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Introduction

The Third Five-Year Plan (1961-66) aimed at reducing the crude birth rate in India to 25 per 1,000 population by 1973. However, this goal has not been achieved even to this day. Several other demographic goals were set later, to be achieved by specified years, but they were either deferred or revised. One major reason for the failure to achieve these goals was thought to be the lack of adequate infrastructural facilities for the family welfare programme. Therefore, it was decided to improve the institution– population ratio and worker—population ratio.

Currently, for primary health centres (PHCs) the national norm for the rural areas is one for every 30,000 people, and one for every 20,000 people in the hilly and tribal areas. Earlier, the norm was one PHC for every 100,000 people. The earlier norm of one subcentre (SC) for every 10,000 people has been revised to one SC (with one auxiliary nurse midwife (ANM) and one male health worker) for every 5,000 people, and one SC for every 3,000 people in the hilly and tribal areas.

Only recently have policy-makers begun realising the importance of, and the need for improving the quality of family welfare services (like maternal and child health, and family planning) in hastening a decline in the birth rate.

How does one define quality? According to the International Organisation for Standardisation, quality is 'the totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs' (Raghupathy, 1992: 18). The quality of a product can be more easily monitored and measured than that of a service because, 'unlike a product which is a tangible good, service is an activity or process generally between a customer and a service employee' (*ibid*.).

There are differing opinions on what is meant by the quality of care or the quality of family welfare services. According to Bruce (1990), Jain (1989) and Jain and Bruce (1989), the quality of family welfare services

incorporates six elements: (a) choice of methods, (b) information given to clients, (c) technical competence, (d) interpersonal relations, (e) mechanisms to encourage continuity, and (f) an appropriate constellation of services. These six elements are not exhaustive. It is true that the technical competence of providers influences the quality of services. But equally important are factors like the attitude of the providers towards the concept of family planning, towards their clients and towards family planning methods.

Family welfare services are not merely a service provided. They also represent elements of the manufacturing sector, in the sense that product like Cu-Ts, condoms and oral pills are used. Indeed, there will be less or no demand for them, if their quality is poor.

A study conducted in Karnataka (Reddy and Gopal, 1988) revealed wide gaps in the knowledge, skills and practices of medical, paramedical and non-medical personnel. The situation would not be different in other parts of the country.

An evaluation study conducted by a task force of the Indian Council of Medical Research (ICMR, 1991) has shown that the quality of prenatal, intranatal and postnatal services, immunisation services for children, and family planning services was poor.

In their study in Gujarat, Visaria and Visaria (1992: 113-38) have identified some problems related to the quality of family planning services, especially with regard to the choice of family planning methods, services for spacing methods, venue of sterilisation and pre- and post-sterilisation care.

A study of the clients' view of the quality of health and family planning services in rural Uttar Pradesh identified various factors that influence the quality of care, such as experience with the effectiveness of treatment, thoroughness of examination, care by a doctor and waiting time (Levine *et al*., 1992: 247-65). Reviewing various studies, Khan and Patel (1993: 114-15) have identified various aspects of family welfare services in Uttar Pradesh that were unsatisfactory.

Verma *et al* (1994) have studied the perceptions of clients and providers regarding the quality of family welfare services and care, and the relationship between the perception of quality and the utilisation of services (Verma *et al*., 1994). According to them, the perception of eligible women clients of various components of the quality of services

varied district-wise within the same state; the behaviour of the doctors was thought to be better than the services of workers, facilities at the PHCs and their accessibility; and there was little variation in the perceived quality of services according to the age, education and caste of women. With regard to providers' perceptions, it was found that there were wide inter-district variations in the level of knowledge and motivation of the workers; the organisational climate followed different patterns in different states; the pressure of achieving sterilisation targets was felt by the majority of workers in all the three states; and the maintenance of eligible couple registers was not adequate in all the three states. In terms of the relationship between the perception of quality and the utilisation of services, it was found that clients' perceptions of the quality of services influenced the utilisation of health and family planning services; and follow-up services by the workers influenced the utilisation of health and family planning services by the clients.

As Khan and Patel (1993: 114) have observed, 'there is hardly any study which has systematically addressed all the six elements of the quality of care'. Moreover, there are very few studies of the quality of care in India, and those employing qualitative methods even fewer. There is, therefore, an urgent need to study the quality of family welfare services in different parts of India, especially by using qualitative research methods.

Objectives

The primary objective of this study is to assess the quality of interaction between clients and providers, and the quality of family welfare services. More specifically, the study examines the following issues:

- How family welfare programme personnel interact with clients in a given setting?
- The quality of such interaction.
- How frequently such interaction takes place?
- The provider's view of, and satisfaction with, the information and quality of family welfare services provided.
- The client's view of, and satisfaction with, the information and quality of family welfare services received.

The focus of the investigation is on the family welfare programme, that is, the maternal and child health (MCH) and family planning programmes.

Institutions Studied

It was earlier decided to randomly select one district, two PHCs in the district and three SCs under each of the two PHCs. Accordingly, Kolar district was selected. The two PHCs selected were Masthi and Vokkaleri. Under Masthi PHC, the three SCs selected were Dinneriharohalli, Kudiyanur and Santhehalli, and the three SCs selected under Vokkaleri PHC were Arabikothanur, Beglihosahalli and Settykothanur. Of the six SCs, only two (under each of the two PHCs) had male health workers in addition to ANMs.

In Karnataka, as in the other states, there are two types of PHCs those established under the Minimum Needs Programme (MNP) and are called MNP-PHCs and those established under the Government of Indian Pattern (GOIP) and are called GOIP-PHCs. The latter cover a larger geographic area and hence a larger population, and have more staff than MNP-PHCs. At the time of writing, of the 1,357 PHCs in Karnataka, 1,088 were MNP-PHCs and 269 GOIP-PHCs. Of the two PHCs selected for study, one was a MNP-PHC (Masthi) and the other a GOIP-PHC (Vokkaleri).

The Masthi PHC was established on 12 December 1983 by upgrading the existing primary health unit (PHU), which is a smaller health institution than a PHC. This has been functioning in a newly-constructed building from 24 May 1994. It covers 113 villages, including Masthi, and a population of 49,197 (according to the 1991 Census). It has 15 SCs, including one at the PHC. The medical officer of health (MOH) was unable to tell us about the area covered by the PHC.

The Vokkaleri PHC covers a population of 70,158 and an area of 185 sq. km. It has 11 SCs, including one at the PHC. The MOH has been on unauthorised leave for the past eight months. The lady medical officer (LMO) could not give information on when the Vokkaleri PHC was established on the number of villages covered by it.

The number of villages served by the three selected SCs under the Masthi PHC varied from five to seven, and the population served by

the three SCs from less than 2,000 to over 4,000. The distance between the villages and their SC headquarters varied from 1 km to 11 km. The names and population of the villages covered by the three selected SCs under the Masthi PHC and their distance from the SC headquarters are presented in Appendix-I.

The number of villages served by the three selected SCs under the Vokkaleri PHC varied from six to eight, and the population served by the three SCs from approximately 3,500 to a little over 5,000. The distance between the villages and their SC headquarters varied from 0.5 km to 7 km. The names and population of the villages covered by the three selected SCs under the Vokkaleri PHC and their distance from the SC headquarters are presented in Appendix-2.

What is striking is that the number of villages and the population covered by a SC under the GOIP-PHC (Vokkaleri) was larger than that served by a SC under the MNP-PHC (Masthi).

Since the MOH was not trained to conduct vasectomies and tubectomies, no family planning clinics were conducted in the Masthi PHC. Therefore, all the women who wanted to adopt tubectomy or laparoscopic tubectomy from the Masthi PHC area were sent to the nearest general hospital at Malur, the taluka headquarters. The LMO of the Vokkaleri PHC, who is trained to conduct tubectomies, occasionally conducts tubectomies in the PHC. However, the majority of the women who wish to adopt tubectomy or laparoscopic tubectomy from the area covered by the Vokkaleri PHC are sent to the nearest general hospital at Kolar, the district headquarters. While the LMO performed tubectomies at the Vokkaleri PHC whenever there were three or four women, tubectomies were performed in the general hospitals at Malur and Kolar every Friday, and laparoscopic tubectomies twice a month, usually on the 16th and the 30th.

Material and Methods Used

Multiple qualitative research methods were employed to collect information, including observation, informal interviews and discussions, semi-structured interviews and focused discussions. The advantage of qualitative methods is that `they produce contextual or holistic explanations for a smaller number of cases, with an emphasis on the

meaning rather than the frequency of social phenomena' (Simmons and Elias, 1994: 6).

The method of observation, including participant observation occasionally was employed at the antenatal/immunisation clinics and family planning clinics held in the hospitals (the taluka hospital at Malur, the district hospital at Kolar and the Vokkaleri PHC) and to study the activities carried out during the field visits of health workers.

Three tubectomy camps and two laparoscopic camps at the taluka and district hospitals were observed. In addition, three tubectomy camps at the Vokkaleri PHC were observed. Invariably, at both the PHCs and SCs, antenatal clinics and immunisation clinics were conducted together. Immunisation clinics were also organised in the villages by informing people in advance during the visits of the ANMs. Three antenatal/ immunisation clinics at the two PHCs, two at the six SCs and one in each village under the six SCs were observed. The antenatal/immunisation clinics at the PHCs were conducted every Thursday. However, there was no fixed day for conducting these clinics at the SCs and in the villages. Clinics were conducted whenever there was sufficient demand.

An investigator observed the ANM for seven working days in each of the SCs. This provided an opportunity to study the ANM in the clinic as well as in the outreach area (i.e., in the villages when they provide services to the community).

One male health worker in an SC under each of the two PHCs was observed by a male investigator. One was observed for four days and the other for three days. In Karnataka, a large number of posts of male health workers have not been filled. The authorities are in no hurry to fill these vacancies, perhaps because male health workers are not considered an asset and the posts have to be financially supported by the state government.

Semi-structured interviews were held with the MOH at the Masthi PHC, the LMO at the Vokkaleri PHC, the six ANMs and the two male health workers. Information was collected on their socio-economic background, educational qualifications, experience, attitude towards the people to whom they were providing services, commitment to the job they were doing, and so on.

One focused group discussion among the providers was conducted in each of the two PHCs to assess their perceptions on the

quality of care provided at the clinics and during their interaction with clients. These discussions were conducted at the PHCs on the days of their monthly meetings. During these discussions, issues such as the type of clients covered, the problems they faced when providing services and the division of tasks between ANMs and male health workers were addressed.

Two focused group discussions in each SC were also conducted. These discussions were held in the same village covering two socio-economic groups one among people belonging to the upper castes and classes (usually residing in the centre of the village), and the other among people belonging to the Scheduled Castes, Scheduled Tribes and other lower castes and classes (usually residing at the periphery of the village). The participants in the focused group discussions were mostly currently married women and the husbands of these women.

Informal interviews and discussions were held with both the functionaries and beneficiaries to assess their perceptions on the quality of interaction and family welfare services.

Organisation of Fieldwork

Six investigators were employed to collect data from six SCs, one investigator per SC. In addition, two supervisors were employed — one for every three SCs (i.e., one in each PHC) – to help the investigators in the collection of data and to oversee the progress of fieldwork. The principal investigator frequently visited the study area, guided the fieldwork, and personally observed the quality of interaction between the providers and the clients and the quality of the family welfare services.

The investigators and supervisors were postgraduates in social science. The two supervisors had three years experience collecting primary data. Before the investigators and supervisors were sent into the field, a three-day training programme was organised for them, where the nature and objectives of the study, the unstructured interview schedules and guidelines, qualitative methods of data collection and the conduct of focused group discussions were explained. They were given (anthropologists') notebooks to record their observations on the quality of care from various settings, discussions and conversations. The

fieldwork was completed in two months, during which the investigators and supervisors lived in the study area and collected data.

Findings

Primary Health Centres (PHCs)

Cleanliness appeared to be a major problem in both the PHCs studied. Although both the Masthi and Vokkaleri PHCs were swept and cleaned in the morning, by evening the premises were dirty because the people who came to utilise the services littered the area with paper, banana leaves (in which they brought their food), and so on. Sometimes, clients would park bullock-carts in the PHC compound, and the dung, grass and hay would dirty the premises. In addition, the hospital staff would occasionally throw bandages and cotton swabs in the compound. There were no litter bins. The Vokkaleri PHC had plants, trees and lawns which were watered everyday with water stored in a container. The Vokkaleri PHC was relatively better maintained than the Masthi PHC, perhaps because the former was a GOIP-PHC while the latter was a MNP-PHC. In addition, the LMO lived at the Vokkaleri PHC, while the MOH did not live at the Masthi PHC, and the Vokkaleri PHC was managed by a lady doctor while the Masthi PHC was managed by a male doctor.

PHCs in Karnataka function from 8 a.m. to 12 noon and 3 p.m. to 5 p.m. Although the gates of the two PHCs studied were opened at 8 a.m., only one or two staff members came to work on time. Most reported for work around 10 a.m. The clients also started coming in at around 10 a.m. It is difficult to say whether the providers in the PHCs reported for duty late because the clients came in around 10 a.m. or the clients came late because the providers reported for duty late. The MOH of the Masthi PHC lives in Bangalore and commutes daily by bus covering a distance of 67 km each way. He often reaches the PHC late and leaves early.

Generally, only educated clients know about the working hours of the PHCs. They know that the PHCs open late and providers come late. When asked whether she knew about the working hours of the Vokkaleri PHC, one antenatal mother said, 'We are illiterate people. We do not know the working hours of the PHC. We wait till the PHC is opened and till the services are provided.' When asked what he felt about the PHCs

opening late and the providers coming late, a graduate at the Masthi PHC said, `No asking, no telling. What can I do?' Thus, though educated people know the working hours of the PHCs, and resent the PHCs opening late and the providers coming to work late, they do very little to rectify the situation.

Invariably, the staff members of the two PHCs were busy with their own work. Frequently, they would away on their time while clients waited for services. Generally, the providers were pleasant to their clients. When there were too many clients, providers frowned on them and tended to be serious so that they could provide services to all the clients in time so that the providers would not be required to go home late. Some of the providers said that there was no need for them to be serious about their work because it was 'routine' and mechanical'.

At the Masthi PHC, a lady health visitor (LHV) said, 'we are here to provide services to the community. But we want the patients to remain calm until we provide services to them. We want to provide services to all of them before the PHC is closed for the day.' At the Vokkaleri PHC, an ANM remarked, 'we are paid by the government to provide services to the people. Therefore, we should not turn away patients without providing services. But when there are many patients and when they become unruly, we get slightly annoyed. Otherwise, we are very considerate and friendly with the patients.'

The doctors and other senior staff members at the two PHCs were pleasant to their clients. However, the junior staff members were rude, especially when there were a large number of clients. The providers did not maintain a distance from their clients, nor did they mix freely with them. Their interaction was mechanical and businesslike.

On enquiry, one female patient at the Vokkaleri PHC said, 'while *doctoramma* (the LMO) is nice and kind, *nursamma* (the nurses) are unkind.'

The two PHCs provided a range of services, such as preventive services, curative services, family planning services, MCH services, school health services, malaria eradication services and Japanese encephalitis control services.

As in the other PHCs in Karnataka, antenatal and immunisation clinics at the two study PHCs were conducted every Thursday. While the LMO at the Vokkaleri PHC occasionally conducted tubectomies at the

PHC, family planning clinics (i.e., tubectomy clinics) were conducted every Friday in the taluka hospital at Malur and the district hospital at Kolar. As a policy, family planning camps outside PHCs and hospitals are not held in Karnataka. Laparoscopic tubectomy camps were held twice in a month, invariably on the 16th and the 30th, in the taluka and district hospitals. Since the Masthi PHC is closer to Malur, those who wanted to adopt tubectomy or laparoscopic tubectomy from the Masthi PHC area were taken or sent to the taluka hospital at Malur. Since the Vokkaleri PHC is closer to Kolar, those who wanted to adopt tubectomy or laparoscopic tubectomy from the Vokkaleri PHC area were taken or sent to the district hospital at Kolar.

Family Planning Clinics

Observation of the family planning clinics in the taluka hospital at Malur and the district hospital at Kolar showed that the interaction between providers and clients, and the treatment given to the latter by the former were satisfactory. The concerned ANMs participated in the clinics. First, they prepared their 'cases' for tubectomy of laparoscopic tubectomy by washing the patient's abdomen with soap and water. They also helped in the laboratory examination and giving injections, the streptopenicillin test dose, and a soap and water enema. The ANMs also assisted in testing the women for diabetes and HIV infection. Then they arranged snacks and refreshments for their clients. The clinics were conducted under fairly satisfactory sanitary conditions. Informal discussions with women, both before and after adopting tubectomy or laparoscopic tubectomy, indicated that they were satisfied with the treatment given to them by the medical and paramedical personnel and with the quality of care they received. The concerned ANMs were on hand to help in every way, both before and after the operation. In fact, the women who adopted tubectomy or laparoscopic tubectomy said that if they did not receive good treatment and care, it would be difficult for the ANMs to motivate women for family planning in future.

A 26-year-old woman, who was waiting for a tubectomy operation in the Malur taluka hospital said, 'My mother and I came here in the morning. Our ANM has told me that the operation [tubectomy] will be

performed in the afternoon. The doctors and nurses in this hospital are not unkind. But our [SC] ANM is nice. She is taking good care of us.'

Another woman, about 25 years old, who was waiting for a tubectomy operation at the Kolar district hospital said, 'our ANM looks after us well because she has to bring other women for the operation.'

One woman, aged 28 years, waiting for a laparoscopic tubectomy in the Kolar district hospital said, 'this is a big hospital and the doctors and nurses are very busy. But they will perform a 'current operation' [laparoscopic tubectomy] on me this afternoon. We should have patience. However, our ANM is looking after me well.'

Further observation of the family planning clinics revealed three limitations. One, while the ANMs admitted the women to the family planning clinics at 9.30 a.m., case preparation started only at 11 a.m. or 12 noon. The doctors came only between 2 p.m. and 4 p.m. to perform tubectomies or laparoscopic tubectomies. The operations were over at about 6 p.m. Thus, the clients were required to wait for a long time.

When asked what they thought about waiting for a long time at the hospital for a tubectomy or laparoscopic tubectomy operation, one woman in the Malur taluka hospital said philosophically, 'We are the ones in need. Therefore, we have to wait till the doctors and nurses turn up. Perhaps they are busy with other patients'. Another woman, who was waiting for a laparoscopic tubectomy operation in the Kolar district hospital, said, `we are poor and rural people. I cannot force the doctors and nurses to perform laparoscopic tubectomy on me immediately. We should wait patiently for our turn.'

Two, it was observed that the women who came for tubectomy or laparoscopic tubectomy were given prescriptions to buy preoperative and postoperative drugs. Some of these drugs were then given to the doctors for administration. However, hospitals are required to provide these drugs free of cost.

On enquiry about the necessity to purchase pre-operative and postoperative drugs, one woman at the Malur taluka hospital said, 'We are poor people. We cannot afford to buy these drugs. I wish the government had provided these drugs. We are able to buy these drugs because we get some [incentive] money after the operation.' Another woman at the Kolar district hospital said, 'We understand that the government provides the drugs. But after we came here, we were told to

purchase the drugs. We cannot argue with the doctors about the drugs. We buy the drugs although we are poor people. Please tell the authorities to provide free drugs to poor people like us.'

Three, it was also observed that incentive money was paid in full to the tubectomy and laparoscopic tubectomy acceptors. Some acceptors distributed this money among the doctors, helpers and *ayahs*. However, when acceptors did not give them money, the doctors and other staff told the ANMs that their 'cases' did not give them 'anything'. Then, at the suggestion of the ANMs, the acceptors distributed their incentive money (some of them the entire amount) among the medical, paramedical and non-medical personnel. It needs to be pointed out that the ANMs were not taking money from the clients. The extortion of money from clients by the providers in the PHCs and hospitals is a major problem in the health and family welfare programme in Karnataka.

One ANM from Kudiyanur SC said, 'Doctors, nurses and helpers in this hospital expect money from tubectomy acceptors. We cannot protest against this practice because this has been going on for a long time throughout Karnataka. If money is not given, there will be unpleasantness, and services may be delayed or even denied.'

Another ANM from the Beglihosahalli SC said, 'tubectomy and laparoscopic tubectomy acceptors distribute a part of their incentive money among the doctors and nurses. Some of them do this on their own. But if some acceptors do not pay money, the doctors tell us to advise them to give money. Even though we do not like to, we tell the acceptors to give a part of the incentive money to the doctors, nurses and others.'

Family planning clinics at the Vokkaleri PHC were conducted when there were at least three or four women to accept tubectomy. Indeed, the LMO's convenience also mattered. The clients came to the PHC around 9 a.m. The headquarters LHV and ANM prepared the 'cases'. They washed the abdomen of the women with soap and water and gave them the necessary injections. They also gave soap and water enemas. Women were tested for diabeties, but not for HIV infection.

Interaction between the LHV and the ANM on the one hand, and the clients and their attendants (relatives) on the other, was somewhat formal. The former were mostly indifferent to, and unconcerned about, the latter. The LMO performed tubectomies at about 4 p.m., after

attending to the out-patients and resting from 12 noon to 4 p.m. Thus, the clients had to wait. According to the clients, they were satisfied with the treatment and services given to them by the providers.

The tubectomy acceptors at the Vokkaleri PHC had two complaints. One was that the LHV, ANM and other helpers demanded and took most of the incentive money. The other was that they were not provided food during their stay at the PHC for six or seven days. They had to make their own arrangements for food: either their relatives who accompanied them cooked near the PHC or they bought food from a restaurant.

One tubectomy acceptor said, `although I was given (incentive) money to adopt tubectomy, much of it was taken away by the *nursammagalu* [nurses, meaning the LHV and ANM]. They know that we are poor, yet they demand money from us.' Another tubectomy acceptor said, 'We were under the impression that we will get food during our stay at the hospital. But they are not giving food. We are cooking food with great difficulty because we did not bring the necessary utensils. We cannot afford to buy food from hotels.'

One reason why the clients did not complain about the providers' behaviour, or the facilities and services, could be that perhaps the clients' expectations were not high. What ultimately matters is the gap between clients' expectations and experience. Rural people, who are illiterate or barely literate, ignorant and poor live in unsanitary conditions. Add to this their ingrained tolerance and humility. All these qualities make the rural people have low expectations of, and remain largely uncritical about, providers' behaviour, and the facilities and services.

After accepting tubectomy or laparoscopic tubectomy, many women went to their mothers homes to rest for a few weeks. This was usually in an area not covered by the ANMs who had motivated them. Even so, the concerned ANMs went to the women and provided follow-up services because they did not want a single dissatisfied acceptor who could ruin their efforts to motivate others in future.

The proportion of Muslims in the population was higher in the Masthi PHC area than in the Vokkaleri PHC area. All the castes and classes utilised the services at both the PHCs. However, the Muslims utilised the services at the Masthi PHC the most while all the religious groups equally utilised the facilities at the Vokkaleri PHC.

The MOH of the Masthi PHC was of the opinion that the upper-class people were clean and courteous. Most of the others were dirty and rude. 'They do not have any manners', said the MOH. But they listened when he told them to keep the area around the PHC clean. He said that most people were 'unrealistic' because they attributed all their health problems to tubectomy or laparoscopic tubectomy, even though they had adopted it years ago. In contrast, the LMO of the Vokkaleri PHC was of the opinion that the people who utilised the services at the PHC were 'somewhat clean'..... They are courteous and have good manners. They keep the PHC premises clean. They appreciate my services. I am very strict with them and I treat them equally. I maintain a queue system. Even then they appreciate the services which I provide. Family planning cases attribute every problem to operation [sterilisation] only. Muslims utilise the services better because they need a reason to come out of the house. Therefore, they will visit the hospital.'

According to the MOH and LMO, most people in the two PHC areas had a good opinion about the providers. The MOH at the Masthi PHC said, 'Old people and poor people appreciate the services better. Youth and rich people are arrogant and they do not have any manners.' The LMO at the Vokkaleri PHC said, 'Generally, all the people appreciate our [PHC] services. The drugs provided by the government are not sufficient. When drugs are not available, I give prescriptions. This is resented by the people, especially young and rich people.'

In general, people had a better opinion of female providers than male providers. In fact, many male providers were disliked by the people.

The MOH of the Masthi PHC said, 'I am not satisfied with the quality of services provided because there are too many health programmes and there is no time to do justice to all of them. His official jeep had been taken away to the taluka hospital at Malur four months ago. He does not have a vehicle to visit the SCs and the villages in his PHC area. In order to improve the quality of services, he requires a jeep and more money to fuel the jeep. The current transport allowance (Rs.15 per tubectomy or laparoscopic tubectomy acceptor) needs to be revised to Rs.45. The LMO of the Vokkaleri PHC was, by and large, satisfied with the quality of services provided. According to her, `We provide good quality services in this PHC. I am satisfied with them. If there are any

shortcomings, they are beyond my control.' However, she was of the opinion that the quality of services could be improved by appointing a separate doctor to look after the administration of the PHC; the other doctor could provide services to the clients. She also said, 'This is a large PHC. The MOH is not there. I have to look after the administration of the PHC as well as provide services. If there is an MOH who can look after the administration of the PHC, I can concentrate on the services and further improve their quality.' Another important suggestion she made was that adequate and quality drugs should be supplied to the PHCs.

The MOH at the Masthi PHC is a Hindu Vaisya. He is 50 years old, married and has three sons. His wife has accepted tubectomy. He has been working as a medical officer (MO) for more than 20 years, and for more than five years at the Masthi PHC. He chose the medical profession because employment was assured, he had an aptitude for the medical profession, and he wanted to serve humanity. He did not want to take up any other job, even if it fetched him a higher salary. This indicates that he is committed to his job. As will be seen later, he is not committed enough to provide services to the clients.

The LMO at the Vokkaleri PHC is a Scheduled Caste Hindu. She is 42 years old, married and has two sons. She has adopted tubectomy. She has been working as an LMO for 15 years, and for nine years at the Vokkaleri PHC. She chose the medical profession to serve humanity. Like the MO at the Masthi PHC, she too did not want to take up any other job even if it fetched her a higher salary. She also seems committed to her job.

The MOH at the Masthi PHC asks the couple about the number of living children they have before prescribing or advising a particular family planning method. According to him, either couples choose a contraceptive method themselves or he discusses options with them, and then they choose a contraceptive method together. The couples who chose the contraceptive themselves were usually educated, while illiterate couples took his advice. His advice to newly-married couples was to have a child as soon as possible, and then adopt a spacing method. However, he was of the opinion that couples should not adopt any family planning method between marriage and the first child. According to him, society and culture expect newly-married couples to

demonstrate their child-bearing capacity. Therefore, it is not worth the effort to motivate newly married couples to adopt a spacing method.' He advised couples with two or more children to adopt `tubectomy.' He was of the opinion that one should tell couples only about the advantages of various family planning methods, since 'if one tells couples about the disadvantages and side effects of different family planning methods, they will not adopt any family planning method.'

He usually advises couples with one child to adopt an IUD, and those with two or more children to adopt tubectomy or laparoscopic tubectomy. It is difficult for couples with one child to use condoms or oral pills, because the adoption of these methods requires a high degree of motivation. While, he used to visit all the communities and SCs earlier, ever since the PHC jeep was taken to the taluka hospital at Malur, he has not been able to visit the remote SCs. He said that some couples were resistant to family planning due to religious reasons (Muslims), blind beliefs, illiteracy, objections from elders and fear of operation. He was of the opinion that his counselling (motivation) had a definite impact on the acceptance of family planning.

He thought that the provision of follow-up services would help the providers to enlist the cooperation of women and couples for the MCH and family planning programmes. He also felt that it would be impossible to provide follow-up services to all the MCH and family planning beneficiaries.

According to the MOH at the Masthi PHC, 'Targets, especially family planning targets, adversely affected the quality of services and other programmes, including the MCH programme.' He also observed that `Targets should be there but workers should not be compelled to achieve them, and no punitive action should be taken against workers if they fail to achieve the targets.'

He refused to specify the problems he faced from higher authorities when he provided services to the people. But he said, 'Community leaders and members demand services and drugs, which are sometimes not available at the PHC all the time. They want the doctor to stay at the PHC headquarters.'

The MOH at the Masthi PHC also noted that he spent more time on curative services. He did not think that he needed further training in effectively providing MCH and family planning services.

The LMO at the Vokkaleri PHC would enquire about factors like marital status of the man or woman, number of living children, age of the youngest child, blood pressure and diabetes, before prescribing or advising a particular family planning method. She said that she would discuss options with the couples and arrive at a decision regarding the contraceptive that they should adopt. She advised newly-married couples, and couples with one child, to adopt a spacing method, and those with two or more children to adopt a terminal method. She, too, was aware that it was difficult to motivate newly-married couples to adopt a spacing method. But, she said, 'Efforts should be made to persuade them to adopt Nirodh or oral pills.' She also noted, 'One should tell couples about the advantages, disadvantages and side effects of different family planning methods because couples can choose the method themselves, and they would not get perturbed when they experience side effects.' But she hastened to add that `while discussing side effects, they should not be emphasised; couples should be assured that proper follow-up services will be provided promptly and side effects will be cured immediately.'

The LMO at the Vokkaleri PHC also advised couples with one child to adopt an IUD because 'illiterate people will not remember to take oral pills or use a condom regularly.' Moreover, according to her, disposing of used condoms is a problem in the rural areas. She, however, wanted newly-married couples to use oral pills or condoms because IUDs cannot be adopted by newly-married women.

She said, 'I visit all the communities and all the SCs because there is a jeep available for me.' According to the LMO, Muslims were more resistant than Hindus to the idea of family planning. She also said that Muslim women in one of the areas under the Vokkaleri PHC were receptive to IUDs and the medical termination of pregnancy (MTP). She added that in these cases, she promptly provided family planning services.

The LMO at the Vokkaleri PHC was of the opinion that it is necessary to provide detailed information about every family planning method to couples. This would ensure that they choose the method that they most like, they are aware of the possible complications and are prepared to face them psychologically.

She said that it was not possible to provide follow-up services to all the MCH and family planning acceptors because the PHC area was too large. In addition, she was the only doctor at the PHC and she had to look after the hospital as well. But she noted that the provision of follow-up services to MCH and family planning acceptors would generate a sustained demand for these services.

She did not face any problems either from the higher authorities or from community leaders and members when she provided services to the people. She said, 'I have been forcing the staff to achieve family planning targets because of the pressure from "above" and, as a result, other programmes have suffered.'

The LMO at the Vokkaleri PHC spent more time on preventive and curative services. Like the MO at the Masthi PHC, she, too, did not think that she needed further training in effectively providing MCH and family planning services.

The lady doctor like the female health workers, had more sympathy for the clients than the male doctor. The clients, too, appreciated the lady doctor more than the male doctor. Thus, there was reciprocity between the providers and the clients. In the Vokkaleri PHC, a tubectomy acceptor said, '*doctoramma* [the lady doctor] is a nice person. She has patience. She answers all our questions and clears our doubts. She treats us well.' An antenatal mother at the Masthi PHC said, 'The [male] doctor is seldom seen in the PHC. He is very impatient. He often shouts at us. What can we poor people do?'

The process of sterilisation

The process of tubectomy, from the time a woman is motivated till she returns to the village after surgery, is interesting. As mentioned earlier, ANMs motivate currently-married women in the reproductive age for tubectomy while providing antenatal, intranatal and postnatal services. The women are informed about the days on which tubectomies are done in the Malur taluka and Kolar district hospitals.

A day before the operation, either the ANMs collect the women in their respective SCs and take them to the taluk hospital or the district hospital, as the case may be, or the ANMs tell the women to reach the

hospital on their own. Generally, they travel by bus and the women pay the bus fare.

After reaching hospital, the women are admitted into the ward by the ANMs, who register them by name. This is done by 3 p.m., a day before they are operated. Lady doctors examine all the women. The examination includes a general check-up, and a check for blood pressure, albumen/sugar in the urine, haemoglobin, and abdomen palpation. If a woman is late and reaches after the lady doctors have finished examining the women, she is asked to return the following week.

In the evening, after an early dinner, the women are given a soap and water enema by the ANMs. Abdomen preparation is also done by the ANMs.

The next morning only coffee is served to the women. Test doses of tetanus-toxoid, zyloken and streptopenicillin are given three hours before the operation. The operations start any time between 11 a.m. and 4 p.m., depending on the convenience of the surgeons. A zyloken injection is given during the operation and a tetanus-toxoid injection is given after the test dose. Streptopenicillin injections are given for five days, starting three hours after the operation.

The sutures are removed on the seventh day. The women are discharged and advised not to do any strenuous work or lift weights for about a month. The ANMs take the women back home by bus. Follow-up visits are provided.

As in the case of tubectomy acceptors, women coming for laparoscopic tubectomy are registered. All the examinations are done on the day of the laparoscopic tubectomy. Test doses of zyloken, streptopenicillin and tetanus-toxoid injections are given. A tetanus-toxoid injection is given after the test dose, zyloken during the operation and streptopenicillin three hours after the operation (only once). A couple of hours later, the women are discharged. They are sent home by official jeep and their transport money (Rs.10) is withheld. Before they are discharged, they are given the same advice that is given to the tubectomy acceptors. The ANMs provide follow-up visits.

The wards and rest-rooms are clean. Syringes and needles are sterilised before use. New gloves are used for every patient. The linen is fairly clean.

Antenatal and Immunisation Clinics

As mentioned earlier, antenatal and immunisation clinics were conducted together in the PHCs and SCs. Immunisation clinics were also conducted in the villages by informing the villagers in advance during the visits of ANMs to the villages. Clinics were conducted in the PHCs every Thursday. However, no single day was fixed for conducting clinics in the SCs and villages. Whenever a sufficient number of beneficiaries were available, clinics were conducted at the SCs and in the villages.

Antenatal and immunisation clinics in the PHCs generally start around 9 a.m., by which time the peons and *ayahs* have arranged the chairs, tables and benches. The LHVs supervise the arrangement of vaccines, syringes, iron and folic acid tablets, and the steriliser. The MOH and LMO come to the PHC at 9 a.m. or sometimes well after 10.30 a.m. When the pregnant women, infants and their mothers come at 9 a.m., they are made to sit on a bench. The ANMs first register the infants and then check the immunisation status. The infants are then vaccinated, according to their requirement. The arm or hip of each infant is cleaned with a cotton swab dipped in boiled water, but not with spirit, before vaccination. It was confirmed that there was no supply of spirit.

The mothers are told that the infant might develop fever and that they should not worry. They are also told to give a bath daily to the infants, and are advised to bring the infants for further vaccination after four weeks. They are instructed to preserve the immunisation card of the infant safely. The whole procedure takes about an hour, without much unnecessary conversation by either the providers or clients.

Next, the antenatal mothers are registered by the ANMs. Almost all the antenatal mothers were attending the clinic for the first time. Their height and weight are estimated and entered in a card or register. They are given a tetanus-toxoid injection and 30 iron and folic acid tablets. Only in some cases is the fundal height checked, urine examined, haemoglobin estimated and oedema assessed. It appears that these checks were not done when the number of beneficiaries was large.

Only antenatal mothers who were anaemic and visibly weak were identified as high-risk. They were advised to eat nutritious food and postpone the next pregnancy by adopting a spacing method, or to stop further pregnancies altogether by adopting tubectomy or laparoscopic

tubectomy. Virtually no attempt was made to identify high-risk groups by para.

Occasionally, after ascertaining the age of the antenatal mother, she was asked about the number of living children she had and her family planning status. Any mother who said that she had two or more children, and that she had not adopted any family planning method, was advised to adopt tubectomy or laparoscopic tubectomy.

The antenatal mothers were advised to eat nutritious food, like green leafy vegetables, milk, eggs and fish. They were asked to visit the PHC again after four weeks. But the providers said that they would not comeback to the PHC, and that follow-up services would be provided by the ANMs in the villages. The antenatal mothers were also advised to visit the PHCs for deliveries or to call the ANMs or trained *dais* to conduct deliveries.

No, information, education and communication (IEC) aids were used to convey information. Sometimes, important out-patients visited the PHCs. However, such interruptions were not many and did not affect the interaction between providers and clients. The total time taken for interaction varied from one to two hours.

Sometimes, the antenatal and immunisation clinics started late and the clients were required to wait. While the doctors, LHVs and ANMs interacted well with the clients, the *ayahs* who send the mothers one by one into the room for a tetanus-toxoid injection and iron and folic acid tablets were rude. The *ayahs* appeared impatient and domineering.

Antenatal and immunisation clinics were conducted at the SCs as well. Some of them were attended by MOHs/LMOs. The number of beneficiaries was smaller in the antenatal and immunisation clinics conducted at the SCs than in those conducted at the PHCs. Interaction between the providers and clients was warmer, and more friendly, courteous and lively in the clinics conducted at the SCs than in those conducted at the PHCs. There were informal conversations between the providers and the clients.

The process of vaccinating infants in the clinics conducted at the SCs was almost the same as at the PHCs. The advice given was also the same. However, the atmosphere at the clinics conducted at the SCs was different from the clinics conducted at the PHCs. For instance, the

beneficiaries were much more free and relaxed in the clinics conducted at the SCs than in those conducted at the PHCs.

For antenatal mothers, abdomen palpation was conducted to assess the height of the uterus and the position of the baby, a urine test was done for albumen and sugar, a haemoglobin test was done, and blood pressure and oedema checked. Height and weight were not measured. A tetanus-toxoid injection and iron and folic acid tablets were given. Information on antenatal care was provided. Antenatal mothers were advised to eat nutritious food, including green leafy vegetables, milk, eggs, fish and fruits. They were also advised to visit the PHC or any government hospital for their delivery or call the ANM or a trained *dai* to conduct the delivery. Hardly any attempt was made to identify high-risk groups, except to advise women who were anaemic to eat nutritious food, and adopt a spacing or terminal method for family planning, depending on the number of living children they had. Counselling on family planning was better in the clinics conducted at the SCs than in those conducted at the PHCs. Clients were advised to visit the SCs after four weeks. No IEC aids were used to provide information. There were no distractions or interruptions. The total time taken was about one hour. The quality of interaction and services was markedly better in the clinics conducted at the SCs than in those conducted the PHCs.

Immunisation clinics were conducted in the villages also. However, no antenatal clinics were conducted. The venue of the clinic was the anganwadi. Where there was no anganwadi, the clinic was conducted in a school. Invariably, the ANM concerned, with the assistance of an *ayah*, set up the clinic at the anganwadi, while the school teacher and the anganwadi worker went around the village advising mothers to bring their infants for vaccination. The vaccination process and the advice given to the mothers were the same as in the SCs and PHCs. In the clinics conducted in the villages, infants were vaccinated against the six killer diseases. Vitamin A tonic was also given to children between 3 and 5 years.

At times, immunisation clinics were conducted in the villages by a team of providers, comprising of one LHV, two or three ANMs, one male health worker and one or two *ayahs*.

It was observed that when an antenatal clinic was set up in one of the villages, most of the people were away working in the fields. The

ayah would visit them there and bring the women back to the village. The women then bring their infants to the clinic and have them vaccinated.

More time was spent on family planning counselling in the clinics conducted in the villages than in those conducted at the SCs and PHCs. More important, the interaction between the providers and clients (mothers of infants) was warmer, and more informal and courteous, in the villages than in the SCs and PHCs.

Mothers were informed about the possible side effects of different vaccinations. When asked whether they inform mothers about the side effects of the BCG vaccination, the ANM from the Kudiyanur SC said, 'I tell them that after about 40 days of the BCG vaccination, there may be a scar infection. Then you can come to me and I will take you to the doctor at the PHC, or you can immediately go to the PHC for treatment'. On being asked whether every child, after a BCG vaccination, will develop a scar infection, she said, 'Generally, if the prick is deep, the child gets a scar infection.' Another ANM at the Beglihosahalli SC said, 'Normally, there are no side effects of the BCG vaccination. So I do not tell mothers about the side effects'.

The ANMs invariably told the mothers that after the polio and DPT vaccination, children develop fever. One ANM at the Settykothanur SC said, 'I tell the mothers that the children will develop fever after the administration of the polio and DPT vaccinations. I give paracetamol tablets to the mothers, and advise them to give one tablet to each child after the administration of the polio and DPT vaccinations.' Another ANM at the Arabikothanur SC said, 'I tell the mothers that after polio and DPT, children may develop fever. There is no need to worry. Also, at the site of the DPT injection pus may form after a week. I advise them to come to me for treatment.'

All the ANMs said that there were no side effects of the measles vaccination.

The Sub-centres

Of the six ANMs studied, five were Hindus and one was a Christian; and, of the five Hindus, one belonged to a Scheduled Caste, three to backward castes and one to a dominant forward caste. Thus, the nursing

profession is yet to attract a sizeable number of females from the forward castes. The age of the six ANMs ranged from 27 to 42 years, the average age being 34.5 years. All the six ANMs were married. One was currently pregnant for the first time. Two had a son and a daughter each, and both had adopted IUDs. One had a daughter and a son, but she had adopted tubectomy, and one had two daughters and had adopted tubectomy. The last one had a daughter and a son, but her husband was using a condom.

The total work experience of the ANMs ranged from about four years to 14 years. They had been working in the SCs studied from four months to eight years.

Of the six ANMs studied, four chose the profession to 'serve the people; one had simply followed her fathers advice and joined the nursing course; and one had adopted this profession because employment was guaranteed and she could not pursue higher education for financial reasons. Three ANMs did not want to take up any job even if it fetched them a higher salary. They were probably totally committed to their job. Of the three ANMs who were prepared to take up a new job, two were willing to do so if it fetched them a higher salary, and one for even the same salary, indicating that perhaps they were tired of the arduous nature of the job.

Four ANMs lived at the headquarters of their SCs. One ANM did not live at her SC headquarters because there was no SC building. The SC had started only two years before. She was living 42 km away from the SC and was commuting daily by bus. The other ANM was living in Kolar, the district headquarters town, which was at a distance of 6 km from the SC, although there was a SC building with a residential portion for an ANM.

Quality of Interaction

As mentioned earlier, the investigators accompanied the ANMs for seven days and observed their activities when the ANMs visited the villages under their respective SCs to provide information and services to the people. The interaction between the providers and clients was described as 'good', 'cordial' and 'informal'. As soon as the ANMs approached the villages and met the villagers going to work, they greeted each other.

When the ANMs approached the households where there were pregnant women, nursing mothers, infants, young children, potential tubectomy acceptors or women who had recently accepted sterilisation, they greeted the heads of the household and other adult members, and their greetings were reciprocated. In many households, the ANMs were offered snacks, coffee, tea, milk or green coconut water. This is a clear indication that the ANMs were accepted by the community. In the 1950s. when the post of the ANM was introduced, only females belonging to lower castes and Christians adopted this profession. People belonging to the upper castes did not utilise their services. Thus, there was `structural incongruency'. However, the situation is different now. Although even now, the majority of the ANMs belong to the lower castes or are Christians, people belonging to the upper castes accept them and utilise their services.

The ANMs who visited the villages, visited all the households, and did not discriminate between upper-caste and lower-caste households. However, five out of six ANMs first visited the upper-caste households and then the lower-caste ones. This they did unconsciously. However, one ANM consciously visited the Scheduled Caste and other lower caste households before visiting the upper caste households, because she believed that the former were more cooperative and in greater need of her services than the latter.

The ANMs visited the households with pregnant women and nursing mothers on priority. They did this to establish a rapport with them and to motivate them to adopt tubectomy or laparoscopic tubectomy at the appropriate time. Households with women who had recently accepted sterilisation were also visited on priority to provide follow-up services and to ensure that they would not become dissatisfied acceptors.

When the ANMs visited the villages, they often carried ANC and PNC cards to register new cases. They also provided oral rehydration solution (ORS) packets, oral pills, condoms, iron and folic acid tablets and aspirin tablets. Thus, they provided not only MCH and family planning services, but also treated minor ailments. The study area is a malaria-prone one. Therefore, the ANMs occasionally took blood samples from persons suffering from fever, although this is the responsibility of male health workers. These blood samples were later

sent to the laboratory at the PHC, or the taluka or district hospital, for analysis.

Antenatal Services

The antenatal services provided varied from ANM to ANM. Sometimes, the antenatal services provided by the same ANM varied from one pregnant woman to another. Generally, ANMs assessed the height and weight of pregnant women. They examined them for anaemia and oedema, and checked the foetal heart beat. Invariably, they took the fundal height. They did an abdomen palpation to gauge the height of the uterus and the position of the baby. However, urine and blood tests were not done. Pregnant women were advised to go to the PHC or taluka hospital at Malur, or the district hospital at Kolar, for these tests. Tetanus-toxoid injections were given on the immunisation day.

The ANMs invariably distributed iron and folic acid tablets to pregnant women in three instalments (30+30+40) to avoid wastage. Each instalment was given after ensuring that the previous instalment had been consumed by the pregnant woman.

Pregnant women were given much useful advice by the ANMs. For instance, they were advised to eat nutritious food, like vegetables (especially green leafy vegetables), eggs and fruit, and to drink milk. One ANM was observed telling pregnant women to drink more water too. Pregnant women were also advised to cut their nails and keep them clean, to keep a new blade and washed clothes ready to be used at the time of delivery, and to go to a PHC or a government hospital for the delivery or to call an ANM or a trained *dai* to conduct the delivery. There was not much talk of family planning at the time of providing antenatal services.

Delivery Services

Each of the six ANMs conducted two to six deliveries during the study period. Most of the deliveries attended by the ANMs were in the villages of the SC headquarters. The way deliveries were conducted varied from ANM to ANM, and from delivery to delivery conducted by the same ANM. On the whole, the quality of delivery services leaves much to be desired.

Some ANMs gave the women a soap and water enema before the delivery. All of them washed their hands before conducting deliveries, although only some used soap. After the delivery, one ANM did not clean the baby's eyes, nose and mouth. The ANMs did not use the rubber sheet provided in the kit supplied under the Child Survival and Safe Motherhood (CSSM) programme, for the mother and the baby. After expulsion of the placenta, the baby was separated. Local thread was used instead of the sterilised cord ligature available in the delivery kit. A new blade was used to cut the baby's umbilical cord. Some ANMs gave the mother and baby a bath. Only some ANMs removed blood clots from the uterus. Diapers were made from old saris. In one instance, the baby was put on a flat bamboo basket used to clean foodgrains. One delivery was conducted by an ANM on a mat. After the delivery, the mother was made to lie on a bed of dry grass spread on the floor. The ANMs were conducting deliveries like *dais*. Possibly, ANMs lacked both the knowledge and proper attitude to conduct deliveries. However, whenever ANMs were requested to conduct deliveries, they readily obliged.

In one of the villages in the SC headquarters, a woman developed labour pains at 1.45 a.m. Her husband requested the ANM to conduct the delivery. The ANM readily agreed and went with a disposable delivery kit and a weighing scale. The delivery took place at 4.15 a.m., and the ANM came home at 5.30 a.m. after conducting the delivery.

In addition to conducting deliveries, the ANMs advised mothers about the need for, and importance of, breast feeding babies from the very first day, immunisation, infant care, postnatal care, giving a bath daily to both the baby and the mother, and keeping the surroundings of the mother and baby clean. The ANMs would ask postnatal mothers whether they were experiencing excessive bleeding. More importantly, the ANMs advised mothers or elders in the family to take all the babies with a birth weight of less than 2.5 kg to the PHC or taluka hospital at Malur, or the district hospital at Kolar, for observation and treatment. After the birth of a baby, the ANMs tried (and often succeeded) in motivating women to accept a method of family planning. Generally, the ANMs suggested IUDs to women with one child and tubectomy or laparoscopic tubectomy to women with two or more children. Women with two or more children were allowed to choose between tubectomy and

laparoscopic tubectomy. But virtually no attempt was made to motivate men to use condoms or adopt vasectomy. Thus, the ANMs did a lot of family planning promotion at the time of providing delivery services. The ANMs were probably aware that the post-delivery (postpartum) period was the point of highest motivation for family planning.

Once, on a visit to a village, the ANM was asked by one woman for medicine for her infant who was suffering from cough. However, the ANM advised her to give *kasayam* (water boiled with cumin seed, pepper and turmeric) to the infant. Another woman in the same village wanted medicine from the ANM for her 2 year old child suffering from dysentery. Again the ANM advised the woman to give reddish mud water with poppy seeds rather than medicine.

Family Planning Services

When visiting the villages, the subject of family planning was high on the agenda of the ANMs. Invariably, they carried oral pill cycles and condoms with them, but not IUD kits. On one of her visits to a village under an SC, two women wanted the ANM to insert an IUD. Since the ANM was not carrying the IUD kit, she advised them to visit the SC the next day and have the IUD inserted. While one of them came the next day to have the IUD inserted, the other woman did not turn up. Two observations can be made here. One, had the ANM carried the IUD kit to the village, the other woman would also have adopted an IUD. Two, the woman was not sufficiently motivated to go to the SC and have the IUD inserted. Another woman in the same village wanted the ANM to remove her IUD. Although the ANM advised her to go to the SC the next day, she did not turn up.

The ANMs gave oral pill cycles to the women. The oral pill users were not many. They did not give condoms to the men, but gave them to their wives. This is because men were embarrassed about getting condoms from the ANMs and the ANMs were embarrassed to give condoms to the men. The ANMs focused chiefly on women with two or more children who had not yet adopted tubectomy or laparoscopic tubectomy. They approached the women every time they visited the villages, and often succeeded in making them adopt sterilisation. Once a woman accepted tubectomy or laparoscopic tubectomy, the ANM either

took her to the PHC at Vokkaleri (the MO at the Masthi PHC did not perform tubectomies or vasectomies) or to the taluka hospital at Malur, or the district hospital at Kolar a day before the family planning camp day. Otherwise, she would ask the woman to come directly to the PHC at Vokkaleri or the taluka or district hospital where the ANM would meet her and admit her to the camp. At the family planning camps, the ANMs were busy looking after the arrangements for the sterilisation of women from the villages of their SCs.

It needs to be emphasised that some women, who were self-motivated, approached the ANMs to enquire about the date, place and availability of tubectomy or laparoscopic tubectomy services. The ANMs gave them the necessary information.

There were a number of instances, especially among the Muslims, where women were willing to adopt sterilisation, but their husbands and/or fathers-in-law and mothers-in-law were against the idea. The ANMs were, therefore, educating, in addition to women with two or more children, husbands, fathers-in-law and mothers-in-law, about the advantages of a small family and the disadvantages of a large family.

The ANMs made it a point to visit the women who had recently adopted sterilisation, and provide follow-up services wherever necessary. If the side effects of sterilisation were serious, the concerned ANM took the women to a PHC or taluka hospital at Malur, or a district hospital at Kolar, for treatment by a doctor. The ANMs were very keen to ensure that no sterilised woman became a dissatisfied acceptor because they knew that the image of the programme and the ANM created by 100 satisfied sterilised women could be ruined by one dissatisfied case.

There appeared to be a considerable latent demand for the medical termination of pregnancy (MTP). Three ANMs took three pregnant women to the district hospital at Kolar on three different days. A lady doctor examined the three pregnant women and performed MTPs.

Often, the ANMs visited anganwadis and enquired about the new pregnant women, nursing mothers and fever cases. They also signed the register in the anganwadis as proof of their visit to the villages.

There were problems regarding the timing of the visits of the ANMs to the villages. Invariably, they left the SC headquarters around 10.30 a.m., visited one or two villages (depending on the size of the village and its distance from the SC headquarters) and returned to the

SC headquarters by 2 p.m. or 3 p.m. During this time, many villagers were away working on their farms or as agricultural labourers. One investigator estimated that about 40 percent of the houses in the villages under one SC were locked when the ANM visited. When a house is locked, the ANM puts the date of her visit in a circle on the wall next to the main door of the house. This is proof to her supervisor, the health assistant (female), who was earlier known as the lady health visitor (LHV), that she visited the house. Often, the ANMs left information in the village about the date of their next visit so that those who were in need of their services could stay back.

Generally, the ANMs visited every village once a week. However, the villages located in remote areas, which did not have transport facilities, were visited less frequently than those that were easily accessible. As might be expected, people in the villages in the SC headquarters received services from the ANMs more frequently than those in the other villages. This may be the reason for the observation by the investigators that the ANMs had a better image in these villages than the other villages under the SCs.

Male Health Workers

As already mentioned, a large number of the posts for male health workers are vacant in Karnataka. Of the three SCs selected from the Masthi PHC, only one (Dinneriharohalli) had a male health worker who had to provide services not only to the villages under the Dinneriharohalli SC, but also to those under the two other SCs (not covered in the present study). In all, he had to provide services to 26 villages. Similarly, of the three SCs selected from the Vokkaleri PHC, only one (Arabikothanur) had the services of a male health worker. He had to provide services not only to the villages under the Arabikothanur SC, but also to those under two other SCs (not covered in this study). In all, he had to provide services to 23 villages. Although they said that they made with difficulty, one visit to each village in a month, one paid one visit each to four villages under the Dinneriharohalli SC during the two- month study period, while the other paid one visit each to three villages under the Arabikothanur SC.

The male health worker providing services to the villages under the Dinneriharohalli SC was 52 years old, married, with four children. He had had 10 years of schooling. His wife had accepted tubectomy. He was living in Dinneriharohalli. He had recently been trained and promoted as a male health worker. Earlier, he was a peon in the Masthi PHC. His total work experience is 27 years, and he has been working as a male health worker in the Dinneriharohalli SC for the last 15 months. He did not want to take up another job, even if it fetched him a higher salary. The male health worker providing services to the villages under the Arabikothanur SC was 41 years old, married, with three children. He was a graduate. His wife had accepted tubectomy. He was not living in Arabikothanur but in the headquarters of another SC not covered by this study. He has been working as a male health worker for 14 years, and for the last three years in the present SC. He was willing to take up another job if it fetched him a higher salary.

When the male health workers visited the villages, they randomly visited houses and mechanically enquired about the health of the children and adults. They obtained blood samples from people suffering from fever, to check for malaria, and sent them for analysis either to their respective PHCs, or the taluka hospital at Malur, or the district hospital at Kolar. They gave chloroquin tablets to people suffering from fever. This was called presumptive treatment, meaning that all fever cases were assumed to be due to malaria. Primaquin tablets were given to those who were confirmed to be suffering from malaria. This was called radical treatment.

It is important to note that the male health workers did not apply spirit on the finger before obtaining blood samples. In fact, they did not even clean the finger with water although the people in the villages generally have muddy hands as they work in the fields. It appears that there was no supply of spirit by the government medical stores.

The male health workers tried to impart health education to the people. Health education centred around personal hygiene and environmental sanitation. They advised the villagers to locate poultry farms at least 2 km from the village.

They also enquired about the births and deaths that had taken place in the village since their last visit and the new antenatal and postnatal cases. This information was entered into registers.

They advised recently delivered mothers to get their children immunised. They carried condoms for the men who wanted to use them, although most of the men were away working in the fields. They talked very little about family planning.

The male health workers visited the villages from about 9 a.m. to 1 p.m. During this period, many people were away working in the fields.

Focused Group Discussions (Providers)

As decided, two focused group discussions were conducted among the providers, one in each PHC, to assess their perception of the quality of care provided at the clinics and the interaction between the providers and the clients. During these discussions, issues such as the need for further training and method-mix, and the problems faced in providing services, were addressed.

The providers were confident that they were fairly well-trained for the job. However, many of them noted that they had been trained some years before, and they needed reorientation or even re-training. Some ANMs said that they needed further training in inserting IUDs as they were not sure whether they were inserting them properly. They said that they were given training for 15 days on inserting IUDs. Since they were trained in large batches (each batch containing about 50 ANMs), they did not receive adequate training. Some ANMs said that they required additional training in immunising children, pregnant women and nursing mothers. A number of ANMs said that they needed further training in conducting deliveries. Some ANMs said that they had been trained to conduct deliveries by other ANMs, but not by doctors. Therefore, they wanted to receive further training from doctors in conducting deliveries. Some providers said that a few clients were resistant to the idea of family planning. Therefore, they wanted training in motivating couples to accept family planning methods.

Regarding the need to promote method mix, the responses followed a set pattern. Virtually all the providers stated that couples with one child should be motivated to use an IUD, oral pills or condoms, almost in that order, while those with two or more children should be motivated to adopt tubectomy or laparoscopic tubectomy or vasectomy. When asked whether they would suggest a spacing method to couples

with two or more children and a terminal method to couples with one child, with a view to meeting method-specific targets, they all replied in the negative. They said that when couples with two daughters refused to adopt a terminal method because they wanted to have a son, they suggested a spacing method. It is clear from the observations made in the field that more efforts were made by the providers to promote the adoption of terminal methods by couple with two or more children. The providers were not concerned about achieving the targets for spacing methods. However, the targets were always achieved. This leads to a doubt whether the performance statistics of spacing methods are reliable.

The opinion of the providers about the need for, and possibility of providing detailed information to clients and its impact on the acceptance of contraceptives was divided. Some said that couples should be taken into confidence and told not only about the advantages of different family planning methods, but also about their disadvantages and possible side effects so they would not get unduly perturbed when they experienced side effects. They also said that the clients should be assured of proper follow-up services, especially when they experience side effects. But most said that clients should be told only about the advantages of different family planning methods and not about their disadvantages and side effects. They also said that people already had erroneous notions that they would not be able to work after vasectomy, tubectomy or laparoscopic tubectomy. If they were told about the disadvantages and side effects, many couples would not accept any terminal method. Similarly, the providers said that people were under the impression that condoms lead to skin diseases, oral pills to cancer and IUDs to heavy bleeding. Therefore, the providers were of the opinion that if the clients were told about the disadvantages and side effects of different family planning methods, they would not accept any method, and targets would never be achieved.

Many providers admitted that they faced problems in the community when providing MCH and family planning services. These included refusal by about 5 percent of the pregnant women to take tetanus-toxoid injections and by about 25 percent of the pregnant women to have iron and folic acid tablets. Some pregnant women develop diarrhoea when they take these tablets, which may be the reason for their refusal to take them. Similarly, some mothers did not want their children

to be immunised against measles because of the belief that children should have measles so that they can develop immunity to it later. The providers said that in providing family planning services, they faced resistance not so much from the couples as from the elders. Some of the providers said that the elders 'scolded' them and drove them away for promoting family planning. They also faced problems promoting the adoption of terminal methods among the Muslims.

The providers said that most villages were connected by road and were accessible by public transport. The providers reached the villages by trekking 4-5 km either from the SC headquarters village or from the nearest bus stop. Some villages were accessible by private transport, like jeeps or tempo, vans for which the providers had to pay a high fare. The providers experienced great difficulty when they organised immunisation clinics in the villages because they had to carry vaccines, equipment, and so on. They wanted a jeep to be provided when they organised immunisation clinics in the villages.

All the providers agreed that it was very important to provide follow-up services, especially to the tubectomy and laparoscopic tubectomy acceptors. They know fully well that the demand for tubectomy and laparoscopic tubectomy will dwindle if they do not provide follow-up services. They said they paid three or four follow-up visits to the 'operated cases', the first one within a week of the operation for dressing. When asked whether they did this only with the purpose of sustaining the demand, the providers answered in the affirmative, and added that they were also concerned about the health of the acceptors. They admitted that it was not possible to pay timely follow-up visits to all the IUD, oral pill and sterilisation acceptors. They also observed that they provided follow-up visits to all the sterilisation acceptors in time, but not to the IUD and oral pill acceptors. These clients were provided follow-up visits when the providers found the time. The providers also said that they paid timely follow-up visits to all the antenatal and postnatal cases, and immunised children. One important problem faced by the providers when providing follow-up services to the sterilisation acceptors was that they were not supplied with follow-up drugs and dressings. With their money the providers purchased 'Band-Aid' and nebasulpha powder for dressing the operated wound. Another ANM said that she faced problems when she provided services, such as non-

cooperation from her supervisors, who did not provide her with sufficient drugs, vaccines and a jeep to visit the villages and organise immunisation clinics.

The providers were fully aware that postnatal follow-up could be a good strategy to promote the adoption of tubectomy or laparoscopic tubectomy. They succeeded, to a great extent, in promoting the adoption of sterilisation by providing postnatal follow-up services.

The providers agreed that family planning targets were demoralising and distorted the quality of services. In monthly meetings at the PHC, while reviewing the percentage achievement of family planning targets, the MOH/LMO rebuked the ANMs who were lagging behind in their targets. Such rebukes, in the presence of other colleagues, was regarded by the providers as an 'insult.' Therefore, they tried to achieve their targets without concentrating on the quality of services. Thus, the quality of services suffered because of targets. However, this did not influence their recommendation of contraceptives to prospective clients because the major thrust was on the promotion of sterilisation, especially tubectomy and laparoscopic tubectomy.

The providers were unanimous in their opinion of the need for, and importance of, involving males/husbands in the family planning programme. Some providers said that special techniques should be developed to motivate men to accept condoms or vasectomy. Others were of the opinion that mass media like radio, television and film shows should be employed more rigorously to promote the adoption of condoms and vasectomy. In fact, they were critical that mass media propagated female family planning methods more often than male methods. Some of the providers said that, in a way females/wives were responsible for the lack of demand for condoms and vasectomy because they did not want their husbands to practise family planning, especially vasectomy, since they believed that vasectomy would harm their health, affect their working capacity adversely and so on. All the efforts to provide information, education and communication have not eradicated these beliefs. Condoms were not used because, it was believed they led to a lack of sexual satisfaction, and side effects like irritation. Also, the quality of the condoms supplied until recently was considered to be poor. Some of the old and experienced providers said that in the past there was a demand for vasectomy. However, this demand had almost

completely disappeared because the wives of many vasectomy acceptors became pregnant and this created a serious social problem. There were two main reasons for this 'failure': in mass vasectomy camps, vasectomies were not done properly and men were either not given condoms to use after vasectomy or when condoms were provided they were not used. Thus, both males/husbands and females/wives believed that tubectomy or laparoscopic tubectomy was the best family planning method. One of the important suggestions offered by the providers to involve males/husbands in the family planning programme is that male health workers should be given targets and asked to motivate males to adopt condoms or vasectomy.

Focused Group Discussions (Beneficiaries)

Focused group discussions were also conducted among the beneficiaries. As decided, two such discussions were conducted in each SC. These discussions were conducted in the same village - one among people belonging to the upper castes and classes, and the other in the peripheral area of the village where people belonging to the Scheduled Castes, Scheduled Tribes and other lower castes and classes live. Thus, in all, 12 focused group discussions were held among the beneficiaries. During the discussions, issues such as clients' expectation of services, accessibility of government and private clinics, and counselling by the providers were addressed. What follows is an analysis of the points that emerged from the group discussions among the two types of beneficiaries.

It may be mentioned here that the discussions conducted among the upper caste and class people were attended by a larger number of beneficiaries. One reason maybe that the number of people from the upper castes and classes was larger than the number of lower caste and class people living in the periphery. More important, beneficiaries from the upper castes and classes were more vocal and participated more actively in the discussions than those from the periphery.

The beneficiaries, especially those belonging to the upper castes and classes, said that for a number of reasons they preferred to go to private hospitals for health care. For one, unlike, government hospitals, doctors in private hospitals were readily available, and they were not

required to wait for a long time. Some beneficiaries said that in government hospitals, tablets were given, not injections, and these tablets were not effective. Others said that doctors in government hospitals prescribed medicines and injections which had to be bought. Injections had to be brought back to the doctor for administration. This meant that much time was wasted and a day's wages were lost of the people who accompanied the patient. However, in private hospitals, doctors gave tablets and injections immediately, and the people who accompanied the patients could go to work without losing any wages.

In government hospitals, doctors and nurses demanded money for treatment, and the paramedical staff were very 'rude' to the beneficiaries. But, in private hospitals, both the medical and paramedical staff were courteous. In government hospitals doctors advised beneficiaries to make four or five visits to the hospital, even for complaints like mild fever and headache, whereas in private hospitals one or two visits were sufficient. Some beneficiaries, especially from the lower castes and classes said that rich people went to private hospitals and poor people to government hospitals, although the latter knew that even after four or five visits to a government hospital they would not get any relief.

Interestingly, people preferred to go to government hospitals for family planning services. For one, it was felt that government hospitals were 'equipped' to provide family planning services, unlike most private hospitals. Second, the beneficiaries said that the ANMs gave them information on different family planning methods, helped them to get family planning services in government hospitals and provided follow-up services. Third, incentives were provided for adopting terminal methods in government hospitals.

The beneficiaries said that doctors from the PHCs should regularly visit SCs and provide services to the people living in the remote villages. They should not be required to go to PHCs, other government hospitals or private hospitals which were located far away. They said that they should be given effective and 'advanced' medicines, especially injections, free of cost, so that they can get immediate relief. Many potential family planning acceptors said that after the 'operation' (sterilisation), they should be given 'very good' tonics, free of cost, so that they can regain their strength quickly. They also wanted substantially large incentives for sterilisation acceptors to fully compensate for the wages foregone by

them. Thus the services of qualified doctors, free and effective medicines and injections and large incentives for sterilisation acceptors were considered to be good health and family planning services.

The number of government and private clinics known to the people and their distance varied from village to village. For some villages, government hospitals (PHCs) were closer than private hospitals, while for others both government and private hospitals were equidistant. The distance of a PHC or a government hospital from a village varied from 3 to 18 km and that of a private hospital from 8 to 22 km. Most of them were functioning regularly. While in private hospitals health workers were available at a scheduled time, they were not available in all the government hospitals at a fixed time.

The beneficiaries said that the providers gave them all the information requested, disseminated information on different family planning methods and explained how to use them. While some beneficiaries said that they were told about the possible side effects of different family planning methods, others said that they were not told about them. All the beneficiaries said that if complications occurred, they were advised to go to a PHC or a government hospital, or call the ANM.

The beneficiaries said that the providers regularly conducted clinics at the PHCs, but not at the SCs. The doctors at the PHCs were not visiting the SCs regularly and therefore, the clinics were not conducted regularly at the SCs. The beneficiaries observed that the ANMs were fairly regular in their field visits. They also added that the ANMs frequently conducted immunisation clinics in the villages. The beneficiaries were informed well in advance about the date of the visit of the providers and about the date of immunisation clinics. The providers treated the clients with courtesy and affection. Similarly, the clients treated the providers with respect and affection. The providers were frequently given snacks, coffee, tea, milk or green coconut water, by their clients.

The beneficiaries confirmed that the ANMs advised them on follow-up activities. They also said that the ANMs paid follow-up visits to the clients. When the providers visited the clients, the former were informed about the date of their next visit, including the follow-up visit. The beneficiaries said that the ANMs considered follow-up visits necessary.

Most of the people said that they were satisfied with the services provided in the outreach (i.e., in the villages), but not with the services provided in the PHCs. They said so because, with the limited time and resources available to the ANMs, they were doing a good job. However, the doctors and nurses in the PHCs demanded money, did not provide services promptly, did not give effective medicines and injections and were very rude. However, most of them said that they would recommend the services to their friends.

The beneficiaries gave a number of suggestions to improve the services. For one, they wanted a PHC to be set up close to the villages, failing which they wanted the doctors in the PHCs to visit SCs at least once a week so that they could receive services from qualified doctors. They wanted facilities to be provided in the SCs to treat cases of snake-bite. Incidentally, during the study period there were three cases of snake-bite in the Vokkaleri PHC area, but treatment was not available at the PHC. Two persons were treated at the Kolar district hospital, and survived. One was treated with traditional methods and died. They also wanted modern and effective medicines and injections to be given free. For family planning acceptors, especially sterilisation acceptors, they wanted tonics to be given free and larger monetary incentives.

This in-depth study illustrates the importance of assessing the perceptions of both clients and providers regarding the quality of health care services. Similar studies should be undertaken in other states of India, which will help to identify the areas where health care services are lacking, so that suitable measures can be taken to improve them.

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Appendix - I

Villages Served by the Three Selected SCs Under the Masthi PHC and their Distance from the SC Headquarters

Name of SC/Village	*Population (1994)*	*Distance from SC Hqs. (km)*
Dinneriharohalli (SC)	980	0
Thirumalahatty	545	1
Mattanakapara	141	4
Hobbatty	392	3
Niddadagatta	428	1
TOTAL	2,486	
Kudiyanur (SC)	2,000	0
Halakempanahalli	57	3
Aranighatta	400	4
Channigarayanapura	381	9
Gunur	207	11
G. Kappa	543	10
Ramapura	500	4
TOTAL	4,088	
Santhehalli (SC)	773	0.0
Turugalur	122	1.5
Manishettihalli	350	3.0
Ramanathpura	130	4.0
Sonnapanahatti	560	4.0
TOTAL	1,935	

Appendix - II

Villages Served by the Three Selected SCs Under the Vokkaleri PHC and their Distance from the SC Headquarters

Name of SC/Village	*Population (1994)*	*Distance from SC Hqs. (km)*
Arabikothanur (SC)	1,094	0
Nagalapura	263	5
Cheluvanahalli	607	4
Chunchadenahalli	545	2
Pennashettahalli	517	6
Kendhatti	564	4
Madiwala	50	4
TOTAL	3,640	
Beglihosahalli (SC)	1,531	0.0
Chathrakoodihalli	1,422	2.5
Choolaghatta	657	5.0
Beglibenatenahalli	580	1.5
Singoondahalli	499	3.0
Lakshmisagara	380	5.0
TOTAL	5,069	
Settykothanur (SC)	930	0.0
Bettabenajenahalli	480	0.50
Chikkanahalli	270	0.75
Bettahalli	180	1.00
Mangasandra	840	5.00
Choudadevanahalli	280	6.00
Kallandur	502	7.00
Settyganahalli	855	0.50
TOTAL	4,337	

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