Faith, Trust and the Perinatal Healthcare Maze in Urban India

S. Raman

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Abstract

How women access and utilise health services through pregnancy, childbirth and infancy needs to be understood if we are to improve the delivery of and access to appropriate healthcare. Drawing on ethnographic observations of clinic encounters and in-depth interviews with women in Bangalore, South India, this paper reports on the complexities of negotiating healthcare throughout the perinatal continuum in urban India. Key themes identified include faith and trust in health services, confusion over right to healthcare; and the contested nature of choice for women. What is revealed is a socially restrictive framework that results in choices that seem arbitrary, irrational and self-defeating; poor women being particularly vulnerable. Given the current policy support for public-private-partnerships in reproductive healthcare delivery in India, both public and private health services need to move substantially to achieve true partnership and provide care that is respectful and valued by women and children in urban India.

Keywords: *Private healthcare; perinatal continuum; access; healthcare utilisation; India*

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I. Introduction

In a small, sparsely furnished clinic room in a busy tertiary hospital, a burqa clad young woman Fatima[1]*, is being briskly examined on the bed for menstrual irregularities. Fatima says little, holding onto her 10 year-old daughter, who interprets for her mother. In the same room another young woman, obviously pregnant, is being asked a few questions about her pregnancy, while a third waits impatiently at the open door for her turn to be seen, clutching her outpatient card. It is 9.30 am on a Tuesday morning at the Out Patient section of St John's (SJ) Medical College Hospital in south Bangalore, and already the waiting room is full to overflowing.*

I first encountered Fatima, a Bengali Muslim woman in her mid twenties, in the one room dwelling that she called her home. She appeared exhausted, pale and thin, and she carried her young infant around with her. Fatima lives with her husband and three daughters, the youngest 11 months old, in outer metropolitan Bangalore. Along with her husband, father, brothers and sisters-in-law, Fatima had moved to Bangalore from Kolkata some years ago. The family works in the zardosi (embroidery) trade – the men skilled embroiderers, but poorly paid. The entire family occupies four single rooms adjacent to each other on a dirt road, with one shared external latrine; a larger (fifth) room is devoted to embroidery work. Fatima has had some high school education and speaks a smattering of Hindi. None of the women work outside the home, none speaks the local language. Their interactions with the world outside are largely mediated by the males in the family.

The baby is pale, undernourished, sickly looking and cries constantly. Fatima's husband and father often respond to questions put to her, many times suggesting that "everything is in the hands of Khuda (God)." Fatima herself says little, except that she misses her own mother (in Kolkata), very much. Fatima had attended SJ Hospital for her previous pregnancies, and for other medical care, as she had been sick with "thyroid problems". The whole family sought medical care at SJ, "we know it is good care and they know we are poor, so they give us inexpensive medical care." Fatima discovered she was pregnant while being treated for the "thyroid" problem, was told that pregnancy was risky, that she had to be extra careful, and that she would have a "small baby". She had attended antenatal clinics at SJ Hospital, ("we have full faith in SJ, they gave me some tablets"). For all hospital visits Fatima had been accompanied by her father or husband; from her previous house, this entailed two bus rides. When she went into labour late one night at term, her husband was able to locate a car through friends, at some expense, and she was taken to SJ Hospital. Delivery was "normal", but birth weight was about 2 kg – according to Fatima and her husband this was "too low". Fatima stayed in hospital for about a week, because "she was sick".

[1] Names have been altered to preserve identity of all participants.

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Since moving to their current residence when the baby was a month old, none of the family has been able to find health or support services nearby, "we only know SJ, which is too far" (about 20 kms away). They admit to feeling stressed about their current situation, "we are poor, and in a difficult situation, there are no facilities here." The local primary health centre is visible and within walking distance, and the Anganwadi (child and mother care) centre is in the next neighbourhood. Fatima has not been visited by the auxiliary nurse midwife; she thinks she does not qualify for such care. Fatima is not sure if her baby is doing well or not, she has not been weighed, measured, examined or immunised after discharge from hospital. The baby is still largely breastfed, with some supplementary bottle-feeding. Fatima says there is "no one to give any advice about the child. In the old house we were close to a private paediatrician, there is no one here."

Perinatal conditions, too frequently epitomised by stories comparable to Fatima's, account for the largest contribution to disease burden in low and middle-income countries (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006) making the perinatal period i.e. pregnancy, childbirth and infancy, a key period for health intervention. India contributes the greatest number of child deaths and malnourished children in the world and has a dubious record on women's indices generally (Ministry of Health and Family Welfare, 2008). India also has one of the most privatised healthcare systems in the world in terms of delivery and finance (Balarajan, Selvaraj, & Subramanian, 2011; Rao, Bhatnagar, & Berman, 2012). There has been increasing interest in the role of the private health sector (Floyd et al., 2006; Radwan, 2005), and in particular the ability for public-private partnerships to deliver interventions in the perinatal period necessary to achieve the millennium development goals in maternal, newborn and child health (Bhat, Huntington, & Maheshwari, 2007; Brugha & Zwi, 1998). The Indian government's own policy states that they welcomed participation of the private sector in all areas of health activities, specifically acknowledging that it would be difficult to provide comprehensive health services in the context of the very large number of poor in the country (MOHFW, 2002).

Much has been written about India's medical pluralism, its range of traditional and modern healing systems, both from the point of view of delivery of healthcare (Helen, 2012), and attempts to understand patients' choices in utilising a multiplicity of modalities of care (Khare, 1996; Nichter, 1980). Social scientists have been fascinated by the medically diverse character of India's health care landscape for at least the last two decades, although Khan cautions against ignoring issues of power, domination and hegemony that may also fuel this "co-existence'' of varied medical traditions.(Khan, 2006) Nowhere is the need to understand patterns of utilisation more pressing than the perinatal period, wherein over two-thirds of care utilisation is in the private sector (Baru, 2003). While the public health community has been understandably focussed on equity issues in access to reproductive health services (Mohanty, 2012), there is little understanding of why people choose the private health sector, why the two sectors collaborate so poorly and how to address equity issues within the very large private health sector delivering perinatal care in India. This sector is characterised by heterogeneity, from small and large private hospitals or 'nursing homes' with fewer than 30 beds at the secondary level to tertiary and super specialty hospitals (Deosthali & Khatri, 2010). De Costa's study exploring the barriers of (mis)trust between the private and public health sector in Madhya Pradesh, suggested that these had social, moral and economic bases (De Costa, Johansson, & Diwan, 2008).

There is robust evidence that skilled maternal, newborn and child health services help in reducing maternal and child morbidity and mortality (Adam et al., 2005). The utilisation of health services by women and their infants is a complex phenomenon influenced by many factors, and its determinants are not the same across socio-economic and cultural contexts (Navaneetham & Dharmalingam, 2002). Large scale research studies based on demographic health surveys have highlighted maternal education, socio-economic status, religion and the service delivery environment as important determinants for the use of maternal health services (Bhatia & Cleland, 1995; Jat, Ng, & San Sebastian, 2011; Kesterton, Cleland, Sloggett, & Ronsmans, 2010). While there have been some excellent

anthropological explorations of pregnancy and childbirth in South Asia, particularly focusing on the rural setting (Blanchet, 1984; Gideon, 1962; Pinto, 2008; Ram, 1994; Rozario, 1998), there is less work done in urban India. Van Hollen's ethnographic study of childbirth in Tamil Nadu in the 1990s, interrogating modernisation's influences on women's childbirth practices both in semirural and urban settings is a notable exception (Van Hollen, 2003).

Fatima's case is typical of those encountered in my ethnographic study in Bangalore, poignantly raising the difficulties women and their families have in negotiating healthcare through the perinatal period. In this paper I explore women's access to and utilisation of health services through the perinatal continuum in urban south India.[2]

II. Methodology

In 2003 a prospective birth cohort study was undertaken in SJ Medical College Hospital, a tertiary, private faith-based health service in Bangalore, to explore the association of maternal health and nutrition with maternal and child health outcomes. SJ Hospital services a large mixed population; poor patients are treated for very little money or for free, while middle class patients have to pay for services. Greater Metropolitan Bangalore is a contemporary urban landscape not unlike other metropolises in low and middle income settings, and includes large areas previously classified as villages (rural), that have recently been incorporated to the city. Ethnography consisted of formal and informal encounters with women and their families recruited to the cohort study as well as observation of clinical encounters. Between August 2008 and February 2009, I conducted in-depth interviews with 36 women from the cohort, who had been through pregnancy and childbirth within the last two years. I used maximum variation sampling (Grbich, 2003), to ensure a mix of social and cultural groups from within three education levels. These included women with low education levels (primary school- Group 1), women with medium education levels (completed high school- Group 2) and women with high education levels (tertiary education – Group 3). With the help of a research assistant, I conducted interviews in five different languages – Kannada, Hindi, Tamil, Telugu and English – the language of interview being chosen by the participants.

In December 2010, I observed health encounters occurring in ante-natal clinics, post-natal clinics and child health clinics, in SJ Hospital and in a government hospital clinic. In these observations, my role ranged between 'observer as participant' and 'participant as observer' in the Gold range of research roles (Green & Thorogood, 2009), using "participant listening" as a key technique (Forsey, 2010). As with Zaman in his Bangladeshi hospital study (Zaman, 2004), I had distinct advantages in gaining access to the clinical environment, having both "insider" and "outsider" status. I am a doctor (paediatrician) of Indian origin, undertook early medical training in the institution (SJ), and further training in paediatrics and public health in Australia. My identity as a doctor and a former student helped me gain easy access to the hospital and clinics; I was also easily accepted within the public health research community.

Thematic analysis of transcribed interviews and ethnographic field notes was carried out (Braun & Clarke, 2006). Overall analysis was iterative, being guided by the principles of phenomenology, incorporating both descriptive and interpretive elements (Green & Thorogood, 2009).

Ethics approval for the study was obtained from the Institutional Ethical Review Board of SJ Medical College & Hospital.

[2] This study is part of a larger study exploring socio-cultural factors influencing perinatal health, including women's support needs and experience of pregnancy and childbirth in urban South India

III. Findings

"We have a lot of vishwās in that hospital" – the importance of faith and trust

As Fatima's case illustrates, for many women and their families it was in part a matter of 'faith' or "vishwās" (loose translation) in SJ Hospital. As Gulabi, a 22 year old middle-school educated Muslim woman said, "All problems we go to SJ Hospital only, our family has been going there for 25-30 years." She also said that she took her baby to SJ for all visits including immunisations. "My mother's sister just had open heart surgery at SJ Hospital. We have a lot of vishwās (faith) in that hospital." There was a strong perception that one received better care at this hospital. Reliance on SJ Hospital was not only for pregnancy and delivery care but also for post-natal care, preventive child-health visits and emergency care. As 25 year old Roja, with limited education said, "for everything I went to SJ only, because they are giving good treatment there and they are not careless."

Faith in the hospital was reinforced by a successful outcome in the pregnancy. Several women in our sample had attended SJ hospital due to infertility problems. These women spoke glowingly of the hospital, the staff and the service. As 26 year old Champaka said about her first successful pregnancy, "we didn't have children for six years; after taking treatment there (SJ hospital) we got a child […] that is why we have faith in SJ."

> I used to have irregular periods. We tried everything (to get a successful pregnancy). We tried a mixture of Unani and Ayurvedic treatment. It didn't work; we tried so many places for treatment. Finally I went to SJ, many people said go to SJ, they will help you…Dr J, from Endocrinology Department. She found a 'tumour' in the brain, then I got tablets for six months. Then everything is success! (28 year old Padma, middle-school educated).

Muslim women were particularly likely to use SJ because their extended family members used it, and possibly as there would be little mention of contraception, it being a Catholic healthcare service. They also perceived that at this hospital there would be less medical intervention. As Gulabi explained, "we like it because they try their best to do a normal delivery; not like other private nursing homes, where they like to do operation."

Closely connected to notions of 'faith' in the hospital and in the staff, was the notion of 'trust' or nambiké, a more complex concept incorporating confidence, reliance and hope. This played out more in the negative, i.e. as a lack of trust or active mistrust the respondents and their families had in the government system of care. As Sugandha, an assured and articulate 30 year old woman said, "all my family members go to SJ for all their care, because in the government hospital negligence jaasti" (too much), and too much corruption." The mistrust of government services was often based on hearsay; many respondents told us that they heard government hospitals used unclean needles for immunisation. As 28 year old Padmamma who lived in a village setting said, "I won't go to Anganwadi or any government hospital. If they give him (baby) injection […] it will be a big-big needle, baby will get too much pain." Sometimes husbands explicitly forbade their wives from seeking government healthcare. One husband stopped his wife from accepting the free supplementary food and medicines offered by the visiting nurse in the antenatal period. "Husband said, "don't take it, won't be good quality"; we have no trust in government hospitals or government services." Only two women in the poorly educated group and one woman from each of the other groups actually had positive impressions or experiences of government services. Sometimes there was fear of doing the wrong thing. As one aunt recounted about her 22 year old niece, "for her first delivery she had post-partum bleeding, the (Government) doctor advised her not to get pregnant for four years. When she got pregnant again after two years we got bhaya (fear), from that time we are showing in SJ."

"In the city, they are not giving anything" – the confusion over right to healthcare

Several women and their families were confused about what government services they were entitled to. Fatima's family were not just confused but ignorant about their entitlements and access options. Some women thought that when they moved from their ooru (village) to their urban residence, they lost their eligibility. As 26 year old Champaka said, "I didn't get anything here (referring to government Anganwadi); they told me you have shown in private hospital, so we can't give (referring to free nutritional supplements)." Her mother went on to say that in their ooru her daughter-in-law got special food, childcare kits and money, leaving her to conclude that in the "city only they are not giving anything".

Others felt that they may not qualify if they were not poor enough; still others did not want to be seen as needing government services. One 32 year old woman living in obvious poverty with her extended family commented, "I didn't get "bhagyajyothi scheme" (specific government initiative for families living below poverty) benefit; because ration card is in my mother's name, I didn't get any 'facility' here (English word used)." Not qualifying or having access to one sort of government scheme for the poor often translated to not having a right to government health and support services.

Exercising choice?

For many women, there was little active choice exercised in seeking healthcare through the perinatal period, as Fatima's case demonstrates. Many went to SJ because their family expected them to, their husbands chose the hospital or they were in the catchment area of the hospital. Women with tertiary education however, seemed to have many more options for healthcare. Some educated women chose SJ for antenatal care and delivery, another private provider such as a local paediatrician for their well child's care visits and had a back up private 'nursing home' (privately run small health facility with some emergency capacity) that they might access in emergencies. For example, 29 year old Geeta said she went to SJ "for all immunisations and paediatric visits" and to Kemp Fort (local private clinic) for "emergencies to see the child specialist." Educated women also were able to choose the public option if they found that there was no difference in quality, such as 31 year old Mallika, who had an IT job. "I used to go to SJ for immunisations before, now I am attending (the local) government hospital for immunisation; I am happy with the care there."

There were a few specific situations where women actively exercised choice for their perinatal healthcare. Often these related to the lack of contraceptive options they might be offered at SJ. Women who wanted their "family planning operation" (tubal ligation) after their second pregnancy, would make a decision to deliver at a government hospital, even while accepting antenatal and postnatal care in SJ:

> I went to SJ Hospital only for pregnancy care, but as they said they won't do family planning operations, I went to my father's place. I delivered in Sindhuja Hospital, and at the same time they did the family planning operation (Kaveri, 27 year old, high school educated, second pregnancy)

IV. Field Notes

Private clinics: Obstetrics & Gynaecology (O&G) and Paediatric

The SJ outpatient department is a large, busy, area right at the entrance of the Hospital. The small waiting area fills up by 9.15 am with patients and their families. There is no separate or private interviewing area. The clinic rooms are small and clean but rather severe. The waiting room has one health promotion poster on 'expressing breast milk'; on the opposite wall (in Kannada, local language) there is an anti-abortion poster. The general atmosphere is one of constant movement, patients are called by a bell, patients and families move in and out of

chairs, examination beds, waiting areas, or are sent off to other parts of the hospital. The paediatric clinics are situated in the older part of the hospital and are therefore more crowded than the O&G section.

The patients: obedient

The patients are from a range of social classes; the youngest I saw attending the O&G clinic was 14 years old, the oldest in her seventies. There is a great cultural mix, many languages spoken and three religions: Hindu, Muslim and Christian. According to the outpatient cards, they come from around SJ, from the outskirts of Bangalore or from inter-state. All patients are accompanied by at least one family member, usually a mother, especially for antenatal or postnatal visits. Men are usually not allowed into the clinic. Reasons for the visits include incontinence, routine antenatal or postnatal visits, infertility, urinary infections, pelvic infections, gynaecological cancer and menstrual irregularities. Patients have little opportunity to expand on their symptoms; sometimes they wordlessly hand over their card, other times their support person does all the talking, as in Fatima's case. It is the norm to have one patient being examined in the bed, while the next is questioned, another discharged. In general patients are compliant; ask few questions, accepting of management advice and leave. Paediatric patients range in age from newborns to adolescents. Reasons for paediatric clinic visits include well child visits (over half the visits), fever, malignancy, failure to thrive, infectious diseases, and post-hospital discharge. Encounters rarely take more than five minutes; there is little expectation of personal attention.

The clinical staff: efficient

Each clinic room has a senior consultant (usually a female gynaecologist or paediatrician), two or three junior doctors and a nurse who is shared between clinics. The history taking is quick and efficient: at routine antenatal visit the maternity card is perused, results of available investigations are examined. The examination is likewise quick and efficient, followed by some advice. There is little time for counselling; no mention is made of available government services for poor patients. Occasionally the family or support person is called in to discuss issues such as arranging a hospital admission.

Researchers: empathic

Public health nutrition researchers have been engaged intermittently in maternal and child health research studies in SJ since 2001. One such research cohort is currently in full swing. The recruitment clinic room has a more relaxed feel. The researchers are young, female professionals, usually dieticians or social workers. They are friendly, competent and empathic in their engagement with the women. Women attending the research recruitment clinic may attend for a first visit (up to 45 minutes) or subsequent antenatal or postnatal visits. Each visit, conducted in the language most convenient to the patient is a laborious and painstaking affair. Despite the length of the visits, patients appear to be happy to sit and talk to the researchers. During the visit, the researchers may remark about previous blood or other results if available and provide the appropriate advice. Some women have already been part of the cohort for their last pregnancy/ childbirth; there is no payment given for being part of the cohort, but they are given iron and calcium tablets free. Patients appear to relate well with the researchers; some of them enthusiastically greet their researcher by name and exchange pleasantries for the first few minutes, some even request advice on personal and health related matters.

Government Clinic

The Corporation Hospital in Hosahalli is reportedly the largest and busiest corporation health service in Bangalore, averaging about 3,600 deliveries annually. The patients serviced are all poor, and come from a range of cultural backgrounds. The building looks like a generic government health clinic. The entrance/foyer doubles up as a waiting room; there are roughly 50 people crammed into the space at any time. At one end, a nurse takes down details from patients, sometimes delivers an intervention (such as immunisation) and sends them away. There are

several colourful health promotion posters, generally about pregnancy and childbirth, or HIV/AIDS prevention or dog bites. Two rooms side by side are clinic rooms; each has a bed, a desk and a stool. Adjacent are the labour rooms and operating theatres.

Staff: Matter of fact

There is a gynaecologist in each room, they are called away regularly to attend deliveries. Women are screened first by nurses, who have a much more hands-on role here. Nurses manage to engage in small talk within a very busy clinical setting, sometimes cajoling or scolding patients as required. A paediatrician is also at hand, to attend to caesarean sections or provide paediatric outpatient services. There are no junior doctors or medical students. Despite this, doctors and nurses (all women) appear cheerful, and offer practical advice in the most economical manner. Clinicians move seamlessly and effortlessly between outpatient and acute roles. Patients are treated with obvious empathy. I witness several instances of women requesting terminations of pregnancies or 'family planning' operation; these requests and others are always dealt with in a practical manner.

Patients: Stoic

Patients range in age and complaints; from young children being brought in for prophylactic rabies immunisation, to women coming for antenatal, postnatal or gynaecological visits. Patients are seen two to three at a time, but with no dividing curtain or room between them. In the same clinic, there may be a woman being examined for a gynaecological problem, another being given a routine antenatal check, a third being given advice about 'family planning' operation. Women are usually accompanied in the waiting room by their families, no males are allowed into clinic rooms. Patients come in expecting to be seen and sent away quickly. Antenatal visits account for over a third of presentations. All women in pregnancy are provided immunisation, iron and calcium tablets; and supported to attend other health centres or referred for tertiary care either to private or public services.

V. Discussion

Investigating how and why women in Bangalore accessed the biomedical healthcare they did through the perinatal continuum, reveals a socially restrictive framework through which choice is exercised. Women in this study did exercise "choice" at some level, but this choice is enacted in the political-economic context of today's India, and often appeared arbitrary. Women articulated their choice in a myriad of ways, from choosing the tertiary private health services for both preventive and curative interventions, choosing to ignore the freely available government services and choosing their 'family planning' operation, as my field notes illustrate. Fatima's case exemplifies how choice is often exercised by family units rather than individuals, and decisions are shaped by socio-cultural factors peculiar to the urban setting. The critical role of the extended family in providing support and advice has been described in another paper from this research study (Raman et al., 2013). Educated, middle class women did appear to have a greater range of choices for their healthcare, some of them even choosing the free government preventive care, while poor women often made choices detrimental to their overall health; in keeping with Barros et al's findings on the inequity of reproductive healthcare delivery in low resource settings (Barros et al., 2012).

Faith played a big role in all clinical interactions. The cultural and religious connotations of 'faith' in India cannot be ignored; faith in a doctor, faith in a hospital, faith in God. Khare in his study of 'practiced medicine' in India explored how a (biomedical) doctor, a vaid (Ayurvedic practitioner) and a hakim (Muslim Unani practitioner), all invoked the relevant ideas of divinity, and shared a cultural ethos of articulating religious ideologies in the clinical encounter (Khare, 1996). Again Fatima's family, who expressed their disempowerment in the context of finding the appropriate services and 'left everything in the hands of God', is illustrative. Having their faith confirmed with a live, healthy baby when previously infertile, again reinforces the religious underpinnings of their faith. Kakar speaks about the role that a "therapeutic" religiosity occupies in Indian society, the sheer number and variety of healers being only one manifestation of this preoccupation (Kakar, 1984).

Choice between paradigms of care such as home versus facility in the perinatal period has not been investigated here; see (Van Hollen, 2003). Instead I have tried to unpack motivations behind choice of a particular institution. The women who chose to have their baby in the government hospital had their contraceptive and preventive health needs responded to promptly. Similarly, the women who 'chose' to spend their time talking to and getting advice from the nutrition researchers clearly got much needed support and nurturing from these encounters (Raman et al., 2013). In Van Hollen's study, women in peri-urban Tamil Nadu, 'chose' to have home deliveries performed by a private midwife, not because they rejected hospital deliveries but because this particular health worker had an air of professionalism, used medicines and technologies (often unnecessarily) associated with modern birth and they trusted her (Van Hollen, 2003).

The perception of better quality of care delivered by the private sector is not unique to my study; similar findings are mirrored in studies from Africa (Fotso & Mukiira, 2012; Jallow, Chou, Liu, & Huang, 2012). A recent study in rural Karnataka also found that perceived quality of care was found to be an important factor in health seeking behaviour, along with socioeconomic status, maternal education and experience of previous problems in pregnancy (Matthews, Ramakrishna, Mahendra, Kilaru, & Ganapathy, 2005). According to the last National Family Health Survey, the main reasons reported by women for using private sector reproductive health care were proximity and quick service (Ministry of Health and Family Welfare, 2008). Women in urban Bangalore however travelled great distances to reach their chosen private healthcare provider, bypassing their 'free' government service, often due to a perception of poor services in the government sector. Fatima's example tragically highlights this anomaly. De Zoysa's ethnographic study of care seeking practices in an urban slum in New Delhi found that while many mothers were able to identify signs of their infants' ill health, they were unable to discriminate among the many sources of healthcare available, preferentially choosing local unqualified private practitioners (de Zoysa, Bhandari, Akhtari, & Bhan, 1998). Pinto (2008), describes the widespread, visible and even intrusive presence of government reproductive services, however inadequate, in rural Uttar Pradesh. Poor women in urban and rural Tamil Nadu complained about corrupt and heavy handed practices of government services but nevertheless used them (Van Hollen, 1998). By contrast, I found that for many women in urban and peri-urban Bangalore, government services are effectively 'invisible'.

Empirical observations of the private and public clinical encounters for reproductive and child health in Bangalore did not provide a sense of why there was such a mistrust of government services. Das and Hammer interrogating both public and private medical clinics in New Delhi, found overall quality, as measured by the competence necessary to recognise and handle common and dangerous conditions to be low, albeit with tremendous variation and little difference between private and public doctors (Das & Hammer, 2004). Deosthali et al's study of private maternity care providers in Maharashtra state found poor standards of care in many cases, and few or no qualified nurses or a duty medical officer in attendance (Bhate-Deosthali, Khatri, & Wagle, 2011). The authors, citing other studies reporting on poor quality services provided by the private sector, concluded that the state needed to regulate the quality of care, and enforce minimum standards for the private sector.

Today, urban health is the battleground that must be traversed if India can even begin to dream of a healthy population in the 21st century (Bhaumik, 2012); the urban poor are 20 times less likely to have any antenatal care, a third as likely to be immunised as their rural counterparts. As this study shows, confusion about urban women's access to perinatal health care services mirrors the confusion of the services themselves – why should a tertiary hospital routinely deliver preventive care? Public-private partnerships are being heavily promoted by the government particularly for maternity services (MOHFW, 2002), while civil society and advocacy groups have provided good evidence for caution against unbridled privatisation (Gangolli, Duggal, & Shukla, 2005). More than a decade after Van Hollen's study in Tamil Nadu (Van Hollen, 2003), women in urban Karnataka may appear to have more choice in perinatal healthcare services.

Implications for Policy

Further impetus for getting access and equity right for women and their families comes from the Government of India's stated commitment to universal healthcare access (HLEG, 2011). Public health advocates have supported the 'call to action' for universal health care access by 2020 (Reddy et al., 2011), whilst pointing out the failure of this plan to emphasise community involvement, civil-society engagement, and action on the social determinants of health (Narayan, 2011), and the dangers of a blanket integration of the private sector into a universal health system (Sengupta & Prasad, 2011). Stacy Pigg drawing upon her research in Nepal advocates for a practice of patient ethnographic "sitting" as a means to understanding, as a form of critical reflexivity; particularly useful for public health policy (Pigg, 2013). Drawing upon my reflections from this study, I would argue for greater attention to be paid to the socio-cultural and behavioural determinants of women's access to and utilisation of perinatal healthcare services. What is needed is comprehensive reproductive healthcare that is respectful, acknowledges the perinatal continuum and importantly "incorporate[s] the voices of women themselves" in shaping future services (Langer, Horton, & Chalamilla, 2013). Berman bemoans the missed opportunity in getting more from private healthcare particularly from not-for-profit providers, and suggests that private and public sectors must come together in a spirit of collaboration and problem solving (Berman, 2001). The call to action also suggests that the key components of a universal health care access package for India are a strengthened public health system as the primary provider of preventive and curative health services in India, and a well regulated private sector integrated within the national health-care system (Reddy et al., 2011).The findings from this study suggest that both private and public health services in India need to move substantially to achieve true partnership and provide care that is respectful. As the case study of Tamil Nadu in South India illuminates, effective partnership between government and non-governmental agencies is possible if accompanied by other health system strengthening efforts, such as widespread availability of district health managers with skills in public health and management (Balabanova et al., 2013). The private sector has a duty of care to ensure that the poor are facilitated in their access to freely available government services including preventive healthcare, while the public sector needs to improve their visibility, accessibility and relevance to women and children in urban India.

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