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# Reproductive Health: A Public Health Perspective

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This article examines the concept of reproductive health as it emerged in the 1980s, its consequences for health research and family planning programs in India, its advocacy for the third world agenda and the reasons behind it, its epidemiological basis, and offers an alternative public health perspective for understanding reproductive health.

## Introduction

Scrutiny and control of women's sexuality and women's reproductive role by the state are well recognized in the history of societies [Sarkar 1993]. Tribal wars over possession of women were rooted in the struggle for survival of the tribe itself. Later, when households became the center of productive activities women's skill and labor began to be valued as much as their ability to give birth. With the advent of the factory system, women also became the keys to the upbringing of the labor that they reproduced. The control of women's fertility was thus considered necessary for both economic and social reasons. Studies of the 19th and early 20th century show how the institutions of religion [Chakravarti 1989], law and education [Desai and Krishnaraj 1990] perfected the instruments of control. In the latter half of the 20th century, largely women-centered family planning programs (FPP) initiated by the government became the main instrument of this control. The appreciations of the needs of civil society in the regulation of fertility were gradually marginalised by these official programs. Demography emerged as a discipline [Bose 1988] that appropriated the area of population studies.

In contrast to the state and the dominant view within societies, women themselves were concerned with the self-regulation of their fertility (dubbed `illegal abortions') as also with their reproductive health. The emerging women's movement took these up as part of 'women's rights' issues [Agnihotri and Mazijmdar 1995] and questioned the prevailing images and roles of women. 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 1970s, 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 being the sole decision-maker in the matter of having or not having a baby [Anderson and Zinsser 1988]. On the other hand, 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 the western women's movement, even in the post-1970s period, they focused on the marginalisation of women in the workforce, the dwindling health and educational facilities of the public sector, rising prices, and sexual exploitation of women.

This does not mean that issues of reproductive health were not relevant to them. It only reflects the fact that in their given conditions, a lot of ground work was necessary to generate a broad based and open debate on these highly sensitive and personalized issues and their links with the socio-economic and political fabric of the society. Guided by the expressed demands of women, these movements concentrated on empowering women economically, politically, and socially [Desai and Krishnaraj 1990:270-320], before they could question the deep rooted assumptions of both women and men about reproductive rights.

There have been two very different, reactions, among western feminists, to this basic difference in the content of women's movements in 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 situation [Doyal 1995]. It recognizes the differences of approach within the feminist movement and emphasizes the significance of links between health and reproductive health as well as between structural adjustment programs and women's empowerment [Hartman 1993]. The other trend highlights factors of commonality and emphasizes strategies which place reproductive health centrally in dealing with women's health both at the policy level as well as within the women's movement [Sen et at 1994].

It is within this context that this article examines the concept of reproductive health as it emerged in the 1980s its consequences for health research and FPP in India, its advocacy for the third world agenda, and the reasons behind it. We examine its epidemiological basis, and offer an alternative public health perspective for understanding reproductive health.

The need for such an exercise emerges in the light of two developments: firstly, the current shifts visible in FPP where the buzzword is 'reproductive health' [GoI 1994a].

Secondly, the emergence of a school of thought that views reproductive health and rights as the central concern of women across the globe. Activities around these are visualized as the common minimum programmatic activities for all activists and policy-makers in the area of women's health [Dixon-Muller 1993].

**Concept of Reproductive Health**

The 1980s saw the emergence of a new perspective on family planning. Reacting to the earlier emphasis on 'overpopulation' and projection of women as 'producers of too many babies', members of the International Women's Health Coalition focused on the tendency to neglect other aspects of women's reproductive, health. They argued that a reproductive health approach could strengthen existing family planning and health programs as well as accrues dignity and basic rights to women. They identified reallocation of resources among existing programs, attention to reproductive health issues of women at all ages, empowerment of women to manage their overall health and sexuality, and their participation in policy-making, as central issues [Germain and Ordway 1989]. In other words, though the basic concern remained population growth (especially in the third world), there was an attempt to change the strategy to deal with it.

The professed concern about the population problem was refined over time by invoking the feminist principle that every woman has the right to control her own sexuality and reproduction without discrimination: this would ensure the highest possible level of reproductive health care which was fundamental to the exercise of her reproductive rights. The new paradigm referred to a woman's capability to. (1) Understand and enjoy her sexuality by gaining full knowledge of it; (2) regulate her fertility through access to services and information; (3) remain free of reproductive morbidity (and death) and (4) bear and raise healthy children. The paradigm based itself on the belief that such a formulation "moves birth control out from under the umbrella of family planning and planned parenthood, with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health" [Dixon-Muller 1993].

Reproductive health, then, was posed as an ideal, a dream to move towards: it obviously required different strategies specific to the varying social contexts prevailing in different parts of the globe. But this was possible only through recognizing the interdependence of reproductive health, general health, and socio-economic conditions. Yet, despite its potential clarity of scope, the concept of reproductive health failed to clearly articulate its linkages and the strengths in these linkages.

**Population Numbers Versus Needs and Livelihood**

There have been some cosmetic attempts to fill in these conceptual gaps. The human development approach "within which reproductive health, empowerment and rights are central objectives" [Sen et al 1994], is now being emphasized. However, there are problems in this emphasis. Firstly, for the advocates of this approach, there is still pride of place granted to population numbers in the issues of development and of environmental degradation. For them then this is sufficient basis for proposing the coming together of opposing ideological streams through a problem oriented approach. This proposed common program aims primarily at fertility control. Despite the human development lobby's insistence on the relevance of basic needs and the importance of `demand side' dynamics of livelihood and welfare, population control strategies still remain their key to achieve `sustainable development'. Livelihood and welfare are never strategies and population policy is defined as fertility control [Sen et al 1994:63-73]. In short the 'universalists' pay no heed to the difference in priorities within different ideological streams. In the process, structural issues and concerns about the very nature of development in different ideological positions are pushed out of the domain of the population policy debate. Instead the essence of population policy becomes linked to sustaining existing patterns of development and to adjusting population numbers.

Secondly, structural and economic issues, if mentioned as factors in equitable and sustainable development, are never examined, analyzed or targeted for intervention. The inevitability of a growth oriented globalized market economy is accepted amid much talk to issues of ethics, equity, human rights and women's empowerment. As a result, the growing structural constraints on meeting livelihood demands are underplayed, and fertility regulation is perceived as a point of convergence for feminists and environmentalists to mobilize support for a 'population and family planning program' framed in the context of health and livelihood agenda [Dixon-Muller 1993]. Even when the issue of fertility is put into its larger context, the only linkages brought out are between fertility, family planning and reproductive health: not the larger link to basic needs and livelihood strategies.

**Reproductive Health As Against Women's Health**

The replacement of the concept of 'women's health' by `reproductive health' is yet another key contribution of the advocates of human development. Instead of visualizing health issues as women of different regions see it for themselves, they merge them into universal reproductive health and rights issues. As a consequence of their own priorities, they never really examined either the epidemiological basis of

reproductive health or the reasons behind some women's silence vis-à-vis reproductive health problems. Had they done so, the immensity of women's health problems and the social constraints on women's lives would have revealed the inadequacy of their isolated strategy in the context of the expressed needs of women for land rights, freedom from atrocities, food, security system, minimum wages and communal harmony [Women in Action 1994] along with the need for health services. We explore in a later section, patterns of women's illness and its implications for planning health care services.

**Expanding Boundaries of Reproductive Health**

Given the complexity of the environment we live in the causality of reproductive illness is no more confined to the conventional medical domain of infections, sexual or reproductive processes. At times causes of reproductive ill health lie outside the conventional medical boundaries and even when they severely affect reproductive health, they may not be amenable to cure through reproductive health strategies. Yet, once reproductive health is placed center stage, strategies are evolved for direct intervention in a wide range of reproductive problems, including those not actually rooted in the medical domain but where reproductive damage is merely a spin-off. The proportion of reproductive health problems which are symptomatic of causes that are strictly speaking outside the conventional medical domain, increase the creative component of reproductive health strategies without any prevention impact.

As an example, the proponents of reproductive health include in its domain areas such as nutrition [Jejeebhoy and Rama Rao 1995] and high foetal wastage due to industrial pollution and ensuring environmental degeneration [Mira et al 1995]. But the problem of undernutrition is more fundamentally linked to agricultural policy, pricing and the public distribution system. Similarly, it is a well-known fact that obstetric events are used as biological markers to assess environmental degeneration [Bengt 1988]. However, any corrective medical intervention without changes in industrial policies can at best be palliative. A clear example is the Bhopal gas disaster, where women's reproductive health was badly affected [Sathyamala 1993], as they bore the brunt of a callous industrial policy.

Expanding the domain of reproductive health on the basis of symptomatology, and not the underlying causes that actually lie outside the domain of reproductive health, creates two kinds of problems. One, it leads to a superficial and medicalised interventive strategy which will never touch the real causes of reproductive ill health. Two, it underplays the importance of industrial and agricultural policy shifts for health

and assumes that reproductive health interventions are sufficient in themselves. This false assumption actually becomes the basis for creating a health market where, in the absence of major policy shifts, which have a preventive role, perpetual ill health is ensured and technological solutions can be sold.

**Biological Vulnerability**

Despite all the emphasis on 'empowerment' and 'enabling conditions', the concept of reproductive health has derived heavily from the notion of 'biological vulnerability' of women [Das Gupta et al 1995] (who are in fact, biologically the stronger sex!), and the concept of 'life cycle'. This has brought about a subtle shift and transformed the social process of bearing and rearing children into an essentially biological event. The notion of 'life cycle' compartmentalizes women's lives, creates artificial disjunctures and places bio-demographic aspects above class and gender influences on health. In addition, it imbues the image of women with the instinctive and mindless existence of the invertebrates, de-emphasizing their power to intelligently act upon and transform they're own environment.

The neat divisions of 'life cycle' approach can at best denounce social tragedies like child marriages, deaths of young women in childbirth and sexual exploitation or gynecological suffering of widows. It the cannot however, explain them and therefore help change the situation since it fails to emphasize the continuity of exploitative processes begun in childhood which in fact, add on to the problems of various age groups. It is the ill-fed malnourished girl who becomes a sick, overworked, self-denying mother, who then enters the post-reproductive phase, carrying the burden of ill health. The life cycle approach, by identifying, reproduction as the criterion for defining-stages of life, actually medicalises it and undermines the social processes at work. This emphasis on common bio-demographic aspects of women across the globe is challenged by the glaring differences in the age specific maternal mortality rates between women of the first and the third world as well as the rich and the poor women within countries [Wishwakarma1993].

**Implications for Praxis and Theory**

Having thus marginalized the role of socio-economic and political factors on the lives of women, the life cycle approach open intimate spaces for intervention at two levels-individual and family health. At the individual health level it, is argued that the original definition of maternal and child health is limited and we need to broaden the scope and adopt a reproductive health approach on an ethical basis [Pachauri 1991]. Thus the

unfinished task of controlling mortality is diluted further by expanding its scope activity at a time when the resource crunch is actually weakening the infrastructure of health rather than strengthening it. It is not surprising then that death due to childbirth have risen from 2.1 percent of total female deaths to 2.9 percent between 1982-93 (Model Registration Scheme data). At the second level the family rather than the social context within which it is located, becomes the, arena of activity. Gender and reproductive roles are projected as purely intra-household events [Das Gupta et al 1995], and therefore, further dissociated from the macro socio-economic process.

This compartmentalized perception of family and reproduction performs an important theoretical function. It breaks the unity of production and reproduction in human societies [Krishnaji 1983] not-withstanding the fact that several field studies [Mamdani 1982 and Ansari 1994] have established the intimate links between the two: at the level of family labor requirements within given patterns of production add entitlement and property transfers. Such a schism has two consequences.

One, isolated activism, where empowerment can be granted through reproductive health activities alone. This was reflected in the series of women's meetings organized by international funding agencies in India before the ICPD and Beijing Conferences [Co-ordination Unit 1995] and [CHETANA 1996]. The focus of discussion was reproductive health in its medicialised garb where reproductive tract infections, contraception, and AIDS became central. The issues of socio-economic influences and the links between general health and reproductive health were often missing.

Two, ignoring the necessity of creating a sense of security at the social level, while intervening with alacrity at the family level. The family as an institution in a patriarchal capitalist society is structured to absorb economic and social pressure generated outside it. The most important absorbent is the women herself. In traditional societies her self-perception has been assiduously nurtured to make her labor for `love' to protect her dear ones. Any demand for help and support in performing her tasks, or for change in the nature of the task itself means shifting the power balance. For this, support must come either from within or from outside. Those who attempt to intervene from outside must also evolve external support systems and recognize the importance of simultaneous action at social and family levels. These support systems can be developed only when, one takes up issues of entitlement, wages, work and education which make women's assertion plausible not just for reproductive but social, economic and political rights as well. In other words, issues of livelihood and survival must be integral to any strategy for health: general or reproductive.

The conceptual problems inherent in the notion of reproductive health lead to a range of interpretations depending upon one's ideological inclinations. This has consequences for the operationalization of reproductive health, research, articulation of needs, and FPP strategies.

**Technocentric Focus**

The population council experts, for instance, define reproductive health as, "prevention and management of unwanted pregnancies, services to promote safe motherhood and child survival, nutrition services for vulnerable groups, prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), reproductive health services for adolescents, health, sexuality and gender information, education and counseling, establishment of an effective referral system" [Pachauri 1995]. They thus transform reproductive health into a gamut of services all based on technology. It is inevitable, therefore, that the actual operationalization further narrows the scope to contraception, maternal and child health, nutrition, services for RTIs and STDs, AIDS, abortions, and sterility.

This technological fix has been further narrowed down by the World Bank, which sees FP services alone as a necessary input to improve women's health. Hence fertility control *per se* becomes the key to a public health package [World Bank 1993]. The United Nations Fund Population Activities, in a less commercial fashion, place reproductive health of women center stage and links population development, and environment to it [UNFPA 1992]. Given its perception that population growth is the main cause of poverty, women are identified as the central focus of intervention to reduce population and thereby, poverty.

These organizations used the terminology of reproductive health and making use of its conceptual ambiguity marginalised the social dimensions of empowerment and the right issues. Helped by the life cycle approach the emphasized `biological' processes, the medicalisation of reproductive health also became easy. Deprived of its social content, medicalised reproductive health can be as coercive as the previous FP services were.

**Research**

There has recently been a spurt of activity to emphasize reproductive health. The international community did not 'discover' until 1994 that third world women also want

contraception [Population Information Program 1992]! In the official FPP a need-based approach [GOI 1980] was adopted as late as the 1980s. Before this however, no real effort had been made to assess needs in India. The emphasis was on 'motivation' and 'education' of target populations with the basic assumption that ignorance alone is the biggest barrier to acceptance of the small family norm [Rao 1974]. Today huge funds are being invested by funding agencies to generate data on reproductive health. Organizations such as the Ford Foundation and the MacArthur Foundation are supporting social science research and interventive strategies to improve the reproductive health of women. The Ford Foundation in its strategy paper for the 1990s expresses its eagerness to invest in building institutional capacities for research in reproductive health, as it did earlier for demography. It proposes to propagate reproductive health research not only through social science and bio-medical institutions but also through non-governmental community based organizations. The latter are seen as a means of direct intervention to promote reproductive health. Unlike formal institutions they are also less likely to have "Sociological orientation emphasizing theoretical disciplines, and lacking implications for action" [Ford Foundation 1991]. The MacArthur Foundation in its brochure lists seven areas of research for which it provides financial assistance. Of these only two touch upon the broader social aspects of reproductive health and sexuality.

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 programs for reproductive health and in generation `objective data' which is free from the shackles of contextualisation, be it the associated problems of illnesses of a general nature or the socio-economic and cultural constraints on women. Guided by the agencies' professional experts, the participating NGOs often adopt the given methodologies and conceptual framework. Those who ask questions or have alternative research design arising out of their work experiences have problems getting support. Others feel exalted with the financial assistance and the proximity to power centers. The consequence is that reproductive health research does not arise either out of the perceived needs in women's lives or the epidemiological priorities.

Under, the onslaught of funded research on reproductive health; studies, which bring out the element of conscious choices that women make, are few and scarce. Those which focus on women's strategies for livelihood are brushed aside as evidence of the 'culture of silence': talking of other important issues in women's lives besides reproductive health is deemed to reflect no more than a shyness about addressing the 'real issues'. Thus while the concept of reproductive health theoretically appropriates areas of welfare and development, women's actual demands for discussing these are seen as an expression of 'suppressed need' for reproductive health programs. Whatever

women say, they can only be expressing an overt or a covert need for reproductive health programs. Women, it appears, can have nothing else to say!

**Ignoring Differences**

There is no denying the fact that the suppression of reproductive health and rights issues in the third world is rooted in women's oppression under the exploitative patriarchal structure of the family that function as the basic unit of the capitalist system. However, this reality is not sufficient to argue that reproductive health and rights issues of first and third world women can be treated at par [Garcia et al 1994].

The 'universalist' approach tends more to represent some of the middle class activist's views rather than what the third world working class women themselves are actually saying. While the latter struggle for basic minimum livelihood, food, shelter and health for their families, the underlying unstated assumption of reproductive health advocates that ordinary women, especially the poor, do not have this capacity to make choices. Therefore, choices have to be made for them. The contradiction lies within the universalist's individualized notion of rights, and the third world working class women's perception of family as their only means of survival. Despite patriarchal power relations within it, the family is the only structure on which most women can depend. Reproductive health strategies as conceived by the 'universalizes', may provide technological and educational services, but they offer nothing that initiates and supports the shift from a dependent woman to an independent one within or outside the family. The 'universalizes' then, is not incorrect when they talk of women being suppressed. The point is that they offer no strategies for changing this beyond benevolently, making decisions for these women.

A corollary to this contradiction is the idea that a population policy based on the principles of reproductive health empowers women to struggle for a better life. There are two serious lacunae in this view. Firstly, it obfuscates the reality that women are constantly choosing between risks and adversities in their ongoing struggle to minimize the tensions and strains of living, where these risks are a mix of social, reproductive economic, physiological and health factors. This denial of women's ability to think and act for themselves, and the denial of the legitimacy of their context-bound concerns, are in fact, counterproductive and disempowering. It does not build on women's vision of their priorities but on a pre-conceived notion of what they ought to need and ought to do. Secondly, this imposed strategy of empowerment does not take into account the preparedness of women to assert their reproductive rights or the implications of such assertions on priorities strategies of survival. Nor does it consider women's strength to

cope with the tensions generated by such assertions in the absence of support from their spouses and families. As a consequence, their health may improve but it does not change their status or their relationships. An illustration of this from a study in West Bengal shows that over time women have acquired much greater access to maternity services and delivery care [Soman 1992]. This right has been granted by the families but in the area of work, education, and political participation they still remain far behind.

Two forces seem to-have come together to push to the fore reproductive health and rights as a universal issue. One is the population lobby, which has come to terms with the need to shed FPP's technocentric and dogmatic stance and embrace a more subtle approach, and the reproductive health approach fits the bill. The other is a section within the international women's movement, which believes that a humane fertility control policy is possible within an economic framework that continues to push structural adjustment policies. Despite fully appreciating the conceptual and paradigmatic differences between ideologically differing groups that are working for sustainable development [Sen 1994], this section proposes fertility control through reproductive health as the common minimum agenda for them. Though they speak for the unorganized poor women, they do not understand that a poor woman pouring out her heart and seeking a set of services when she meets a sympathetic, listener is not, same as one independent asserting her rights for the same in absence of support and sympathy. The first does not call for restructuring survival strategies; the second cannot imagine being successful without them.

These two forces are thus pushing reproductive health center stage in the name of women's liberation irrespective of the constraint of class, caste and gender and issues of entitlement, health, employment, and educational status of women. How far they will carry forward women's struggles is predictable.

**Shifts In Fpp Strategies**

A major consequence of this development has been the current reformulation of FPP strategies. Failing to adopt the 'development is the best contraceptive' strategy [Singh 1974] proposed in the 1970s, the program had been groping for a less blatant but doubly effective means of population control. The pressure for achievements from IMF and World Bank, the scare of decline in foreign aid, the fear of AIDS, the knowledge of links between AIDS and RTI, availability of new contraceptives such as injectables, implants and Quinacrine (surer if not safer), and the failure of past strategies of FPP, coalesced to create condition for the acceptance of a reproductive health strategy within the national FPP [GoI 1994b].

The new strategy expanded the scope of fertility control activities, kept the pressure for achievement on and projected a shift out of the umbrella of the target oriented strategies of population control. Supported by the international funding agencies at the ICPD at Cairo, the reproductive health strategy was accepted in principle officially, without any discussion on development strategies or structural adjustment policies (SAP). The new policy statement of 1996 talks of achieving socio-demographic goals through panchayats and men's emancipation via the five principles of 'panchsheel' without any concrete economic or legislative measures [GoI 1996]. Given the worsening socio-economic conditions of the majority, it is doubtful if any of these will actually materialize. The basis of the shifts is in fact more political than epidemic-logical. The little data that exists is conveniently ignored and the shift in strategy is accepted in the hope that this will bring the eagerly awaited foreign aid.

**Public Health Perspective**

Reproductive health is a part of primary health care and therefore the responsibility of the state. Reproductive health concept as advanced by the state and the aid agencies, focuses on fertility regulation irrespective of health and developmental strategies. Its operationalisation into technocentric strategies, rather than into social, structural and legislative alternatives, its neglect of eminent general health problems, and its, inability to confront the detrimental impacts of structural adjustment policies on women, make it amenable to appropriation by the technologically oriented population control lobby. The official concept of 'reproductive health', then is not necessarily pro-women, it is only women-centered. There is therefore, a need to grasp the full complexity of the term 'reproductive health' and to put it in a public health perspective.

There is no denying the fact that reproductive health constitutes an important aspect to women's health. However, the challenge is to define priorities within it according to the objective and subjective definitions of women's needs, and to make it a part of a larger development program, based not only on equity of distribution but also on access and control of productive resources.

The subjective definition of reproductive health depends upon women's life experiences and is reflected in their perceptions and what they themselves say. Deeply rooted in the social matrix of each society, the actual expression of reproductive health needs depends upon the status and social position of women in it. Thus, it is not necessary that women would be in a position to articulate these need in there entirely, especially in the third world. This does not mean that till women start articulating their needs, no

interventions can be made. On the contrary, it calls for identifying the possible levels of interventions as well as evolving strategies for intervention.

Instead of looking at inter, and intra-household relationships as two distinct sets of relationships as [Das Gupta and Chen,1995] do, we need to understand power relationships between sexes within the socio-economic context which constantly impinges and alters power relations within families [Adams and Castle 1994]. This social level of intervention is one, which calls for social and political mobilization to create conditions that make women's assertion of needs within families easier. It also calls for sensitive and perceptive policies based on women's needs and priorities. To this extent the proposed activation of panchayats (local bodies) to implement socio-demographic agenda at village and community levels are a welcome step. Whether they will actually be effective will depend on the degree to which the new panchayats are able to change power structures, and the kind of support they get from the government and the civil society.

In a milieu where privatization, cutbacks in allocation to the social sector, shrinking wage structures and work opportunities, and dwindling food security system are hitting women the hardest, their basic survival needs cannot be given a secondary status. The fact that women are being pushed back into the unorganized sector or the boundaries of their homes to help families absorb the shock generated by a receding state, makes them even more vulnerable. At the family and community level, therefore, the only way to tackle reproductive health issues is to locate them within the broader spectrum of needs as experienced and perceived by women. To do otherwise would mean rejecting women's context, their perceptions and their strategies for survival.

At the policy level again, debate on health can be meaningful only if it addresses fully the socio-economic and political context of health (including reproductive health). In other words, the adverse impact of SAP on the poor, especially women, cannot be ignored. Even within the liberal framework of 'SAP with a human face' a population policy focusing on fertility control through the reproductive health approach cannot be considered sufficient unless it also spells out its strategies for meeting people's basic needs.

In the following section we examine the epidemiological basis for assessing the health needs of Indian women.

**Epidemiological Priorities**

Over the past few years there has been a spurt of literature on reproductive health. The field studies are either clinical or exclusively focus on women's reproductive health problems [Bang 1989] and [Sundari Ravindran 1995]. Though important, these reproductive diseases are not the only health problems of women. We examine here the mortality data from the Model Registration Scheme of the government of India to get an idea of the reality. Two things need to be stated:

a. The Model Registration Scheme has its limitations as it is conducted by non-medical investigators, uses symptom complexes for a retrospective diagnosis, and samples only PHC villages. Yet, it provides systematic information on causes for 7 to 10 thousand deaths annually.

b. It has become a common argument that looking at deaths is not sufficient and that reproductive morbidity's constitute a major indicator. Within a comprehensive public health perspective however, the link between morbidity and mortality should not be lost. Preventing deaths at times leads to higher morbidity but lower morbidity with high death rates is not necessarily indicative of good health. Therefore, when resources are limited, a judicious handling of the two with a focus on handling those problems first, which lead to mortality, is an accepted principle. Our assessment of data therefore will be within this perspective.

Table 1 shows the age specific and total female deaths in India over the decade 1982-93. It highlights the very high proportion of mortality in 0-4 years of age (22-28 percent) as compared to the 5-14 year age group (4.7 - 5.4 percent). While the highest mortality proportions of age group 45 years and above are expected, the proportions of death among 15-44 years over the decade (16-19 percent) is a matter of concern. It is also worth noting that while in the 0-4 year age group the lowest proportion of death was achieved in the 1990s, reversal began in 1991. For the 15-42 year age group there has been a slow and consistent increase from 16.36 to 19.13 over 1982-93. The proportion of death in more than 45 years age group shows an increase over 1988-91 and then again comes back to the initial levels in early 1990s but in 5-14 year age group there is very little change over the 11 year period.

**Table 1:** Total Female Deaths In India, 1982-93

| Age Groups in Years | 1982 | 1983 | 1984 | 1985 | 1986 | 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 (4.48) | 654 (4.92) |
| **15-44** | 1168 (16.38) | 1340 (17.27) | 1300 (16.45) | 1319 (17.12) | 1414 (17.27) | 1603 (15.9) | 1724 (18.16) | 1661 (18.09) | 1770 (17.66) | 2144 18.89) | 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) |
| **> 15** | 4761 (66.78) | 5301 (68.33) | 5377 (68.04) | 5231 (67.91) | 5606 (68.47) | 7223 (70.28) | 6733 (70.92) | 6653 (72.47) | 7207 (71.89) | 8142 (71.59) | 9379 (70.56) |
| **Total Deaths** | **7129** | **7758** | **7902** | **7702** | **8187** | **10283** | **9494** | **9180** | **10025** | **11373** | **13291** |

Figures in Parenthesis represent percentages out of total deaths.

Source: Government of India, Survey of Causes of Death (Rural), RGI, Vital State Division, Annual Reports 1982-93

An examination of the main causes of death in Table 2 reveals that deaths due to childbirth constitute 2.1 to 2.9 percent of the total female deaths. The main causes of death among women remain respiratory diseases, causes peculiar to infancy, disease of the circulatory system (which includes anemia), fevers, and digestive disorders. Time trends show very little decline in these proportions. The proportion of death due to injuries actually increases slightly and those due to fevers decline over the entire period. For causes, falling within the purview of maternal and child health (childbirth and pregnancy, causes peculiar to infancy and diseases of the circulatory system including anemia), there is an initial decline in proportions till 1988-89. Then a slight but consistent reversal of this trend sets in.

**Table 2:** Deaths Among Females In India By Major Causes, As Percent Of Total Female Deaths 1982-93

| Major Causes | 1982 | 1983 | 1984 | 1985 | 1986 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 |
| **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 |
| **Fever** | 10.4 | 10.8 | 10.7 | 9.9 | 11.0 | 8.8 | 8.2 | 8.2 | 7.9 | 8.5 | 7.35 |
| **Digestive disorders** | 7.4 | 7.8 | 7.8 | 7.6 | 7.7 | 6.8 | 6.9 | 6.8 | 6.7 | 6.9 | 7.22 |
| **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 |
| **Disorders of 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 |
| **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 |
| **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 |
| **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 |
| **Sanility** | 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, Annual Reports.

To acquire a better idea of the distribution of cause we have identified from each group specific communicable diseases. Deaths due to gastroenteritis, cholera, dysentery, tuberculosis, pneumonia, whooping cough, meningitis, jaundice, tetanus, chicken-pox, measles and polio myelitis 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 animas. Table 3 presents the age specific death load for these three groups. The important features of this analysis are that in all, age groups communicable diseases cause the highest proportions of deaths. In the15-44 years age

group these deaths are more than double the proportion of deaths caused by maternity deaths. A visible trend is the virtual stagnation of the pattern of distribution of deaths within this age group. The slight declines in the proportions of deaths due to communicable diseases in the 15-44, year age group are compensated by the slight increase in the proportions of maternal deaths. The non-communicable disease and anemia deaths show little change except over the years 1992-93, which needs cautious interpretation.

**Table 3**: Female Age Specific Death Load Due To Specific Causes

| Age Group in Years | Causes of Deaths | 1982 | 1983 | 1984 | 1985 | 1986 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-14 | Communicable disease | 1079 (45.56) | 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 | 1 | - | - | - | - | - | - | - | - | - | - |
| | General anemia | 34 (1.44) | 96 (3.91) | 98 (3.88) | 117 (4.73) | 132 (5.11) | 151 (4.94) | 125 (4.52) | 148 (5.85) | 137 (4.86) | 152 (4.07) | 198 (5.06) |
| | Non-communicable disease | 1254 (52.96) | 1249 (50.83) | 1226 (48.55) | 1203 (48.68) | 1213 (47.00) | 1427 (46.70) | 1350 (48.91) | 1303 (51.56) | 1496 (83.09) | 1856 (52.44) | 2114 (54.04) |
| | Total all causes | 2368 | 2457 | 2525 | 2471 | 2581 | 3056 | 2761 | 2527 | 2818 | 3231 | 3912 |
| 5-44 | Communicable disease | 443 (37.93) | 489 (36.49) | 470 (36.15) | 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 | 161 (13.78) | 200 (14.93) | 175 (13.46) | 241 (18.27) | 176 (12.45) | 182 (11.35) | 202 (11.72) | 209 (12.58) | 251 (14.18) | 270 (12.59) | 384 (15.10) |
| | General anemia | 24 (2.05) | 52 (3.88) | 56 (5.15) | 44 (3.34) | 49 (3.47) | 69 (4.30) | 75 (4.35) | 58 (3.49) | 69 (3.90) | 95 (4.43) | 135 (5.31) |
| | Non-communicable | 540 (46.23) | 599 (44.70) | 599 (46.08) | 561 (42.53) | 685 (48.44) | 820 (56.15) | 902 (52.32) | 904 (54.43) | 953 (53.94) | 1155 (53.87) | 1249 (49.12) |
| | Total all causes | 1168 | 1340 | 1300 | 1319 | 1414 | 1603 | 1724 | 1661 | 1770 | 2144 | 2543 |
| > 45 | Communicable disease | 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 | 6 | 6 | 4 | - | - | - | - | - | - | - | - |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **General anemia** | 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) |
| | **NCD** | 2958 (82.33) | 3168 (79.98) | 3301 (80.77) | 3149 (80.50) | 3452 (82.35) | 4793 (84.62) | 4288 (85.61) | 5327 (88.90) | 4598 (84.57) | 5117 (85.31) | 5835 (85.36) |
| | **Total all causes** | **3593** | **3961** | **4077** | **3912** | **4192** | **5664** | **5009** | **5992** | **5437** | **5998** | **6836** |

Figures in Parenthesis represent percentages of age specific death load due to that cause.

Source: Survey of Causes of Death, Annual Reports.

Table 4 gives the distribution of communicable diseases over ill age groups and shows the heavy casualty it causes for those 14 years or less. Of all communicable disease deaths, 47-53 percent occurs in young girls and 21-24 percent in 15-44 year age group. The proportion of deaths due to communicable diseases in the reproductive age group increases after 1991. As a result, for 1993 in the 15-44 age groups, the proportion of deaths due to communicable diseases out of total deaths within this age group is higher than the proportion of such deaths out of total female deaths due to communicable disease across age groups (30:24 for 1993). This proportion reverses to 40:49 in the younger group and to 12:35 in older women for 1993. Similarly, when we look at female deaths due to child birth alone, in Table 5, we find that in the reproductive age group divided into 15-24 25-34 and 35-44 years these deaths constitute more than 14-19 percent of the deaths due to communicable diseases till 1990. However, by 1993, this proportion in the 15-44 years age group rises to a total of 24 percent. This increase over time is perhaps due to complications of pregnancy related to rising communicable diseases (Table 4) and improved recording of maternal mortality. The poor recording of communicable diseases lately cannot also be completely ignored.

**Table 4**: Age wise Percentage Distribution Of Female Deaths Due To Communicable Diseases 1982-93

| 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) |
| **All Ages** | 28.1(2008) | 28.5(2216) | 28.4(2247) | 28.8(2225) | 28.7(2351) | 26.6(2736) | 25.1(2348) | 23.6(2163) | 23.5(2362) | 22.5(2569) | 24.0(3195) |

Figures in parenthesis represent number of deaths.

Sources: Survey of Causes of Death, Annual Reports.

**Table 5**: Female Deaths Due To ChildBirth In India Expressed As Percent Of Female Deaths Due To Communicable Diseases

| **Age in Years** | **1982** | **1983** | **1984** | **1985** | **1986** | **1988** | **1989** | **1990** | **1991** | **1992** | **1993** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **15-24** | 56(6.03) | 95(8.57) | 66(5.96) | 70(6.52) | 79(7.09) | 68(5.40) | 72(6.56) | 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(3.52) | 30(4.71) | 54(5.03) | 30(2.69) | 30(2.38) | 34(3.10) | 21(1.93) | 58(4.93) | 43(3.19) | 69(4.31) |
| **15-44** | 161 (17.3) | 200 (18.0) | 175 (16.7) | 241 (22.4) | 176 (15.7) | 182 (14.4) | 202(18.3) | 209(19.2) | 251 (21.3) | 270 (19.9) | 384 (24.0) |
| **> 45** | 6(.64) | 6(.54) | 1(0.09) | 8(0.74) | - | - | - | 2(0.18) | - | - | - |
| **> 15** | 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) |
| **Deaths due to communicable diseases (>15)** | 928 | 1108 | 1046 | 1074 | 1115 | 1258 | 1098 | 1087 | 1177 | 1356 | 1595 |

Figures in parenthesis are death as percentage of female deaths due to communicable diseases in age group 15 years.

Source: Survey of Causes of Death, Annual Reports.

The relative proportions of deaths induced by child birth related and communicable disease as in Table 6, in 15-44 year ages group out of the total female deaths are 1.7 percent to 2.8 percent and 5.1 percent to 5.8 percent respectively over the period 1982-93. In other words the importance of communicable diseases within the reproductive age group cannot be ignored. The same table also gives the relative contribution of these two causes taking all age groups together. Over the entire period of 1982-93, communicable disease deaths remain the most eminent, and emphasis the fact that isolating reproductive age group performs the function of ignoring heavy mortality caused by communicable diseases in the age groups 15 years and under and 45 years and above.

**Table 6**: Relative Proportion Of Maternal And Communicable Disease Deaths In Women, 15-44 Years of Age

| 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 |

Figures in parenthesis represent percentages to total female deaths.

Source: Survey of Cause of Death, Annual Reports.

When we look at deaths due to anemia in the 15-44 years age group (Table 7), we find that as a complication of pregnancy it has certainly not declined as its share has come down from 3.4 percent to 1.93 percent in 1988 and then again risen to 3.07 percent in1993. General anemia (without pregnancy) is an equally serious threat to women's

lives. Even if the 1993 figures are treated with caution, the rising contribution of general anemia to deaths cannot be denied.

**Table 7**: Distribution Of Deaths Due To Anemia With And Without Pregnancy Among Women Aged 15-44 Years

| | **1982** | **1983** | **1984** | **1985** | **1986** | **1988** | **1989** | **1990** | **1991** | **1992** | **1993** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Deaths due to anemia with pregnancy** | 40 (3.42) | 37 (2.46) | 41 (3.15) | 42 (3.18) | 30 (2.12) | 31 (1.93) | 41 (2.38) | 41 (2.86) | 50 (2.82) | 53 (2.47) | 78 (3.07) |
| **Death due to anemia only** | 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 deaths due to anemia** | 64 (5.47) | 89 (6.34) | 108 (8.28) | 86 (6.52) | 79 (5.58) | 100 (6.23) | 116 (6.73) | 99 (6.35) | 1196 (6.72) | 148 (6.90) | 213 (8.38) |

Figures in parenthesis are percentage to female deaths in 15-44 year age group.

Sources: Survey of Causes of Death, Annual Reports.

If we add to this the low levels of average caloric intake, as shown by the National Monitoring Bureau (1980) data, the picture of general health becomes very poor. For example, in nine major states, for 1975-78, the women who were sedentary workers (requiring 1900 calories) showed a mean caloric intake of 1307-1816 in all states except one. For moderate female workers too, all except one of the nine states had values less than the required 2200 calories and here top the range of mean intakes was 1141-1976. This reflects the severe deprivation of adult women its Kerala, Tamil Nadu, Andhra Pradesh, Maharashtra, Gujarat, Madhya Pradesh, West Bengal and Uttar Pradesh. In 1996 among the sedentary workers the mean caloric intake went above the recommended levels in two out of eight states, and for moderate women workers four states had values above the required. In the 1996 data however, UP and West Bengal were replaced by Karnataka and Orissa!

**Maternal Mortality and Diseases**

Women's is poor nutritional status, high prevalence of animas, and communicable diseases complicate reproductive health. This fact needs to be highlighted. Unfortunately very little recent national level data exists to demonstrate the association. During the 1960s however, when reporting systems were more open, the ministry of health and family planning published some useful statistics on this problem which were subsequently discontinued.

For the years 1966-68, we present cumulative data on deaths due to toxemia, hemorrhages, and complication of pregnancy, sepsis, abortion, and post-natal complications. Along with these we also examine maternal (obstetric) deaths with associated medical conditions such as tuberculosis, anemia, dysentery, and small pox. A majority of these were certified by doctors but some were not. We club this data in Table 8 and find that among the total registered maternal deaths, up to 16.39 percent mortality is caused by complications due to associated causes. Given that not all deaths were certified by medical personnel, and complications such a cerebro-vascular diseases, diabetes, etc, have not been considered, the detection of associated causes can only be an underestimate. In other words the underestimation of the underlying ill-health associated with obstetric deaths is not an insignificant issue. Even though such data for the present is not available, given the almost static levels of mortality and the return of epidemics of malaria, kala azar, hepatitis, plague and dengue, grave doubts exist that the 1990s present a more hopeful scenario.

**Table 8**: Distribution Of Maternal Deaths By Obstetric Causes: (Direct And Associated With General Diseases)

| | Direct Obstetric Mortality | | | Indirect Obstetric Mortality | | | |
|---|---|---|---|---|---|---|---|
| **Year** | **Certified by Doctor** | **Not Certified by Doctor** | **Total** | **Certified by Doctor** | **Not Certified by Doctor** | **Total** | **Grand Total** |
| **1966** | 49672(92.79) | 3858(7.20) | 53530(89.17) | 5898(90.69) | 605(9.30) | 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 |

Figure in parenthesis indicate percentage.

Sources: Health Statistics of India, 1966 to 1970, DGHS, Ministry of Health and Family Planning, Government of India, New Delhi.

The Model Registration data thus emphasize the following:

(1) The importance of dealing with the health problems of under 15 year old girls, who bear a high load of mortality, and who enter reproductive age with a disadvantage.

(2) The importance's of communicable diseases, which not only kill the young but also remain the second major killers of women in the 15-45 years age group.

(3) The inappropriateness of exclusive reproductive health interventions for women in the reproductive age group when communicable, diseases, animas, and malnutrition are their major killers across all age groups.

(4) The need to retain the focus on maternal mortality, before opting for broadening the base of maternal and child health services in the face of severe cuts in health sector investment. This broadening into peripheral areas of reproductive health will dilute the efforts of the public sector, which through the FPP is already concentrating investment in contraceptive services.

(5) The need to recognize the impact of general illness on maternal health as the complications caused add to maternal mortality.

This data gives a clear basis for policy level interventions in the area of public health. It also explains partly the 'silence' of poor Indian women on the issue of reproductive health and rights other than basic maternity services.

**Reproductive Health as a Part of Primary Health Care**

Despite the above evidence, the increasing emphasis by reproductive health advocates on AIDS, STD, RTIs, abortion, and contraception, has pushed open the scope of maternal and child health without actually completing the task of bringing down

maternal mortality to acceptable levels. This broadening of the scope of maternal and child health therefore may either lead to diluting the emphasis on reducing maternal deaths or demand diversion of primary health care resources to 'reproductive health'. The original definition of maternal and child health as conceived by the WHO adequately included the additional dimensions which are today being included as 'new'. WHO had also emphasized the importance of dealing with associated health problems especially communicable diseases [WHO 1952]. Concerted efforts to lower maternal mortality through the provision of preventive and emergency maternity services and efficient working of all national health programs, therefore, continues to be the primary need of women.

For this, adequate referral services at the community health center level - and not the private institutions as perceived by the, World Bank - must be made mandatory as the majority of women who are poor and need help can only depend upon the public sector. This is evident from the NSS data on utilization of indoor services [Purohit and Siddiqui 1994]. A critical input, which the services have not as yet acquired, is the long promised obstetric and gynecological specialist at the community health center with basic minimum infrastructure and functioning referral system. Such a facility will not only deal with obstetric problems but also the RTIs, STDs and gynecological problems and even abortion services for which women may need help.

A review of expenditure trends by the central government reveals that the proportionate investments over the 1990s do not strengthen the maternal and child health services even though the total expenditure on family welfare has more than doubled (Table 9). The central government's expenditure puts much more emphasis on family welfare than on public health. This relatively higher input into FPP is evident from the grand totals and sectoral expenditures shown in Tables 9 and 10. The budgets for FPP have risen by 30 to 40 percent over the years. The expenditures into maternal and child health over 1982-93 in fact declined in proportion. Inputs into supportive programs such as post partum programs and community health guide schemes have remained static or have actually declined. From 17 percent of the budget, the expenditure on these three activities has declined to about 12 percent, with proportionate expenditures on maternal and child health remaining under 1982 levels. This mean that, despite all the noise, real emphasis continues to be on contraceptive and sterilization services.

**Table 9**: Annual Expenditure on Family Welfare (Rs Crore)

| Year | 1989-90 | 1990-91 | 1991-92 | 1992-93 | 1993-94 | 1994-95 |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| MCH | 72.45(11.23) | 88.60(11.15) | 99.60(11.49) | 95.25(9.06) | 125.24(9.75) | 151.59(10.51) |
| PPP | 22.00(3.41) | 28.25(3.55) | 28.25(3.25) | 50.30(4.78) | 49.65(3.80) | 49.47(3.43) |
| Voluntary Sector | 5.4(0.84) | 5.34(0.67) | 5.80(0.67) | 6.97(0.06) | 10.00(0.78) | 8.80(0.61) |
| CHG | 18.00(2.79) | 50.00(6.29) | 24.00(2.77) | 21.00(2.00) | 21.00(1.63) | 10.00(0.69) |
| Grand Total | 645.04 | 794.72 | 866.60 | 1051.41 | 1284.91 | 1442.03 |

Figures in parenthesis are column percentages.

The figure do not add upto the total as expenditure on FP services such as FW centres, compensation, are projects, CC distribution, transport, etc have not been noted.

MCH = Maternal and Child Health

PPP = Post Partum Programme

CHG = Community Health Guide

Sources: Government of India, Annual Financial Statement of the Central Government, Expenditure Budget, Volume II, 1990 to 1996.

Similarly, the health budget's proportionate expenditure into public health (Table 10) shows drastic cuts over 1990-92. The apparent improvement in the later years is actually due to the expenditure on kala azar and plague epidemics and increase in blindness control program allocation in 1994-95. If, for example, the 80 crore invested into these programs are deducted from 1994-95 expenditure on public health; the proportion of investment falls to 35 percent. The only communicable disease controls programs, where there is a significant improvement in the proportion of investment are the ones for leprosy and AIDS. The tuberculosis program shows a marginal increase in its share (from 7 percent to 10 percent) while malaria and filaria share maximum cuts [Qadeer 1995]. The consequences of these shifts for people's health are obvious.

**Table 10**: Annual Expenditure on Health (Rs Crore)

| Year | 1989-90 | 1990-91 | 1991-92 | 1992-93 | 1993-94 | 1994-95 |
|---|---|---|---|---|---|---|
| **CGHS** | 50.26(11.66) | 63.07(13.16) | 67.32(12.81) | 79.46(10.82) | 107.72(12.76) | 120.00(12.07) |
| **Hospital/dis-pensary** | 33.80(84) | 39.75(8.29) | 48.02(9.14) | 70.25(9.57) | 75.11(8.90) | 81.14(8.16) |
| **Medical education, training and research** | 147.16(34.14) | 171.93(35.86) | 180.03(34.27) | 239.24(32.59) | 260.75(30.90) | 293.84(29.56) |
| **Other systems of medicine** | 18.41(4.27) | 22.1(4.61) | 21.99(4.19) | 29.01(3.95) | 33.62(3.98) | 39.09(3.93) |
| **Public Health** | 164.23(38.10) | 165.19(34.45) | 179.41(34.15) | 291.82(39.74) | 346.90(41.10) | 431.78(43.44) |
| **Other Programs** | 9.15(2.12) | 8.28(1.73) | 19.13(3.64) | 11.50(1.57) | 5.95(0.71) | 12.46(1.25) |
| **Group Total** | 431.00 | 479.42 | 525.31 | 734.15 | 843.94 | 993.89 |

Figures in parenthesis are percentages. The figures do not add up to the total as expenditures on public enterprises, DGHS, etc, have not been noted.

Source: Government of India, Annual Financial Statement of the Central Government, Expenditure Budget, Volume II, 1990 to 1996.

The government of India's draft population policy 1996, which pays lip service to issues of social justice, equality, poverty and gender, continues to strategies only population control through its focus on reproductive health. It does that by promoting the use of primary health care infrastructure to expand contraceptive delivery and by adding service for abortions, RTIs, STD and AIDS to those of maternal and child health. It professes that, "the policies of globalization increase the gap between the rich and the poor besides damaging basic life support systems", but yet maintains that, unless numbers are reduced, the fruits of development cannot be equitably distributed. Its only positive contribution, as we pointed out earlier, is a proposal to generate through panchayats socio-demographic reforms to minimize social evils such as child marriages, female foeticide and infanticide, maternal mortality and female illiteracy.

Unfortunately, it has no solid legal or economic strategies to ensure women's participation.

These obviously distorted patterns of policy and funding with cuts in the health budget, stagnation of investment in maternal and child health along with an unflinching emphasis on contraceptive services through exclusive FPP infrastructure and focus on AIDS in the area of communicable diseases, do not augur well for either women's reproductive health or their general health. Despite these distortions and contradictions, the contention is still that financing reproductive and sexual health services is critical for the third world. Having first advocated a broad-based health and development oriented concept of reproductive health, the 'experts' eventually narrow down to medical services for STD, AIDS, abortion, maternal and child health, maternal malnutrition, in addition to contraception, which they themselves say has received too much attention. The propose household surveys to assess reproductive health budgets at the family level. The donors too are urged to play a key role in financing reproductive health services, even if they form only 3 percent of the national health and family welfare budget in third world countries [Zeitlin et al 1994].

**Conclusion**

From a public health perspective two things are clearly needed. Firstly, within reproductive health, priorities should be clearly, articulated and reflected in the budgetary allocations. Secondly, maternal and child health, nutrition, contraceptive services, and communicable disease control must be integrated. Within the sphere of the health service system this will provide a solid foundation for women's health including their reproductive health. Handling reproductive health in isolation is not only an inefficient way of dealing with the problem of women's reproductive health but it also robs them of their dignity. An integrated approach alone can give optimal results by handling women's health as an entirety. To achieve the best results the health service system needs supportive social, economic and legislative action favoring women.

The issues of women's health (including reproductive health) thus go well beyond the domain of the public sector in health. Woven into the fabric of society, it is open to intervention at different levels. Policy, welfare programs, training health activists, and community level mobilization can influence it deeply. It is therefore, incumbent upon those who choose to intervene that they should grasp the limits of the levels at which they intervene and the complexity of women's health. It requires an effort to link up these levels and create a multipronged strategy for intervention. The blurring of this

matrix and isolated interventions, can create an illusion of achievements where little exist.

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