Women and Economic Reform in India: A case study from the health sector

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Introduction: The Premises of Economic Reform

In 1991, under the overall rubric of economic reform, the Government of India put into operation a set of wide-ranging policies and programmes. While some of these had been on the anvil from the mid-eighties onwards, it is only in the present decade that several measures were initiated with a certain determination. However, the reform package has had a mixed response, with considerable apprehensions of how these are going to affect certain sectors of the population; various people's movements including the women's movement have been greatly concerned with some aspects of globalisation and how it will affect the less privileged. For instance, the introduction of Free Trade/Zones has generated the need for cheap labour; but what will more, low paid jobs mean for women's status? With increasing competition and the thrust towards already over-crowded urban centres there will be an increase in crime and violence; how will women - major pillars of the national as well as individual family economies - cope with more stress and tension? Thus, before analysing the implications of the reform package, it is important to look at some basic parameters of Indian women's lives today. As we proceed, it will be clear that women's health and well-being - the focus of this paper - are intrinsically linked to other aspects of their status.

For most of this century, the decennial Census operations have recorded an adverse sex ratio for women: it declined from 934 females for a 1000 males in 1981 to 927 in 1991. Coupled with increasing information on foeticide and infanticide, it is clear that the Indian girl child - and later, woman - is the subject of discrimination and prejudice. The prevalence of a dominant family ideology which strictly demarcates definite roles and obligations for girls and women leads to their devaluation and marginalisation. The basic assumption. is that girls are inferior, physically and mentally weak, and above all, sexually vulnerable. In a society which lays so

much stress on purity and pollution, various oppressive structures - including early marriage - are encouraged so as to restrict feminine mobility and freedom. Not unexpectedly, then, access to various resources such as education, health care and nutrition as well as parental love and care are determined by a range of factors.

That fifty years after independence, only a little more than a third of women are literate, is indicative of the overall attitude towards women and their roles. In addition, in keeping with the world-wide trend on exposing such data, information on violence against Indian women and girl children has brought into focus their extremely fragile position , both within the family and in public spaces (Karlekar et al 1995). Yet, there has been slow progress in certain vital areas: female life expectancy at birth has risen, the sex differential in infant Mortality Rates is almost bridged, and an increasing number of women are joining the work force. The chief achievements of the last decade - and certainly among the most important features of the post-independence period - have been the 73rd and 74th Constitutional Amendments of 1993 which reserved 331/3 percent-,of seats for women in elections to local bodies in both the rural and urban areas.

The outcome has been a virtual revolution in the political scenario of independent India: it is estimated that when elections are completed in the 21 states of the Indian union where the Amendments are applicable, over 1 million women will have been elected to these local bodies. However, clearly traditional holders of power are unhappy with this shift in focus: a recent report (The Hindu, New Delhi, April 9, 1997) from Rajasthan, a state notorious for negative female development indicators, quoted two women sarpanches or heads of Panchayats (village-level elected bodies) as saying that they had been impeached by the male majority because of resentment against their development-oriented plans and drive against corruption. In other words, the patriarchal order will resist what it feels are invasions of its bastions of power and authority.

Against this backdrop, it becomes important to assess how drastic economic reforms will affect women's lives and well-being. In other words, the paper argues that State policies and programmes are for and about people: however, given the irrevocable mandate of globalisation on the one hand and internal economic decline on the other, it has at times been all too easy for the Indian State to concentrate mainly on overall strategies to face such challenges. In the process, blueprints for progress often overlook the claims of those negatively affected by such changes. It is then left to the voices of dissent to narrate a cautionary tale: the democratic polity represents an increasingly aware electorate, one which is not only concerned with individual rights but which also has certain expectations from a State poised to enter the global

economy. For, if political structures are to endure they have to move beyond the narrow confines of contractual relationships (see Fiona Robinson [1997] for a discussion on how global politics must incorporate an ethics of care based on a commitment to people and not only policies)-. The following analysis of health care in India shows how the State has not taken into account the implications of its policies; in fact, by encouraging privatisation of health care - often as we shall see, by default - it is reneging on its contract with its citizens: far from an ethics of care, the Indian State is increasingly adopting a minimalist position as it labours to keep at bay divisive forces and growing discontent.

At the time of independence from the British in 1947, India was "a low productivity agrarian economy" (Krishnan and Rao 1995:3). The newly elected government adopted a mixed-economy approach: while the public or government sector was to handle major responsibilities such as power, steel, mines and heavy industries, food grain production, the manufacture of consumer goods as well as some capital goods were controlled by private enterprise. The mixed economy philosophy and Five Year Plans defined priorities and allocations maintained through an elaborate system of licensing and quality control which regulated the latter. By the seventies it was clear that economic policies had not been able to contain inflation nor deliver social justice: if the low rate of growth, spiralling inflation and impending balance of payments crisis had to be tackled, a fresh look at existing strategies and programmes was necessary.

In the years before the current phase of reform, there was enough evidence to suggest that poverty alleviation measures were not taken too seriously. Economist Pranab Bardhan has commented that while there was "some general progress over the years in the provision of public consumption and welfare measures for the poor" (Bardhan 1984:4), these remained woefully inadequate. He identified low investments, the absence of an adequate administrative machinery as well as organisational and managerial bottlenecks as being responsible. Further, during a financial crisis, "the axe falls most heavily on the social welfare programmes for the poor"(ibid.:4). That, in the post-independence period, investment and planning for the social sector has not been given the attention necessary for a country of India's size and dynamics is evident by a quick look at some figures: half a century after independence 130 million people in India do not have access to any kind of health facilities, 185 million have no access to drinking water and while the government claims that 80 per cent of villages have safe drinking water, a million children die each year from diarrhoeal diseases (Shiva 1995:114).

While by the mid-eighties there was a re-thinking on economic policies, it was the crisis of 1990-1 which "shook the very foundations of Indian development strategy and planning" (Krishnan and Rao 1995:7). According to the authors, the crisis was triggered by the, Gulf War

when, due to a number of factors, including a drying up of foreign remittances from the Middle East, the country's foreign exchange reserves shrank to "the value of a single month's import bill"(ibid.:9). However, others (Krishnaraj 1993) feel that the situation was in fact in the making due to a faulty import policy and other related factors brought about by political exigencies. With few other options, the country approached the International Monetary Fund and the World Bank for "extraordinary accommodation"; the funding institutions, in turn, made stabilisation and structural Adjustment conditional for the receipt of such assistance.

The incumbent package of economic reforms consisted of the four strategies of devaluation, privatisation, liberalisation and globalisation (Krishnaraj 1993). All of these, have, in one way or another, affected the life of the average household in a number of ways. The philosophy of open competition and privatisation has substantially permeated the social sector; as we shall see, in health care, a history of unsatisfactory state-run facilities has led to the burgeoning of the private sector. In the post-reform period this tendency is exacerbated, and, when combined with a de-regulated drug market, costs of health care shoot up. While advocates of the reform package do not rule out intervention on behalf of the poor, they assume that "the really effective weapon for poverty alleviation is accelerated economic growth ' (Vyas 1993:406). V. S.Vyas argues that this trickle down theory is based on certain premises which may not be valid. For instance, not only does the rate of growth have to be high - between 6-8 per cent - but also the composition of this growth is vital. He concludes that an agriculture-led growth is likely to be faster and the spread effect of growth will be more "if it is accompanied by investment in infrastructure and in human resource development"(ibid.:406).

Arguing that "structural adjustment may have limited impact in terms of augmenting growth" but "will have disastrous social consequences on the long-term development of the nation" Maithreyi Krishnaraj (1993,69) points out that it is vital to critically assess the composition of terms such as 'growth' and 'output'. In other words, a skewed growth rate which boosts the consumer market is unlikely to benefit the underprivileged. Evidence from other economies which have gone through this kind of reform indicates that the need to reduce fiscal deficits has forced Latin American countries to cut back on subsidies and certain kinds of social expenditure. A sudden rise in the cost of living can result in widespread protest and often violent rioting, as happened in the Dominican Republic, Zambia, Brazil and other Latin American countries. Analysing such economies Ajit Kumar Singh has pointed out that there has been a fall in standards of working class populations with the slowing down of employment opportunities, withdrawal of subsidies, rise in the price of public services as well as contraction of government expenditure(Singh 1993; see Also Mathew 1995 Panini 1995; Pathy 1995). As a

consequence, governments have been forced to undertake ameliorative measures. In structural adjustment programmes, the safety net component focuses on enhanced social sector spending, subsidised essentials such as food grains, cooking oil and fuel, as well as items of daily consumption.

While agreeing that during structural adjustment "the burdens on poor women ... have increased" economist Diane Elson nonetheless points out that it is important to know whether it is the programmes themselves which add to the burdens or whether there is a need to look more closely at the economic crisis which resulted in the programme, being initiated (Elson 1994:149). For instance, poverty in India has been a major issue in the post- independence, pre-reform period and in 1991, a third of the, population lived below the poverty line. Thus, what is significant is that not only did a crisis exist but it was exacerbated by a) certain retrogressive measures and b) an inability, to re-orient strategies to combat the crisis. This is evident if we take into account that the percentage of those living below the poverty line for 1992-3 had gone up to 41.7 as against around 35 per cent in the earlier years. C.H. Hanumantha Rao and Hans Linneman (1996) have drawn attention to the fact that absolute poverty has increased in the immediate post-reform period even though these years witnessed good harvests, a rise in agricultural production and real wages. They conclude that this situation could have been avoided "if the policy package and the measures adopted had taken due account of the vulnerability of the prevailing socio- economic structure, especially in rural areas, to the shock of adjustment' (Hanutnantha Rao and Linnemarn, 1996:27). In other words, according to certain socioeconomic parameters, economic reforms have only heightened certain existing negative trends through unimaginative strategies which do not take into consideration the needs of the people.

In the general elections of 1996, the Congress Party which had initiated economic reforms in 1991 was voted out of power. A certain amount of speculation on the future of reform followed, particularly when the coalition United Front government took over in May. A clear statement on its approach was enunciated in the Common Minimum Programme document which stated that the Front is committed to giving the Indian people "a higher standard of living and a better quality of life through faster economic growth and enhanced social justice" (CMP 1996). Arguing that "growth with social justice will be the motto of the United Front government", the CMP further reiterates that as "there is not substitute for growth. . . the country's GDP needs to grow at over 70/o per year in the next ten years in order to abolish endemic poverty and unemployment'(ibid.:8-9). Accordingly, the update on the Economic Survey presented to Parliament in July noted that though the growth rate of 7% is

reassuring, this was due mainly to industrial production; on the other hand, agriculture, forestry and fishing which support the bulk of the population recorded an extremely low rate of 2.4%. Recognising that "existing special programmes for employment generation and poverty alleviation need to be strengthened", the document spoke in vague generalities about improving programmes for education and health.

Most official documents in the fifty years of India's independence have, with 'varying degrees of candour, admitted to limited success in bridging the gap in the population's access to basic rights such as education, health, nutrition, housing, sanitation and so on. Nor has civil society been silent on the declining role of the State: for instance, from 1975 onwards, the women's movement has drawn attention to certain negative socio-economic trends and how these affect the status of women and children. The many voices from the women's movement as well as from other broad-based people's movements fractures the, discourse on liberalisation by providing counterpoints and critical appraisals of avowed promises and preferred solutions. Accordingly, this paper examines the health sector with a view to highlighting myopic policies and faulty implementation strategies. By doing so we hope to contribute to an alternative discourse, one which questions the votaries of liberalisation, their expectations of the market, trickle-down theories of development and naive belief that the social sector can take care of itself.

An Overview of the Health Scenario in India

In keeping with the World Health Organisation's definition, in this paper health is,viewed broadly as a state of mental and social well-being, to be regarded as a human and civic right. In India, the provision of basic health services is the responsibility of the State, where the Five Year Plans lay, down priorities and directions. The Constitution of India placed public health and sanitation in the state list; in other words, under the federal system of governance, the Indian states, rather than the Central government have a primary obligation for these two aspects of civic life. While the idea of holistic health - preventive, curative and promotive - is a part of the current Indian development literature, actual implementation falls far short of people's needs. Not unexpectedly, women and children (particularly those from underprivileged homes) are: easy victims of inadequate delivery systems and outreach programmes.

According to a recent policy document the Government of India admits that as human development indicators such as "life expectancy, literacy, school enrolment and medical care lag far behind those of most East Asian countries"; people who "are our most valuable resource"

should be "at the centre of our strategy of economic reform" (GOI 1993b:26). Pointing out that education and health care of the privileged have skimmed off a major share of budgetary allocations in these areas, the document argues for a redirection of priorities which will lead to "much higher shares of the budgets for education and health on primary education, basic health care and women and child welfare". Not unexpectedly, high birth and fertility rates are identified as major actors in this scenario of declining well-being and productivity: the document states quite, unequivocally that "the effectiveness of the family planning programme will need to be greatly improved" particularly in the high birth rate states of Uttar Pradesh, Bihar and Madhya Pradesh.

The Economic Survey presented to the Parliament in 1996 states that after the introduction of economic reforms, the Central Plan outlay for programmes of the Department of Health has been stepped up from Rs. 302 crores in 1992-3 to Rs.670 crores in the 1995-6 period. A large percentage of these funds are ear-marked for the, control of communicable diseases such as malaria, tuberculosis, leprosy, blindness and now AIDS (Rs. 421 crores) as well as salaries and maintenance (GOI 1996). A longitudinal analysis by K.N. Reddy and V. Selvaraju of GDP health, expenditure between 1974-1991 indicates that though spending under the heads of family welfare, nutrition, water supply and sanitation - all clubbed under the health budget - increased, that of medical and public health declined. It is also important to note that during the period 1974-5 to 1990-1, the total expenditure on medical and public health declined from 62.14% of the relevant budgetary head to 48.62% (Reddy and Selvaraju 1994). In addition, while salaries accounted for a large percentage of the outlay, non-salary components such as medicines, equipment and fuel were inadequately -funded (Duggig 1995). This has meant the rapid growth of the private sector in health care.

Not surprisingly then, the Eighth Plan document also emphasised that "in accordance with the new policy of the government ... private hospitals/clinics will be supported'. This rationalisation for a minimalist State position in health care is born out by the findings of a nation-wide survey conducted by the National Council for Applied Economic Research to establish the market structures for a variety of consumer good. The survey, which was conducted across 6,354 rural and 12,339 urban households in 1992-3, and collected data on morbidity, health care utilisation and health expenditures in considerable detail, established the importance of the private sector in health care. For instance, only 22 per cent of the population in Kerala, 27 per cent in Uttar Pradesh and West Bengal, 30 per cent in Madhya Pradesh,. 37 per cent in Bihar and 38 per cent in Maharashtra used public health facilities (Shariff 1995:17). While the "private health markets" served two thirds and more of the sick in Uttar Pradesh, Kerala and

Andhra Pradesh, the share of private hospitals in the last two states is also considerable. Not unexpectedly, then, the survey found that the poorer households spend 7-8 per cent of their household income on health care as compared to the 2 to 3 per cent spent by the richer households. The study also noted that per capita expenses were much higher when individuals used private facilities: for instance, all-India per capita health expenditures on fees and medicines only for hospitalised and non-hospitatised medical episodes based on data from selected urban areas in a number of states was Rs. 2611 for a public hospital and Rs. 1,115 for a private hospital, and Rs. 36 and Rs.81 for non-hospital expenses in the public and private sectors respectively(ibid.:49).

Given that the public health system works through sub-centres, Primary Heath Centres (PHCS) and Community Health Centres (CHCs), it is important that these should function effectively. Though the number of Public Health Centres went up almost three and a half-fold between 1981-91 as against the one and a half-fold increase between 1971-81, field studies show that not only is there a concentration in certain states, but also that the large majority of centres are ill-stocked, inadequately staffed and too far from the target population. Thus, there was already a crisis in the State-run health sector prior to 1991; a mere enhancement of funds which are allocated without- much thought being given to changing needs results in wastage, under-utilisation and in exacerbating already existing inequalities and imbalances. A recent evaluation of the public health care infrastructure in the country noted that the system which "caters to the needs of 25-30% of the population is grossly deficient" (Government of India 1996b). Further, a good percentage of the Central budget on health goes on providing services for its employees through the Central Government Health Scheme (CGHS). While we acknowledge that this is a responsibility of the State, it should not dominate government thinking nor allocation of resources to the detriment of the underprivileged sectors of the population who neither have secure jobs nor access to facilities.

The number of medical practitioners in 1991 was 4.7 per 10,000 population (as against 1.7 in 1951); however, almost 50 per cent of sub-centres, PHCs or CHCs. did not have buildings of their own. A recent Indian Council of Medical Research (ICMR) study on family welfare services at the Primary Health Centre level observed that only 22.6 per cent of the PHCs had properly equipped operation theatres; in a majority of PHCs in Bihar, Jammu and Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal, operating theatres were not properly equipped. In short, PHCs in most parts of the country are ill-equipped. In addition, water supply was safe in only 71 per cent of the PHCs evaluated (ICMR 1991: 17, 19). If we juxtapose infant mortality and poverty

figures with the dismal picture of PHC facilities, we find that the states of Uttar Pradesh, Orissa, Madhya Pradesh, Assam-, Gujarat, Rajasthan and Bihar had above average Infant Mortality Rates (IMRs); of these Bihar, Madhya Pradesh, Orissa and Uttar Pradesh had a larger population living below the poverty line. In other words, poverty, lack of facilities and high infant mortality rates are vitally linked. This led the Government of India to admit that "the lack of buildings, shortage of drugs, equipment etc. constituted major impediments to full utilisation of these units" (GOI 1993a:206). Further, a recent government document points out that "biases in, favour of curative vis-a-vis preventive and of secondary and tertiary health - care facilities rather than primary, need to be corrected" (GOI 1994:153).

The Eighth Plan went on to point out that it is not only the rural poor who are deprived: in large cities, where about 40-50 per cent of urban dwellers live in slums, their health status "is as bad, if not worse than in rural areas". Further, "the infrastructure for primary health care in urban areas hardly exists" (VHAI. n.d.). In a situation where about two- thirds of the total health expenditure goes on personnel, it is not difficult to envisage how the rest of the money is spent. The increasing withdrawal of the State from a vital sector of developmental activity means that health care for a growing proportion of the population depends on private institutions and individuals. It is not surprising, then, that recent health expenditure studies show that household expenses on medicare is three to four times that of the government's total health expenditure. Studies have shown that the chief beneficiaries of domestic expenditure on health are men and children.

Women as Reproducer: The Dominant Image

When, in 1975, Towards Equality, the Report of the Committee on the Status of Women in India, pointed out that demographic indicators suggested that "child bearing in India, for the majority of women, is more a health hazard than a natural function" (GOI, 1975:315), it was recording an unpalatable fact of life: the average woman becomes pregnant about six to eight times within the 15-45 year age group. Thus, "of the total 360 months of reproductive life, 200 months or 50 to 60 per cent of the time are spent in pregnancy and lactation" (Gandhi and Shah 1992 : 104, quoting Jaya Rao and Kamala:). Not unexpectedly, then, much of a woman's ailments are related to her reproductive history. Apart from this, women's heavy domestic-cum-work burden also makes them prone to a range of ailments.

On the whole then, as Srilatha Batliwala points out the national health system is geared towards viewing the woman as mother and reproducer. Thus, "the health system has yet to

waken to the fact that there are a large number of women in need of health care who are neither pregnant nor lactating" (Batliwala, n.d). This attitude finds expression in inadequate sensitivity and training in non-maternity related health care issues as also in ill-equipped facilities and programmes. As Ravi Duggal has noted

Both the private and the public health system's core attention towards women is viewing the latter as mothers. While the private nursing home sector comprises of maternity homes, the public health sector's major concern vis-a-vis women is to prevent them from becoming mothers (Duggal 1996:2).

Even for these limited programmes "health workers and infrastructures.... are grossly inadequate and of poor quality". When the facilities are not available, are too far away', and the personnel is unsympathetic , the opportunity costs in missing out on daily wages is too great. The NCAER study showed that 39 per cent of all rural patients in Himachal Pradesh, 34 per cent in Madhya Pradesh, 31 per cent in Tamil Nadu and 26 per cent Karnataka had to travel more than 10 kilometres to reach the nearest hospital for Out Patient (OPD) facilities (Shariff 1995: 17). Further, when it is a question of using private facilities, the expenses may be such as to allow only the more privileged family members, namely men, to use them. According to recent statistics, Punjab, Kerala and Maharashtra had one PHC for a population of 6,928, 23,442 and 29,243 persons respectively. So far, the requisite government ratio is one PHC for a population of 30,000 (George and Nandraj, 1993). In many of the less developed states, a single PHC takes care, of the needs of 1,20,000 individuals. Again only 15 per cent of such centres had the required number of health personnel and there was an acute shortage of Lady Health 'Visitors (LHVS) (ICMR 1991:1 1). Distance of facilities, difficult terrains and inadequate transport facilities further exacerbate a reluctance to use the formal network (Visaria and Gumber 1982). Though awareness of the official health care system is high, a study of users and non-users established that 65 per cent of non-users said that the services were poor, 55 per cent found distances too great and another 16 per cent complained of non-availability of medicines. Dissatisfaction among users was also high (Mukhopadhyay 1993 - 63-5).

A study (Ramalingaswami 1987) of women's access to health care in the economically-backward Vishakapatnam district of Andhra Pradesh which had a substantial tribal population showed that maternal and child health services, were, at the time, almost non- existent in the tribal areas of the state. Yet, 67 per cent of the women knew of the PHCs and had used them particularly when they had accidents or there was a serious illness in the family. Two programmes which did reach the women were the National Malaria Eradication Programme and the family welfare schemes. In another study (Murthy and Barua 1995) of Pamer block in

Ahmednagar district of Maharashtra established that the overall coverage by maternal health services such as ante-natal care, deliveries by Trained Birth Attendants (TBAS) and immunisation services was much higher in PHC headquarter villages. Such villages are few and far between and CHCs are inadequate. Even when the physical structures are present, staff shortage is endemic. Often the Auxillary Nurse Mid- wife (ANM) is the only staff member present and it becomes difficult to recruit women physicians in the rural areas. Not surprisingly then, in order to meet the shortage, the government is planning to contract private practitioners (Pachauri 1995). Thus it would be safe to surmise that in all parts of India, the absence of sufficient medical facilities is increasing the dependence on private medical care.

For instance, the network of Community Health Centres record and deal with only a small percentage of pregnant women (Mathai 1989). Consequently, the percentage of such women receiving iron and folic acid tablets as well as tetanus toxide injections is quite low. Not unexpectedly, anaemia is high: over 50 per cent of normal women and 65 per cent of those pregnant suffer from caromic anaemia (Shiva in VHAI 1992 : 282; see also Mathai 1989 and World Bank 1996 for a detailed discussion). As a result, coupled with overall malnourishment and unfavourable socioeconomic conditions, pregnant women are prone to miscarriages, stillbirths, excessive bleeding and infection. In other words, a woman suffering from malnutrition "has to go through about eight pregnancies to have five births (of which only three or four may see adulthood), exposing herself to potentially grave consequences each time" (Shiva 1992: 276).

In this context, it is important to note that well over 60 per cent of births are' domiciliary in nature, and of these, a substantial number take place without any attendants (VHAI 1992:269). Among tribal communities, the percentage of domiciliary births could be as high as 90 per cent (VHAI 1992). An evaluation of 398 Primary Health Care Centres in 199 districts in 18 states and one Union Territory by the Indian Council of Medical Research (1991) for the availability of antenatal, intranatal, postnatal and neonatal care established that facilities and service's were inadequate, and the outreach of personnel unsatisfactory. For maternity and family planning activities, the PHCs function through LHVs and ANMS. In addition, Traditional Birth Attendants (dais) "form a crucial and important segment of primary health care system" (ICMR 1991:1 1).

In fact the dais are the linch-pin of childbirth practices in India. This fact is reflected in the following figures from the ICMR study: 55 per cent of deliveries in villages with PHCs were domiciliary, while the figure rose to over 80 per cent in sub-centre and remote, villages; this led the report to conclude that "for a long time to come intranatal care will have to be provided on

non-institutional basis", i.e. through the network of dais(ibid.:24). Information available from other studies (Chanda 1988; Chatterjee 1983; Gupta and Borker 1987; Mathai 1989; Visaria and Gumber 1992 and VHAI 1992) also all point to the fact that the majority of Indian babies are and will continue to be born at home.

This fact brings into sharp focus three points: first, inadequate institutional facilities, second, a reluctance to use these facilities and third, the need to strengthen the indigenous system. Even when facilities are available why do Indian women prefer to have their babies at home, quite often attended to by barely competent helpers? Lack of faith in the public system is accentuated by shortage of medicines, distance, the need to have someone to go with and an overall belief that "we will not be treated as humans". While women seemed willing to go for prenatal check-ups to PHCs and municipal dispensaries, they drew the line at institutional deliveries. There were several women who went to the PHCs or nearby hospitals for prenatal check-ups and tetanus toxide inoculations. In addition to a fear of unsympathetic staff, many women felt that money which would have to be spent on medicines, injections, cotton wool and so on could as well be used for food and essential commodities at home.

Another important factor was the requirement of an attendant at the hospital or Centre: this meant that either the husband or someone else, would have to take time off from work to be on duty in the hospital. Lack of child care facilities meant that for the time that the mother was away, arrangements had to be, made -for other children. The ICMR study confirmed the lack of many basic medicines in the PHCs resulting in patients having to buy them in the open market. In a study in a Maharashtra village, out of 131 births in seven years, only one delivery was conducted in a PHC. Distance of the Centre, paying for a companion and the cost of food, medicines and other necessities led women to deliver at home. Further, there is also a fear of being coerced into sterilisation (Chatterjee 1989; Quadeer 1986).

Both reproduction and reproductive health become major talking points in structural adjustment programmes as a fast growing population is viewed as being detrimental to economic development (GOI 1993a; 1993b; 1994). Not unexpectedly then, of late, the State has decided to intervene more actively in reproductive control -through (a) disincentives and (b) experimenting with a range of new female-oriented contraceptives. Both are geared to the achievement of a Net Reproduction Rate (NRR) of unity by 2016 A.D. It is important to understand fertility and reproductive behaviour during a period of economic transition as is the case with India today. By and large, "during the transition, population initially increases rapidly because the mortality rate declines well ahead of the fertility rate" (Palmer 1991 : 53). In subsistence-level economies children are treated as commodities "who not only compete for

scarce resources" but also help in the generation of these as well as of disposable income. There is evidence from developing countries that with an initial rise in incomes, fertility increases, only to decline later. An important input into all these debates is the employment status of the, woman: while data from industrialised societies indicate that there is a negative relationship between female labour force participation and fertility, the same is not true of many countries of the third world(ibid.:59). Again there are important cultural factors such as producing sons for the lineage, which influence reproductive decisions. Above all, child mortality rates are of crucial importance.

In India, though the infant mortality rate which is around 73 per 1000 is declining every year, it is still extremely high. This results in several conceptions so as to ensure between 2 and 3 living children. The current thinking in family welfare and birth control strategies in India is an excellent testing ground for notions of intervention, boundary maintenance and sense of individual identity. Under the guise of providing more choices - and hence respecting a woman's sense of self - the State is seeking to intervene in her life through a series of invasive measures. It is not difficult to link the sudden frenzy surrounding new reproductive technologies and structural reform. As already pointed out, population growth has been identified as a major hindrance to economic development: A recent official document on the economic scenario has zeroed in on population growth as a "critical problem". Accordingly, the Department of Family Welfare has identified 90 poor performing districts" - 83 of which are in the BIMARU states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, "to provide special inputs". It was proposed that the entire World Bank assistance available under the social safety net programme for family welfare for 1992-4 is to be used for these districts (GOI 1994: 149). Clearly, the controversial issue of reproductive control and concomitant strategies impinge directly on ethical problems such as who makes the decision, the scope for choice-making, to woman's integral right to control her body and so on. Equally evident is the fact that in order to have an impact, the State, as the primary agency for effecting population control, has to work out carefully its policies and plans for implementation.

While the State has not felt obligated to act to improve the working conditions of the majority of women, its enthusiasm over new contraceptive technologies, a direct intervention in a very sensitive area of their lives is significant. In other words, the State is a selective interventionist. Even if it's accepted that due to the nature of women's work, the scope for intervention is limited, there are other areas, namely improved and extensive child care and school facilities and access to health care, through which the State can improve the quality of Indian women's lives. There is little evidence, however, of these being priority areas. As a result,

women combine their innumerable roles often with little or no support from the State. Expected help from family members shifts the responsibility disproportionately to female children.

The large majority of Indian women combine a multiplicity of roles, each with different health implications; however, the role of producer seems to dominate over other functions because women are producing most of the time. Either as home workers and managers, unpaid family labour or as workers in the competitive gender-biased employment market, women spend a major part of their lives in production. This aspect of existence occupies much more space and time than do consumption and distribution. It is also one where interfaces between different situations have not been worked out. In fact, while there is an abundance of women and work studies, few look at the implications of hours of labour on a women's body and mind. Nor is this neglect limited to research and analysis: the State has done little to improve the quality of life of those who constitute the backbone of many occupations and industries.

Women's Health and Well-being in the Era of Reform

We now look at some trends in the post-reform period. Data from Sri Lanka which started on a programme of economic reform in 1977 indicates that an increasing awareness on health issues is coupled with the growing incidence of diseases associated with stress, particularly those of the cardio-respiratory kind (Gunawardana 1995). A similar pattern is emerging in India with the advent of tropical diseases like falciparun malaria and Japanese B encephalitis, stress-and-environment related cardiovascular complaints, respiratory and endemic intestinal problems as well as nervous disorders (Ghosh 1996). It is likely that with continued rural-urban migration, the mushrooming of unhealthy towns and cities and the degradation of the natural environment combined with jobs which increasingly concentrate workers in industries, Export Promotion Zones and sweat shops, the range of diseases and illnesses will increase. Women and their health will be adversely affected as they form the basis of the pool of cheap labour, essential for the growth of EPZs.

In the context of the health sector it is important to look not for growth per se, but for growth which is the result of a well-thought out strategy based on an assessment of felt needs. In this case, attempts at satisfying safety net requirements by focusing on targets and numbers and thereby pumping more money into physical infrastructures and salaries and not human resources, means that the needs of the people have to be satisfied by the private sector: with the emphasis on privatisation, the marketised health sector is growing rapidly, putting, as we have seen, an increasing load on the family budget.

Growing dependence on the private sector in health is coupled with spiralling drug prices. In keeping with the reformist ideology, the New Drug Policy (1994) and the Drug Price Control Order of 1995 granted major concessions to the drug industry by way of reduced price and production controls (Shiva 1995). Not only is the consumer market flooded with drugs- many of which have registered a price increase of between 50-150 per cent after 1993 - but also quality control has been an early casualty. Health activist and, researcher Mira Shiva has commented that while a majority of the 80,000 drugs in the Indian market today are spurious, ineffective and even hazardous, the Drug Control Authority is so over- stretched that it cannot carry out basic quality control tests(ibid.:117). The following studies show how patterns of health care have changed in the post-reform period in some selected areas. Among other things, due to an increasingly minimalist State presence, dependence on the private sector is growing.

Even before 1991, Kerala was the best example of an Indian state with positive development indicators - and a high rate of use of available health facilities: female literacy is almost 90 per cent, it is the only state with a sex ratio favouring women and lower than average birth and death rates. Recent surveys have shown that the state's population is extremely health conscious, with high percentages of child immunisation as well as institutional deliveries of babies, the figures for which are well above the national average. At the same time, it is also a state where death due to vehicular accidents and suicide are high; interestingly both these are major causes of mortality in developed countries. In a study of health status in Kerala, Irudaya Rajan and K. S. James(1993) concluded that the increasing prevalence of deaths due to cancer, diabetes and disorders of the nervous system indicate that "diseases of poverty have been substituted by diseases of affluence".

Clearly, whatever the cause, "the achievements of the state with regard to mortality decline can be heavily attributed to the utilisation of health services" (Irudaya Rajan and James 1993:1890). Not only is health expenditure - at both the individual household, and state levels - one of the highest in the country but also it is the growing private sector which is being increasingly patronised. Due largely to foreign remittances, the average family in Kerala is able to afford health care and medical attention. At the same time, the state also has a higher than average morbidity rate, and sickness prevalence has increased as the mortality rate has decreased. This seeming paradox is easily understood if we take into account changing perceptions of health with higher levels of literacy and awareness is well as an "excessive concern with the health of children and pregnant women". Citing data from developed countries the authors conclude that "the low mortality and high morbidity syndrome is not a paradox but a common rule"(ibid.:1892).

Apart from the gratifying conclusion that certain positive indicators lead to greater awareness of health and well-being, in the contemporary Indian context it means that such services are available increasingly from the high cost private sector. Another recent study of the post-reform period of 52 households in the semi-urban locality of Kozhikhode (Kerala) showed that the per capita medical expenditure has risen by 141 per cent in the 1991-4 period (Kunhikannan and Aravindan 1996). The expenditure on drugs per capita rose by 75.9 per cent for the same period; this rate was much higher than the overall consumer expenditure for all the households. In the present context it is particularly alarming that most of the expenditure is in the growing private sector where unscrupulous doctors with their arsenal of medical equipment, laboratories, tests, scans and so on are becoming increasingly popular. It need hardly be added that the entire public health system is not able to cope with the "increasing demands from a population which is conscious of the quality of care"(ibid.:87).

It is not difficult to extrapolate from the case of Kerala that in time the rest of India is likely to follow suit; however, what is even more disturbing is that even before other development indicators have caught up, a self-interested private sector in health care is likely - to take over. In other words, the inability of the State to satisfy a growing demand - which may be caused by a combination of better awareness as well as an actual growth in disease and illness - will result in an increasing reliance on whatever facilities are available. Our argument here is that there is enough evidence to suggest that with access to institutional facilities in either the public or private sector, not only do mortality and morbidity- rates come down, but also perceptions of health and general well-being improve.

In his review of S.Gillespie and G.Mcneill's Food, Health and Survival in India and Developing Countries Jean Dreze has drawn attention to the fact that nutritional status does not depend on standard economic variables such as income, expenditure and consumption alone: for instance, the nutrition of a girl child, is determined not only by household income and its uses but also by "the educational level of her parents, the time-utilisation decisions of her mother, the number of her siblings, her vulnerability to gender discrimination, her activity level and exposure to social stimulation, the quality of the environment etc." (Dreze, 1993:276). Health care together with nutrition is a household resource whose disbursement depends on perceptions of entitlements as well as the ability to satisfy these entitlements. While the internal dynamics and resources of a household are instrumental in determining entitlements, certain exogenous factors either facilitate or hinder these decisions. This means access to as well as

ability to use institutions and opportunities which will increase the resource base - material, emotional and otherwise - which underpin entitlements.

The following discussion will illustrate how child health is dependent on levels of maternal advancement which are determined by factors - both endogenous as well as exogenous - to the household. Using the variables of women's educational, occupational and marital status as determinants for infant survival, A.K.Shiva Kumar has constructed an Index of Maternal Advancement (IMA) (Shiva Kumar 1995). While these factors may act independently or interdependently, the author concluded that there was an inverse relationship between the IMA and Infant Mortality Rates (IMR). Emphasising that the context becomes very vital in determining IMA, Shiva Kumar drew attention to the fact that between 1971 and 1991, the percentage population of Manipur which lived below the poverty line fell from 73 to 17; for the same period, that of Bihar remained more or less the sane - at over 65 per cent. In 1981, infant mortality in Manipur was 32, well below the national average 0f 110. Among external factors which contributed to IMA were an above the national average state, expenditure on public health, delayed marriage, high female work force participation rate, better nutritional levels, clean living spaces and sanitation as well as the role of community organisations. In short, a combination' of changed perceptions and available facilities led to an improved IMA.

Interestingly, Shiva Kumar's case study of Manipur indicated a low level of female literacy; clearly, in this instance, other variables were able to compensate for this absence. On the whole however, there is a positive co-relation between health status and access to education. This is true not only of mortality data but also of morbidity patterns. Looking at some selected health indicators we find that in 1987-90, Madhya Pradesh had a birth rate of 38.70 (India:31.50) and a death rate of 13.60 (India:10.40) and an infant mortality rate of 119 - one of the highest in the country - as against an all-India average for those years of 80. Immunisation of children and births attended by either ANMs or TBAs were well below the national average (George and Nandraj 1993:1672). The female literacy rate of 28.85 per cent is well below the national average of 39.29 per cent, and the IMA is 25, while the national figure was 33 (Shiva Kumar 1995:75).

On the other hand, the IMA for Kerala is 61, being second only to the Seven Sister states of the North-east known for a high rating for women on most parameters. As already discussed, Kerala has a female literacy rate of almost 90 per cent; of this percentage, levels of education determine access of women to ante-natal care. For instance, while 85.4 per cent of illiterate women went for regular check ups, all women with higher education did, so as well. The latter figure is hardly surprising and is likely to be the same in most other part of the country; what is interesting is that the presence of other positive indicators encouraged illiterate women to

utilise the existing health services. There is an urgent need then in the post-reform period to improve women's access to education, information and communications, through formal schooling, informally through community groups, NGOs and the National Literacy Mission; in the present context, it is of vital importance for the sustained health of not just the woman but also of her family members, and in particular the girl child. We would argue that it is of vital importance to understand the role of family and community traditions, local knowledge systems, word of mouth communications through voluntary organisations and NGOS, and indeed the State, on health status.

Clearly the Indian State is dragging its feet in the social sector both at the level of allocation of funds as well in an assessment of priorities. In doing so, it is limiting its competence in moving out of the endemic crisis situation in the social sector. The question is, why is the State reluctant to make the safety net work? India is a federal structure where financial responsibilities are shared between the Central government and the states. A look at how states allocate their funds for the social sector becomes relevant in this assessment of priorities. In her comprehensive analysis of allocations, K.Seeta Prabhu concludes that in the post-reform period, most Indian states "have shown no marked thrust on public health" (Seeta Prabhu 1995:249). The Central government together with the governments in the state share the financial burden of health care, and priorities are discussed across the table.

While states such as Kerala and Tamil Nadu "which have a strong political commitment to the goals of human development" had "protected" expenditure in the areas of health and education, this was not the case in the BIMARU states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. As we have seen, these were already the states with low levels of achievement in development indicators. There is also information that these states have an above average annual increase of reported crimes against women. A study of 17 villages conducted to assess the impact of economic reforms on women's health indicated that women are now under increasing levels of stress and rarely have the time to visit a health centre or a doctor (Shatruguna cited in Ghosh 1996). In other words, though women's lives are becoming more difficult and they are subjected to increasing degrees of violence within the home and at the work place, strategies and policies are not fine tuned to these realities. An approach which takes into account voices from the grassroots is vital if the present crisis in the health sector is not to lapse into a phase of irreversibility. Such an approach would also take into consideration that access to a facility is dependent on a range, of factors, not unimportant among which is the cost of the facility.

Despite its inadequacies and shortcomings, the State-run health care system is heavily subsidised; thus, access to it should be improved and not replaced by the private sector. Yet, under the economic reforms of the Congress government led by P.V.Narasimha Rao, there, were ample indications that large-scale privatisation of health care was being seriously considered. In March 1995, a meeting of government officials, NGOs, health activists and others was convened in Jaipur to debate a recent World Bank document, Policy and Finance Strategies for Strengthening Primary Health Care Services. The recommendations of the meeting asked for more private sector involvement and "experimentation with private contracting of public health services" (Purohit and Mohan 1996:452). The spirit of the meeting was clearly the need for alternatives to the "fragile public health system"(ibid.:451).

The situation may be somewhat different now as it is unlikely that the United Front government will push through privatisation of health services; the question is, will it empower the State to do more for the disprevileged? At the same time, it is clear that a structural Adjustment programmes will, at one point of time or the other, look to the marketability of a product or service. There is no evidence in the fifty years of India's Independence that its health sector has been 'marketable'; the question of course is, should health care policy be governed by market forces or by the needs of the large bulk of its population who are unable to afford private medical attention ?

Some Concluding Observations

In the Country Report prepared for the Fourth World Conference on Women held in Beijing in 1995, the Government of India acknowledged that due to the new policies, "over-all, the economic pressures may compel households to resort to various difficult survival strategies"; further, "the anticipated reduction in services implies that women may also have to allocate more time to activities that were previously at least partially provided by the state " (Government of India 1995:54-5;) Concluding that more research and time were necessary before the impact of structural adjustment programmes on women could be assessed, the document was hypothesising on likely fall outs. This paper has followed a similar line of argument: while it may be too early to be categorical, it is clear from whatever data is available that unless safeguards are introduced, economic reform of the kind initiated by the State in 1991 is not going to reverse the trend of an overall decline in women's status. Nor is the safety net package going to perform miracles particularly if the net effect is a curtailment of services and a reduction of State initiative. By definition, market forces are not sympathetic to sectors which

bring little profit to them. In this case, it is the large bulk of the Indian population which is of little consequence to those who seek benefits through the market.

Clearly, if the Indian economy is to be competitive it has to liberalise and become a part of the global nexus. However, this does not mean that the State should be free to adopt an increasingly minimalist position in areas which determine the survival of a large bulk of its population. Health care is one such area; descriptions of the inner life of the household indicates how a complex interplay of factors determine entitlements and shares. The inability of the State to provide a workable system of health care only exacerbates the tensions experienced by underprivileged women whose daily lives are, in any case, becoming increasingly difficult. Yet, there is little to suggest that the United Front government is going to adopt a position very different from its predecessors: an analysis of the Front's budgetary allocations for rural employment shows that schemes will be done to 0.31 % of the GDP from 0.49%, and the State's social spending has stagnated at around 1.5 - 1.7% of the GDP (Bidwai 1996). It is not difficult to see how these cuts will impinge on nutrition, well-being and health of the more vulnerable sections of the population. At the same time it is clear that the crisis in the social sector existed prior to 1991 and a myopic, top-down approach which seeks refuge in allocating more funds will not work.

Any reform should be preceded by a period of intense debate, discussion and an elaboration of strategies and goals. It can be assumed that stabilisation and the structural adjustment programme were adopted after such exercises had been carried through. However, no such thinking seems to have influenced thinking on the social sector. At this point of time, there are no indications that it will not be the same story of more funds for a battery of new targets to be achieved. Those in positions of authority need to develop an unblinkered approach and look beyond their traditional information brokers and panacea of well-worn methods and approaches. A genuine commitment to distributive justice and equity requires much more than declining budgetary allocations; apart from a political will which means business it also requires the freedom and inclination to think of options and alternatives, to recognise that theories of rights and obligations will not work "by maintaining a depersonalized, distancing attitude towards others" (Robinson 1997: 130). Above all for such a commitment to be meaningful, the State has to be prepared to listen to the multiple voices which question its policies; in other words, the State and its functionaries have to acknowledge the role of civil society in providing the 'human face', the critical edge, to reform and and its often unacceptable assumptions about the citizens of a country faced with wide-reaching re-definitions of both their public and private spaces.

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