HEALTH CARE FACILITIES AND AWARENESS FOR PREGNANT WOMEN IN RURAL AREAS OF HYDERABAD –KARNATAKA REGION

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❖ *Abstract*

This research study examines women's perspectives and utilization of health care services during Pregnancy and childbirth in a rural community in northern India. Health most important aspect for the survival of human being. With the passage of the time survival concept, knowledge on various issues, skills are developed over period of time and infrastructure in the field of healthcare have been changed and evolved through the evolution of human societies. Hover, due to gender differences in differences traditional societies the priorities of women role and her status has been neglected. Gender differences in health status are significant though higher men enjoy status life expectance than man but the class of life they lead is poor in conditions. Women's health complication and problems are existed during are phase of life Since childhood to old age but the reproductive health complication or problems are most important and required urgent attention the issue was raised in the Copenhagen conference the IPCD mainly focused on subject health needs of women and children.

Key words; women's, child, health care, facilities.

Introduction;

Maternal mortality rates in India are alarmingly high. This study examines women's utilization of healthcare services during pregnancy and childbirth in a rural area Women within the community were asked to share their experiences and healthcare services they used during their own childbirth experience, as well as identifying obstacles in obtaining maternal care. In addition, the women stated their perspectives on how to improve utilization of care within their own communities. The need to address women's access and barriers to health care resources, adequacy of resources, and utilization of services is vital to the health and well being of rural Indian mothers. Nationwide, healthcare utilization rates show that private health services are primarily directed at providing primary healthcare and financed by private resources, which places a disproportionate burden on those living in poverty. Health related expenses are among the most important causes of rural women indebtedness and impoverishment (India Together, 2004). For some, the choice is often between healthcare in private systems that are financially beyond their reach, or death. The World Health Organization (2004) states the majority of the

maternal deaths could be prevented if women had access to and utilized skilled care during pregnancy, childbirth and family planning. The WHO (2004) also points out that maternal mortality is a human rights and equity issue. Women everywhere should have the right to safe, affordable and accessible health care.

Objectives;

To assess the health care facilities of pregnancy women's and child.

To assess the health care awareness of pregnancy women's and child.

State and National Health Programmes

A number of 'National Health Programmes" have been launched by the Central Government and it also many international agencies like W.H.O., UNICEF, UNFPA, World Bank as also a number of agenesis are SIDA, DANIDA, NORAD and USAID have been providing technical and material assistance in the implementation of these programmes. Some of these programmes are-

- National Malaria Eradication Programme - 1953
- National Filaria Control Programme – 1955
- National Leprosy Eradication Programme – 1955
- National Tuberculosis Programme - 1962
- Revised Tuberculosis Control Programme - 1992
- Diarrhoeal Diseases Control Programme Sicth Plan
- The Acute Respiratory Diseases Control Programme – 1990
- National Aids Control Programme - 1987
- Guinea Worm Eradication Programme 1983-84
- Reproductive and Child Health Programme 165
- National Surveillance Programme for Communicable Diseases 1997-98
- National Iodine Deficiency Control Programme 1962
- National Mental Health Programme 1982 - 7th Plan
- National Cancer Control Programme 1975
- National Diabetes Control Programme
- National Cardiovascular Diseases Control Programme
- Oral Health Project 1995
- National Emergency Preparedness Plan - Disaster Management
- India Population Project

- Basic Minimum Services Programme
- National Water and Sanitation Programme 1954
- Other Vector Borne Diseases Control Programmes are: a) Kala Azar Control Programme b) Japanese Encephalitis Control Programmes c) Dengue
- Nutritional Programmes are: a) Integrated Child Development Services Scheme - 1975 a) Programme Against Micronutrient Malnutrition 1995 b) Midday Meal Programme 1962-63 c) Special Nutrition Programme 1970-71 d) Balwadi Nutrition Programme 1970-71 e) Wheat Based Supplement Nutrition Programme 1986 f) Applied Nutrition Programme 1936 166 g) Tamil Nadu Integrated Nutrition Programme 1980 h) National Nutritional Anemia Prophylaxis Programme - 1970 i) National Programme for Prophylaxis against Blindness in Children due to Vitamin - A deficiency -1976 j) World Food Programme. There is some consensus today that these programmes are cost effective only for diseases that are eradicable, but should not be permanent features of health care [EPW 2002].

Integrated Child Development Services (ICDS);

ICDS Programme is a country wide centrally sponsored scheme, which provides a package of services viz, supplementary nutrition, immunisation, health check- up, referral services, and education on health and nutrition and non-formal preschool education. Vulnerable section of the population is covered under this scheme i.e., children below six years of age, pregnant women and nursing mothers. The package of services is provided to the beneficiaries through the Anganwadi Centres managed by an anganwadi worker and helper at the. village level and in slums in urban areas. The programme began in 1975 with the help from UNICEF in 33 blocks and few urban areas, and now after 30 years, it has expanded to cover most of the country. It is considered as the biggest child welfare programme in the Asia. Most importantly, the priority groups under this programme have been children from low socio-economic groups.29 In Kamataka, the ICDS programme was launched as a pilot project in Mysore district on 2"d0ctober 1975. The Programme has expanded its network to cover 166 rural, 9 tribal and 10 urban projects across 176 taluks. Throughout the state, there are 40015 anganwadi centres among which 36184, 2801 and 1030 are in rural, tribal and urban areas respectively. The programme envisages a package of services covering a supplementary nutrition programme for children below 6 years and pregnant and nursing mothers, pre-school education for children in the 3 to 6 age group, immunisation of children and mothers, health checkups by medical officers, referral services and health and nutrition education. At present, there are 185 projects functioning in the state, covering all the 33.83-lakh beneficiaries. During 2004-05, Rs. 12280.15 lakhs was incurred up to the end of March 2005 under plan towards administration cost of 185 ICDS projects, which is met by Government of India. Apart from this, the state government incurred an amount of Rs. 3568.77 lakhs upto the end of March 2005 for payment of additional honorarium to Anganwadi workers and helpers. 30 The information and data available in the Department of Women And Child

Welfare indicates that up to December 1998, against the targeted 13 lakh children in the age group 0-3 years, 11.33 lakh children were reached; against a targeted 12.86 lakhs in the age group 3-6 years, 11.72 lakhs were reached; similarly, there is general shortfall in reaching pregnant and lactating mothers and adolescent girls. Around 24 per cent of the beneficiaries belong to the Scheduled Castes and Scheduled Tribes, while 12 per cent belong to minority groups.

Community Monitoring Project;

The Community Monitoring Project was started in June 2002 in Manvi Taluk ofRaichur district of Hyderabad-Kamataka region to improve the quality of life of the people in the talk by increasing their access to and control over education, early childcare and safe motherhood. The major goal of increasing the quality of life of over 2,65,400 families in the 4 taluks of Raichur and Gulbarga districts is done through an organized and hierarchical system of village level volunteers and organizers who monitored the quality of government services at Primary Health Centers (PHCs), Anganwadi schools and other delivery centers. A Number of government officials, elected representatives and community volunteers interacted to improve the existing systems and build on them which is considered as the first notable step of the government to make health an integrated issue. The Community Monitoring Project, which was seen as a highly potential community health programme has many broad based objectives, which makes the project unique and special. The project has an objective to support village development monitoring committees to review the status of their community's health, educational and nutritional status and to plan and monitor their access to appropriate education, health and nutritional services to meet both the demand for these services and to correct the gaps identified. Besides, it also aimed to facilitate an interdepartmental team of officials from the departments of Education, Health and women and Child Welfare, to review the effectiveness of their programmes and to meet 'Red Alert' requests from the community on an emergency footing. It also attempted to build the capacities of the four partner NGOs in the pilot taluks by establishing a forum for sharing their experiences and learning from each other. The CMP also took measures to facilitate public access to the learning generated and issues in Manvi taluk ofRaichur district. It was to create an environment that will facilitate up scaling and replication of the pilot project. More significantly, the CMP created a constituency of development workers, decision-makers and policy-makers, who will, in able to make informed inputs to child and women development in their own operational areas. Thus, the CMP was successful enough to increase both an 158 understanding of and demand for similar services from the larger public, which is the most significant outcome of this project.32 The officials of the UNICEF, the funding international agency put the performance of the project to evaluation after two years of its completion. The team not only expressed satisfaction over the performance of the project in Deodurga taluk of Raichur district but also advised the implementing authorities to include the issue of high school dropout in the region and steps to be taken for re-enrolling them to the school. The team also

advised the PHC doctors to review about their programme and got suggestions to review the project in detail to improve the quality of the programme through people's participation, which is the most significant step. Despite its extra ordinary success in the Deodurga taluk of Raichur district, this pilot project has been discontinued and merged with Swasthh Plus programme of the Department of Health. Swasthh Plus Programme Swasthh Plus programme is one of the most latest and broad based health care programmes implemented today in the most backward districts of the state, particularly in Hyderabad-Kamataka region. It is an integrated programme encompassing school, social communities, NGOs and Gram Panchayats. The characteristic feature of this programme is that it attempts to support village based interventions that encourages social communities to take action on all aspects of development that will ensure: a safe healthy, hygienic physical, social and emotive environment for children: supportive actions for child survival and healthy growth and supportive action to ensure that all children will have opportunities for learning and completion ofbasic schooling. Among the major objectives of the Swasthh Plus programme, the process of empowering community-based organisation to plan and monitor performance has been very significant. Besides, there is a strong school-community linkage where community ensures enrolment, attendance and completion of primary schoolboy all children.33 Besides, the programme attempts to create a system of monitoring, which ensures a process of joint planning and monitoring at each level with a system for redressal of problems so that the service departments could participate and respond to community needs. It also provides an opportunity to all convergent departments to coordinate among themselves and review progress along with the community and initiate corrective action at local level. This process has no doubt, enabled the community to take up the responsibility to lobby and demand services from the concerned departments. This would also enhance accountability, efficiency and better service delivery mechanism over time. The role of NGOs in making the Swasthh Plus programme effective has been well laid out. NGOs as one ofthe key stakeholders have been useful in the process of village planning and implementation of the programme. The five component NGOs of this programme have continuously been undertaking major tasks to ensure that all staff and other facilitators are fully trained as per an agreement with the UNICEF.34 Besides, the NGOs have facilitated in the development of a neighborhood networks that ensures each neighborhood to nominate youth volunteers who will be the link between the development programme and the village. They also train and build capacity of the volunteers to function as the village animators following up on the village action plan as well as help communities to meet regularly and take up new activities as they deem fit. NGOs have been in the forefront to support the community to monitor key indicators, especially those related to children, through formation of different committees and thus ensure regular monthly meetings. They have also encouraged the participation of the Panchayat members in the village planning process and thereafter in the activities. National Rural Health Mission The recently. announced National Rural Health Mission (NHRM) by the UPA government at the Centre is considered as a milestone in rural health. It is expected to strive to improve the access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health

care. It also attempts to provide effective health care to people living in rural and backward areas across the country and also lays special focus on rural populations in 18 states with poor health achievements. The mission is also expected to take an integrated view of health by women and child.

Public Spending on Health;

The role of state government in correcting regional imbalances in terms of availability of health care facilities is understood by looking at public spending on health care and infrastructure. Although the district-wise data is not easy to gather on public spending on social development, as there are multiple government departments involved in ensuring health care such as Department of Health and Department of Women And Child Welfare to name a few. It becomes difficult to aggregate the data received from all the departments at the district level. Hence, the study has attempted to provide a state picture in terms of public spending on important sectors of social development. In Kamataka, about 8 per cent of total expenditure of the state was earmarked for health and family welfare, nutrition, water supply and sanitation services over the years. At 1991-02 prices, per capita expenditure on these services was Rs. 117. About half the expenditure was on medical and public health, one-tenth on family planning services, on fifth on water and sanitation services, and one-sixth on nutritional programmes.36 It was also observed that as much as 80 per cent of the total funds allocated to medical and public health went to urban health services and assistance to local bodies, corporations, etc. leaving little for rural health services. If over 80 per cent of expenditure on health, nutrition, and sanitation services came under the non-plan category almost all the expenditure of family planning and twothirds of expenditure on water supply was under the plan sector. Thus, there exist an urban bias in public spending and rural regions continue to remain neglected in terms of state attention. The following table provides information on public spending on health for the period of 1990-91 to 1995-96.

References;

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- ✓ No.4, July 2005, pp.613-640 for measures to improve the nutritional status of children. 30 Annual Report, 2004-05, Department of Women and Child Development, Government of Karnataka, Bangalore, 2005, p.l4.
- ✓ Lokshin Michael et al, "Improving Child Nutrition? The ICDS in India", Development and Change, Vol.36, No.4, July 2005, pp.613-640. The article also lists measures to make the ICDS programme successful and result-oriented.

- ✓ To know more about the CMP, see the Report of the Community Monitoring Project for the period July 2004 to March 2005, Department of Women and Child Welfare, Government of Kamataka, Bangalore, 2005. 33 Raichur District Report Card of the Swasthh Plus Programme, Office of the Deputy Director, Women and Child Welfare, Zilla Panchayat, Raichur, 2005.
- ✓ The five component NGOs of this programme are Janakalyan, Prerana, Samuha, Mahila Samakhya and Ingrid. These NGOs have been doing extra-ordinary work in the field of health and women empowerment in the most backward districts of north Karnataka.