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Social Medicine: Its Implications for Women's Health in India

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In this paper an attempt has been made to study the implications of social medicine for women's health in India. The paper focuses on how social conditions play an important role in determining health conditions of women in India. It also highlights the consequences of a market oriented health care system for women's health in general and its possible implications for women's health in India.

[**Keywords**: women's health, social medicine, National Policy on Empowerment of Women, Elimination of discrimination against women, The Alma Ata Declaration, commodification of health]

Introduction

Many dimensions of women's health in India are intricately woven into the social web of their existence. It is not only in reproductive health that society makes its presence evident, it, along with the political economic processes prevalent, pervades all areas of women's health. Hence the importance of social medicine in issues of women's health has to be taken up in right earnest as health reflects the gendered nature of our social existence.

The term social medicine was introduced by Jules Guerin a French physician (Porter and Porter 1988); the concept was reviewed by Alfred Grotjahn of Berlin who stressed upon the importance of social factors as determinants of health and disease. Prof. Crew defined social medicine as standing on the pillars of medicine and sociology. The laboratory to practice social medicine is the whole community; social therapy does not consist in administration of drugs but social and political action for the betterment of living conditions.

This more of less conforms to the political economy perspective in studying health related phenomena the foundations of which had been laid by Engels as early as 1845 in 'The Conditions of the working class in England'. Engels analyzed the etiology and distribution of typhoid, tuberculosis and ricket in the population and concluded that since they had a direct association with the relations of production under capitalism; medical intervention alone was insufficient for the eradication of diseases. This was the background of the enactment of The Public Health Act of 1848 in England when a new thinking began to take shape that the state has direct responsibility for the health of the people. The fact that the macro policies governing the state would reflect its ideology became clear, hence health, which constitutes a very important dimension of a community's life was widely accepted as a reflection of the same ideology. The understanding that health is centered in the political economy of a state presupposed that there is little to be gained by attempting to understand health and health care by reference to the activities of individuals or to the institution of medicine alone, they must be placed within a broader socio-economic and political framework. Social medicine accepts the proposition that diseases have social causes, social consequences and social therapy. Nineteenth century health and social reformers had been concerned with developing the political role of medicine in creating egalitarian societies. This concern continued to be a primary goal of twentieth century medical academics like Rene Sand (Sand 1952) who wanted to integrate medicine's social role into the training of physicians through the creation of a new discipline of social medicine inspired by the experiments in sociological medicine and social hygiene in revolutionary Soviet Russia. In the 1920s it was believed that the creation of a socio-political role could be achieved by turning it into a social science. The goals of social medicine as an academic discipline developed in the inter-war years and were mostly linked to the political programmes of

social reform and were concerned with establishment of socialized medicine and eradication of health and socio-economic inequalities.

The content of social medicine was therefore manifestly related to the political programmes undertaken by nation states at a particular point of time. The discipline of social medicine acquires great significance in the current era of technology based health care. At a time when health has become one of the biggest industries in a globalized world with the market invading every nook and corner of health care, current state of political economy suggests that health care is increasingly being directed at the increasing sources of earning profit rather than the all around physical and mental development of citizens of a state.

In this paper an attempt has been made to study the implications of social medicine for women's health in India. This paper will focus on how social conditions play a very important role in determining health conditions of women in India, it will also try to focus upon the consequences of a market oriented health care system for women's health in general and its possible implications for women's health in India.

Social Medicine and Women's Health in India

The subject matter of social medicine emphasizes upon the fact that medicines and biotechnological interventions are not sufficient to take care of health of a community. As this paper deals specifically with women's health the same will be dealt with in the relevant context.

In an article reviewing the reports on convention for the Elimination of Discrimination against Women (CEDAW) Verma, (Verma 2007) points out that the Indian ruling class has been criminally negligent in its implementation of programmes for empowering women. The Five Year Plans, the National Policy on Empowerment of Women, the Plan of Action on Women's Empowerment, Declaratory statements on CEDAW have failed to bring out meaningful action on the part of the government to empower women. The efforts of the government gives an illusion of earnestness on its part to address women's issues while it actually ensures that patriarchy is not undermined and continues to flourish.

The question of women's health thus suffers under the twin burden of state apathy and social norms, values, attitudes and practices which all support patriarchy and negligence of issues pertaining to women's health. It is true that women belong to different socio-economic categories and they are not equally placed as far as their health care in concerned. This paper will focus upon those belonging to lower socio-economic categories but it will also try to show how modern health care often cuts across class categories in causing harm to the health of women.

Women's health conditions are intricately related to the perceptions prevailing in society regarding the worth of a section of society which remains behind men in all avenues of life. The process of socialization which women undergo, their own views about society and self worth, the norms of behavior and values which sustain society all contribute to the health status of women.

Perceptions regarding health means how society views the health conditions of its constituent sections, the attitude one nurtures, how man view the health requirements of women or even their right to be born. Women themselves often become the torchbearers of patriarchy which makes them to easily accept their inferior status. Perceptions regarding health also include the question of what women themselves consider to be of greater value their own health or the health of other members of their families, how policy framers and implementing agencies show their judgment in implementation and formulation of health policies. Transformation of the body through gendered social practices informs the study of social medicine through gendered lens. As stated by Lorber and Moore: 'In societies where women's status is low their life expectancy is reduced by a combination of social factors- eating last and eating less, complications of frequent childbearing and sexually transmitted diseases because they have no power to demand abstinence or condom use, infections and demorrhages following child birth, neglect of symptoms of illness until severe and restricted access to modern health care'(Lorber and Moore 2002: 5). All these are true in the Indian situation.

The Alma Ata Declaration with its slogan of '*health for all*', had begun as a movement, and the first health policy of India reflected the spirit of the declaration, but like all governmental programmes for the common people we no longer hear about it anymore. On the other hand, the new health policy has given a lot of scope for the entry of the private sector in health, the inaccessibility of private health care to the poor is widely

accepted and one can only surmise how far health issues of women will be looked after in this currently prevailing health scenario.

Socialization of the Girl Child

The process of socialization transforms a biological being into a social being, different agencies of socialization like family, school, neighbourhood, religious institutions all operate as part and parcel of a wider society which has different ways of viewing life situations of men and women. Even entry to schools is regulated by the value which society gives to education of the girl child, thus the girl child is imbibed with values which teaches her to place her own requirement behind that of others. In a study of the rural areas of Gwalior district of Madhya Pradesh Tekhre and Menon (Tekhre and Menon1998) observes that socialization is linked intricately with socio-cultural values and a girl child is socialized in a way which makes her to obey the socio-cultural values in the family and follow patterned norms of behavior. They are expected to retain a low profile and not disturb the peaceful atmosphere within the family, any way of behaving which does not follow established and desired norms are likely to threaten the equilibrium of the family. Even if a girl child is given some liberty at childhood she is expected to follow patterned behavior as she grows up which often leads to psychological impairment as it becomes difficult for her to behave like an ideal woman after having been allowed to have the same expectations as her brother or being allowed to believe in little difference between a boy and a girl child.

The girl child looks upon her mother as a mirror glass self and imbibes her patterns of behavior. In the case of women belonging to the lower socio-economic sections of society the girl therefore grows up keeping her own requirements to herself, not talking about her physical ailments till it becomes unbearable, taking the full responsibility of planning a family upon herself, giving importance to the health and nutritional requirements of the males of the family and in the process reproducing her low position within the family and society. Women's health and nutritional status thus is inextricably linked with social, cultural and economic factors that influence all aspects of their lives and it has consequences not only for the women themselves but for their children too, and for the functioning of households and the distribution of resources.

The socio-economic environment, cultural, religious and political dimensions of life which affect women's life leads to their getting marginalized. Increasing cost of medical care has emerged as the second cause of rural indebtedness where around 80 percent of women are anemic and denied adequate food, spiraling cost of food as well as of medicines will further marginalize women's medical care. Needless to add most of the debts incurred in rural India for health care are for the male members of the family (Biswas2000).

Thus the relevance of social medicine for women's health starts from the time of their birth, the process of socialization mainly for the poor sections needs to be reconstituted and recognized in a manner which makes women to be better placed within the family itself. The taken for granted approach to the issues of concern to women must be adequately addressed. It should also be recognized that this is actually possible only with far reaching changes in the processes working in the wider society.

Areas of Concern Regarding Social Dimensions of Women's Health

The all round commodification of health has placed women's health issues in serious predicament. Issues ranging from antenatal care to surrogate motherhood have put the question of maternity under scanner, when motherhood has got disembodied from the ties of the umbilical cord and carrying an embryo in one's womb for nine months does not make one a natural mother one wonders what havoc the market is creating in the lives of women.

The market with the help of patriarchal values has started moulding all the dimensions which are considered of importance to the health of women. Women belonging to the lower socio-economic sections of society continue to be neglected as children married before the age of eighteen, poor and illiterate, underfed and overworked. Often pregnancies and hard work coincide during a major part of their lives. They are often subjected to harmful traditional practices and denied access to adequate contraceptive practices and maternal health. Studies have shown large members of female infanticides resulting in the lowering of the sex ratio

even in the states which are considered to be better off indicating that economic growth does not necessarily bring better life chances for women (Vijaylakshmi and Ponnuraj 1998).

Women are found to be more anemic than men, and a woman can become more anemic when pregnancy depletes already low reserves of vital nutrients. The NFHH – 3 remarks that anemia affects 55 percent of women and 24 percent of men. The prevalence of anemia for ever-married woman has increased from 52 percent in NFHS – 2 to 56 percent in NFHS – 3. The survey also found women's food consumption to be less balanced than that of men, 55 percent of women compared with 67 percent of men consume milk or curd weekly. 40 percent of women compared with 47 percent of men consume fruits weekly, 32 percent of women compared with 41 percent of men consume eggs weekly and 35 percent of women compared with 41 percent of men consume fish or chicken/meat weekly. Gender differentials in the daily consumption of most of these foods were found to be more among the married. Severe anemia accounts for 20 percent of maternal deaths.

Early child bearing is another matter which impairs the health of women. NFHS -3 reveals that more than half of women are married before the legal minimum age of18. Early child bearing becomes a corollary of early marriage, when the young girl is not physically prepared to become a mother. Risk of medical complications is much higher for young mothers. Adolescent child bearing impairs the future of young girls because their educational and employment opportunities get restricted. Obstetric complications are particularly high in early pregnancy; congenital abnormalities are also more frequent (NFHS 2007). An analysis of data on height and weight of adolescent girls in Kerala revealed that 49-67 percent would have been at risk during pregnancy in the age group of 15-19 years (Vijaylakshmi and Ponnuraj 1998). Abortion is also common in the younger age group due to the practice of entering into unprotected sexual relations among unmarried girls. Often abortions are done by untrained personnel in order to maintain secrecy or to avoid the costs charged by trained practitioners putting the life of the mother under great threat. It is surmised that at least 19 percent of maternal deaths in India are the result of abortion related complications (Vijaylakshmi and Ponnuraj 1998). Abortions and feticide are increasing despite the legal provisions against tests to determine sex of an infant. Smaller families which stick to one or two child norms are likely to go for abortions and feticides to regulate the composition of the family where the birth of at least one son is the desired norm. Thus repeated abortions of married women too would lead to health complications in later phases of life.

Next, in trying to understand the importance of the confluence of sociology and medicine in the context of women's health we will take up the issue of fertility and use of contraceptives. Fertility has gone down to 2.7; however there are variations in relation to state, education, caste and place of residence. Numerous pregnancies, frequent abortions and malnutrition impair the health conditions of women. Use of contraceptive has gone up but their use is the responsibility of women, everything associated with the birth of a child and the responsibilities involved are considered to be that of women. NFHS – 3 undertaken in 2005 -2006 reports that over 100,000 Indian women die every year due to pregnancy related problems and there are 400 maternal deaths per 100,000 births. Absence of proper health care is one reason associated with social factor, absence of pre-natal and post-natal care due to the understanding that child birth is a routine affair and care of the mother is not of primary importance leads to this state of affairs. A study in four villages of North Bengal (Biswas 2000) shows how women take upon themselves the whole burden of family planning, most of the women favoured tubectomy as they felt that husbands would face health risk if they undertook vasectomy. Husbands being bread earners require to maintain good health more than women as their lives are of lesser worth, they were also of the opinion that their husbands too would not agree to undergo vasectomy.

The measures for family planning do not attempt to cover all the dimensions of women's health and are simply technological devices to curb births. Family Planning looks upon women as an object playing an important role in reproduction and its aim is to reduce the reproductive potential of women without realizing that the birth giving function of women is interlinked with her overall position in society and unless she is in control of her reproductive functions birth control measures are not likely to be successful.

Family Planning measures and the way they have been implemented shows that they have not become a part of health care system of women; it shows an extreme bias against women in the total policy implementation in the sphere of family welfare and planning. This becomes all the more important because the issue of women's health is inextricably connected with reproduction.

The way in which Family Planning measures and child care services were being carried out during the above mentioned study raises a question about the real intention of the government and its sense of responsibility towards the poor and illiterate women of our country. There is no planning or coordination of the programmes, it is not realized at all that health is related to overall socio-economic condition of villagers, which provides the essence of health status. The World Health Organization's definition of health as not only absence of physical illness, but also a state of overall well being has already faded into oblivion. The meager allotments made for health adds to the malfunctioning of the health care system and makes its utilization more or less a farce in whose hands the poor and specially women suffer. The earlier Child Survival and Safe Motherhood Programme has been replaced by the Essential Reproductive and Child Health Schemes Package (RCH) which has come up during the Structural Adjustment Programme (SAP)(Sagar 2001).

The RCH Package consists of family Planning, safe abortion, safe motherhood, prevention and management of reproductive tract and sexually transmitted infection, child survival, health, sexuality and gender information, education and counseling and referral services for all of the above. The government claims that this Package would improve women's health, but the cut backs in social sector expenditure and increasing entry of private investment in health make the availability of the above package to the poor women of our country highly doubtful. The increasing use of technology in health and negligence of institutional factors in health care would make the availability of reproductive health to poor women increasingly difficult. In a study of the relevance of RCH Package for the health of poor women of a slum (Sagar 2001) shows the gaps between perceptions of doctors and women regarding health needs of the latter. While doctors perceive health problems related to reproduction as pathological manifestations women relate their health problems with their social existence and life chances they have. The expectations from women in a poor family forces her to play roles and perform duties even when they have a telling effect upon her health and make her to place her own health in the lowest position in her list of priorities. She writes that one woman stated (Sagar 2001:511): 'if I die he (my husband) will bring a new wife who will hopefully take care of my children, but if he dies our lives are ruined for who will take care of us?'

Sagar goes on to state (Sagar 2001: 511) 'many women stated that it was pointless for them to waste their time talking and worrying about circumstances that needed to be changed but which they had no power to charge. Most of them had learned by bitter experience that there was precious little they could do about it'. The women concluded that it was best that one should not be born if she was a girl.

The technocratic approach to health neglects the fact that health is closely related to all other dimensions of life and also to the nature of provisions which the state offers to its citizens. In a situation where the poor sections are facing crises in all areas of their everyday lives, health will not be left out, women's health is doubly cursed as besides being affected by poverty it is informed by prevailing traditions, values and attitudes which are all detrimental to women's health.

Domestic Violence

Women are subjected to different types of violence including rape, forced prostitution, domestic violence or are even punished for witchcraft. Of all these, domestic violence could be said to have the most serious impact as it is inflicted by someone with whom the victim has intimate relationship. We are all familiar with the song that says 'there is no place like home'; it is a place where members of a family are supposed to feel most secure. One imagines a home to be a place where one can retire after a hard day's work or where one can live in the midst of one's own people who will take care of one another through the working of different relationships as parents, spouses, children or siblings. However often the home becomes a social space where violence is inflicted upon the physically weaker members by those considered stronger.

The health consequences of domestic violence could be very grave and could be placed under the purview of the discipline of social medicine. What is of greater concern is that women often accept the legitimacy of some types of domestic violence like wife beating from the premise that husbands are senior and superior and hence have the right to punish an errant wife.

Violence within the family includes wife beating and battering, dowry deaths, sexual abuse of female children, female feticides and infanticide violence from alcoholism, impact of patriarchal values and domination and control within family leaving aside female feticides and infanticide the NFHS – 3 reveals

that more than a third (34 percent) of women in India aged between 15-49 have experienced physical violence and 9 percent have experienced sexual violence.

The NFHS-3 reveals that women whose husbands drink have significantly higher levels of violence. Emotional violence is three times as high, physical violence is more than two times as high and sexual violence is four times as high for women whose husbands drink frequently.

Of all the ever married women who reported ever experiencing physical or sexual violence 36 percent report cuts, bruises or aches, 9 percent report eye injuries sprains and dislocations or burns. 7 percent report deep wounds, broken faces, broken teeth or any serious injury, 2 percent report severe burns. Notably 38 percent of women experiencing physical or sexual violence report having experienced at least one of those groups of injuries. At least one in seven ever married women between ages 15 – 45 in India have suffered injury resulting from acts of spousal violence. One could add the violence inflicted upon women from other members of the husbands family due to non-payment of dowry or to a negligible error in undertaking household chores. Another very significant revelation of the NFHS-3 is that only one in four women has ever sought help to end the violence they have experienced. Two out of three women who have ever experienced domestic violence have not only never sought help but have also never told anyone about the violence, this shows that the relationships within the family do not arouse confidence in the victims which is absolutely necessary for her to share her experiences.

A large majority of women who have experienced only sexual violence have never told anyone about the violence which is as high as 85 percent. The striking fact about help seeking behaviours among women who have ever experienced violence is the lack of differentials by most background including education and wealth. The institution of family which is accepted as an important foundation of society comes out in clear relief as an institution in which many women in addition to having a low status have to live a life of extreme insecurity in which not only their physical well being but also existence may be at stake. The responsibility of the state is not witnessed in these areas of women's life as the question of empowerment of women remains a mere rhetoric without any serious meaningful steps taken in this regard. In a society in which markets are playing an increasingly important role with ever increasing consumerism it is highly doubtful as to whether domestic violence will decline in the near future despite the existence of laws which remains outside the reach of countless Indian women.

Health Issues related to Work and Problem of the Aged Women

It is established that women perform nearly two thirds of the world work, a study on the total well being of Indian women (Vijayalakshmi and Ponnuraj 1998) shows that despite bearing this workload they receive one tenth of the world's income. In India 14 – 16 hours, or nearly two thirds of a women's day is spent in working. In the era of globalization women are increasingly being absorbed in the unorganized sector and there is increasing feminization of labour, as a consequence women are becoming important earners in the family. However work conditions remains poor, unhealthy workplace, long hours of work inadequate maternity benefits and the compulsory domestic chores tell heavily on women's health. It is said that the feminization of labour is a case of wolf in sheep's clothing as women remain poorly paid and are forced to work in inimical conditions face an uncertain future and are deprived of all the benefits of the formal sector.

Another area of concern is the extremely insecure nature of work in the informal sector; women employed with little or no training on the job are quickly dispensed with when they become pregnant or marry. Work which is home based involves low pay socio-economic invisibility and long hours of labour. Women who are poor and malnourished work up to the advanced periods of their pregnancy and this endanger their own health as well as the health of the baby to be born.

There are other dimensions too which affect health of women in the context of the work they have to perform. New working conditions which include sub contraction, price rating, flexible work rescheduling and part timing has marginalized them and they are not recognized as regular workers.

The problems of the aged are emerging as an important area of concern in Indian society. Breaking down of age old values which respected the aged has lowered the status of the aged in society, small family norms, the struggle for survival, changing values and absence of proper institutional care for the aged is placing the aged in a precarious position in Indian society. Economic and health conditions of the aged deteriorate as they grow older and in a market society where everything has to be bought their life chances are greatly

affected, despite living a longer life their quality of life remains poor and often are considered as burdens of their families. Here too women are in a relatively weaker position than men, this is due to various reasons one of which is that the longevity of females is more than that of males and hence they have to deal with the deprivations of old age to a higher extent as compared to men. Their lifelong practice of keeping their health problems to themselves continues to their old age and the general neglect which most of them face adds to their physical sufferings.

Commodification of Health

With the increasing use of technology in health care all avenues of health are getting commodified, every nook and corner of health is increasingly being sought to be dealt with technological means which have the capability to offer huge profits to private investors in health. Women's health has not been left out of this market driven, technology oriented health care system which is totally averse to the realization that health issues are situated within the realms of social existence.

Health care is being increasingly privatized since 1991, along with technology centric health care, user fees have been introduced in government health institutions and public expenditures in health is being consistently curtailed, rising prices of drugs and the private-public tie ups have provided scope for the private sector to increase their profits. This leads to a situation where the poor are left without any care and as women constitute a majority of the poor their health care is also affected.

As Gupta observes in her unpublished paper on globalization and women's health, by allowing globalization through deregulation, privatization and free trade under the guise of increasing cost effectiveness, governments are practicing a more insidious form of colonization which commodifies women and the poor into dispensable and cheap factors of production. Privatization of health care commodifies and targets women's reproductive health needs providing TNC's and MNC's a large opportunity for profit making at the expense of burdening women with increased costs. Poor and even middle class people without medical insurance are getting increasingly indebted in order to get medical care and in a social set up where women are considered as dispensable entities increasing debts for meeting their medical expenditure would not be to the same extent as that for men.

The nature of market intervention in women's health and the states approval for it in a poor country like India can be understood if we see how insensitive the state is to the issue of women's health even in America whose model of development is followed by us through the dictates of the World Bank and other agencies of globalization. Six billion women were taking Hormone Replacement Therapy (HRT) on July 9, 2002 when the National Institutes of Health announced that HRT, estragon/progestin portion of the largest hormone study done on healthy women was being stopped(Worcester 2004). Investigators of the Women's Health Initiative (WHI) showed that women taking HRT had 26 percent increase in breast cancer, 41 percent anemia in strokes and 200 percent increase in the rate of blood clots in legs and lungs. HRT also increased the risk of women's heart disease. HRT symbolizes the greed of the pharmaceutical companies to earn huge profits from untested, unneeded drugs given to healthy women. If, in a conscious community like that of the Americans this can happen one can imagine the condition of poor women in India.

One may get consoled from the fact that HRT is far removed from the poor women of India and they need not panic, but the next case is not distant from them. The intrauterine contraceptive device is making a comeback now, this had become very popular in America in the 70s, and this product was being marketed aggressively by the manufacturer who falsified safety studies and pregnancy prevention rates (Holtz 2006). This device caused Pelvic Inflammatory Disease, infertility and was withdrawn from America after it caused further deaths. However the manufacturer dumped thousands of the devices on unsuspecting consumers around the world, and in a poor country like India the harmful consequences would go un-noticed. New products keep on coming to the market and the main criterion to measure their acceptability is not whether they are causing any harm or not but whether they are providing huge margins of profit to the manufacturer. Thus the issue of health becomes an issue with politico-economic connotations where the real issue of health care is no longer important, avenues of life are judged from the perspective of their marketability only.

Conclusion

From the above discussion we can observe that the question of health in general and that of women's health in particular are closely linked with the cultural, social, economic and political conditions prevailing at a particular period of time. Poor women bear the double burden of class and gender and if they belong to the tribal groups or low castes their burden gets trebled.

In 1848 the German physician Rudolf Virchow laid the foundation for the practice of social medicine and laid down three principles on which health care rested (1) the health of the people is a matter of direct social concern, (2) social and economic conditions have an important effect on health and disease, and these relations must be subjected to scientific investigation and (3) the measure taken to promote health and to combat disease must be social as well as medical. In the present study all of the areas of women's health are directly related to the principles outlined by Virchow. Whether women would be healthy or sick is determined to a large extent by the spatial and temporal dimension of their existence, the physical and social conditions in which they live, what and how much they eat, the work they do, the status they occupy, the way they are socialized the degree to which they can resist the discriminations they face and the nature of medical care they receive.

There is at present a great deal of importance attached to technological dimensions of health care, and very little importance to the social science dimension of health. This is evident from the marginal position of practitioners who have gained expertise in community health in the community of medical practitioners. Virchow had developed his principles when the teachings of Karl Marx were bringing in radical ideological changes which changed the way intellectuals viewed society bringing in a transformation in their ontological and epistemological dispositions. With the decline of socialism and spread of neo liberal globalization it is natural that such principles would continue to be ignored. However human agency needs to be reoriented to address the extreme inequalities in society which is necessary for evolving a pro-people and pro-women health care system. Inequalities caused by macro social forces which perpetuate poor health have to be looked into if any real improvement in women's health is to be brought about. Social scientists can play an important role by unveiling the experiences of suffering and health care and get true knowledge of health conditions of the poor through reflexive studies.

Human agency requires to be geared to bringing about change in social values and doing away with discriminations faced by women. Women should be made visible by incorporating gender perspective in policies and plans; they should not only be visible and heard at family, regional, national and international platforms. Initiatives to address issues of concern regarding women's health must be placed at the centre of development initiatives of the state.

The government should also take steps to raise expenditure in health and restrict privatization of health care; there is also a need to break the nexus between health providers and sellers of technological interventions in reproductive health care. It is unlikely that the march of technology driven health care will give much space to social medicine in the prevailing socio-economic and political conditions and empowerment of women along with human agency in the form of health movements seem to be the only way out to bring back social medicine to the place of prestige it deserves.

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