INTRODUCTION
A review of some critical indicators of women’s health reveals that much remains to be done. The maternity mortality rate (MMR) of 20 per 1000 live births was recorded in 1946. It came down to 12.4 per thousand live births by the end of 50s and by 1971, the estimated MMR was 3.9 per 1000 live births. It constituted 10.3 per cent of the female deaths in reproductive age group. The National Family Health Survey (NFHS) estimated the average MMR for the two years preceding the survey in 1992-93 as 420 per 100,000 live births, i.e., 4.2 per 1000 live births. According to latest NFHS-2, MMR is estimates to be highest – 540 per 100,000 live births. This trend of MMR shows that after an initial decline, there has been a relative stagnation. The efforts to bring down MMR have not been sufficient. In fact, NHFS-2 indicates a slight increase in MMR. Added to this trend is the declining sex ratio in India. The ratio of women per 1000 men has declined from 946, 933 to 929 in the census of 1951,1981 and 1991 respectively. These trends call for an examination of the evolution of health planning and programmes for women.

Maternal health services in India after independence were set up in accordance with the recommendations of the Health Survey and Development Committee, popularly known as Bhore Committee. These services were an integral part of the health service development in India. Bhore Committee and the sub-committee on National Health of the National Planning Committee (Sokhey Committee) underlined the enormous dimensions of health problems of women. Laxmi Bai Rajwade, member of Sokhey committee emphasised maternal and child welfare as a basic health service that has primary claim on public fund. Both these committees pointed out that maternal mortality was high in India as compared to other counties. Blair Bell, one of the members of Bhore committee estimated that for every woman who died as a result of pregnancy or childbirth, twenty suffered from impaired health and lowered efficiency. The committee estimated that about 200,000 women died annually from the causes of childbirth in a year in British India, and about four million suffered ill health as a result of pregnancy or childbirth. Both these committees recommended that Maternal and Child Health (MCH) must have the highest priority in any programme of health care development in the country and should be an integral part of the health services.
The government began its efforts towards building up maternal health services with a view that "MCH is a service that is to be kept in forefront in the planning of health programmes. The protection of the health of the expectant mother and her child is of the utmost importance for building a sound and healthy nation". Side by side government also conceded that family limitation and the spacing of children was an essential step for securing better health for the mother and better care in bringing up children and, therefore, an important part of the public health programme. The Ministry of Health set up a Family Planning Research and programmes Committee in May 1953. This was followed in May 1954 by the establishment of a Family Planning Grants Committee for examining and recommending applications for family planning work and research. Thus India became one of the first nations to initiate family planning programme. This programme has influenced other health programmes significantly, especially maternal and child health programme.

From the 1960s, the family planning programme was given the highest priority. It contributed to the infrastructure at the PHC and district levels and it added personnel to the MCH services. Logically, family planning work should form a part of MCH services, in actual practice, however, MCH services became part of family planning work. This instead of invigorating MCH services undermined it, as MCH services became a tool for achieving family planning targets to control population. The First UN Advisory Mission in 1966 recommended that staff at the PHC level, i.e. ANMs should be 'relieved of other responsibilities such as maternal and child health and nutrition' as to concentrate on Family Planning Programme (FPP). The government declared Family planning programme as a centrally sponsored programme and the allocation for this programme rose to 300 crores in the Fourth Five-Year Plan from a mere 65 lakh in the first plan. Later in 1968 with the second evaluation by the UN and the Planning Commission, the government emphasised integration of MCH with family planning to make it more acceptable and effective. The services that were to take care of pregnant and lactating mothers concentrated on controlling numbers and women became the easy targets as they were seen as the reproductive agents.

MCH work was later sought to be strengthened by the inclusion of a number of preventive services for women and children. The Alma-Ata declaration (1978) signed virtually by all countries called for a new approach to provide comprehensive health services for all sections of the population. Even though an attempt was made to develop
a comprehensive approach towards health through the concept of Primary Health Care, MCH for all practical purposes remained as technocratic as ever. In 1981-82, UNICEF proposed its child survival strategies where focus was on maternal nutrition, family planning and education of women.\textsuperscript{14} The entire approach emphasised immunisation, institutional deliveries, and distribution of iron and vitamin supplements. The government later admitted that, "the achievements during the plan period fell short of the targets, especially in the minimum needs programme whose objective was to create adequate infrastructure for health care services in rural areas. Indeed, the nation's health status still remains a matter of serious concern". \textsuperscript{15} The government also admitted that, "the resources are mostly utilised by those who can either pay for them or by those who get them as part of their other emoluments. The vast majority of the poor people are left to fend for themselves". \textsuperscript{16}

The emphasis on family planning continued though a massive expansion of infrastructure was taken up in the 1980s. The review of the developments over the 7\textsuperscript{th} plan period reveals that the government yet again accepted that the achievements of the 6\textsuperscript{th} plan fall short of targets particularly in sterilisation. \textsuperscript{17} Reviewing MCH programme, the plan document stated that, "the performance of the MCH programme during sixth plan, particularly in the field of immunisation and antenatal care is far from satisfactory. Measures for strengthening the programme and increasing the child survival rate are essential for the success of the programme". \textsuperscript{18} We thus see that till the middle of the 80s emphasis remained on family planning and child survival alone. The notion of safe motherhood came as late as 1990s in health planning. \textsuperscript{19}

Continued priority for fertility control over other programmes made women an easy target of government strategies. The government stated that, "to achieve the long-term national demographic goals, education and enlightening people on the benefits of late marriage and its social enforcement will have to be greatly emphasised. Special programmes and incentives oriented towards eligible couples, particularly in the younger age groups are needed. Incentives for attracting couples with two children and younger age-groups are necessary". \textsuperscript{20} As regards maternal mortality, the government emphasised that "vigorous steps will have to taken to reduce maternal mortality. More than two-thirds of the women in rural areas are still being attended to at childbirth by untrained Dais and there is, therefore, need to augment the Dais training programme". \textsuperscript{21}
It was interesting that despite recognising that health of women and especially maternal health is a spin-off of the social and economic status of the women, the planners continued to look for remedies in trained medical help. Trained medical help is important in itself, but there is sufficient evidence to demonstrate that it does not address the larger issues that are the root cause of women's ill health. 22 The Plan document remained selective in its approach and chose areas where only technological investments were to be made. For example, it stated that, "health of the mothers is significantly affected by induced abortions performed by unqualified persons under unhygienic conditions". 23 The government planned to provide safe Medical Termination of Pregnancy (MTP) at all public health centres during the 7th five-year plan period. 24 However, the social action needed to reduce the occurrence of unwanted pregnancy were not tackled.

The development of comprehensive health services has suffered at the cost of family planning programme. The continued focus of public resources on population control at the cost of other health services is thus obvious. High growth rate of population continued to be the major problem for the government. Though government accepted that despite massive investment in family planning, there was hardly any remarkable achievement to bring down growth rate, 25 it continued to concentrate on achievement of family planning targets. It targeted to reduce IMR to 90 per thousand live births and maternal mortality to the target that was fixed in the seventh plan. It is important to note however, that no maternity mortality targets have been fixed either in the seventh plan document or in the mid-term appraisal of seventh plan document. The emphasis in the seventh as well as in the eight plan has been on couple protection rate. Its preoccupation with population control was also evident as Plan document pointed out that, "containment of population growth is not merely a function of couple protection or contraception but is directly correlated with female literacy, age at marriage of the girls, status of women in the community, IMR, quality and out reach of health and family planning services". 27 Hence, the need for National Population Policy was expressed. 28 In other words these services (maternal care services) were worthwhile not for themselves but for population control.

The Eight-Plan document stated that "It is towards human development that health and population control are listed as two of the six priority objectives of this plan". 29 The plan document focused on the marginalised. It stated that "the Health for All
(HFA) paradigm must take into account not only high risk vulnerable groups, i.e., mothers and children, but must also focus sharply on the underprivileged segments within the vulnerable groups". 30 To achieve this, the government encouraged private initiatives, i.e., private hospitals and clinics. Privatisation became the driving force of reforms. The Ninth Plan document also peruses the same approach, with emphasis on reproductive health and population control to improve women's health. The support and encouragement to private and non-governmental (NGO) sector became an important strategy. Primary health centres thus have become 'primary level care' as secondary and tertiary care is largely left to the private and non-governmental organisations. 31

It is evident that the government focused on population control on the understanding that the efforts of economic development could be seen only if population could be controlled. Women – especially poor women – have been the targets of government’s population control policies. From mid 1980s Reproductive Health has occupied the centre stage to address women's health needs. The history of population control shows that population control as a concept focuses on attempting to convince women to use contraceptives. 32 Often, it can lead to coercive, unethical and ineffective family planning programme. 33 This has been the case in the Indian context. Despite huge investment in the family planning programme it has failed to achieve desirable results. It has targeted poor women in the name of reproductive health care and contraceptive choices. These women are covered with the so-called 'services', without any consideration for side effects on their health. Intra-uterine contraceptive and long acting hormonal contraceptive have adversely effected women's health. 34

These issues are not new, nor is the government ignorant. The limitations of such interventions within the narrow bio-medical frame are well recognised. Working Group on Population Policy (1980) emphasised integrated approach towards MCH. Draft National Health Policy accepted that "Health cannot be viewed in isolation from the overall goals and policies of national development. Development implies progressive improvement in the living conditions and quality of life enjoyed by the society and shared by its members". 35 As regards MCH, it stated that "if the limited resources in the health sector are to be preferentially applied, it should logically flow to children and mothers. Infant mortality, child mortality and maternal mortality in this country are stark figures
signifying our inability to achieve break through in this field". 36 As regards, maternal and child health the draft national policy stated that “vigorous steps (are) needed to achieve reduction in the birth rate, we need to improve facilities available to mothers and children to assure the families of the safety of their progeny. This, by itself, will have psychological impact and would over a period favour reduction in the birth rate". 37

In addition to these official documents, the institutions set up by the government also expressed similar views. The joint committee of the Indian Council of Social Science Research and Indian Council of Medical Research (ICSSR-ICMR) pointed out that “family planning programme is far from being a success”. 38 The report also stated that “the public health services have reflected social attitudes in regarding all women primarily as mothers or potential mothers. Health services for women have therefore, been termed as maternal and child health (MCH) services. This has resulted in a de-emphasis of general health services for them”. 39 It further argued that “the MCH services in the country...have been crowded out by pressures of the Family Planning Programme....They are patchy and rudimentary and have not been able to touch even the fringe of the problem”. 40 The report argued that health services for women and children could be improved only if associated with a substantial change in the social status.

Both national and international scholars have stressed the importance of overall development of general health services and improvements in economic and welfare sectors for the acceptance of family planning programme. 41 Some other scholars have emphasised the need to look at maternal mortality in relation to larger socio-environmental conditions, and have mobilised evidence to show the linkages between them. 42

Banerji argues that family planning has highjacked all resources at the cost of general health services. Coercive means to achieve family planning targets have neglected the development of public health perspective in the health services. 43 It is the political leadership at the top that has to bring about change in the perspective to make services pro people. “Action to strengthen public health practice must start from the political level....It would be necessary to search for highly intelligent and dedicated public health workers and bring them together to form a “critical mass” which could
strengthen the key institutions for practice, research, education and training in public health. Hartman argues that population control in the third world is based on the false assumption that over population as the main cause of poverty and hunger. Hence, population policies presumably aim to reduce birth rates by providing women with modern contraceptives. "A big difference exists between low quality family planning programmes which are targeted at poor women and designed to drive down birth rates as far as possible, and the high quality service whose aim is to serve the totality of women and men's reproductive needs in a respectful and voluntary fashion", argues Hartman.

The planners and the privileged however have been convinced by the International agencies who have contributed substantially to the narrowing of the focus of development planning to fertility control. The role of international agencies in targeting poor women to achieve demographic goals is well recognised. In 1965, United States began funding population control through USAID, Ford Foundation, International Planned Parenthood and Population Council. In 1967 UNFPA was established to coordinate the growing international funding and transfer of contraceptive technology to developing countries. In 1974, the Secretary of State and Director of National Security Council, Henry Kissinger called for support for population control in counties of political interest to the US and that included India also. The international economic interests in the developing countries resulted in declaring overpopulation as a cause of environmental degradation at the Earth Summit in Rio de Janeiro in 1991.

Control of population in the third world countries thus overshadowed the need for achieving women's health. The international pressures influenced Indian policy makers to adopt isolated, technocentric strategies without assessing their suitability and desirability for improving women's health in the Indian context.

Some critics felt that population growth of the third world was seen as a security threat to the International financial institutions. Population control policies are a vital component of structural adjustment process, as well as the New World Order Security Plan. The population control could not wait for the solutions in the socio-economic development, hence, international agencies and donor agencies targeted women, especially the poor women to stabilise population. These short-term solutions failed to
appreciate that the problems that are rooted in the socio-economic environment can not be tackled within the narrow medical frame. It is not surprising then that the 'Reproductive Health Approach' to family planning of the 1980s that aimed to replace the limited and potentially abusive 'Population Control' approach was conceptualised by Ford Foundation, International Women's Health Coalition (IWHC), and Population Council and was accepted by WHO. 52

There are a number of problems in the way international agencies look at Reproductive Health Care. One, that at conceptual level it replaces women's health by reproductive health. Two, though they talk of reproductive rights, it is never linked to other dimensions of human rights, particularly for the women of third world countries. 53

By putting reproductive health centre stage the women's health issues become a part of universal health and rights issues. Whereas there it a marked difference in the way women of the third world and women of developed countries view their priorities. 54 The reproductive health and rights issues in the third world are rooted in the women's oppression under the exploitative patriarchal structure of the family. It is therefore not correct to argue that reproductive health and rights issues of the first and third women can be treated at par or in isolation from their context. 55

The contradiction between the above-discussed assessments and the actual strategies for promoting maternity health is therefore quite evident. It is easy to put all the blame on international agencies for this dichotomy. However, it is important to understand the socio-political processes that permit international interests to become so pervasive. The interests of local populations are undermined by their own elite, political representatives, professionals and bureaucrats who tend to align themselves with the international interests to undermine the interests of local populations.

The shifts in policies and strategies reveal two trends. One, that to address women's health issues, the focus of the policy makers has remained on fertility control. Two, that attempts have been made to bring about change in women's health status through technological interventions alone. Contraceptive technology is offered to limit families and presumably to improve women's health by avoiding repeated pregnancies. The reproductive health approach aims to empower women by offering them 'choices', and encouraging them to exercise their 'rights'. It however pays no attention to the prevailing patriarchal family relations that make women's status secondary, her options