REPRODUCTIVE HEALTH SERVICES AND ROLE OF PANCHAYATS IN KARNATAKA

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Abstract

The paper presents an analysis of the reproductive health care services available to women in rural areas in Karnataka, and the various factors influencing them. Based on survey data on the status of Primary Health Centres (PHCs), and the availability of maternal health services, we analyze the status of reproductive health services, their access and reach. The paper also examines the role of Panchayati Raj Institutions (institutions of rural local government) in providing these services. Three sets of explanatory variables are used to examine maternal health care seeking viz. *institutional structure* (which includes coordination between the institutions of local government and the health department, the services available at different levels, the network, and availability of funds) *quality of services*; and *social factors*.

The findings indicate that the resources available for health care are meager, particularly to Reproductive and Child Health (RCH) in rural areas. The primary source of funding for RCH is largely central government grants. Inadequate devolution of funds, functions, and functionaries contributed to panchayats not taking any significant initiatives to improve maternal health care. A majority of women indicated that there are severe constraints in access to government maternal health services. Although the demand is high, the public health system is inadequate in providing maternal care. Women from low-income groups incur high expenses in accessing private facilities during pregnancy and childbirth. While preference for institutional childbirth was evident, the incidence of non-institutional childbirth is mainly because of the poor reach and high costs that are involved. The incidence of non-referral pregnancies is also high.

Keywords: **Reproductive health services, quality of healthcare, panchayats, PHCs, ANMs, maternal mortality and morbidity**

Maternal Health has been one of the major concerns in the Human Development Goals. This relies on the quality of services in the social development sector related to health services, infrastructure, and management. The constraints related to health services are at various levels - in the allocation of resources, planning, coordination between the implementing agencies and quality of services. In the context of reproductive health care the important question is about the reach, accessibility, and affordability of these services to the women living in rural areas. High incidence of maternal mortality and morbidity indicate considerable inadequacies in the quality and reach of reproductive health care. The maternal mortality rate at the national level is 453 and for Karnataka is 450

maternal deaths per 1,00,000 women[1]. It was estimated that 27.4 per cent of the disability-adjusted life years (DALYs) lost by women aged 15–44 years in Karnataka can be attributed to reproductive ill-health.[2] There is substantial empirical evidence from elsewhere and in India to suggest that maternal and perinatal mortality and morbidity are related to antenatal care.[3] The inadequate attention paid by the government both at the national and state level to reproductive health care continues to be a major development issue.

The 73rd Constitutional Amendment makes it mandatory that functions related to the provision of primary health care - maternal health and family welfare are the responsibility of the PRIs. Besides the various development sector departments come under the functional jurisdiction of the district panchayat. Creating a health system with the panchayats being made responsible for supervising and monitoring health services seems an ideal model. The RCH policy at the national level also emphasizes the role of panchayats. However the extent to which reproductive health care is enhanced by the panchayats depends on the funds and functions devolved to them for carrying out these responsibilities. Clarity in the separation of powers between the elected representatives and the bureaucracy at the local government are important in this context. While the development targets include reducing the incidence of maternal mortality and morbidity, the question still remains whether the institutional interventions and resources allocated are adequate to address these problems.

Keeping a balance between providing adequate maternal care as well as holding down government expenditure has been an important factor in health policy. The reproductive health policy supported childbirth at home under the

[1] The Progress of Indian States, UNICEF, New Delhi 1995

[2] Estimated by Global Burden of Disease study, quoted in Jagdish Bhatia and John Cleland, 2001. 'The contribution of reproductive ill-health to the overall burden of perceived illness among women in southern India', Bulletin of the World Health Organization, 79 (11).

[3] See Fauveau V., Stewart K., Khan S.A. & Chakraborty J. (1991) Effect on mortality of community-based maternity-care programme in rural Bangladesh. *Lancet* 338:1183–1186; Jagdish C. Bhatia and John Cleland. 1995 'Self-reported Symptoms of Gynaecological Morbidity and Their Treatment in South India'. *Studies in Family Planning*; 26, 4: 203-216.

supervision of a trained attendant as an option where there is low risk. This, up to a point, overcomes the lack of adequate government facilities and poor access, while for most women, childbirth at home is a cost effective option. Intra-partum care, however, cannot be looked at from the cost-benefit point alone. The crucial factor here is whether it was a medical doctor or trained person who decided that childbirth at home is a viable option. There is evidence to suggest that the choice of intra-partum care was not determined by medical opinion. This also assumes importance considering minimal emergency and obstetric care available in rural areas. The risk factor, therefore, increases in many cases where proper medical advice was not sought at the right time. How the health delivery system is geared to reach women and the effectiveness of reproductive health care mechanisms are important factors in maternal morbidity and mortality.

The paper examines the following questions: How effective are the various institutional linkages between the panchayats and the health department, in providing these services? What is the quality of these services and what factors affect quality? To what extent are prenatal, perinatal and postnatal services accessible to mothers and neonates? What services do women access, and what are the factors that determine such choices? Are the services provided by the appropriate sources of care?

DATA AND METHOD

We examine these questions based on our study in two districts Chitradurga and Chamrajanagar in Karnataka [a south Indian state], which are backward in terms of MCH indicators. We use three sets of data. First, the status of PHCs and sub-centres, staff pattern, total expenditure incurred, infrastructure available, and provisions for reproductive health care. Second, data from the interviews with 140 women under the age of 35 on accessibility, reach, affordability and quality of reproductive health care; the type of maternal health care they access and the cost involved. We also use the information on spending patterns of pregnant women, drawn from the tracking survey of 275 pregnant women from the time of confirmation of pregnancy to three month

after childbirth. Third, interviews with elected representatives (145 panchayat representatives) and health officials to understand the institutional and operational structure of reproductive health services.

The paper is organized into the following sections. Section I deals with the role of the Local Government in Reproductive health care in the context of the 73rd Amendment and the Karnataka Panchayat Raj Act of 1993. Section II looks at the quality of maternal health care (government and private institutions) in the two sample districts – experiences of women who have utilized services. Section III discusses the findings.

LOCAL GOVERNMENT AND REPRODUCTIVE HEALTH CARE

The provision of primary reproductive health services are under the administrative jurisdiction of the local government at the district and sub-district levels and the health department at each of these levels. The elected representatives have supervisory functions. At the district panchayat there is a health standing committee, which perform functions related to health services, maintenance of the hospitals, and implementation of family welfare programmes. The Chief Executive Officer (CEO) at the district level and the Executive Officer (EO) at the taluk panchayat have administrative control of the various line departments. The District Health Officer and Taluk Health Officer head the health department at the district and taluk levels respectively, who have the responsibility and control of the activities of health services at these respective levels. They are responsible for planning, implementation, supervision and monitoring of health and family welfare programmes. There is also an officer for Reproductive and Child health (RCH) at the district level. Despite having functions and powers, the authority of the elected representatives in monitoring health services is ambiguous. While the health officials are under the administrative jurisdiction of panchayats, they report to the CEO at the district panchayat, and EO at the taluk panchayat and to their department heads. The PHC, CHC and referral hospital at the taluk level report to the taluk health officer. Besides, there are health agencies at the district which have specific functions in national health programmes such as the control or eradication of blindness, TB, Malaria, leprosy, and HIV/AIDS.

Several factors contributed to the poor management of maternal health services at the PHC.

- The inadequacy of funds to the PHCs is one of the important factors in the poor quality of services. The annual budgetary allocation (for non-salary expenses), for example, is Rs. 60000 to Rs. 75000 per PHC serving a population of 30000.[4] It would be hard to expect better health services and an emphasis on vital issues such as maternal health. It is also important to note that this amount is meant for the purchase of medicines for general health and not meant for maternal health services alone.
- The PHCs are understaffed and do not have the capacity to provide maternal health services especially in complicated cases. In a majority of PHCs there were no female doctors or nurse, thus discouraging women from seeking maternal health care there. The ANMs had to carry out multiple tasks and the time available for house visits was limited. The routine antenatal and postnatal care could not be regularly provided.
- Poor infrastructure facilities at the PHCs, which do not have basic minimum requirements such as water, electricity, telephone connection, vehicles and hygienic surroundings.

The low emphasis on maternal health at the PHC level in many ways is reflective of the asymmetries in the health budget allocation at the state level, with very little funds set aside for maternal health. There is limited financial devolution to the local governments. Only part of the health budget expenditure is devolved to the local government. A significant proportion is spent through the health department. The state budget figures for family welfare, for plan[5] and non-plan show that the allocations are lower than those

[4] Other estimates indicate that the per capita RCH expenditure in Karnataka is Rs. 15/-.see Bhatia and John Cleland, 2001, *ibid*.

[5] Government investments are made through five-year plans. A new project taken up in a Plan is called a Plan scheme and is funded by Plan allocations. After the five years it becomes a normal scheme and is to be funded under the non-Plan allocations. Over the years, states have not had the non-Plan funds to take over such new schemes, and have continued to use Plan funds for such schemes. Thus the distinction has lost any meaning today.

of the Centre. Although there has been an increase in the overall allocation and expenditure[6] the problem is that over the years the expenditure has been far below the allocations. The question is not one of more money being allocated, but of improving the absorptive capacity of the RCH service delivery system. There are both bureaucratic rigidities and poor accounting practices that are partly at fault. From our analysis of the PHCs it was evident that most of the PHCs have vacant positions, which to a certain extent explains the difference in allocation and expenditure. The entire RCH programme is centrally sponsored and there is no state budget for RCH. Even within the RCH programme both at the national and state level the emphasis is on the family planning programme and child immunization, while minimal attention is given to maternal health.

The spending pattern had considerable implications for accountability in the provision of health services in general, and the reproductive health care in particular. The ambiguity in the separation of powers between the panchayats and the health departments, the overlapping areas of responsibility has contributed to ambiguity in accountability in health services. While the panchayats have the supervisory powers, the health department does not function in coordination with the panchayats. The health department functioned as a parallel structure, the department staff do not consider themselves accountable to the panchayats, and their line of accountability is extended only to their department.

The perception of the elected representatives about their functions and responsibilities in the provision of healthcare varied across the tiers, with total indifference at the level of gram panchayat and limited involvement at the taluk and zilla panchayats. One of the reasons for this is that the responsibility of service provision was tied to the funds allocated to the panchayats. They did not consider the supervision and monitoring of health services as a part of panchayat functions.

[6] If one were to look at the overall trend in allocation and expenditure between the years 1994-95 and 2002-03 there has been a significant increase over the years. The budget allocation increased from Rs 6174.96 lakhs to

Interviews with 127 elected representatives in gram panchayat points to the wide gap in the expectations from local government and what was actually delivered. The expectation from the lowest tier of the local government is mainly in two areas. The expectation is that since the elected representatives at the gram panchayat are in close contact with the electorate there is a greater understanding of the health concerns of the electorate. There are mechanisms such as gram sabhas (village assembly) for people to voice their concerns. It will be easy to identify the constraints in service delivery in gram sabhas and follow them in the gram panchayat meetings. The other expectation pertains to the significant presence of women in panchayats. Since there are over 40 per cent of seats occupied by women representatives in gram panchayats it is expected that these women representatives would raise gender related concerns such as reproductive health care. This in turn will get reflected in the nature of discussions on health care services and spending of gram panchayat and in taking up health care delivery at other levels of local government. Our findings show that these expectations were not actually manifest in the functioning of the gram panchayat. There was lack of awareness and indifference on the part of the gram panchayat representatives about their monitoring and supervisory role in healthcare service delivery. Their role was limited to making arrangements for health camps, and hospitality for visiting officials.

Health care delivery was seen by a majority of elected representatives as the responsibility of the health department, and they do not consider that grama panchayat has a supervisory role in ensuring proper delivery of services. Many of them were not aware of what comprised the role and responsibility of panchayats in healthcare service delivery. Barring a few, most of the representatives were not aware of the 73rd Amendment, the 11 schedule, and the healthcare and the RCH functions devolved to the panchayats (see Table 1). The issues related to health care were not discussed in the grama sabhas or in the gram panchayat meetings (see Table 2).

Rs 1,23,1243.8 lakhs. While the expenditure also shows an increase from Rs 6187.01 in 1994-95 to Rs 9,7396.3

There was also indifference among the people in taking up healthcare issues in the gram sabhas. We found that almost everyone in our household survey and tracking study indicated dissatisfaction with the quality of health services and reproductive health care. Yet, they did not take up healthcare delivery issues in the grama sabha meetings. One of the main reasons for this was that the discussions in the gram sabhas were guided by the funds allotted for a particular purpose, and was not aimed at identifying needs of the community that would in turn guide prioritizing the spending. Discussions in most panchayats, therefore, were confined to activities for which money was available (such as provision of water, repairing village roads, poverty alleviation and so on). Since gram panchayats do not have any budgetary allocations for health or reproductive health care these issues were never discussed in the gram sabhas and gram panchayat meetings.

Table 1. Awareness of responsibilities and role of gram panchayat in reproductive health care

Awareness of elected representatives	**Aware**	**Somewhat Aware**	**Not Aware**
73rd Amendment to the Constitution	8	17	102
11th Schedule	6	13	108
Role and responsibilities of the gram panchayat in healthcare and reproductive health care	6	13	108

Table 2. Health and RCH issues taken up by the grama panchayats

	No. of elected representatives		
	Always	**Sometimes**	**Never**
Are health issues discussed in grama sabhas	--	4	123
Are RCH issues discussed in grama sabhas	--	--	127
Are health issues discussed in grama panchayat meetings	--	16	111
Are RCH issues discussed in gram panchayat meetings	--	1	126

in the year 2002-03, it has fluctuated twice during this period.

As has been pointed out earlier the health department staff (including the doctors and para-medical staff at the PHC) do not consider themselves answerable to panchayats. From the viewpoint of health professionals the elected representatives are not technically qualified to assess their work. The point which is often missed is that it is not technical expertise of the elected representatives, but it is their role in identifying the needs and inadequacies in health care delivery and supervising the attendance of health functionaries. More importantly the elected representatives have a vital role in decentralized governance in coordinating with the higher level of local government for funds and other resources. These aspects are missing almost entirely in the provision of reproductive health care at the gram panchayat level.

There are problems at the institutional level, related to the devolution of funds, functionaries, functions, and in the coordinating and monitoring role that these institutions are expected to play. In the case of gram panchayats there are no funds and functionaries although some functions have been devolved. In the case of taluk and zilla panchayat a small proportion of funds are devolved although there is limited transfer of functions and no transfer of functionaries. The nature of devolution of funds to the taluk and zilla panchayat is programme driven, largely confined to the central government programmes. Only part of the health budget is devolved to the zilla (district panchayat). For example, for the year 2004-2005 out of the total Rs. 9071.42 lakhs, the funds devolved to the zilla panchayat and taluk panchayat for the health programmes are Rs. 3308. 28 lakhs. State sector plan schemes that ought to have been devolved to the district panchayats are Rs.5763.14 lakhs. In the case of family welfare programmes, the state sector programmes devolved to the zilla panchayats are Rs. 887.32 lakhs while the funds that are under the control of the health department is Rs. 5638.60 lakhs. Only central government funds for health and family welfare programmes (Rs, 1074.52 lakhs) are devolved to zilla panchayats.[7] There is a health standing committee, which takes decision on expenditure on health programmes at the district level. This committee does not assess the quality of health services.

[7] Department of Rural Development and Panchayati Raj, Government of Karnataka.

In assessing the role of panchayats in the provision of healthcare in general, and maternal health care in particular, the main parameters would be – whether there are mechanisms to identify problems and make changes; whether the functioning of the health department is monitored and strengthened through the intervention of the panchayats, community participation; and more importantly have the quality of health services improved and are responsive to the needs of the community. Judging along these parameters the role of panchayats in the provision of health services has been weak. The severe limitations in the health, particularly reproductive health also suggest that there are areas in the decentralisation model that need to be strengthened- particularly in the devolution of funds and functionaries and in giving panchayats autonomy in carrying out functions. As it exists there is no decentralized governance of health services as the health department has control over a large section of funds and state sponsored programmes.

QUALITY OF MATERNAL HEALTH CARE

Three broad indicators were used to examine the quality of maternal health care, which include the facilities available (physical facilities, staff, infrastructure, equipment and medicines), to what extent they actually meet the demand, and the perception of the users. In this section we examine these indicators of maternal health care service. While examining the quality of maternal healthcare the focus is largely on the government services. The quality of maternal health care has a significant impact on the demand for government services. On the other considering the limited resources available for health services, more demand reduces the quality of services.

Government Maternal Health Care

In Karnataka the responsibility for maternal health care is mainly at the sub-centre and Primary Health Centre (PHC), which provides pre-natal, childbirth, and peri-natal and post-natal services through the Auxiliary Nurse Midwives (ANMs). There is a PHC for every 30, 000 population in the plains, and

20,000 in tribal and hilly regions. Under the PHCs there are six to eight sub-centres, one each for every 5000 population in the plains and 3000 population in tribal and hilly regions. The Auxiliary Nurse and Midwifes (ANMs) are the paramedical staff trained in reproductive health care and are based in sub-centers or at the PHC itself. The ANMs have multiple responsibilities. They maintain the records for the health department, documenting information related to fertility, pregnancies, childbirth details, and immunization. Besides, they enrol pregnant women and are expected to provide at least 3 house visits, conduct deliveries at sub-centre/PHC and provide postnatal care. ANMs have the important task of identifying high risk pregnancies during antenatal care and refer them for institutional deliveries. Being the first point of contact for pregnant women, ANMs take the referral decisions.[8]

The second level of service is at the PHC where a medical doctor and nurse are available for consultation and childbirth. Maternity facilities were available only in a few PHCs. The most common staffing pattern at the PHCs was a medical doctor and an ANM, apart from administrative staff. There are 1700 PHCs in Karnataka, and the status and quality services provided by them are important indicators of the quality of reproductive health services. The next level of services is the Community Health Centers (CHCs) and referral hospital at the sub-district level, and general hospitals and maternity hospitals at the district level.

The above structure of the provision of reproductive health care assumes that there is networking and coordination between the various levels of health services and there is timely provision of maternal health services. To what extent this coordination exists and the various factors involved in their effectiveness are examined using data collected from 35 Sub-centres, 45 PHCs and 4 CHCs.

Facilities available for maternal health care

[8]They work closely with *anganwadi* (child care centres) workers and Trained Birth Attendants. The main responsibility of *anganwadi* workers is the ICDS programme or the nutrition programme. Anganwadi workers are not trained in RCH and do not have a direct role in maternal health care.

Maternal health care should be viewed in the overall context of the health facilities available in rural areas, services being needed all the time, and which are easily accessible. Within the larger health care system there are two main areas of focus that are relevant for maternal care. These include reproductive and child health and family planning programmes. The RCH staff are, therefore, responsible for reproductive healthcare, (which includes maternal health and the family planning programme), and child healthcare. The ANMs who are the first rung of the health department personnel available at the village level have a crucial role in the reproductive and child health care system. They however have multiple responsibilities including the documentation of household RCH information that they have to do from time to time. Antenatal care and childbirth support during uncomplicated delivery are among the y responsibilities of the ANMs. There is no specific staff whose sole work is related to maternal health. It was common for the ANMs to pay more attention to filling up different forms of demographic information. The responsibilities in the area of antenatal care are neglected. The ANMs are responsible for recording pregnancies, three mandatory visits (ANC i.e. ante natal care) to the pregnant women in the jurisdiction of the ANMs, ensuring that blood and urine tests are carried out, immunization and supply of folic acid and iron supplements, identification of the high risk symptoms, and referral support. As shown in Table 3 the high priority for ANMs is documentation of information and meeting the targets of the family planning programmes. A majority of pregnant women in our sample said that the ANM did not visit them at home at any point of time. The pregnant women were asked to go to the anganwadi center on a specified day to get the TT injection and iron/folic acid tablets. There was no provision of 'ante-natal *care'* which is emphasised in the national RCH II and I programmes.

Serious limitations in antenatal care were evident in our tracking as well as household sample. Eighty nine per cent of the pregnant women were not visited at home by the ANMs during their entire period of pregnancy. A similar pattern was reported during their earlier pregnancies. It was also reported that the ANMs would send word that they will be at a particular place and the pregnant women are expected to go to them and give information about their

Table 3. Responsibilities of the ANMs

Jurisdiction (coverage)	Activities							
	Family planning target		Maintenance of records		Immunisation		RCH related	
Approximately population of 3 to 5 thousand								
	Identifying eligible couple for family planning programme	√	Demographic details of birth, death	√	Child immunisation	√	Identifying pregnant women,	√
	Enrol a specific per cent (set by the HD) of couples in the FP programme	√	Eligible couples, IM, Child morbidity, and other RCH indicators	√			Three antenatal visits	X
							Ensuring the pregnant women received TT injection, iron tablets, had done necessary tests	X
							Identify risk cases	X
							Referral advice	X
							Assisting childbirth (in uncomplicated cases)	S
							Postnatal support	X

Note: √ --Carryout; X—Do not carryout; S—Carryout sometimes

pregnancy. In a few cases they visited the pregnant women, it was with the intention of mobilising them for the family planning programme. There were 32 per cent of pregnant women who did not consult any doctor or paramedics and did not undergo any tests. None of the pregnant women were assessed for risk symptoms. Twenty one per cent did not receive TT injection. There

were eleven cases in our sample who have all the symptoms of high-risk pregnancy. These women were not visited by the ANMs or referred to the higher level hospitals where emergency obstetric care was available. . What is particularly noteworthy is that these women were not even aware that their pregnancy was one of high risk, and that they needed to take adequate precaution and plan for institutional childbirth. This is important considering the long distance and transportation problems in reaching the referral medical centers for emergency obstetric care. The case information card is either not provided or not filled up. There is a case information card which is in two parts with similar information on both. The information that needs to be documented on this card include details of the pregnancy, weight, blood pressure, history of pregnancy related complications if any, TT, iron and folic tablets received, child immunization. The information on this card was meant to be updated from time to time, and one part of the card is to be given to the pregnant women when contacted at the time of registration of pregnancy by the ANM. The other part is to be retained by the ANMs, which will help them monitor cases that have complications and high risk. What we have seen is that either the card is not given at all, and even when provided there was no recording of any nature on the card. In a few cases the TT injection and folic acid and iron tablets that were given to the women were recorded. However, information such as history of pregnancies and childbirth, weight, tests conducted was not recorded. The card, therefore has limited utility as a case information when the pregnant women go to referral care or to any other doctor. There are many cases where the pregnant women went to different doctors and received TT shots more than once and also got tests repeated.

Quality of services at the Sub-centres and the PHCs

While ANMs are the mobile part of the reproductive health care to provide antenatal, post-natal and postpartum care, the stationary health facilities are the sub-centre, PHC, CHC, referral hospitals at the taluk and district levels. We examine here the accessibility and facilities available at the sub-centre and PHCs as the crucial links in maternal healthcare.

Table 4. Accessibility of health facilities

	Government health facility			***Private health facility***			
	Sub-centre	**PHC**	**CHC**	**Maternity hospital**	**Doctors clinic**	**Nursing home**	**hospital**
Nearest government health centre**	***61%***	***31%***	***--***	***---***	***21%***	***--***	***6***
Mean distance	***1.5 kms***	***5kms***	***8kms***	***18kms***	***8 kms***	***20kms***	***20kms***
Mode of transport	***--***	***Private/public***	***Private/public***	***Private/public***	***Private/public***	***Private/public***	***Private/public***
Availability of transport	***--***						
Day		***Easily available***	***Easily available***	***Easily available***	***Easily available***	***Difficult***	***difficult***
Night		***Easily available***	***Difficulty***	***Difficult***	***Easily available***	***Difficult***	***Difficult***
Most frequently used facility**		***23 %***	***13%***		***41 %***	***17 %***	

Note: ** multiple responses were given

Sub-centre

The sub-centre is the first point of access for women to institutional health facility. While there is no uniformity in the distribution and location of sub-centre, the mean distance to the sub-centre was 1.5 kms. The sub-centre in a majority of cases was part of the residential accommodation provided to the ANMs. The facilities to handle deliveries were minimal. Sometimes, the ANMs assisted the delivery at the house of the pregnant woman. Similarly, in the case of sub-centres which were not part of the ANMs residential accommodation, there were limited facilities to provide antenatal care or assist delivery. The sub-centres did not have any facilities to qualify for institutional childbirth. The ANMs were not provided with any equipment to examine the pregnant women, and are only given a delivery kit.

The ANMs who had several tasks to fulfill were not available at the sub-centre. On a specified day every week (on Thursdays) the ANM were present at the sub-centre as a part of he immunization programme, and on the remaining days the ANMs had to be contacted at the PHC or during their visits to the village Anganwadi center as a part of their documentation work. A large majority of the ANMs did not attend to childbirth after the official hours of work, which was from 10 Am to 5 PM. None of the women in our sample delivered at the sub-centre. We observed several instances where the childbirths attended by the ANM at the houses of the pregnant women were registered as institutional birth. The sub-centre therefore serves a limited purpose in either providing antenatal care or facilities for institutional childbirth.

PHCs

The PHCs also exhibit varied patterns in terms of staff and the facilities available (see Table 5). There were PHCs which had only limited staff, comprising a doctor and a small number of supporting staff including an ANM and a male health worker (MHV). In a few PHCs there was a woman nurse. These PHCs did not have facilities such as labour room or beds. They provided mainly general consultation. In terms of provisions of maternal care

there are limitations as only the ANMs or the female nurse are available to attend to childbirth, and that was only for a limited period during the day.

The second type of PHCs were larger in size, and had infrastructure such as beds, labour room and laboratory. These facilities were also used for family planning services and not for caesarean section or hysterectomy. Deliveries were done in the PHCs where there was a lady doctor. However, not many PHCs had lady doctors. Only 4 out of the 45 PHCs we studied had lady doctors. Male doctors referred the pregnant women to government maternity hospitals at the taluk level. There was in any case, a marked reluctance among women to consult male doctors for maternal health care.

The distance to the PHCs was in the range of 1 Km to 8 Kms., which could take more than an hour using whatever means of transportation that was available immediately. Considering the difficulties in being able to arrange private transport it is often not easy for women to reach the PHCs in an emergency situation at night. In remote rural areas arrangement of transportation has to be made much in advance and the timely availability of transport is a crucial factor in preventing maternal mortality.

A majority of the PHCs were not equipped to provide maternal health care (see table 5). While the quality of medical personal and inpatient service was not assessed, we examined the availability of the medical and paramedical staff for providing maternal health care. It was a common pattern in both the districts that women did not seek antenatal care at PHCs when there was a male doctor at the PHC.

The infrastructure in a majority of PHCs was minimal. While 4 out of 45 PHCs had a labour room the basic minimum infrastructure was found lacking. The PHCs did not have water, clean linen, gloves, and facilities for organic waste disposal. The labour room was unhygienic, with rusted delivery tables. The doctors, therefore, avoided conducting deliveries the PHCs especially prima-gravid or those with a history of obstetric complications at. We also found that the PHCs which were used for family planning services were better staffed

and also had better equipment and infrastructure. The supply of drugs was inadequate and it was a common practice to prescribe the medicine which can be bought from local pharmacies.

Table 5. Health facilities at the PHCs

Total No 45

Facilities available	***No. of PHCs***
Medical Staff	
At least one doctor	45
Two doctors	7
More than two doctors	3
Lady doctor	4
Paramedical staff	
ANMs	45
Average no.of ANMs at the PHC	2
LHVs	23
Female Nurses	14
Male paramedics (MHVs, male nurses)	29
Services	
General medical consulting	45
Reproductive health care	
(a) Antenatal	4
(b) Childbirth services	6
(c) Post-natal care	4
(d) Emergency obstetrics	1
Family planning	14
Infrastructure	
Health centers with availability of beds	14
Average number of beds	2
Labour room	4
Sterilizing equipment	32
Electricity	45
Water	29
Vehicles	4

Private Health Facilities

Besides the government health services there are private health facilities mainly concentrated at the district and taluk level. The private health facilities include traditional (Ayurveda, Unani, homeopathy, folk medicine), and modern systems of medicine. Private nursing homes and clinics run by medical doctors provided neonatal, maternity and postnatal services. While the poor quality of government services was one of the reasons for preferring private healthcare, it was also found that expenses in the case of government

services were almost as much as private services, increasing the motivation for seeking private maternal care facilities.

In both the districts there was a preference for private health care especially in the moffusil areas. Several reasons were stated for such a preference. These include immediate accessibility of the doctors and medical staff, better care and cleaner facilities. Further, there was also the opinion that since one has to pay for even the government health care irrespective of the economic status of the care seeker; private healthcare was preferred as it meant paying a little more for better health care.

The important factor that contributed to the preference for private health care is the availability of lady doctors. Although most private hospitals did not have gynecologists any woman doctor was considered acceptable. Most women and their families were reluctant to consult male doctors at the PHCs regarding maternal health.[9]

MATERNAL HEALTH CARE SEEKING BEHAVIOR AND EXPENDITURE - HOUSEHOLD DATA

Characteristics of the women

Of the 400 women included for the present analysis from Chitradurga and Chamrajanagar districts, 145 were from the interviews of the households and the remaining from the tracking data. It is a predominantly rural sample (with only a few women taken from areas at the taluk) and 74 per cent were Hindus, 17 Muslims and 9 per cent to other religious groups.

The education levels of the women was generally low. Less than 2 per cent had education above the school level and 31 were illiterate. Among those who had attended school 6 per cent had 10 years of schooling, and 18 per cent had 4 to 7 years and the remaining less than 4 years of schooling.

[9] They were even more hesitant to discuss problems related to RTI/STI.

The average age of the women was 28 years. The age at marriage of a majority of women was between 13 to 17 years - the average age at marriage was 16 years in Chitradurga and 14 years in Chamrajanagar. The overall average number of children ever born was 4 and average number of pregnancies was 4. The average number of children among women married for 3 to 12 years was 3 to 5 children. (6.29%) Similarly the average number of pregnancies for women married for 4 to 7 years was 5.

The awareness level of the women regarding maternal health and safe motherhood was poor. A majority followed what was being told to them by the other women in the family, or by the neighbors. The awareness about contraception was considerably higher when compared to other reproductive health issues. While 71 per cent of the women were aware about contraception, 46 per cent also mentioned a few contraception methods. The most prevalent contraception methods reported were oral pills and copper T.

Prevalence of antenatal morbidity and care seeking

During the antenatal tracking, we asked about the complications, which women were suffering from, and what kind of medical treatment they had. Seventy nine women suffered from one or more health problems. The most common health complaints during antenatal period are listed in Table 6. The risk symptoms that were reported were water retention, bleeding, and white discharge. It was also found that 69 per cent of women were anaemic, 39 complained of back pain and pelvic pain, 52 per cent blurred had vision, and 41 percent of excessive tiredness.

Maternal care-seeking behaviour related to morbidities was examined during antenatal complications (Table 6). There was no adequate medical attention received to treat these health complications (see Table 6). Less than 1 per cent of the respondents with reported haemorrhage and 0.5 per cent with white discharge sought treatment. For most other complications the

respondents did not seek any treatment at all (see Table 6). A small section who did seek treatment approached private doctors.

Table 6 complications during the antenatal period, and care seeking

Symptoms	Percentage reporting complications	Treatment status (per cent)		
		Received treatment		No treatment
		Government Doctor	Private Doctor	
High blood pressure	14	22	32	46
Anemic	69	4	12	86
Tiredness	41	--	--	100
Pelvic pain	39	--	6	94
Back pain	39	--	2	98
Giddiness	4	--	1	99
White discharge	4	--	0.5	99.5
Palpitation	3	--	--	--
Blurred vision	52	--	1	99
Water retention	29	--	--	100
Low intensity fever	6	--	--	100
Cold/cough	1	--	--	100
Urinary problem	2	--	--	100
Haemorrhage	1	--	100	--
Fits/convulsions	0.5	--	--	100

Expenditure on maternal health care

In the household survey we used the recall of the expenditure incurred during the birth of the last child, and in the case of tracking, expenditure for antennal care and childbirth was recorded every 15 days. The expenditure was highest during childbirth. A majority of the households spent very little for antenatal care and postnatal care . The expenses incurred was for diagnostic tests like blood, urine tests, some ultra-sound scanning The average expenditure during antenatal care was Rs. 300 in the case of entirely government healthcare, Rs. 500 when both government and private healthcare was used and Rs. 700 in the case of private health care alone. The average expenditure during childbirth for government healthcare was Rs.2500 and for private healthcare it was Rs3500. It was much higher when there were complications during childbirth and when caesarean section had to be carried out. The lowest expenditure during childbirth was when the delivery was conducted by the TBA (Rs. 50 and food grains), followed by ANM (Rs 250 –Rs. 300). It was

highest when the caesarean section was carried out at a private hospital (Rs. 8000 to 15 000). The expenditure in the case of government and private maternity care included expenses involved in purchasing medicines and getting tests done.

Factors in maternal health care choice

Households based their choice of healthcare on many factors including availability of clinical services, lady doctor, flexible timings, past history of obstetric complications, pre-evaluation and satisfaction perception regarding adequate facilities and cleanliness. This excludes emergency situations when no particular choice was exercised and availability of the doctor was the primary concern. Some of these factors are examined below.

Number of children

The average number of children was high in both the districts and it is one of the factors that significantly affected maternal care seeking. The reasons for opting for a bigger family was the persistent child morbidity, couples perception of anticipatory child mortality, risk of child mortality and male child preference. The incidence of neglect of antenatal care, and childbirth at home was greater in the case of households where the fertility rate was high. Considering that most of the households were of low income and below the poverty line, the expenditure at childbirth was largely met by taking loans from local money lenders, and they could not afford spend for more than one pregnancy.

First pregnancy

The maternal care-seeking pattern indicates that using private care facilities was greater during the first pregnancy and when there was a medical history of complications. A contributing factor was also that during their first childbirth the maternal care expenses were paid by the parents of the pregnant women. According to the social customs and practices it is the maternal home which has to meet the expenses incurred during the childbirth of the first child, as also was the custom of expectant mothers going to the parents' house for childbirth.

Household income

There was a relationship between the better economic status of the household (with an annual income of Rs 75000 and above) and accessing maternal healthcare. Among the higher income group households there was a preference for private health care. Higher income levels were also inversely related to number of children at the household level which contributed to accessing better maternal health care. In the households below poverty line the expenditure on antenatal care was minimal and public health facilities was used for childbirth.

Literacy level

The other factor that had some influence on both maternal health care seeking and the number of children was the education level of the mother. Women who had more than ten years of schooling showed a strong preference for a smaller family, compared to those who had fewer years of schooling (3 to 5 years and less than 3 years) and were not particular about the small family norm. The instances where there was no relationship between education and number of children was when there was a preference for a son and women were willing to go through multiple pregnancies till a son was born.

Accessibility

Proximity and time factors determined maternal care seeking. There was a preference for private healthcare if it was in the proximity, although the doctors' fee was higher than in the government hospital. The reasons given were that they could save on transportation expenses and save time. The waiting time at the private clinic was lesser than at the government health center. There was also a higher tendency among those living closer to the taluk head quarters to use private health care, compared to those who had to travel from interior/remote villages.

DISCUSSION

The findings of the study point to severe limitations in the provision of maternal health care by the government health care system. The role of the panchayats in improving maternal health care services also had its own constraints. The preference for private health care is mainly due to poor quality of public health care and fewer women doctors in government health centres in rural areas. Despite the preference for private health care, the study also points out that a large section of women did not receive any antenatal care from the second pregnancy, and were not in a position to afford institutional health care during childbirth.

The poor quality of government maternal healthcare points to the lacunae in the implementation of the national RCH programmes. It was evident that the emphasis of the programme has been on child immunization and family planning programme. There was minimal focus on maternal health (including RTI and STI). While the RCH II policy document acknowledges the importance of maternal health, the emphasis remains on population goals.

The role of the state government in providing resources for maternal health has been minimal. There are no funds allocated in the state government budget for RCH. The contribution of the state government is mainly for the salaries of the PHC staff, which comes under general health care. The national policy document does not have any mandatory provisions for state governments that would contribute to the improvement of the reproductive health care. The paucity of the financial resources is only one of the issues. In Karnataka there is no adequate emphasis on the maternal health care within the overall health policy framework of the state. The more recent initiatives in the state, funded by The World Bank did not give adequate attention to the maternal health and other aspects of RCH.