# Programming 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 or to further bind a woman to her traditional role albeit in subtler ways? The article contends that the entire primary health programme reflects social attitudes towards women, viewing them primarily as mothers or as potential mothers.*

IT is no more a disputed fact that working class women participate in production with men and that like the latter 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 the former are alienated from the means of reproduction as well. Juliet Mitchell argues that as in capitalist production the social product is confiscated by capital, so is the child snatched away from a woman (Mitchell, 1966). Not strictly speaking, perhaps so. In patriarchial society, the child, a result of physiological and emotional interaction is seen as property, and male property at that. Concepts of illegitimacy and patriarchial 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 since 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 too 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 rather destabilised, say for example through a divorce or through voluntary rejection of marriage by a sexually involved couple. However, the psychological and sociological functions and grip of the family remains the same—it creates the 'masculine' and the 'feminine', resulting in a 'man's world' and a 'woman's world'. It also conditions the newly born infant to accept and appreciate the 'security and stability' that the bourgeois family has to offer.

The prescribed role model of the husband-wife-child determines and influences the roles that men and women perform within and outside the family. As a vivid example, one may quote the doctor-nurse-patient relationship being analogous to the earlier mentioned hierarchal familial triangle. Looking deeper, these role models by virtue of their predecided status determine 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 living single or with the children and without a man, often means a drastic drop in the standard of living for women, if not abject impoverishment.

With enforced backwardness, it is also easy to push women out of the labour force more easily than it is to push men out, be it due to automation, unemployment or the omnipresent and omnipotent reproductive duties. Women thus become a reserve army which will work at half pay and who will be reabsorbed 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. Unfortunately, though the condition of working class women is ideal for the creation of a powerful political force, 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. With the decline of labour-intensive industry and with the emergence of capital-intensive industrialisation however, the main economic task of the family would no longer be to produce a large number of children, since then quality rather than quantity would be important in the labour market (Morton Peggy, quoted in Mitchell, 1966). 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 in question 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, abortions or even good maternal health care, 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 in 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 a woman to her traditional role, albeit in subtler ways, calls for examination.

## MCH: Sexist Bias in Planning

In a patriarchial world, it is no great surprise that male hegemony would exist 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 which is 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 the risk of dying, especially during those 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 it 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 childbearing role.

The entire primary health programme reflects social attitudes towards women, viewing them primarily as mothers or as potential mothers; in fact health services for women have been termed as 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 thirty five years in spite of improved MCH programmes, mainly due to the fact that women are more 'at risk' nutritionally and yet that 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 the upper limit of child bearing permitted by the government's family planning (FP) programme.

The infant mortality rates too are highly unflattering (114 per 1000 live births in 1980 as compared to 129 in 1971) and there has been no appreciable improvement in the nutritional level of children, in spite of programmes directed towards them, neither has primary education become universal.

To shift resources towards women as a group, it is necessary for policy makers to be firstly convinced that women contribute greatly towards world production—within the family, in the agricultural sector, in traditional as well as modern sector 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 to the 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 and so on. 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 considered (ibid).

MCH activities, in an informal manner, began in India around the turn of the nineteenth century: mostly voluntary efforts ranging from enrolling women students in medical colleges to training of midwives and Lady Health Visitors. The first transition of the official control over voluntary direction in MCH came 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 (Sethna, 1978).

The Indian government's official MCH package includes the antenatal, perinatal and postnatal care, the Integrated Child Development Scheme (ICDS), the National Programme for Control of Blindness, the Programme for Control of Diarrhoeal diseases and Family Planning.

There exists undoubtedly a role, however limited, that MCH can play in a woman's and child's life, provided it is universally available and is of high quality. However, in the absence of a woman'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-folic acid tablets, a mindless target oriented approach towards immunisations and 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 clinic 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 partcipation from their own end 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 ten percent of under five children in deprived sections are nutritionally normal, expensive growth monitoring is unnecessary. If 50 per cent of underfives 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 millions for salaries, $ 20.0 million for Salter scales (one per 100 underfives) and additional expenditure for repairs, replacements, maintenance, transport and new growth charts (Gopalan and Chatterjee, 1985).

Such luxurious and unnecessary 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 resources for child care, a social *group* that faces a high risk of nutritional problems needs to be identified and standard intervention is necessary to *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 FP' 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 year, three courses were conducted, which nine teams of twentyseven professors attended (GOI, 1985, p 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 2000 AD, it is essential that the younger group of eligible couples be motivated to accept spacing and the small family norm ... *Moreover, use of spacing methods ... has a significant impact not only on curbing the population growth, but also on the health of the mother and child*' (p 116).

The Ministry's own assessment states that the crude birth rate (CBR) at the end of 1984 should have been 32.6 per 1000 population, whereas actually it was slightly higher—33.6. Whereas 29.4 per cent of couples were 'protected' by the end of 1984 (sterilisations 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 FP 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 intensive development of health and family welfare. 'The objectives are reduction of fertility and reduction of maternal and child mortality' (GOI, 1985, p 150).

The government has introduced the concept of Net Reproduction Rate Unity (NRR-1) in its 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 2000 AD, with a birth rate of 21.0, death rate of 9.0 (life expectancy at birth being 64.0 years) and infant mortality rate less than 60.0. In order to achieve this goal, the National FW programme has been and will be strengthened. It is a voluntary programme ..." (GOI, 1985, p 164).

In the context of these new goals set by the Indian government, the stranglehold of FP 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 efforts on FP. 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 FP programme came in the form of the Medical Termination of Pregnancies (MTP) Act in the early seventies. Regarded by feminists as a much-desired means to control one's fertility, the legalisation of abortions is in itself welcome. However, the government's interest in this legalisation becomes clear when one notes that by the end of March 1984, in all 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, 1984).

The official acceptance of NRR-1 by the government is especially sinister because in lay person's terms it spells 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 inbuilt within the government's population control (PC) policy.

The government's emphasis on 'child survival' rings another ominous bell. Welcome in itself, the slogan is reduced to 'spacing methods'. The earlier mentioned Report of the MHFW states that "since child survival is amongst the foremost factors which induce the couple to adopt the two child norm, MCH programme has been given due importance." The strategy becomes clearer when along with the slogan of 'child survival', the government has markedly increased its budget for FP 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 spacing methods (GOI, 1985; p. 107).

The government now admits that one-third of all IUCDs ever inserted are removed and one fifth are expelled. The officially accepted dropout rate for IUCDs therefore is 53.3 per cent (GOI, 1986). Naturally, the proponents of population control would be desperate to design a centralised and foolproof system that leaves little or no control in the women's hands to withdraw the contraceptive and it is in this context that the importance of injectable contraceptives (ICs) or implants should be understood. Though ICs as yet do not form a part of the FP programme, a Programme-introductory Study on ICs (Net-En) at PHCs attached to 15 medical colleges is underway. Based on the results of this pilot project it is hoped to introduce this spacing method soon. In fact, according to official plans it was to be introduced in 1984-85. The ICMR is also conducting its studies with Norplant—an implant for women. An appropriate version of this contraceptive was to be available by the end of 1985 to start the programme introduction studies at the PHCs (GOI, 1985; p.107).

It has been decided to intitiate a two million corps of women trained to motivate for FP. These corps will be nonpaid and interestingly, acceptors of FP methods themselves. Another significant move by the government in the near future is to disband all male community health volunteers. Through the IUCD programme, it has been learnt that male motivators cannot do the job where spacing methods are concerned. Male health workers have experienced embarrassing consequences while having to explain Copper-T insertions to a woman or to her husband. To close all loopholes therefore women motivators exclusively would approach women-targets henceforth.

## Motivation: Distortion of Human Relationships

The state's emphasis on women targets and women motivators is a cause of feminist concern for the distortion of human relations which the coercive, target-oriented campaign brings along. When motivators are women, be they the health staff or primary school teachers, they are constantly threatened with dire consequence such as job transfers, sexual harassment, humiliation and delayed salaries it they fail to fulfil their targets. The 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 complete targets. Recently, in March 1986, Manda Padwal, a female health functionary (an ANM) in Talasari PHC of Thane district committed suicide after reprimand and order from the doctor in charge to sterilise twenty tribals (Barse, 1986).

These women, with the proverbial sword hanging over their heads, are forced to see every other woman in the village as a potential target. All their conservation, whether at the doorstep or at the village well, invariably ends with motivation for FP. Little surprising therefore that the village women resent these motivators and consider them as scheming nags. The entire fabric of woman-to-woman relationships is eroded in this situation, with each party outsmarting the other whenever possible and harbouring deep rooted resentment mutually.

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 of these are invisible to the rural working class. The only visible oppressor they see is a poor ANM like Manda Padwal; most often the latter being from their own class and a victim of the present system as well. Therefore, the anger directed towards another helpless victim helps the ruling class through a divide and rule strategy. Not only does it break working class solidarity, but it also diverts the issues, allowing the real enemy to escape without confrontation. It makes the rulers seem like paternal and benevolent Caliphs out 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 the private practitioner in times of illness and the major reason for 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 perinatal or postpartum contact with a woman is immediately seized for target completion in a PHC. Immunisation camps suffer because covertly many such camps are used to gather young mothers for Copper—T insertions.

The overshadow of the population control programme over all other essential public health services is resented by people and results in poor utilisation of all these basic services. It is angering that public health services, especially maternal and child services are used as a bait to lure people towards reducing population growth, without any consideration for the existing socio-economic conditions, the helplessness and the 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 in their own favour.

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 already exploited populations. Patriarchy, which has the art of adapting itself to new situations, in fact of moulding new situations to suit its end, 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, of abortions and the like are snatched away from us and given back to us blunted and decolourised.

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 to build a strong women's movement that attacks both class and patriarchial 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.

### References


Barse, Sheela: *The Afternoon Despatch and Courier*, April 21, 1986.

Gopalan C and Meera Chatterjee: *Use of growth charts for promoting child nutrition: A Review of Global Experience*, Nutrition Foundation of India, 1985.

Government of India: Ministry of Health and Family Welfare, Annual Report, 1984-85, 1985.

Government of India: Evaluation Report on Family Planning Programme, Planning Commission, p. 173, 1986.

Graham Hilary and Ann Oakley: "Competing ideologies of reproduction: Medical and maternal perspectives on pregnancy" in *Women, Health and Reporduction*, (Ed. Helen Roberts), pp. 50-74, Routledge and Kegan Paul, London, 1981.

Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR): *Health For All: An Alternative Strategy*, pp. 131-140, Ind' ute of Education, 1981.

Karkal, Malini, Personal com. ...on, 1984.

Mitchells Juliet: *Women's Estate*, 1966 (Penguin Books, 1971).

Morton, Peggy: Quoted in above.

Nabarro, David: (1984) Quoted in Gopalan and Chatterjee, 1985.

Rowbotham, Sheila: *Woman's Consciousness, Man's World*, Penguin Books, 1973.

Sethna, N.J.: *Maternal and Child Health Services in India*, All India Institute of Hygiene and Public Health, Calcutta, 1978.

United Nation's Advisory Mission. (1966), Quoted in Banerji Debabar, *Health and Family Planning Services in India*, Lok Paksh, New Delhi, 1985.

V. Srilatha: Nutrition Foundation of India (Mimeograph), 1984.

Wayne, Stinson: *Salubritas*, Vol. 8, No. 2, April-June 1985, (Published by the American PH Association and World Federation of PH Associations).



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