Chapter-5

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The Shift towards Globalization and Women's Health

Relationship between health and development shows the healthier position of economy and growth of any country. Women are essential component to the growing economy and children are possessions of the future. Nearly 50% of India's population consists of women. For growth to be truly inclusive, it is imperative to guarantee a nominal level of health care for this segment of the population so as to ensure their protection, well-being, development, participation and empowerment.

If we talk about women's position in developing countries, than the picture of a poor, helpless and deprived woman come in to our mind. Women are facing a number of challenges to their health and well-being in developing countries. According to a study about 200 million women in developing nations are suffering from health problem. Over half a million women die each year from complications during gestation and childbearing, the majority of them are in Africa and Asia. This includes about 70,000 deaths from unsafe abortion.[1]

Globally, nearly 16 million women are living with HIV and constitute almost half (48%) of all HIV-positive adults. With regard to curable sexually transmitted infection (STIs), there are about 340 million new lawsuits each year, and the burden of STIs for women is more than five times that of humans.[2]

Fundamentally, these health problems are a reflection of the inequalities of power that exist between women and men in many societies around the world. Women are often marginalized and denied equal opportunities compared to men. They are likewise restricted in their ability to take part in government and civil society and are unable to influence internal and local decisions that touch on their own health problems.

Globalization, in a wide sense, has considerable potential for improving human health, while facing many challenges. At home, the central challenge is to see how globalization affects people's access to Social Determinants of Health (SDH) and, given an explicit concern with equity, how that access is dealt. The approach taken by the Globalization Knowledge Network (GKN) to assist with this task emphasized the economic aspects of globalization since 1970s on the basis that the policies driving

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[1] Singh S., Darroch J. E., Vlassoff M., Nadeau J., *'Adding it up: The Benefits of Investing in Sexual and Reproductive Health Care'*, 2003. http://www.guttmacher.org

[2] Report on the Global AIDS Epidemic, UNAIDS, 2006-2007, pp. 60-67 http://www.unsids.org

global market integration are the most important with respect to SDH.[3] The globalisation has ensued several measures to meet these challenges. To begin with the efforts to cut across existing national, international and institutional boundries to address issues of trnsnational race.

Globalization affects health and SDH through changes in social stratification, differential exposure or vulnerability, health system characteristics and differential consequences. These changes arise through globalization's effects on power, resources, labour markets, policy space, trade, financial flows (including aid and debt servicing/cancellation), health systems (including health human resources and health services), water and sanitation, food security and access to essential medicines. While not exhaustive, this list covers the principle pathways linking globalization of health that were examined by the GKN.[4]

In the South East and East Asian countries, by contrast, social investments in human development, including health have contributed to more favourable health indicators. The Human Development Index (HDI) for South Asia (0.459) is much lower than in East Asia (0.652), or South East Asia and the Pacific (0.672). The Gender Development Index (GDI) for South Asia (0.412) is also lower than in East Asia (0.626) or South East Asia and the Pacific (0.641).[5]

Maternal Mortality Rates (MMRs) are highest in South Asia (554 per 100,000 live births) although they are also high in countries such as Indonesia (650) and Papua New Guinea (930). In comparison, the Malaysian rate is only 80 and the MMR in Vietnam is relatively low at 160. Stronger government policies towards human development and poverty reduction, as well as higher rates of (female labor-intensive) economic growth in East and South East Asia in the past few decades have been responsible for these differences. However, the previous record of better health indicators among South East and East Asian women is challenged by the current economic crisis, which calls on women to make even greater sacrifices. The gender differentiated impact of government cutbacks in service provision, unemployment, the increase of work burdens on women, women's potential relegation of poverty and into the sex trades, the severity of health care costs, are likely to be significant.[6]

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[3] Labonte, *"Globalisation, Export-oriented Employment for Women and Social Policy: A Case Study of India"*, 2011, pp. 1-15 http://www.unrisd.org , www.globalhealthequity.ca
[4] Ibid
[5] Ibid
[6] Ibid

One of the important effect of the globalization on women's health is the de-regulated experimentatiuon of drugs on women. The free movement of drugs and medical technology as an effect of globalized economies under poorly regulated environments has resulted in its illegal application and experimentation on women. For instance, the liberalization of drug imports made it possible for Quinacrine an anti-malarial drug that has been developed as an alternate for chemical sterilization for women to be imported and tested by private doctors in India even though it had not passed the required toxicology tests and was the subject of significant controversy worldwide.[7]

Over the past several decades, the world has witnessed some astonishing global health success stories. Yet, for all public health and medical advances, a startling number of women still die, approximately 287,000, each year during pregnancy and childbirth.[8]

Table 19: Changes from 1990 to 2010 in Estimated Maternal Mortality Rate (MMR*), with Estimates of Maternal Deaths and Risk in 2010 in Selected Countries and Regions

Location	MMR in 1990	MMR in 2000 (with range of estimates)	Maternal Deaths in 2010	Adult Lifetime Risk of Maternal Death of Current 15 Year Old girl
World	400	210 (170-300)	287,000	One in 180
United States	12	21 (18-23)	880	One in 2,400
Southern Asia	590	220 (150-310)	83,000	One in 160
Sri Lanka	85	35 (25-49)	130	One in 1,200
India	600	200 (140-310)	56,000	One in 170
Sub-Saharan Africa	850	500 (400-750)	158,000	One in 39
Tanzania	870	460 (190-740)	8,500	One in 38
Uganda	600	310 (200-500)	4,700	One in 49
Zambia	470	440 (220-790)	2,600	One in 37

*MMR is the number of maternal deaths per 100,000 live births.
Source: World Health Organization (WHO), *Trends in Maternal Mortality*

The need for an urgent response to the Asian financial crisis as a result of unbridled globalization and for macro analysis of its impact on women, compelled the

[7] Ibid
[8] Nieburg Phillip, "A Report of The CSIS Global Health Policy Centre", *Improving Maternal Mortality and Other Aspects of Women's health: United States Global Role*, Oct. 2012, www.csis.org, see also, World Health Organization (WHO), *"Trends in Maternal Mortality:1990-2010"*, WHO, UNICEF,UNFPA, and The World Bank Estimates, Geneva, WHO 2012, http://whqlibdoc.who.int

joint organization of the "Women's Round Table Discussion on the Economic, Social and Political Impacts of the South-East Asian Financial Crisis" by the Gender and Development programme of Asian and Pacific Development Centre (APDC) and Development Alternatives with Women for a New Era (DAWN), held on 12-14 April 1998, in Manila, Philippines.[9]

The studies also suggests thst the economic neo-colonization of Asia, prescribed by structural adjustment programmes (SAPs) of the World Bank, International Monetary Fund; World Trade Organization (with state complicity and subordination to transnational corporations), was viewed as not only eroding national barriers, the very sovereignty of debt-ridden countries, but has mandated an unprecedented liberalization, deregulation and privatization. Women in this region has been adversely affected by the crisis because it has been established that women bear the burden of the combined effects of inflation, recession and cost-cutting measures in the public sector. Further increased prices of basic commodities, high interest credit, loss of jobs for men and women and the privatization of social services and utilities, comoelled the poor families to survive under extremely difficult conditions. All these directly impinge upon Southeast Asian women who are the household mangers for food, health and daily survival. Thus from a feminist perspective, globalization followed by the financial crisis has added to the unemployment and casualisation of female labour, feminization of object poverty and international migration, commodification of women's bodies and sexuality, dehumanization of and violence against women. In the present era of globilised economy women bear the greater burden of the present political instability, economic crisis and social breakdown of the region which has in turn insidiously undermined the hard-earned gains achieved by the women's movements. Women now suffer the ills perpetuated by globalization and the economic crisis: global competitiveness, homogenization, monoculturalisation, political repression, and gross consumerism, institutionalized opression of the poor, re-emergence of ethnic religious and patriarchal fundamentalism.[10]

International Intervention, State Policy and Women's Health

The inferior socio-economic status of women and their and reproductive role expose them to risks of poor health and premature death. Yet many women's can be rescued and their health problems can be prevented or mitigated through highly cost-effective

[9] Rengam Sarojeni V., 'The Asian Financial Crisis and Women', *Arrows for Change: Women's and Gender Perspective in Health Policies and Programmes,* Vol. 4, No. 1, May 1998, pp.1-12 http://www.asiaconnect,com.my/arrow/, arrow@po.jaring.my

[10] Ibid

interventions. One of the major initiative to improve health, nutrition and fertility was started by the World Bank emphasizing on Health, Nutrition, and Population. Constructive health policies and effective and equitable health services are essential for the broader development goal of breaking the cycle of poverty, high fertility, poor health, low productivity and slow economic growth. The World Bank has been playing a key role and is financing reproductive health activities for almost 30 years, starting with basic family planning projects and moving on to more comprehensive reproductive health projects. The loans provided for population and reproductive health has totaled over $393 million a year since 1992-about one-third of the World Bank's total lending for health, nutrition and population. The figures of loan advanced by World Bank particularly for women's health are not available nevertheless the amount has considerably increased as can be seen in the World Bank's spending on projects addressed to women's health.[11]

The World Bank has continuously explored the avenues to finance reproductive health programs more vigorously. Policy dialogue focuses on linking population to poverty reduction and human development in countries experiencing high fertility rates. The World Bank adopted a view that financing girl's education, microfinance and other income generating opportunities to improve women's health are important prerequisite for overall development. World Bank's continuous effort of partnership with client countries together with other donors and non-governmental organizations (NGOs) have resulted in sustained support for policies that adapt to changing needs. Further, lending is sensitive to country contexts and the Bank is able to mobilize funds quickly to meet new challenges. The World Bank is currently undertaking an evaluation of the effectiveness of our lending program in mainstreaming gender issues. Preliminary findings from this study indicate that the Bank is more effective at addressing women's issues in the area of health and education than in other sectors.[12]

Research in reproductive health underpins both policy dialogue and project design. The World Bank is also playing an instrumental role in financing several research projects related with women's health in several countries, including India, Jamaica, Pakistan, the Russian Federation and Yemen. It has also undertaken regional

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[11] Tinker Anne, Kathleen Finn and Joanne Epp, 'Improving Women's Health: Issues and Interventions', June 2000, *The International Bank for Reconstruction and Development/ The World Bank*, Washington, pp. 1-41 healthpop@worldbank.org

[12] Ibid

studies in Latin America, Middle East and North Africa. In India, the research project related with reproductive and child health was financed on a national scale.

The issues of women's health are both- biological and gender-based. More boys than girls are born, and females have a natural biological advantage over males throughout the life cycle. Under optimal conditions for both men and women, a woman's life expectancy at birth is 1.03 times that of men. In some developing countries, however, the ratio is lower, dropping below 1.0 in parts of Asia-a sign of socio-economic conditions particularly unfavorable to women and girls.[13]

The expectancy of women is longer than men, but this does not necessarily ensure them better quality of life. Even in countries where women live longer, studies have found that they are more sickly and disabled than men throughout the life cycle. There has been much progress in improving women's health still some challenges remain and new ones have emerged.[14]

The Beijing Platform for Action reiterates the agreements reached at the 1994 International Conference on Population and Development (ICPD), particular related with women's reproductive health and their rights, and added new commitments addressing the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Taking a holistic and life-cycle approach to women's health, the Beijing Platform for Action proposed actions towards five strategic objectives. Increase women's access throughout the life cycle to appropriate affordable and quality health care information and related services. Strengthen preventive programmes that promote women's health. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues. Promote research and disseminating information on women's health. Increase resources and monitor follow-up for women's health. The outcome of the twenty-third special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century" called for, inter alia, policies and measures to address, on a prioritized basis, the gender aspects of emerging and continued health challenges, such as malaria, tuberculosis, HIV/AIDS and other diseases having a

[13] Ibid
[14] Ibid

disproportionate impact on women's health, including those resulting in the highest mortality and morbidity rates.[15]

It also called for the allocation of the necessary budgetary resources to ensure the highest attainable standard of physical and mental health, so that all women have full and equal access to comprehensive, high-quality and affordable health care, information, education and services throughout their life cycle as well as full attention to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) commits States parties to take "all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[16]

In 1999, the Committee on the Elimination of Discrimination against Women issued General Recommendation, *further elaborating on Article 12 of the Convention.* Highlighting the importance of past general recommendations on female genital mutilation/cutting, HIV/AIDS, disabled women, violence against women and equality in family relations, the Committee provided additional guidance to States parties on the interpretation and reporting required on article 12. They noted special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl-child and older women, women in prostitution, indigenous women and women with physical or mental disabilities. The Committee raised various issues, using a broad definition of health, including the importance of nutritional well-being by means of a food supply that is safe, nutritious and adapted to local conditions.[17]

In 1999, during its forty-third session, the Commission on the Status of Women further enhanced commitments of the Platform for Action on women and health in its agreed conclusions by drawing attention to women's health issues such as infectious

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[15] Women and Health,
http://www.un.org/womenwatch/daw/beijing/beijingat10/C.%20Women%20and%20health.pdf
[16] Ibid
[17] Ibid

diseases, mental health and occupational diseases. The Millennium Development Goals (MDGs) adopted in 2000 address women's health in two of the eight goals. MDG 5 focuses on improving maternal health by reducing by three quarters, between 1990 and 2015, the maternal mortality ratio. MDG 6 focuses on combating HIV/AIDS, malaria and other diseases. In 2003, the African Union adopted a landmark treaty known as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. As of March 2007, 20 States had ratified the agreement. The Protocol provides broad protection for women's human rights and affirms reproductive choice and autonomy as a key human right. It is the first time that a legally binding international human rights instrument has explicitly articulated a woman's right to abortion when pregnancy results from sexual assault, rape or incest; or when continuation of the pregnancy endangers the life or health of the pregnant woman.

In 2004, the World Health Assembly adopted its first strategy on reproductive health, intended to help countries stem the serious repercussions of reproductive and sexual ill-health. The strategy targets five priority aspects of reproductive and sexual health: improving antenatal, delivery, postpartum and newborn care; is providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological illness and disease; and promoting sexual health.[18]

During the 2005 World Summit, Heads of State and Government committed themselves to "achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.[19]

They also resolved to promote gender equality and eliminate pervasive gender discrimination by, inter alia, ensuring equal access to reproductive health. In 2005 at its fiftieth session, the Commission on the Status of Women issued agreed conclusions on "enhanced participation of women in development: an enabling environment for

[18] Ibid

[19] Enabling Poor Rural People to Overcome Poverty in India: Rural Poverty in India, *International Fund for Agriculture Development (IFAD)*, Italy, November 2011, pp. 1-8 www.ifad.org

achieving gender equality and the advancement of women, taking into account, inter alia, the fields of education, health and work." The Commission underlined the importance of incorporating a gender, human rights and socio-economic perspective in all policies relevant to education, health and work and of creating an enabling environment for achieving gender equality and the advancement of women. It called upon Governments to incorporate gender perspectives and human rights in health-sector policies and programmes, pay attention to women's specific needs and priorities, ensure women's right to the highest attainable standards of physical and mental health and their access to affordable and adequate health-care services, including sexual, reproductive and maternal health care and life-saving obstetric care, in accordance with the Programme of Action of the International Conference on Population and Development, and recognize that the lack of economic empowerment and independence increased women's vulnerability to a range of negative consequences, involving the risk of contracting HIV/AIDS, malaria, tuberculosis and other poverty-related diseases.[20]

Impact of Technology on Women's Health

India is emerging as one of the important global competitive market in the healthcare sector due to the its financial support in the form of economic benefits, technological advancements and policy changes are bound to create a strong opportunity for India to build a global competitive edge in the healthcare sector.[21]

The economic position of women and their access to health are interrelated. It is true that new technology introduced in the field of health is considered gender-neutral but it is a greater challenge for Indian condition. It is well established that India witnessed a lopsided development with respect to rural-urban devide. It would noe wrong to say that modernization of the economy or advancement of the society is a myth for rural women. The gender division of labour within the rural household has remained culturally stubborn. Women as a class are oppressed and subdued by the hegemony of social patriarchy. Economic growth has failed to improve the situation either. Rather,

[20] Ibid

[21] Choudary Pavan, Mahadevan Narayanamoni, 'Progressive Change: Impetus to Medical Technology through Innovation, Incentivisation and Regulation' *Grant Thornton,* New Delhi, 26 September 2013, pp. 1-24, http://wwwgrantthornton.in/insights

technology and labour market imperfections have accentuated the concentration of women in domestic works with non-market roles and activities.[22]

Technology and economic growth has emerged as interrelated phenomena. Improving women's access to technology has been under used in unlocking women's economic opportunities. The gender divide is evident in both traditional and modern technologies. The technology has helped us to control nature and improvr ou life. It has also played instrumental role in establishing dominance and subordination. Whereas it also paves the way for creating a more inclusive and egalitarian society. Imrana Qadeer reasonabally questions that "why is the potential of technology subdued today? Why has this man made asset been so trapped in the wheels of commercialization and free markets, that its progressive potentials have been obfuscated? The reasons we believe are as much rooted in social processes as the origin of technology itself."[23]

Qadeer further convincingly argue that health and health services are dynamic outcomes of changing socioeconomic, political, cultural, environmental and biological conditions and levels of technology and its organization. The term public health refers to this dynamic of the population. It invokes different meanings for different people according to the perspectives they carry. Once it meant hygiene, sanitation and health education within the sanitary perspective. Today, the techno-centric perspective (that ignores all socioeconomic determinants of health) dominates where experts and providers call the shots, as health services are primarily concerned with extensive application of medical technologies for preventing and controlling diseases. Yet another is the holistic perspective, where the social context of health and health services is given weight and prevention extends beyond technological and educational interventions into development and welfare activities to meet basic needs. It recognizes the importance of inter-linkages of health with food availability, drinking water, sanitation and livelihood and also the constraints that power structures impose on access and availability of technology. In other words, this perspective shows the limitations of a techno-centric perspective- in achieving public health goals and shows the limitations of techno-centric prespective in achieving public health goals and shows that to reach the less privileged the level of equality and equity (structural and distributive potentials) must be addressed

[22] Prof. Dr. Das Kumar, Miss Banishree Das, 'Technology and Women in India: With Special Reference to the Rural Sector' XIV, *International Economic History Congress,* Helsinki, Finland, August 2006, pp. 1-21, http://www.helsinki.fi/iehc2006/papers1/Das.pdf

[23] Qadeer Imrana, 'New Productive Technologies and Health Care in Neo-Liberal India: Essay', *Monograph,* November 2010, Center for Women's Development Studies, New Delhi, http:// www.cwds.ac.in, www.cwds.org, pp. 1-67

within a context. Its outlines emerged in the 19th Century with the public health movement in Britain, and it was widely accepted after 1950s, when a plurality of causes of disease became evident and social democracies promoted welfare.[24]

In countries where the governments have failed to achieve equity in welfare, more and more of the societal problems are being labeled as 'technical problems' and pushed into the medical domain. For example, population planning, child abuse and now infertility are seen as purely medical issues. This is primarily because the links between production, reproduction, structure of labour, poverty, caste, class stratification and patriarchy are neglected in planning. Their exclusion from the domain of social planning leads to a shift away from the holistic perspective of public health and the social roots of these problems remains untackled. For example, treating RTIs, STDs, providing better maternity care, safe contraceptives, abortion services and assisted reproduction may, to some extent, control, infertility in certain sections, but cannot reduce it to the extent possible, as infertility is rooted in the social situation that breeds infections, under-nutrition, values that undermine women and inequity of access to services. Purely technological solutions are often too costly; combined with social alternatives they become more feasible, effective and humane. Yet, even within the techno-centric perspective, currently there is a clear shift from a systemic to a disintegrated institutional strategy that promotes tertiary care through competing, discrete institutions within the expanding medical market. A grasp over these shifts of perspective in public health in independent India makes it easier to understand why Assisted Reproductive Technologies (ARTs) have become a part of the private medical market, and how-infertility could be tackled in the holistic perspective. Shifts of perspective determine the relative priority of infertility in service provisioning, technological strategies to deal with it, its linkages with welfare services, and the spaces for public to access service facilities.[25]

In this context Imrana Qadeer explaines the history of the introduction of ARTs in India and its different linkeges with welfare services, technology and forces of market. The first test tube baby was born in a public private partnership, at the initiation of ART research at the National Institute of Reproductive Research. Since then, its slow expansion has been a gradual but steadily increasing phenomenon. In the 1980s biotechnology had acquired the reputation of the cutting edge of applied sciences and

[24] Ibid
[25] Ibid

well meaning scientists, committed to biotechnology, were keen to put it to use for the benefit of the people. One of them argued that through ART, "A woman can give birth to a child from her husband even after the husband is dead. In surrogate motherhood, a couple who is otherwise normally fertile but the wife does not want to go through the nine month pregnancy that would confine her for a substantial period, can have--another woman who would then give birth to a child totally unrelated to her". He also pointed out that over the past 10 years or so, our country has seen a mushrooming of fertility clinics. The grasp of patriarchal influence on social and economic conditions, and cultural values within which women live and his faith in technology is self evident. It was this same faith in technology that inspired the Infant and Child Mortality Rate to support National Institute of Reproductive Research to take up ART research and later to bring it in the Family Welfare Programme and tertiary care service institutions in the Ninth Five year Plan. It was said that couples wanting re-canalization could use ART as a simpler, less invasive method of conceiving. This would make acceptance of sterilization easier for them and would be a boon for the Family Planning Programme. The ICPD declaration in Cairo on reproductive rights and choices emphasized expanding the scope of reproductive health and thus promoted ARTs in the name of women's choices and rights.[26]

This vision of ART brought together both- promoters of medical market interested in generating profits through the sale of ARTs and the pro population control lobby of professionals and policy makers. The Multi National Companies (MNCs), interested in businesses that can be scaled up, soon realized the limitations of this set of highly individualized technologies. Their interest shifted to research on stem cells that have the potential to open up a much bigger market. ARTs for them became the source of obtaining ova and the embryos for research. For the private professionals, however, given the son preference and social stigma against infertility, the present set of ARTs opened up a new opportunity to expand profits. Hence it was argued that higher rates of infections and ensuing complications in absence of adequate gynaecological and obstetric services contributed to high infertility in India. The socio-cultural 'need' of women suffering from harassment and social rejection was also used by providers to give ARTs the image of a gender sensitive technology.

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[26] Ibid

Finally, India's Ninth Five Year Plan introduced management of sterility in its comprehensive Reproductive and Child Health Programme but not in the "Essential" package of RCH. It was said that given an estimate of 5-10 percent sterility, it is essential that couples who do not have children get access to essential clinical examination, investigation, management and counseling. It was proposed that while the expertise would be made available at the tertiary hospitals, basic services to detect causes and carry out preliminary investigations like sperm count, diagnostic curettage, and tubal patency tests will be done at the CHC to screen cases and refer them to appropriate institutions. ICMR guidelines also mention that the scope of providing infertility services in the public sector needs to be explored. It is interesting that, while the Five Year Plans committed to ARTs, the National Public Health Standards evolved for CHC under the NRHM did not included the simple test facilities. This commitment was repeated almost verbatim in the Tenth Five Year Plan yet, the Broad framework for Implementation of the NRHM, while enumerating guaranteed services, talked only about treating RTI and ignored the simple tests for infertility at the CHC level. Thus, in the public sector these services are confined to the tertiary sector and therefore not accessible to the majority.

Therefore, it is clear beyond doubt that ARTs are a part of the glamour technologies projected by India to establish its international standards. It is confined primarily to the private sector and tertiary public sector institutions access to a select few. On the other hand the basic services have no strategy to deal with infertility. The intent of this neglect can be gauged only when the prevalence of infertility and its causes are properly examined.

Improvement in the health and nutritional status of the population has been one of the major thrust areas of the social development programmes in the country. This was to be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition services with special focus on underserved and under privileged segments of the population. Over the last five decades, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors. These institutions are manned by professionals and paraprofessionals trained in the medical colleges in modern medicine and ISM&H and paraprofessional training institutions. The population has become aware of the benefits of health related technologies for prevention, early diagnosis and effective treatment for a wide variety of illnesses and accessed available services. Technological advances and improvement in access to health care technologies, which were relatively inexpensive

and easy to implement, had resulted in substantial improvement in health indices of the population and a steep decline in mortality.[27]

Shift from 'Welfarism' to Private Care

The private health care system in India has grown over the years. The private health sector accounted for only 5 to 10 per cent of total patient care. In 2004, the share of private sector in total hospitalized treatment was estimated at 58.3 per cent in rural areas and 61.8 per cent in urban areas. In case of non-hospitalized treatment, government source account for only 22 per cent in rural areas and 19 per cent in urban areas.[28]

The private health sector has played a significant role in the delivery of health service right from pre-independence days. At the time of independence Public Private Participation (PPP) allowed government doctors for private practice, an arrangement still in vogue in majority of the states. Some of the studies suggest that the private sector has been largely overlooked by Indian policy-makers while formulating policies, plans, and strategies towards achieving the 'health for all' goal. According to one estimates, well over half the available health services were being provided by the private sector even as early as the 1950s. Evidence from studies in 1963 reveal that most illness incident in rural areas were treated by private providers and that only around 10 per cent of the population used government facilities. It has been argued that idealism and faith of early planners that the public sector could indeed 'provide all things to all people', coupled with the low visibility of the private sector and its low involvement with Western medicine, might explain this initial oversight. The private sector has played a critical and an increasing role in providing health care to a growing population in spite of its well-publicized weakness. The challenge before the state is to so guide and manage the private sector that it contributes to national health goals without loss of its enterprise and growth potential.[29]

In India there are two different forms of private health sectors first pro-profit, 'qualified provider' and second form is not-for-profit which includes in its fold Non-Governmental Organitions (NGOs), trusts, charitable and religious endowments. There is a growing concern about trusts and charitable institutions which are changing their

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[27] Tenth Five Year Plan 2002-2007, Planning Commission, Governmetn of India, Acadmic Foundation, New Delhi, 2003, pp. 75-95

[28] Rao P.H., 'The Private Health Sector in India: A Framework for Improving the Quality of Care', *ASCI, Journal of Management* No. 41 (2): 14-39, http://journal.asci.org.in/Vol.41%282011-12%29/41_2_phrao.pdf

[29] Misra Rajiv, Rachel Chatterjee, Sujatha Rao, "India Health Report", Oxford University Press, 2003, p. 102, see also Ninth Five Year Plan 1997-2002.

character to be more aptly classified as for-profit. However it is of equal concern that some expenditure of for-profit hospitals are registered as trusts to avail tax exemptions. The private sector also includes the often overlooked unqualified practitioner, who has a far more significant presence in India's 600,000 villages than is readily acknowledged.[30]

Till the mid 1960s, voluntary effort on health care was confined to hospital-based care. Later, inspired perhaps by the Chinese experience of a motivated health care, delivering care at the community level, models of community health programmes and decentralized curative services began to receive attention. The voluntary effort on health care covers a wide range of activities and can be classified broadly into:

- Organizations implementing government programmes (Family Planning, Reproductive and Child Health, AIDS Control, Integrated Child Development Services);
- The Organization runs specialized community health or integrated programmes for basic health care delivery and community development;
- Organizations delivering care and rehabilitation services for disadvantaged groups (leprosy patients, the handicapped);
- Organizations sponsoring health care for blindness control, polio eradication, management of blood banks, and support during disasters/epidemics (Lions Club, Rotary Club, Red Cross, and Chambers of Commerce); and
- Governing bodies/individuals health researchers and activist who undertake applied research in health service delivery, health economics, health education, and who play an advocacy role.[31]

The private health sector consists of, on the one hand, private general practitioners and consultants of different systems (Allopathy, Indian system and homeopathy) and a variety of non-qualified practitioners and on the other hand hospitals, nursing homes, maternity homes, specialised hospitals, etc. The studies reveals that the private health sector consisting of general practitioners, nursing homes and hospitals involves two thirds of the medical human power in the country. Despite this enormosity there is hardly any effective regulation to check and regulate the private health sector. This is indeed surprising because such activity cannot be carried out without strict control and registration. The medical professional has to be registered with the Medical

[30] Ibid
[31] Ibid, p. 104

Council, which is a statutory body that sets the standard of medical practice, 'disciplines' the professionals, monitors their activities and checks any malpractice's The doctors who decide to set up their own clinics as well as hospitals, nursing homes, polyclinics etc., have to register with the respective local body. The problem with the above is that the controlling bodies are virtually non-functioning. The reason for this is not only lack of interest, but also weak provisions in the various acts. They are also heavily influenced by the private health sector.[32]

The Medical Council of India and the respective State Councils have to regulate medical education and professional practice. Presently beyond providing recognition to medical colleges the Medical Council does not concern itself with the practitioner, unless some complaint is made and a prima face case established. Even the list of registered practitioners is not updated properly by the Medical Councils. The national body at present concerns itself with only recognizing and de-recognizing medical colleges whereas the State bodies function only as the registers for issuing a license for practicing medicine. (The State Councils also facilitate recognition of private medical colleges which the National Council has de-recognized!). The Local Bodies (Municipalities, Zilla Parishads, Panchayat Samitis etc.) have the authority to provide a license to set up a nursing home or hospital and regulate its functions. However, besides providing the certificate to set up a hospital or nursing home the local bodies do not perform any other function, in spite of provision in the Act.[33]

In spite of good government sector infrastructure, a majority of patients in Punjab, Haryana, and Maharashtra went to private hospitals. In Himachal Pradesh, Rajasthan, West Bengal and the northeastern states a majority of the patients seek admission in government infrastructure. In Bihar, poor government infrastructure might be responsible for over 60 per cent of patients seeking admission in private hospitals. Obviously the choice between public and private sector facilities depends on several factors, including the functional status of government infrastructure, the price differential between the public and private sector, the person's ability to pay and the preferences of the community.[34]

During the Tenth Plan appropriate policy initiatives was taken to define the role of government, private and voluntary sectors in meeting the growing health care needs of

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[32] Duggal Ravi and Sunil Nandraj, '*The Private Health Sector in India: Nature Trends and a critique*', Center for Enquiry into Health and Allied Themes (CEHAT), Mumbai, 1 May 2000, www.cehat.org,
[33] Ibid
[34] Op. sit. *Tenth Five Year Plan, 2002-200,* Vol. II, Chapter- 2.8, pp. 81-152

the population at an affordable cost. The public sector developed institutional capability at the central, state and local levels to (a) evolved policies and strategies for providing health care and monitor their implementation, (b) increased public-private-voluntary sector collaborations to meet the health care needs of the poor and vulnerable segments of population, (c) drawn up standards for appropriate quality and cost of care and establishment of accreditation systems for individuals/institutions, (d) monitoring and enforcement regulations and contractual obligations, (e) promote excellence and ethics among professionals, identify and punish professional misconduct and (f) set up an appropriate and speedy grievance restore mechanism.[35]

Growth of private health sector in India had been considerable in both provision and financing. There is diversity in the composition of the private sector, which ranges from voluntary, not-for profit, for–profit, corporate, trusts, stand-alone specialist services, diagnostic services to pharmacy shops and a range of highly qualified to unqualified providers, each addressing different market segments.[36]

The cost of health care in the private sector is much higher than the public sector. Many small providers have poor knowledge base and tend to follow irrational, ineffective and sometimes even harmful practices for treating minor ailment. The bulk of the qualified medical practitioners and nurses are subject to self-regulation by their respective State Medical Councils under the central legislation. In practice, however, regulation of these professionals is weak and close to non-existent. Public spending on health in India is amongst the lowest in the world (about 1 percent of GDP), whereas its proportion of private spending on health is one of the highest. Households in India spend about five to six percent of their consumption expenditure on health. The cost of services in the private sector makes it unaffordable for the poor and the underprivileged.[37]

The privatization of health care has accelerated since 1991 with the unprecedented expansion of the private medical sector, the entry of private insurance in health care and the introduction of payment for medical services or "user fees" in the government sector. Privatization & deregulation have resulted in rising drug prices. New National Health Policy 2002 legitimizes the ongoing privatization of health. The Indian health system is the most privatized health system in the world as per the reports of Citizens Report on Governance and Development 2003, Social Watch India. While the

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[35] Ibid
[36] Op. sit. *Eleventh Five Tear Plan, 2007-2012,* Vol. II, Chapter- 3, pp. 57- 127
[37] Ibid

proclaimed objective of user fees is to generate resources for the public sector, it has resulted in people being weaned away from public to private hospitals as people do not want to settle for what appears to be 'second best' if money has to be paid in both cases. It has also meant that a large number of people are not seeking help from anyone. This has led to a paradoxical situation where the standard of medical care in public hospitals is degenerating even as user fees are introduced as a source of income.[38]

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban-biased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by *'out of pocket'* payments is making healthcare unaffordable for a growing number of people. Trade liberalization allows the entry of cheap products including cheap health products. Health care is now profit-driven. When there is a drive to derive a profit from health care, it ceases being a basic right and a basic social service. It becomes a privilege unreachable to the poorer segments of the population, enjoyed only by those who have resources. If the country's economy has to fight an unequal battle with the developed countries in the international market, its society is doubly burdened by the inequities suffered by women, enhanced by the effects of this unfavorable competition. The availability of services for women suffering from gender-based violence is either inadequate or non-existent. Most of the other countries have reported extensive gender-violence problems. However, barriers such as socio-cultural stigmatization, under-reporting of cases and lack of national prevalence data have undermined the seriousness of the problem. Malaysia and Philippines were the only two countries, which have set up multi-disciplinary integrated public health services for women.[39]

Privatization has led to the sale of government land and closure or scaling down of vital public hospital services in mental health, leprosy and TB. NGOs in India have been raising the issue that spiraling costs of medicines are a growing barrier to healthcare. In India, the increased cost of medical care is the second most common cause of rural indebtedness. Women place their health needs last when cost is an issue, seeking medical care too late or not at all.[40]

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[38] Gupta Kiran Soni, *'Impact of Globalization & Liberalization on Women's Health in India: Future strategies'*, 4 November 2011, http://www.globaljusticecenter.org
[39] Ibid
[40] Ibid

Withdrawal of Government's Public Health Services and NGO's Foreign Funding in Public Health

It was the time when modern concept of development was spreading in India. Health, education and the public distribution system became the basic wellbeing nature of the states during independence India. At the same time, this welfare sector is also part of the same processes of appropriation which steadily transform it into a sector for profit.[41]

The first two Five Year Plans actually attempted to develop basic infrastructures and human resource requirements although less than five percent of the total budget was invested in health. They were inspired by the Bhore Committee's vision, in thus, necessarily required an integrated strategy. Gradually, over the 1960s, however, this vision was to weak. Urban hospitals obtained priority over rural institutions, the training of paramedical workers was overshadowed by growing medical college. Private practice not only flourished but got entrenched into the public sector, making free medical care illusory. These trends negated the possibility of a major social experiment.[42]

The concept of family planning was generat by issue of Maternal and Child Health (MCH), on the basis of expert advice. Adviced by the consultants for The planning commission that the family planning programme acquired the nature of a black hole that swallow up the entire health services. The terms and conditions for drug production were made convenient for the private sector and the MNCs. The primary health centres, which had degenerated into agencies for meeting family planning targets, also served the doctors as a source of their private practice by public sector doctors influenced decisions regarding rural health and private practice by public sector doctors. These process, aided and supported by the state, were accompanied by a shift in resource allocation within the health sector, which was favourable to the professional elite and their select clients, but harmful to the interests of the majority.[43]

According to the Alma-Ata Declaration in 1978, primary health care was to be implemented in accordance with the political, economic, social and cultural patterns of a country. India's health ministry decided to proclaim two of its previously enunciated schemes – the Multipupose Worker for the villages and the CHGS – as the heralds of Primary Health Care. Then the existing programmes of the Welfare Department, Tribal

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[41] Qadeer Imrana, "Public Health in India: Critical Reflections", Daanish Books, Delhi, 2011, *The World Development Report 1993: The Brave New World of Primary Health Care,* p. 337
[42] *Ibid,* p. 341
[43] Ibid, p. 342

Development and Minimum Needs Programme were clubbed together to make the picture complete in paper.[44]

In India the debate between comprehensive and selective primary health care never really took place, either in the realm of policy or of practice. Though India signed the Alma-Ata declaration in 1978 and pledged its implementation, the Sixth Five Year Plan made no memtion of it. The programme of immunization and later, the Child Survival Strategies, were promoted and 'selective' PHC silently became a part of health sector planning. [45]

The two major trends are particularly prominent, within India's health sector. One original but frail, attempting to change the existing balance, reach out to the majority, build basic infrastructures and contextualize health within social and economic development. The other more pragmatic, pushing selective PHC and population control strategies in the name of primary health care. The question that we propose to examine in the next section is, does the World Bank's strategy tend to promote the latter?[46]

In the mid-1970s, the World Bank was ready to wait for the 'trickle down' effect of its strategies. In the 1990s, it is no longer ready to do so. Economic pressures in the North, the globle collapse of all opposition to its grossly exploitative policies, the attraction of the expanded markets in the South (however restricted)and the failure to 'appropriate' technologies to yield profit, have generated a countrdictory situation. As the problems of capitalism multiply in its homeland, the rest of the world offers unfettered opportunities. Aggressive economic policies of those who control international trade, at the coast of their wearker partners, are easily rationalized. At the same time, open denial of welfare would amount to ideological weakness.[47]

The World Bank washed its hands off comprensive PHC in the early 1980s, when it opted for selective PHC. It backed programmes closely linked with population control, such as maternal and child health, but avoided identification with the much maligned family planning programme. These prigrammes, desirable in themselves, treated maternal and child mortality as a purely technical problem, isolated from the socio-economic situation. The latter theoretically grants the possibility of state-run public health programmes where cost-effectiveness is demonstrated. But this possibility of expanding the scope of basic services is now denied under the innocuous title of

[44] Ibid
[45] Ibid, p. 344
[46] Ibid
[47] Ibid

'essential' public health and clinical services and, other than tuberculosis, no mention is made of existing communicable diseases. The market is apparently the favoured solution to all problems of illness and disease.[48]

Agenda for the health sector of World Bank is clear. It proposes:

i. Cuts in public spending on health services including tertiary level medical care and shifts to strengthen population control.
ii. Shifting curative care to the private sector.
iii. Introducing cost-recovery mechanisms in public hospitals.
iv. Defining 'essential' clinical and public health packages.
v. Tackling poverty through structural adjustment policies, education and women's empowerment.

The Country Statement for the international Conference on Population and Development, the Draft Population Policy and the annual budget for the Eighth Five Year Plan of India have already accepted the major recommendations of the World Bank. The government has introduced budget cuts, new drug policy with decontrols, privatization of medical care and is exploring cost-recovery schemes, such as introduction of user fee and health insurance.[49]

The World Bank was now increasingly setting agenda for health. World Bank lending in the health sector is thus larger than the entire budget of the WHO. Within the health sector, and especially following the publication of the influential 1993 Reprot *Investing in Health,*[50] the Bank's health sector policies reforms have meant redefining public spending in health to an essential package of clinical services, and phasing out public subsidies especially for tertiary care. The bank also urges governments to foster competition and diversity in supply of health services. One hallmark of these has been the concept of a fee for public services. These policies have essentially been a clarion call for privatization and a more "cost-effective" version of selective PHC. In the process, public health is dismembered, diseases are divorced from their socio-economic contexts, and the concentration on specific technology dependent programmes sounds the death knell to concepts of PHC.[51]

The World Development Report 1993 investigate the number of people are living in poverty and per capita public expenditure on health as critical indicators for health. It

[48] Ibid, p. 345
[49] Ibid, p. 346
[50] World Development Report 1993: Investing in Health, Washington D.C., World Bank 1993.
[51] Op. sit. Qadeer Imrana, 'Public Health in India: Critical Reflections'

assume 'that one-third of the effect of economic growth on life expectancy, in low income countries comes through poverty reduction and two-third through increased public spending on health.' It, therefore, attempts to 'educate' poor households to cope with poverty through building capacities to use existing services and to redistribute household budgets in favour of the vulnerable. It offers no projections for employment or weges over time.[52]

NGOs are also effectively working on health. Department of Family Welfare in the Ninth Five Year Plan introduced the Mother NGOs scheme under the Reproductive and Child Health Progrsmme. The Department of Family Wefare identified the senctioned grant to selected NGOs, called Mother NGOs under this scheme. Fund has been transferred through these Mother NGOs to other smaller NGOs. The NGO Selection Committee recommends the proposal to the Grants-in-Aids Committee for approval of Mother NGO. Decision of GIAC is informed to State Reproductive Child Health (RCH) Society. Selected Mother NGOs go through induction training within 4-6 weeks of selection by the RRCs. [53] The focus of the orientation is on the relevant aspects including management (technical and financial) of the Mother NGO scheme. [54]

With respect to grants-in-aid to NGOs under National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare, the Comptroller and Audtior General noted that "System of grants-in-aid to NGOs was not established at various levels and State Health Societies released the funds to NGOs without signing Memorandum of Understanding and formulating detailed guidelines for the participatory role of the NGOs towards their functioning, cooperation, monitoring and supervision under the framework of the NRHM. In the absence of any defined accountability structure and monitoring mechanism, activities of NGOs remained unchecked, their funds utilization not fully verified and their contribution towards capacity building and delivery of health services to marginalized sections in underserved and un-served areas could not be realized in full."[55]

The NGO Code of Conduct for Health Systems Strengthening is a measure to regulate growing number of international non-governmental organizations (NGOs) and

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[52] Ibid, p. 351

[53] Guidelines for Department of Family Welfare Supported NGO Schemes , Department of Family Welfare,
Ministry of Health and Family Welfare, http://mohfw.nic.in

[54] India's Funds to NGOs Squandered, *Asian Center for Human Rights*, New Delhi, January 2013, pp. 51-53 www.achrweb.org

[55] Ibid

their increasing flow of financial aids to the health sector. This Code is an important instrument to organize services of NGOs and eventually, financer and host governments. The Code serves as a guide to encourage NGOs practices which contribute in building public health systems and discourage those which are harmful. The document was drafted by a group of activist and service delivery organizations including Action Aid International USA, African Medical and Research Foundation (AMREF), Health Alliance International, Health GAP, Partners in Health and Physicians for Human Rights. The content was further refined in a series of consultations held in the United States and Africa.[56]

The purpose of this Code of Conduct for Health Systems Strengthening is to offer guidance on how international non-governmental organizations (NGOs) can work in host countries in a way that respects and supports the primacy of the government's responsibility for organizing health system delivery. The last decade has ushered in tremendous growth in political will, funding support and organizational structures to improve international health. While gains have been achieved in some areas such as the HIV epidemic, ground has been lost in basic primary care and maternal child health. It is now becoming clearer that NGOs, if not careful and vigilant, can undermine the public sector and even the health system as a whole, by diverting health workers, managers and leaders into privatized operations that create parallel structures to government and that tend to worsen the isolation of communities from formal health systems. These health systems strengthening code is intended specifically to address international NGOs and their roles in training, securing and deploying human resources in the countries where they work. There are six areas where NGOs can do better: 1) hiring policies; 2) compensation schemes; 3) training and support; 4) minimizing the management burden on governments due to multiple NGO projects in their countries; 5) helping governments connect communities to the formal health systems; and 6) providing better support to government systems through policy advocacy.[57]

This code offers sustainable practices in each of these areas of concern. Signatories to this Code of Conduct recognize the role of voluntary ethical codes and country-based codes of conduct that have come before us. Those codes, such as the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in

[56] NGO Code of Conduct for Health Systems Strengthening, May 2008, http://www.oneworldtrust.org/csoproject/images/documents/INTL17
[57] Ibid

Disaster Relief (1992), the Code of Good Practice for NGOs Responding to HIV/AIDS (2004), and the Paris Declaration on Aid Effectiveness (2005) offer practical ethical standards for NGOs and donors engaged in development work. These standards aim to improve the quality and impact of their work. The original drafters of this code are representatives of international NGOs with implementation and advocacy experience in a variety of developing countries; we ourselves have made many of the mistakes that we address. We hope that our Code of Conduct standards will prove useful for NGOs, governments, local institutions and donors by establishing principles to strengthen health systems. Our commitment helps ensure that "health for all" is not a thousand-year project, but well within our reach. The code is intended to be clear, direct, succinct and action-oriented.[58]

[58] Ibid

Conclusions

The establishment of colonial rule created avenues of modern reform in public health services. The health and hygiene however did not initially was the priority of governance but still the colonial regime introduced new concept of health and hygiene based on modern sciences and technologies. The major concern of colonial government was initially for the soldiers of British East Company. Public health was not the responsibility of colonial state for a long period of time. Initially they concentrated on prevention and sanitization but later they introduced modern system of health services based on western medicine. Consequently a number of hospitals and dispensaries came into existence.

When British Government was taking initiative to modernize Indian health system, at that time Indians followed indigenous and traditional method of the health and medicine. *Hakims* and *vedhyas* were to treat people. Their treatment was completely based on herbs and plants which called Unani (Islamic/Graeco-Arabic) and Ayueveda (Hindu) medical system and traditional source of treatment. Western medicine was often the preferred option, but in other cases, especially medication for common diseases, it generally was not. Nor did all Indians have easy access to Western medicine. Rural areas continued to be poorly served by dispensaries and Western-trained practitioners' right through to Independence in 1947. Women were also much less exposed to Western medicine than men, because the latter often forbade them from attending dispensaries and hospitals. Consequently, while the numbers attending such institutions increased under colonial rule, the proportion of women remained consistently low for most of the colonial period. Efforts designed to penetrate the veil of the *zenana*, such as the Countess of Dufferin's Fund to supply medical women for India, were generally limited in scope and tended to concentrate on women of high caste.

During nineteenth century the growing consciousness of women's issues and efforts of Indian reformers ensured preliminary maternity and child health services for women. The Indian reformers were though struggling hard to attain better health facility, still the women's health was neither seen as a matter of individual right for women nor as a means to mitigate the gender inequality during the colonial rule. Moreover the contemporary health facilities suffered from severe handicap of the shortage of medical and nursing staff.

A proper Public Health Ministry came to function only after 1920 with the passage of the Local Self-Government Act. The responsibility to tackle the epidemics and funding of rural health was now put on the shoulder of the District Boards and Union Boards. But they failed to cope with the situation because of scanty reasons and scarcity of health personal. The district dispensaries set up in rural areas were ill-equipped to tackle the health problems. Many municipalities and local boards were unable to raise sufficient revenue for vital sanitary reforms. More government aid and better supervision on the local bodies were necessary. A more concerted effort by government to assist the local bodies would undoubtedly have done much to improve the situation. Although mortality due to epidemic disease was reduced in the 20th century by the remedial measures, there was no remarkable progress in their prevention and eradication programme. What was followed with regard to anti-epidemic policy and public health developments were small scale measures. In comparison of public health in western countries, India was far behind in public health services.

By the second half of the nineteenth century there was shift in policy leading to the development of institutional set up of health services. Consequently number of hospitals and dispensaries started increasing. The exclusive hospitals for women and children also came into being through private and government initiatives. To provide these hospitals with women doctors and nursing staff medical colleges for the women were established and their number increased.

These health facilities did not adequately served the purpose of Indian population nevertheless played an important role in the development of public health services in India after independence. The expansion of medical services required legislations to control and regulate the different category of medical staffs for which laws were enacted.

The United Nations declaration of Human Rights (UNDHR) is an important document that considerably influenced the first extensive effort to reform health services in India. The Bhore Committee Report (1946) was first extensive initiative of reform of health services based on the guidelines of UNHDR. The constitution of India though incorporated health under Directive Principles but later in the light of guidelines and covenants of international organisations, and, Articlr 20 of Fundamental Rights, Indian Judiciary has recognized right to health as fundamental right. In the same manner the Indian government has also ratified the

recommendations of several international declarations on women's health, most importantly Beijing Declaration and Cairo Submit, and therefore is also committed to ensure equal right to physical and mental health for women.

In India the different factors are responsible for poor health of women. The poverty is one of the most important factors for poor health of Indian population in general and women in particular. The caste and class too reinforces patriarchy which plays a crucial role in the distribution of resources, therefore are one of the important impediment in creating disparity in the society. The gender inequality is another important reason responsible for poor health and hygiene of women. The Indian government has taken both the legislative as well as health planning measures to ensure better health facilities for women.

The two important documents which later influenced the Five Year Planning and other planning on health are (1) the recommendations of the National Health and Development Committee 1946 and (2) the report of the National Planning Committee, 1948. Both the committees expressed their concern and worries about the high rate of mortality as well as morbidity prevailing among mothers and children of our country. The scenario of maternal mortality was miserable. Maternal Mortality Rate (MMR) in certain provinces was as high as 12.9/1000 live birth and fifty percent of the maternal deaths were due to puerperal sepsis and anaemia. The Working Group on Population Policy of 1980 considered 'women as the best votaries of family welfare programme" and replaced the view of 'motherhood' by 'womanhood'.

After 1980s the scenario of health services marks a clear departure from the prescription of Bhore committee report. The National Health Service that the Bhore Committee had predicted, which would be available to one and all irrespective of their ability to pay got subjected to the market forces in this sector. The enclave pattern of development of the health sector continued even at present–the miserable, the villagers, women and other underprivileged sections of society, in other language, the majority still does not receive access to affordable basic health care of any reliable quality.

From beginning of the first two Five Year Plans the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources, whereas rural areas received "special attention" under the Community Development Program (CDP). The CDP was failing even before the Second Five Year Plan began. The

government's own evaluation reports confessed this failure. In the remainder of second five year plan and in the commencement of the third five year program, there were nearly 4500 maternity and child welfare centre, each servicing a population varying to 10,000 to 25,000. One third of these centres were situated in the urban regions. In the Third plan, it was proposed to link the maternity and child health services of the primary health units with extended facilities in referral and district hospitals. The emphasis shifted to rural employment programs like National Rural Employment Program (NRHP), Jawahar Rozgar Yojana and Employment Assurance Scheme. Women's empowerment emerged as a major issue of development in the nineties and schemes like Development of Women and children in rural areas, micro-credit programs etc. were suggested and all such schemes were later integrated into the Swaranjayanti Gram Swarozgar Yojana.

The Sixth Plan (1980-85) was to a great extent influenced by the Alma Ata Declaration of Health for All by 2000 AD (WHO, 1978) and the ICSSR - ICMR report (1980). Accordingly, priority was given to the implementation of programs for women under different sectors of agriculture and its allied activities of dairying, poultry, small animal husbandry, handlooms, handicrafts, small-scale industries, etc. Women Employment Program was introduced in 1982 with assistance from the Norwegian Development Agency (NORDA). For the child health the Sixth Five Year Plan reiterated the approach and strategy outlined in the Fifth Plan, and promoted consolidation and expansion of the programs started earlier.

In the Seventh Five Year Plan the Planning Commission constituted Steering Groups for different sectors. Two new schemes of Support to Training and Employment (STEP) and Awareness Generation Program for Rural and Poor Women (AGP) were introduced.

The Eighth Plan (1990-95) adopted the strategy to ensure that benefits of development from different sectors do not bypass women and special programs were implemented to complement the general development programs.

The Ninth Plan (1997-2002) established two important alterations in the conceptual scheme for planning for women. First, 'Empowerment of Women' became one of the nine primary objectives of the Ninth Plan. The overture of the Plan was to create an enabling environment where women can freely practice their rights both inside and outside the household. Secondly, the Ninth Plan attempted convergence of

existing services, resources, infrastructure and manpower available in both women-specific and women-related sectors.

In the Tenth Five Year Plan (2002-07), Planning Commission constituted three Working Groups under the Chairpersonship of Secretary of the Department, namely, (a) Working Group on Empowerment of Women, (b) Working Group on Child Development and (c) Working Group on Improving Nutritional Status of Population with Special Focus on Vulnerable Groups.

The WHO has estimated that India, at present, is spending 4.5 per cent of gross domestic product (GDP) on health, of which 0.9 per cent is public expenditure. India ranks thirteenth from the bottom in terms of public spending on health. The Central Statistical Organization (CSO) reported that final government expenditure on health (which does not include expenditure on family welfare) for 1998-99 is Rs. 10,588 crore, accounting for 0.6 per cent of GDP. For the same year the plan and non-plan expenditure of 26 States and the Central Ministry of Health and Family Welfare alone comes to Rs. 16,771 crore or 0.95 per cent of the GDP.

The following table records the financial assistance given to family welfare. through different five year plans.

Table: 9 Pattern of Investment on Health and Family Welfare (Rs. Crores)[1]

Period	Total Plan Investment	Health	%	Family Welfare	%
First Plan (Actuals) (1951-56)	1,960.00	65.20	3.33	0.10	0.10
Second Plan (Actuals) (1956-61)	4,672.00	140.80	3.01	5.00	0.11
Third Plan (Actuals) (1961-66)	8,576.50	225.90	2.63	24.90	0.29
Annual Plan (Actuals) (1966-69)	6,625.40	140.20	2.12	70.40	1.06
Fourth Plan (Actuals) (1969-74)	15,778.80	335.50	2.13	278.00	1.76
Fifth Plan (Actuals) (1974-79)	39,426.20	760.80	1.93	491.80	1.25

[1] Duggal Ravi, 'Evolution of Health Policy in India' 18th April 2001, www.cehat.org , see Source: Indian Planning Experience – A Statistical profile, Planning Commission, Government of India, New Delhi, 1998

Annual Plan (Actuals) (1979-80)	11,650.00	268.20	2.30	116.20	1.00
Sixth Plan (Actuals) (1980-85)	1,09,291.70	2025.20	1.85	1387.00	1.27
Seventh Plan (Actuals) (1985-90)	2,18,792.60	3,688.60	1.69	3,120.80	1.43
Annual Plan (Actuals) (1990-91, 91-92)	1,23,120.50	1,965.60	1.60	1,805.50	1.47
Eighth Plan (Actuals) (1992-97)	4,85,457.20	8,137.60	1.68	5,972.80	1.23
Ninth Plan (outlay) (1997-2002)	8,59,200.00	*19,374.11	2.25	15,120.20	1.76
Tenth Plan (outlay) 2002-2007	18903968.25	2176734.30	3.68	725048.73	1.23
Eleventh Plan (outlay) 2007-2012		136147.00	-	13043.01	-

*Note i) *: includes outlay of Rs. 266.35 crores for the department of ISM&H.*

Women's health has remained an important issue of discussion at National and International level, and time to time various schemes and programmes are recommended. The Indian government also formulated different programmes and schemes to ensure better health facilities for women.

1. The National Rural Health Mission (NRHM) was launched on 12th April 2005, throughout the country, with an objective to reduce the Maternal Mortality Rate, the Infant Mortality Rate and the Total Fertility Rate.
2. The Janani Suraksha Yojana (JSY) an ambitious scheme launched for safe motherhood intervention under the National Rural Health Mission (NRHM) implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.
3. Janani- Shishu Suraksha Karyakarm (JSSK) aimed to provide free and cashless health care services to pregnant women including normal deliveries, caesarean operations and sick new born (up to 30 days after birth) in Government health institutions, in both rural and urban areas, was approved in May 2011.
4. The state of Madhya Pradesh launched a scheme called Janani Express Scheme in which private transport operators made vehicles available on a 24x7 basis.
5. Integrated Child Development Services (ICDS) Scheme, which was launched in1975.

6. The National Maternity Benefit Scheme (`NMBS) introduced in 2001.

These schemes and other subsidiary schemes by the state governments have proved beneficial for the women's health. But still a lot more is to be done to improve the delivery of these schemes.

The globalization has affected the world in different manner. At the one hand it has opened the barriers of the countries of the world for free flow of men and material while on the other hand it has also created enormous opportunity for the exploitation of weaker section by the dominant class. The forces of market operating have creating inequality in the society which has ushered a new era of exploitation. In the same manner the globalization has affected the health of women.

One of the important effects of the globalization on women's health is the de-regulated experimentation of drugs on women. The free movement of drugs and medical technology as an effect of globalized economies under poorly regulated environments has resulted in its illegal application and experimentation on women. For instance, the liberalization of drug imports made it possible for Quinacrine an anti-malarial drug that has been developed as an alternate for chemical sterilization for women to be imported and tested by private doctors in India even though it had not passed the required toxicology tests and was the subject of significant controversy worldwide.

The opening of the world economy has also led to the influx of foreign capital in India. This is an important factor influencing the public and private partnership in the health sector. Moreover the influx of foreign Non-governmental Organizations is also important for achieving the target of health for all through proper legal framework to regulate them.

The growth of technology is also another global phenomenon which has influenced the prospect of women's health in both ways. The technology has definitely made life easy but has also exposed women's body for different experiments. The birth control technology, stem cell research and other researches related with infertility and to provide alternate has adversely affected body of women, their control over their body, and their social position.