the risk of maternal and child mortality; whether a healthy pregnancy and childbirth coupled with birth spacing gives her more choice and more control over her body- or whether the existing MCH programme, in form and content, ends up merely making her a more healthy and well-programmed baby-making machine. In short, whether MCH, as it exists today, has the potential to emancipate or to further bind woman to her traditional role begs examination.

MCH-Sexist Bias in Planning

In a patriarchal world, it is no great surprise that male hegemony exists in all aspects of health care at the policy level, at the implementation stage and throughout the delivery of this care. Women as a group, therefore, have to receive health care that is designed in their own favour. Effective health care provided free of cost and accessible to all, especially to women during pregnancy delivery and the post-partum period should be considered a fundamental right. We must fight to see that no woman or child is at risk of dying, especially during these crucial months. But we must also emphasise that mere MCH will not do. 'Motherhood is only one of the roles that a woman may voluntarily, wish to perform during her lifetime. She may accept or reject it and, in spite of opting out of motherhood or marriage she is a full human being. Health services must be available to women irrespective of their child-bearing role.

The entire primary health programme reflects social attitudes towards women, viewing them primarily as mothers or potential mothers. In fact health services for women have been termed MCH services (ICSSR/ICMR, 1981). The same report notes that there is positive evidence to conclude that the health status of Indian women has declined over the past 35 years in spite of improved MCH

programmes, mainly due to the fact that women are more 'at risk' nutritionally, and yet they utilise health services less than men do. They are of interest to the health services only when they conceive or when they have reached she upper limit of child bearing permitted by the government's Family Planning programme.

The infant mortality rates are also highly unimpressive (114 per, 1,000 live births in 1980 as compared to 129 in 1971). There has been no appreciable improvement in the nutritional level of children, in spite of programmes directed towards them, and even primary education has not become universal.

To shift resources towards women as a group, it is necessary for policy makers to be convinced that women contribute greatly towards world production-within the family, in the agricultural sector, in traditional as well as modern industries and also in commerce. An estimate of 18-30 per cent of the world's families are solely supported by, women while in many, others the woman's financial contribution is a substantial component (Wayne, 1985). Statistics unfortunately miss family and informal sector activities, resulting in this contribution being overlooked. Within the health care system factors that contribute towards women's ill-health are not considered-their socio-economic status, total workload the daily and seasonal pattern of activity, access to health care, etc.; neither are problems which affect women more severely such as malnourishment anaemia and occupational hazards, or those, which affect women specifically, such as abortion or spouse abuse (Ibid.).

MCH activities began informally in India around the turn of the nineteenth century-mostly voluntary efforts ranging from enrolling women students in medical colleges to training midwives and Lady Health Visitors. The transition to official control in MCH began in 1938. In 1953, following the introduction of training courses for Auxiliary Nurse Midwives (ANMS) and public health nurses, most voluntary health schools closed down (Iyer and jesani, 1995) (Sethna, 1978).

The Indian government's official MCH package includes antenatal, peri-natal and post-natal care, the Integrated Child Development Services scheme (ICDS), National Programme for Control of Blindness, and programmes for the Control of Diarrhoeal Diseases and Family Planning.

Undoubtedly, there exists a role, however limited, that MCH can play in a woman and child's life, provided it is universally available and of high quality. However, in the absence of a women's control over her own reproduction, a culturally and socially conditioned inability within her to be able to vocalise her gynaecological problems to a health worker, especially male, and the latter's

reluctance to bridge the communication gap by demystifying pregnancy, make the MCH a watered-down programme, reduced to a mechanical distribution of iron and folic acid tablets, a mindless target-oriented approach towards immunisation and the endless weighing of children to identify the 'at risk' individuals in an already malnourished population.

The lack of control over one's own body is experienced by many women in the clinical approach to pregnancy and childbirth. Most often, questions that bother a woman deeply remain unasked. The concept that pregnant women should swallow tablets or receive injections for their own benefit without any active participation reveals the ambiguity and myth of 'people's participation' so loftily considered the basis of the Family Welfare Programme in India. In fact, passivity is a fundamental feature of the relationship between the providers and users of maternity services (Graham and Oakley 1981).

Growth charting accepted so enthusiastically, by our health care system, is yet another instance of mystification. When less than, 10 per cent of children under five in deprived sections are nutritionally normal, expensive growth monitoring is unnecessary. If 50 per cent of under-fives in India amounting to 55 million children were to be covered through growth monitoring charts, this activity of weighing and charting alone would require 110,000 workers annually, and would incur an expenditure of US $27.5 million for salaries, $20.0 million for Salter scales (1 for every 100 under-fives) and additional expenditure for repairs, replacements, maintenance, transport and new growth charts (Gopalan and Chatterjee, 1985).

Such activity, in fact detracts from motivational and educational work, which is of primary importance in child health and nutrition programmes (Srilatha, 1984). In a country with limited sources for child care, a social group that faces a high nutritional problem's needs to be identified and standard intervention is necessary for all their members (Nabarro, 1984).

MCH and Population Control

The scope of the already small package of MCH services is further reduced by making it a screen to achieve family planning targets. There is constant talk of integration of MCH and family planning' and, under this euphemistic slogan, a curriculum for undergraduate students of medicine and interns has been prepared by an expert committee. The training, programme has already been adopted by three teaching colleges. In one three courses were conducted, attended by nine teams of 27 professors (GOI, 1985: 125).

In the minds of policy-makers. MCH figures not as an independent programme but as a means to reduce fertility. The Annual Report (1984-85) of the Ministry of Health and Family Welfare (MHFW) states that:

To reach a couple protection rate (CPR) of 60.0 per cent of eligible couples by AD 2000, it is essential that the younger group of eligible couples be motivated to accept spacing and the small family norm. Moreover, the use of spacing, methods has a significant impact not only on curbing, population growth, but also on the health of the mother and child. (GOI, 1985: 116, emphasis added).

The Ministry's own assessment states that the crude birth rate (CBR) at the end of 1984 should have been 32.6 per cent per 1.000 population, whereas actually it was slightly higher---33.6 per cent. While 29.4 per cent of the couples were "protected" by the end of 1984 (sterilisation's accounted for 23.7 per cent of these), a CPR of 60.0 per cent is desired by the turn of the century. To give the family planning programme a boost, especially in backward areas, partial assistance from DANIDA, ODA (UK), UNFPA, USAID and the World Bank has been received to cover 63 districts in 14 states as 'Area Projects' for the intensive development of health and family welfare. 'The objectives are reduction of fertility and reduction of maternal and child mortality' (GOI 1985: 150). The government has introduced the concept of net reproduction rate unity (NRR one) in its Family Welfare (FW) Programme:

After considerable experience in this regard [need to control population growth], the country has set before itself the long-term demographic goal of achieving NRR unity by AD 2000, with a birth rate of 21.0, death rate of 9.0 (life expectancy at birth being 64.0 years) and an infant mortality rate less than 60.0. In order to achieve this goal, the national family welfare programme has been and will be strengthened. It is a voluntary programme. (GOI, 1985: 164)

In the context of these new goals set by the Indian government the stranglehold of family planning over MCH can be fully understood. In fact, the first UN Advisory Mission as early as 1966, had gone as far as to insist that ANMs should be relieved from other responsibilities such as MCH and nutrition so as to concentrate their efforts on family welfare. This mission stated that 'this recommendation is reinforced by the fear that the [FP] programme may be otherwise used in some states to expand the much needed and neglected maternal and child welfare services. (UN Advisory Mission, 1966).

The first double-edged tool within the family welfare programme came in the form of the Medical Termination of Pregnancy (MTP) Act in the early 1970s. Regarded by feminists as a much-desired means to control one's fertility, the legalisation of abortion is, in itself, welcome. However, the government's interest

in this legalisation becomes clear when one notes that by the end of March 1984, 4,553 institutions were rendering MTP services (as compared to 4,170 at the end of March 1983). In Bombay City alone, 50,000 MTPs are registered annually (Karkal, personal communication).

The official acceptance of NRRI by the government is especially sinister because, in lay person's terms, it suggests that only one daughter should replace her mother. Thus, female foeticide through sex determination (amniocentesis, chorionic villi biopsy) or through sex pre-selection (Ericsson- Japanese method) is in-built within the government's population control policy.

The government's emphasis on 'Child survival rings another ominous bell. Welcome in itself, the slogan is reduced to, spacing methods'. The MHFW states that 'since child survival is amongst the foremost factors which induce the couple to adopt the two child norm, the MCH programme has been given due importance' (GOI, 1985: 107.)*. The strategy becomes clearer when along with the slogan of 'child survival', the government has markedly increased its budget for family planning in the seventh Five Year Plan period, and the emphasis will now be on spacing methods for women. It is estimated that by 1990 spacing methods will account for 20.0 per cent of 'protected' couples, against the present level of 5.5 per cent. A contraceptive marketing organisation has been registered to promote methods (GOI. 1985: 101).

The Government now admits that one-third of all intra-uterine devices (IUDS) ever inserted are removed,' and one-fifth are expelled. The officially accepted drop-out rate for IUDS therefore is 53.3 per cent (GOI. 1986). Naturally, the proponents of population control would be desperate to design a and foolproof system that leaves little or no control in the hands of the woman to withdraw the contraceptive, and it is in context that the importance of injectable contraceptives implants should be understood. Though ICs do not as yet a part of the family planning programme, a programme introductory study on Net-En, an injectable contraceptive at primary health centres (PHCS) attached to 15 medical colleges is under way. Based on the results of this pilot project, it is that this spacing method will be introduced soon. In fact, according to official plans, it was to be introduced in The Indian Council for Medical Research is also conducting studies with Norplant--an implant for women. An appropriate version of this contraceptive was to be available by the end of 1985 to start programme introduction studies at the PHCs (GOI 1985: 107).*

Motivation: Distortion of Human Relationships

The state's emphasis on women targets and women motivators is a cause for concern among feminists because of the distortion in human relations brought

about by the coercive, target-oriented campaign. When motivators are women, be they health staff or primary school teachers, they are constantly threatened with dire consequence such as job transfers, sexual harassment, humiliation and delayed salaries if they fail to fulfil their targets. Dangerous limits are reached when these women are the major or only source of livelihood for their families, when they are single, living in an alien village and are unable to meet targets.

These women, with the proverbial sword of Damocles hanging over their heads, are forced to see every other woman in the village as a potential target. All their conversations whether at the doorstep or at the village well, invariably ends with motivation for Family Planning. It is not surprising, therefore, that village women resent these motivators and consider them scheming nags. The entire fabric of woman-to-woman relationships is eroded in this situation with each party out-smarting the other whenever possible and harbouring mutual, deep-rooted resentment.

This distortion of basic human relations and support systems has dangerous political consequences. Sexist bias, international conspiracy and the government's population control policy are responsible for the inhuman family planning campaign. Targets are planned outside the micro-environment in, which the masses live. Dangerous contraceptives are dumped by ruthless, profit hungry multinationals. Yet, all these are invisible to the rural working class. The only visible oppressor they see is a poor ANM, most often from their own class and a victim of the present system as well. The anger directed towards another helpless victim help's the ruling class through a divide and rule strategy.

Not only does it break two working class solidarity, but it also diverts the issues, allowing the real enemy to escape without confrontation. It makes the rulers seem like the paternal and benevolent Caliphs of the Arabian Nights.

As regards the delivery of health services, the 'integration' of FP with primary health care has in fact had an adverse effect on the utilisation of health care at PHCs. A substantial majority of the rural population utilises a private practitioner in times of illness. The major reason for the non-utilisation of government services is the absurd emphasis of the latter on family planning. Women still prefer to be delivered at home by traditional dais or relatives, one reason being that any peri-natal or post-partum contact with a woman is immediately seized for target completion in the PHC. Immunisation camps suffer because covertly, many such camps are used to gather young mothers for copper-T insertions.

The shadow of the population control programme over all other essential public health services is resented by people and results in the poor utilisation of these

basic services. It is annoying that public health services, especially, maternal and child services are used as a bait to lure people towards reducing population growth, without any consideration towards the existing socio-economic conditions or the helplessness and inability of the oppressed sections to rebel. In fact coercion thrives on these very conditions, and it is only a conscious organised working class that can focus on contradictions, unearth the intricate conspiracies and then demand that the health services be geared towards their own interests.

The conspiracy of the ruling class and the inhuman strategies employed by them- often in sugar-coated pills such as maternal and child health or as emancipation through birth control works to control the lives of an already exploited population. Patriarchy, which has the art of adapting itself to new situations, in fact of moulding new situations to suit its ends, prevails in policy-making research, medicine and science. Our own demands, be they of safe deliveries, of our children's survival and their well-being, or birth control, abortions and the like are snatched away and given back to us blunted.

Under the guise of giving us the choice, we are made spectators of our own oppression, be it through dangerous contraception, female foeticide, sex selection, surrogate motherhood or the perpetual tight-rope walk where our productive and reproductive duties are concerned. It is, therefore, necessary to constantly expose this design and build strong women's movement that attacks both class and patriarchal control over the various institutions that govern our lives. We have to relate the personal to the political, and should constantly question our role as women within and outside the family.

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