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Reproductive Health Care in India: A Trajectory

Abstract

Understanding of reproductive health influences the services provided under reproductive health care. As the concept of reproductive health evolved, so did the care, especially in countries like India, from target ridden family planning programmes to the ones focussing on various aspects of reproductive health and not merely the process of reproduction. For this study secondary data were used in the forms of books, journals, reports, etc. to trace the history associated with the evolution of the concept of reproductive health and the trajectory of reproductive health care in India. The study shows that the paradigm shift in understanding of reproductive health came after the ICPD held in Cairo in 1994. On the other hand, reproductive health care in India which initially focussed on containing its burgeoning population has shifted to providing quality health care services to its female population after the Alma Ata Declaration and later by the UN Millennium Declaration which put forth time bound MDGs to be achieved by the member countries.

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Introduction

'Reproductive Health' transpired as an umbrella term at the International Conference on Population and Development (ICPD) held in Cairo in 1994 which marked a radical shift from the limited understanding of reproductive health to an all-encompassing one. Reproductive health has been defined as "a state of complete physical, mental and social well being and not merely absence of reproductive disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994). This elaborated definition overcame the confined scope of reproductive health from mere process of reproduction to addressing its other aspects such as life-cycle approach which transcends the child-bearing years (Sadana, 2002) and having an impact on the reproductive health of an individual. Elaborating further, reproductive health implies a state in which "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the ability to decide if, when and how often to do so. Implicit in this last condition are the right of the men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (ICPD, 1994).

The ICPD's Programme of Action proved as a milestone in changing the discourse of reproductive health. The elaborated definition which was drawn on the working definition of health by WHO drew the attention to various dimensions which had been earlier overlooked and therefore never focussed upon. The above definition can be understood at three levels - 'physical, mental and social', determining the reproductive health of an individual and of general population at large. The first dimension implies that an individual should be physically fit to reproduce, that is he/she is 'capable' of reproducing. The recent development and

understanding of the events in the life course of an individual and that they have a cumulative effect on his/her future well being through the life cycle approach has been crucial in highlighting the fact that it has a bearing upon his/her reproductive health. The most disadvantaged are the children (especially the girl child) and women wherein the differential treatment which they receive has a negative impact on their reproductive health in the later years. In addition, the inter-generational effects are also well known. Thus, physical wellness has become a life course event rather than only during the period of reproduction.

Secondly, 'mental well being' entails that the individuals should have the 'ability' to regulate their fertility as empowered individuals who are well informed about the existing methods of family planning and are able to make choices out of those existing so that they can have 'safe and satisfying sex life.' It also includes the desire of the couples to determine the number and space between their children. Thirdly, the 'social' well being brings into consideration the societal traditions, customs, and norms which are detrimental in acknowledging the need for medical intervention to carry out a safe pregnancy and availing the healthcare services by the individuals, especially women. It also brings to light the fact that mere presence of a healthcare system is not sufficient until the individuals have 'access' to it which is often curtailed by the prevailing cultural beliefs. Although women are the most vulnerable to such norms and values, at times, men too fall a victim to such beliefs.

Reproductive Health Care

'Reproductive health care' on the other hand refers to services such as family planning services, prenatal, antenatal and post-natal care, nutrition for infants and children, prevention and treatment of reproductive tract infections, sexually transmitted diseases (STDs), adolescent reproductive health, etc.[1] The provision of these services is highly dependent upon the understanding of the term reproductive health. Thus, evolution as well as understanding of the concept of reproductive health would eventually determine the type, quality and extent of provision of reproductive health care services. Therefore, evolution of the concept of reproductive health is an important aspect which needs to be holistically viewed and put into a chronology in order of its developments for gaining understanding of this ever-evolving concept. In addition to this, the trajectory of reproductive health care which is highly influenced by the understanding of reproductive health also needs to be traced. Reproductive health care becomes even more important in case of countries like India which have been fighting with the problems including population explosion, high maternal and infant mortality rates, etc. The country has been trying to check the situation with several interventions such as National Family Planning Programme (1952), National Health Policy (1983), National Heath Mission (2005), etc. This paper shall primarily discuss about the series of developments at global level which changed the understanding of reproductive health as a concept by widening its purview. It would also shed some light on the trajectory of events related with reproductive health care in India since the pre-independence era.

Objectives of the Study

1. To trace the evolution and understanding of the concept of Reproductive Health;
2. To delineate the trajectory of events associated with Reproductive Health Care in India.

Research Methodology

This paper is a part of the ongoing doctoral research on reproductive health of women in Punjab being conducted by the author. It is based purely upon secondary sources which include books, journals, drafts of various conferences, reports by varied national and international agencies, etc. These secondary sources were carefully studied to trace the global events which have impacted the understanding and changed the notions associated with reproductive health, ultimately leading to what is known as the paradigmatic shift. The trajectory of events associated with reproductive health care in India including various policies and programmes enforced by the Government of India (GOI) have also been traced.

Reproductive Health: Evolution of the Concept

Fertility and mortality are the two governing factors which ascertain the growth of the population in a particular geographical area (Lee, 2003). Human history, for most of the time, has witnessed an even growth of population which was maintained by a balance between births and deaths leading to a slower growth rate. The first mortality decline was observed in the Europe around 1800 which is largely attributed to the reductions in contagious and infectious diseases, techniques of hygiene, development of the smallpox vaccine, preventive medicine and further advances in medicine in the 20th century (Lee, 2003). The increase in life expectancy and higher fertility lead to the rapid growth of population, which did not last long and many of the European provinces towards the last quarter of the 19th century showed a decline of 40 percent in the marital fertility (Coale & Treadway, 1986: 44; cited in Lee, 2003). Similar trends were observed in the other 'more developed nations' such as North America, Japan, Australia and New Zealand. Thus, the population remained stable with an increase in life expectancy and reductions in fertility which reached the replacement level of 2.1 per woman, although some countries did show a negative growth trend.

On the contrary, the 'less developed nations' continued to struggle with higher fertility and mortality rates until the modern medical techniques were introduced (exported to) in these nations only in the 20th century. However, a rapid decline in the mortality rates was observed in these countries which were still higher as per the historical standards (Lee, 2003). Unlike the 'more developed nations', the fertility rates did not decline among these countries (Notestein, 1960: 278) and more number of people were added to the population with a higher life expectancy than being eliminated which is often termed as 'population explosion'. Population was generally seen as anything but good- rulers saw larger populations as a benison

to their economic and military might. But as the population grew, the gloomier side began to be highlighted. Speculations were made that the world could witness problems like poverty, hunger, unemployment, underdevelopment, environmental destruction, etc. The continents of Africa, Asia and Europe, where the growth rate of population was higher, were seen as the breeding grounds for communist revolution (Willmoth and Ball, 1992) since "communist propaganda thrives on poverty and discontent".[2] Europe was later excluded from the tag of being a potential threat as it recovered economically and western part of it got interlinked with the North American economy (Ibid., 1992).

An increasing need to check the relentless population growth in the less developed countries, especially those in Asia was felt. Thus, in 1967 United Nations Fund for Population Activities (UNFPA) was established as a trust fund to create awareness about the population problems and sponsor population programs, especially in the less developed countries.[3] Meanwhile, a sensational book *The Population Bomb* by Paul R. Ehrlich in 1968, whose 2 million copies were sold in two years, was published which caused a stir about the burgeoning world population leading to a demographic collapse in the near future. In his book, Ehrlich claimed to have an intellectual understanding of population explosion which he linked to his recent visit to the capital of India where all he could see was "people, people, people, people". The concern about the proliferating population coincided with the increased availability of advanced technologies for checking the fertility; the intrauterine device (IUD) and contraceptive pills were readily available in the 1960s which acted as a tool for those interested in checking the ever increasing population in the less developed countries. Although the National Family Planning Program under the population policy was already introduced by the Government of India in its first Five Year Plan beginning in 1952 (Cladwell, 1998) number of such programs became widespread which were first witnessed in Asia in the 1950s later spread to Latin America and Africa by the 1980s (Singh 2002).

The substantial increase in the number of countries (mostly less developed) which adopted the population policies during the 1970s and 1980s can be attributed to the support forwarded by the UN agencies and a varied number of NGOs, one of the well known is the International Planned Parenthood Federation (IPPF) founded in 1952 whose efforts proved seminal in the "political acceptability of family planning among the large segments of public" (Robinson and Ross, 2007: 3). The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was established by the WHO in 1972 with a mandate of "research into the development of new and improved methods of fertility regulation and issues of safety and efficacy of existing methods" (AbouZahr, 1999: 767). All those programs associated with the population policies funded by the variety of NGOs and the agencies of UN as well, at heart, focused only on restraining the population growth. The success of these programs was judged in terms of numeric goals and targets- number of family planning acceptors, couple-years of protection, number of tubal ligations performed, etc. (AbouZahr, 1999: 768). It is clear that the sole interest of these international bodies was only limited to lowering the population growth rate. Other aspects of population such as patterns of migration, socioeconomic, cultural and religious beliefs as well as taboos associated with high fertility rates, distinct needs of the men and women with respect to their reproductive health, etc. were completely ignored which lead to the failure of family planning programs in many Asian and African countries.

Interestingly, the reproductive rights of women were addressed as early as in the 1920s by Margaret Sanger who opened a reproductive clinic in 1916 and Marie Stopes who advocated the right of women to avoid unwanted pregnancy and other social pathologies associated with it (Robinson and Ross, 2007: 1). But it was only in the year 1994 at the ICPD which was held in Cairo that the world community came forward and built a consensus upon the understanding of reproductive health like never before. Reproductive rights came to be seen as inextricable from the human rights which were already recognized in the international declarations ratified by the nations, national and international laws, etc. (Paragraph 7.3 Program of Action). The ICPD 1994 was not a result of the sudden enlightenment of the world community with respect to the reproductive health and rights of women. Rather, the background was already prepared by the earlier conferences which were able to develop considerable consensus to bring to limelight and consider as well "the broad issues of and interrelationships between population, sustained economic growth and sustainable development, and advances in education, economic status and empowerment of women" (Paragraph 1.5) such as the Universal Declaration of Human Rights, 1948; the World Population Conference at Bucharest, 1974; the Convention on the Elimination of All Forms of Discrimination Against Women, 1979; International Conference on Population at Mexico, 1984 and the Fourth World Conference on Women, 1995. AbouZahr (1999) put forth three elements which she considered were "impetus behind the paradigmatic shift that Cairo represents". The foremost was the growing strength and voice of women against the programmes which solely focussed on controlling the female fertility while ignoring all other aspects of the reproductive health. Secondly, the outbreak of the HIV/AIDS as a pandemic shifted the focus on the "consequences of sexual activity other than pregnancy, in particular sexually transmitted diseases (STDs)". This heralded the need to respond and perhaps "it became possible to talk about sex, about sexual relations outside of marriage as well as within it". Thirdly, the international human rights treaties accorded women's health, especially the reproductive health, the status of human right which later gained acceptance during the 1990s.

It was finally in Cairo that the proposed Programme of Action (PoA) defined reproductive health on the lines of the definition of health as stated

by the WHO. The conference proved instrumental in de-emphasizing the target ridden fertility control programs (whose major aim was population control) and giving due consideration to the reproductive health of women. The PoA aimed at making both "qualitative and quantitative" difference and accordingly put forth a set of objectives which included "sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health" (Paragraph 1.12 PoA) before the international community. Ever since the arena of reproductive health of women and the way in which it has been approached completely changed thus including the empowerment of the women with respect to the informed choice of use of contraceptives, availability and access to quality health services and the more recent development of the life cycle approach.

Reproductive Health Care in India: A Trajectory

As per the Hindu belief system, birth was perceived as a highly polluting state owing to which the high caste Hindu as well as Muslim women faced seclusion (Arnold, 1993: 258). Deliveries were carried out by the *Dais* (Midwife) who generally belonged to the lower caste. The western doctors were imported to the colonial India by the British with the sole aim of addressing the issues of the European community in the country whose number was increasing in the second half of century. Western doctors were looked upon "to be reassuring about the prospects of European survival and safe child bearing in India" (Ibid: 255). Although the lying-in hospital was opened in Madras but was shunned by the high-caste Muslim and Hindu women since they considered hospitals and dispensaries as "low-caste" institutions (Ibid: 258). Since the Indian women were reluctant to avail the services of the European doctors (especially male doctors) and trained midwives, Dr. Aitchsen who was the Civil Surgeon then framed a pioneering scheme to retrain the local *Dais* in Amritsar in Punjab in 1866 (Ibid: 258-259). The *Dai*'s School was established in Amritsar in 1880 with the aim of "improving safe midwifery skills and assistance during childbirth" (Kumar, 2010). Later, the first Midwifery Act was passed in London in 1902 in order to promote safe delivery followed by the setting up of Advisory Committee on Maternal Mortality in 1937 by the Indian Research Fund which is now popularly known as Indian Council of Medical Research (Ibid, 2010) to scrutinise the various causes of maternal mortality. It was appropriately identified by the health professionals and planners in the pre-independent India that the focus on safe motherhood and skilled assistance during childbirth would reduce maternal mortality which was later lost in the post-independent era (Ibid, 2010). The All India Women's Conference (AIWC) was the first social organisation to pose the question of reproductive control (Gupta, 2000: 202). At its seventh session in Lucknow in 1932, the Conference took account of the low physique of women and high infant mortality linking it with poverty and thus advocating birth control by instructing men and women in recognized clinics (Gupta, 2000: 203). In October 1943 the Government of India appointed the Health Survey and Development Committee, which is popularly known as Bhore Committee, to make "(a) a broach survey of the present position in regard to health conditions and health organisations in British India and (b) recommendations for future India" (Health Survey and Development Committee Report, 1946: 1). It is considered as one of the most comprehensive health policies and plans documents ever prepared in India. The Report highlighted the poor scenario of health conditions among the Indians and even dedicated a full chapter to the maternal and infant mortality. The poor health scenario was attributed to the prevalence of insanitary conditions, defective nutrition, inadequacy of the existing medical and preventive health organisations, etc. in context of the general health of the people and various social evils such as early marriage and *purdah* particularly with respect to women's health. It proposed structural changes in the then health care system and outlined the curative and preventive primary health care infrastructure for the country which would cater to the needs of the entire population through a comprehensive state-run health service which would be available to all irrespective of the ability of the individuals to pay for the treatment. The Report envisioned universal health coverage free of charge would alter the health of the Indian masses.

In the post-independence era, Government focussed primarily on checking the burgeoning population of the country under the western influence which is reflected in the programmes and policies it endorsed. The Family Planning Association of India (FPAI) was founded in Bombay in 1949, affiliated with the International Planned Parenthood Federation (IPPF) London, to set up a family planning programme across the country. Later, India became the first country to introduce a National Family Planning Programme in 1952 within the domain of Maternal and Child Health (MCH) services but the prime objective remained the reduction in the birth rate to stabilise the population. Even in the Five Year Plans (FYP), the target has been population control. Ever since the First Five Year Plan (1951-56) till the Sixth Five Year Plan (1980-85) the emphasis remained birth control earlier through the 'clinic approach' which was followed by the target oriented 'camp approach' (Fourth Five Year Plan) that made use of the mobile units and is often referred to as 'coercive persuasion' (Gupta 2000: 209-212). Women, till the Fifth Five Year Plan, were seen as subjects of welfare clubbed with other disadvantaged sections of society such as the geriatrics, destitute, disabled, etc. The Towards Equality Report 1974 proved material in changing the course of planning and in the Sixth Plan itself women were viewed as the agents of development. The Seventh Five Year Plan (1985-1990) witnessed a shift and more emphasis was laid on the status of women. The National Health Policy (NHP) of 1983, the first of its kind in the country, was launched which put forth certain goals related to the Mother and Child Health. It envisaged a Universal

Immunisation Programme (UIP) for the infants and pregnant women aimed at reducing infant, child and maternal mortality. It is interesting to note that the NHP came only after the Alma Ata Declaration on Primary Health Care in 1978 which gave the objective for 'Health for All by 2000 AD', to which India was a signatory. The Eighth Five Year Plan (1992-97) document articulated the population and development link. The focus on female literacy, age at marriage, employment opportunities and women's status in society mirrors the shift towards the reproductive health approach (Gupta, 2000). The ICPD held in Cairo (1994), to which India became a signatory, had pronounced implications for the health planning in the country. The focus shifted from target oriented fertility control macro-level programmes to the micro-level woman centric ones. Now, the attention was on the individual women- her rights over her body, her health status and her choice in reproductive matters. Ever since 1st April 1996, the target and incentive driven Family Planning Programme of the country has been replaced with the target free and Reproductive Health Approach. The Ninth Five Year Plan (1997-2002) laid Special Action Plan (SAP) which concentrated on five areas; of which 'health, education and drinking water' was one. Empowerment of women along with meeting the felt need for contraception and reducing the infant and maternal morbidity and mortality were the plan's objectives. Although the needs of women were at the focus, achieving the "desired level of fertility" remained an objective as well. In fact, the National Population Policy 2000 straight away laid down the need to "address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care" as its immediate objective. In contrast, the National Health Policy 2002 stated that the "social, cultural and economic factors continue to inhibit women from gaining adequate access even to the existing public health facilities" which is directly linked to the general wellbeing and development of the whole family and recognized "the catalytic role of the empowered women in improving the overall health standards of the community".

Meanwhile, a historical event, the Millennium Summit, with the largest gathering of the world leaders took place in New York in September 2000. The leaders from across the globe adhered to the UN Millennium Declaration thus "committing their nations to a new global partnership" to act upon eight critical areas of poverty, education, health, etc. which were presented in the form of Eight Millennium Development Goals (MDGs) to be achieved by the member countries by 2015. India being a member country took extensive steps to meet the target of reducing the IMR by two-thirds and MMR by three-quarters taking 1990 as the base year. However, reducing IMR and MMR was one of the objectives of the Ninth Five Year Plan, efforts became more intense after the summit in the subsequent plans. The Tenth Five Year Plan (2002-2007) focussed on bringing down the Maternal Mortality Ratio (MMR) to 2 per 1000 live births and Infant Mortality Rate (IMR) to 45 per 1000 live births by 2007. To materialise this goal the Government of India then launched the ambitious National Rural Health Mission (NRHM) in 2005. Under it an attempt was made to strengthen the primary health care system which would, in turn, lower the IMR and MMR. The race to reduce the MMR to 1 and IMR to 28 per 1000 live birth by 2012 continued in the Eleventh Five Year Plan (2007-2012), this time with a time ceiling. It also aimed at slashing the number of anaemia affected girls and women by 50 percent. The Twelfth Five Year Plan (2012-2017) has again set before itself the goal of reducing the MMR and IMR to 1 and 25 per 1000 live births respectively. Despite concerted efforts India has failed to bring down the incidence of infant and maternal mortality to the desired level.

Conclusion

The discussion shows that reproductive health as a concept emerged as a more comprehensive, exhaustive and encompassing term with each of the above mentioned developments. With the advent of modern medicine in Europe, life expectancy increased coupled with higher fertility rates which eventually came down and kept the population stable. However, the introduction of modern medical techniques in under developed countries brought down the mortality rates while fertility rates remained relatively high leading to population explosion. Fearing the proliferation of communist propaganda/agenda, the intrauterine devices (IUD) and contraceptive pills were introduced in Asia, Latin America and Africa. Several population policies came into force supported by UN and WHO, which primarily focussed upon containing population growth. The paradigm shift in the understanding of reproductive health was mainly the outcome of Programme of Action proposed at ICPD held at Cairo in 1994.

With respect to reproductive health care in pre-independence era, births were carried out by *Dai*s belonging to lower caste in the social hierarchy however, western doctors were then exported to cater to the needs of European women. From scrutinising the causes of maternal mortality and addressing them through skilled birth assistance, to advocating birth control in view low physique of women and high infant mortality, were talked about in pre-independent India. Post-independence, the target-ridden family planning programmes were run to control the burgeoning population and India becoming the first country to launch National Family Health Programme in 1952. Alma Ata Declaration, 1978 proved instrumental in launching of National Health Policy of 1983 with some provisions focussing on Mother and Child Health. The National Health Policies and Five Year Plans came one after another, which talked about maternal mortality and morbidity, contraception, health care infrastructure, etc., while controlling the population remained at heart of all these policies and plans. The impetus to bring down maternal and infant mortality rates was provided by the time-bound Millennium Development Goals (MDGs). Extensive steps were taken by India through it ambitious National Health Mission (NHM) to reduce IMR by two-thirds and MMR by three-quarters which the country has failed to

realise by the end of 2015 though sharp declines were witnessed. The various reasons behind this failure incisively points towards quality of reproductive health care services being provided to the women including poor health infrastructure in the country, lack of specialist doctors, ill-trained health workers especially Accredited Social Health Activists (ASHAs), maternal anaemia, lower body mass index (BMI), etc. which needs to be addressed in a comprehensive manner.

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