Politics of MCH

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MANISHA GUPTE's article (*RJH*, I: 2) provides a broad framework for analysing health policy vis a vis women. The needs of capitalist accumulation mediate through patriarchal structures and relations suppressing women's rights to health and reproduction. This mediation takes different forms in different societies. In a country like India, it is interesing to look at the process by which the needs of capitalist development have simultaneously strengthened and altered patriarchal structures. It is especially necessary to take cognisance of the manner in which the Indian state has coopted and adapted the demands of a 'democratic' polity for its own purpose. The history of maternal and child services in India provide an illustrative example of this. In the evolution of policies and programmes directed at the welfare of mothers and children especially in recent years, it is possible to discern the way in which the state has, responded to the growing influence of the women's movement and has accomodated the demands of the increasingly vocal and influential consumers of health care. 'Programming reproduction' is just one aspect of MCH services. Further, there is also the question of how progressive movements must view such policies and programmes.

As early as the mid-nineteenth century concern for maternal health motivated a series of efforts. This concern was, of course, somewhat spurious. Introducing 'modern' methods of maternal and child care had served multiple objectives. Firstly, it was seen as a means of approaching women so as to "educate them... show them the beauties of christianity, for only then would the regeneration of India be a reality and the conversion of its people an accomplished fact".

Secondly, the MCH movement in India even in its limited spread, enlarged the base of operation of 'scientific' medicine which in England was becoming highly organised and sex and class biased. The MCH rhetoric of the time saw indigenous maternity practices as the main cause of the high maternal mortality and held modern practices, especially in hospitals not only as being progressive but safer and more hygenic. It was to staff these new lying-in hospitals that Indian women were encouraged to take up medicine. This is especially ironic since at about the same time women in Britain were fighting bitter battles to be allowed to train for and practise medicine. Clearly the move in India had little to do with encouraging women to enlarge their sphere of activity in society, but more with the needs of the colonial government.

Thirdly, the promoting of modern maternity practices through the MCH movement fitted well with the philosophy of the reform movement advocating women's education in India—so that as mothers they would be capable of giving birth to and bringing up a new generation of progressive Indians. The MCH movement became a vehicle for bringing about this 'regeneration' of India for both the British and the Indian liberals although it meant different things to the two. Its outreach however, was confined to the upper classes in the urban areas in the presidencies. Needless to say it hardly had any impact on the maternal mortality or child mortality in the country.

MCH continued to be a priority area in the health policies of independent India. The Bhore committee continued to view these services as not only a measure for reducing maternal mortality but as a necessity in order that women could adequately perform the function of motherhood. Facilities for the protection of women's health in the 'productive' sphere were mainly meant to ensure her 'reproductive' adequacy. But at the same time the maternity and child welfare centre "with its combined attack on the health and social problems of the Indian home" was expected to play a vital role in the programme of 'national reconstruction'.

Increasingly however, investments in the reproductive health of the woman became far more important than her health in the factory or the field. "The protection of the health of the expectant mother and her child" (irrespective of whether she occupied a place in the sphere of production) became of paramount importance "for building a sound and healthy nation". The mother became officially recongised in policy as the channel for 'educating' the entire family. After this although MCH continued to be a national programme its focus became increasingly narrow and its implementation poor. Quite apart from the fact that MCH programmes did not recognise the real causes of maternal mortality their impact on the section of the population which accounted for a large proportion of maternal deaths was minimal. Interest in MCH also began to decline. (For example, there were hardly any ICMR research projects in the area after the mid-sixties. This disinterest in the health of the mother is manifest even in those areas outside MCH which had some import for maternal health. For instance, research in anemia—increasingly the focus became narrow and oriented towards developing quantification methods which all but ignored the real problems in the area.)

Recent years have seen a revival of interest in MCH which has to be seen in the context of other developments such as the status and location of women, the current priorities of the state as well as the pulse of popular/mass movements.

In the last decade a great deal of attention became focussed on women's status and issues affecting their status. This decade, the UN Women's decade ironically enough, also saw a deterioration in the economic situation of women. Much work has been done on how the development processes have in fact been the cause of women losing their jobs and the means of livelihood—as for instance happens when the introduction of new technologies in agriculture results in women having to give up their traditional occupations, or when modernisation of processes handled by women in industry results in the loss of jobs.

At another level, the only sector which has recorded a growth in employment, the service sector, has also registered a significant rise in women's employment. In other words it would not be wrong to infer that while the

economic and social status of women of the labouring classes is rapidly declining, women who have access to formal education, generally from the better-off layers of the urban working class and the middle class, are finding jobs in the expanding service sector. This in turn contributes to the growing purchasing power the middle class which provides a market for the products of the expanding consumer industry. This factor has to be kept in mind when assessing the purported objectives and the real impact of any programme such as the MCH.

Secondly, there is the undoubted impact of the women's movement not only on national policies but internationally as well. The movement has had the result of highlighting the low social, economic and health status of women. Indices such as maternal mortality suddenly became major issues which needed to be tackled or at least should appears to have been dealt with.

Thirdly, the health status, health care structure and the priorities of health care have undergone a change. One could well hazard a guess that the class differential in health status has become sharper than ever before (See for instance NIN's nutrition surveys which actually shows a decline in consumption levels—although of course, the NIN has grossly tried to cover it up). Inevitably the sex differential in health status would also have sharpened. As a consequence the class biases in health care delivery have become clearer. In addition, the trend towards increasing privatisation as well as the more widespread use of the fee-for-service principle even in state health services will aggravate the disparities in people's relative access to service. Inevitably of course, the priorities of health programmes have also changed.

All this has to be taken into account in understanding the real nature of MCH programme. Because the state needs to sustain the growth of the purchasing power of the expanding middle class, women's employment in certain spheres is a desirable goal. Thus health care for women so that they are able to handle the two spheres of activity becomes a necessary service which the state accepts responsibility for. Promoting the small family norm is again desirable—both so that resources can be optimised as well as because the process of socialising children to fit into patriarchal society can take place efficiently.

Thus for instance, quite clearly, the nutritional supplement component of these programmes is irrelevant to the section of the population who cannot obtain two full meals. Pumping an expectant mother with vitamins when she has abominably low calorie intake is an absurd exercise—and the state is well aware of it. The component is really meant for a different class—the small farmer/lower middle class, where there is just about sufficient food but not enough to take care of the extra needs of pregnancy. On the other hand, the anganwadi programmes may well be used by all sections, including the poorest women who may then be 'released' to work the fields without encumberances or alternatively at the EGS sites thus increasing the numbers on state dole (which accrues to the image of a welfare state).

But most importantly these programmes are redifining and restructuring the role of women in patriarchal class society at the present juncture. Beginning with the breastfeeding campaign, the immunisation programme and the anganwadis, the woman's role in the upbringing of the child is being redefined. The concept of the family with its hierarchies as the primary socialising institution in capitalist patriarchal society is being reemphasised. Investments of all kinds in the family and in children are rising. In order to ensure the continued existence of the family, the ruling class has to reetch the female stereotype which will accomodate the new feature of an employed mother and wife. The setting up of a department for women and children cannot be regarded merely as a response to the pressures of the women's movement. It has a necessary role to play in drawing up a new image of Indian womanhood. It is in this context that we have to assess any programme, whether in health or otherwise, directed at women.

How then do we regard these programmes? Should we reject them entirely? Or can elements of these be used to advantage to weaken the very structures which the state is trying to strengthen?

While this needs to be tackled in a more elaborate manner, here are some pointers . For one thing, any critique of state services—especially in MCH—must ensure that the trends which emerge as a result do not reject state services by opting for more expensive and perhaps less efficient private care. This will only mean that the tendency of the state towards ridding itself of its welfare obligation will get an added boost. On the other hand, by highlighting the inadequacies of the service, there is an opportunity to initially pressurise for better service but in the long run also to show up the non-viability and insincerity of the welfare goals.

At the same time the sexist and class bias of these services also need to be brought out in the open. The fact that these programmes project a model of Indian womanhood which reinforces existing norms which themselves need to be challenged is a task that the health groups and the women's movement must take seriously. And this is a difficult challenge—it comprises not merely in confronting the real objectives of state services, but in tackling the inherent sexist and class ideology of the medical establishment.