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Perceptions of and constraints upon pregnancy-related referrals in rural Rajasthan, India

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Mortality associated with complications of pregnancy and childbirth remains disproportionately high in the developing world. This paper reports on a study into the reasons for the poor uptake of referrals to specialist medical units in a group of 276 women in a rural area in the state of Rajasthan, India.

Of the 276 cases that were referred, 242 (88%) of the women failed to attend for specialist consultation. In-depth personal interviews were conducted and a series of focus group discussions was held with the women and with their spouses and spouses' mothers. A range of geographic, cultural, socio–economic and medico–administrative factors was identified as influencing decisions to attend referral units.

Recommendations for improving uptake include improving facilities at referral units, providing additional training for healthcare staff (covering technical, managerial and behavioural aspects) and in counselling techniques, a better defined role for traditional birth attendants, improved understanding of the mother's needs by her family (particularly the spouse and his mother) and increasing public awareness of the importance of referral. Finally, there is the requirement that women are encouraged to realize and understand their own needs.

Introduction

Complications related to pregnancy and childbirth kill 500 000 women in the world each year. Only 1% of these deaths occur in the 26% of the population who live in developed countries. The remaining deaths occur in the developing world. The number of maternal deaths each day in India alone exceeds the number of maternal deaths in all developed countries in one month (World Health Organization, 1985). Anaemia, haemorrhage, eclampsia, infections, abortions and the complications of obstructed labour account for most of the maternal deaths in India. When the circumstances in which most maternal deaths occur are examined, one striking feature is that the majority of these come from rural areas. Other notable features of the women who die while receiving obstetric care are (i) they are from remote areas, and (ii) they attend late. The general background is of illiteracy, poverty, malnutrition and socio–cultural problems relating especially to women's status and adverse traditional attitudes and practices. (Harrison, 1985; Khan *et al.*, 1985; Kwast *et al.*, 1985). While it is true that the general features of poverty and deprivation contribute considerably to high

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maternal mortality, the inadequate availability of preventive health services such as prenatal care is a major factor. Examination of the immediate causes of deaths and the circumstances in which they occur vividly demonstrates the grave problem of access to life-saving procedures in emergencies during childbirth (Joshi *et al.*, 1987).

Methodology

The findings presented in this study are based on the follow-up of referred cases from six districts in the state of Rajasthan. A total of 276 cases were investigated from 17 villages (Table 1).

The youngest woman in the sample was a 16-year-old primipara, and the oldest was a 46-year-old multipara with five living children who had also had three abortions and two stillbirths. The average age of the sample group was 26 years and 76% had had three or more deliveries prior to their recent pregnancy. Only 19% had been educated to primary level; the remainder were illiterate. Data were collected between November 1994 and October 1996, a study duration of 22 months.

Although the most genuine cases (haemorrhage, obstructed labour, bad obstetric history etc.) were being referred by the medical and paramedical staff, patients were not reaching the next recommended level, apparently not interested in availing themselves of the services. Therefore our major focus was on understanding what prevented them from using the referral services and also on their perceptions regarding the risk signs of pregnancy, as there appeared to be a gap somewhere between these and understanding the causes and their implications for the overall health of the women. In-depth personal interviews were conducted with selected women and their family members. A total of 276 women were contacted together with their mothers-in-law and husbands as any decision regarding referral of a pregnant woman was not expected to be made without the consent of these two key persons in the family. However, Tables 2 and 3 summarize the responses of the women only. Besides the personal interviews, nine focus group discussions were conducted, three each with women and with men of reproductive age and three with elderly women of the community. We also conducted a few case studies of women who had been referred. Very interesting issues that reflected the perceptions of rural people regarding pregnancy and pregnant women were raised and explored during these discussions. While the men and the elderly women were subjected to simple unstructured questions and answers in discussion sessions, the young women were asked to respond to specific questions. The following five questions were asked:

- How many times did you conceive (i.e., how many pregnancies were there that resulted in living children, abortions and children who died)?
- Who conducted these deliveries and where?
- Did you experience any complications, or were any identified by health personnel, during pregnancy or immediately after delivery; if yes, what were they?
- Were you asked to seek more specialized care; if yes, did you do so?
- If you were advised to seek specialized care and did not, why not?

The interviews were conducted by trained social researchers. A major problem was caused by the lack of proper records pertaining to referrals. Most of the referred cases were advised verbally to approach the next appropriate level, depending upon the type of complication, and no entry was made in the records. We had to depend on the memory of the paramedical staff and the traditional birth attendants (TBAs) to identify the referral cases. Sometimes, recollection of one case informed us about other similar cases and those patients were contacted.

Table 1 *Distribution of persons interiewed and included in focus group discussions*

District	Women	Spouses	Spouses' mothers
Dausa	53	29	40
Jaipur	42	22	30
Alwar	46	13	30
Bikaner	47	19	31
Udaipur	43	15	35
Sawai Madhopur	45	15	31
Total	276	113	197

Results

The quantitative results of the study are summarized in Tables 2 and 3. The responses and reactions of the young men and the elderly women (i.e. the husband and the mother-in-law groups) obtained during the personal interviews and focus group discussions have also

been included in the analysis. Table 2 shows that although cases were being referred promptly to higher levels of care, the response from the cases that were referred was varied, and often negative (Table 2).

Table 2 shows that the non-response rate to the advice of referral was very high (88%). Out of a total of 276 patients who were referred for complications such as obstructed labour, anti-partum haemorrhage, post-partum haemorrhage, bad obstetric history etc., 242 did not make any attempt at all to go to the next level of referral. Good economic status, possession of private transport and close proximity to the health centre, were some of the factors that encouraged family members to take the cases to the next level of referral. A few reported that they could not have gone to the district hospital to consult the specialist if they did not have their relatives staying at the district headquarters. The reasons for not using the referral services were varied (Table 3).

As the information was obtained through in-depth interviews based on five basic open-ended questions, a high amount of qualitative data was gathered. The reasons given in Table 3 were discussed in detail and were later critically analyzed. In the following section, each reason for not using the referral services is discussed with relevant details.

Discussion

Condition of transport, road and first referral units

The condition of roads and transport services in Rajasthan's rural areas is a cause of great concern for villagers, especially when an incipient delivery or a woman in labour is involved. The conditions of the first referral units (FRUs) are poor. FRUs are the district or sub-district hospitals or health centres to which women are referred if identified prenatally as at high risk or when in serious difficulty or emergency during pregnancy or childbirth, or immediately after.

The Government of Rajasthan identified 138 FRUs in the state, but none of them are fully operational (Indian Institute of Health Management Research, 1996). The basic physical facilities, including water, electricity etc., are non-existent in 50% of the FRUs. Patients are remote from the FRUs so that, on average, the travel distance is 17 miles. In some of the desert districts the travel distance is twice the state average, approximately 34 miles. Since most of these centres do not have ambulances, people have to arrange their own transport over dirt roads in 51% of the area (Central Statistical Organization, 1992) and public transport is available only on fixed routes and at fixed times.

In emergencies people have either to hire private transport or to take any locally available transport, including camel cart or bullock cart, or in the best circumstances, a tractor or a jeep.

A case typical of the chaos that can occur during the transport of a woman in labour was that of a woman of Hamirpur village in the Alwar district who underwent tremendous physical, as well as mental, trauma. She was being monitored by a local TBA throughout her pregnancy; when the time came for the delivery, she discovered that the foetus was in transverse position, which soon resulted in a hand

Table 2 *Patients referred and patients who decided not to follow the advice*

Medical reasons	No. of patients referred	Patients who did not attend referral units	
		number	% of total
Ante-partum haemorrhage	32	20	62.50
Obstructed labour	38	27	71.05
Excessive vomiting	23	23	100.0
Oedema	63	63	100.0
Bad obstetric history	54	49	90.70
Persistent lower abdominal pain	40	40	100.0
Post-partum haemorrhage	26	20	76.9
Total	276	242	87.7

Table 3 *Factors influencing non-utilization of referral services*

Reasons	(%)
Condition of roads, transport and FRUs*	85.5
Knowledge and attitude of health staff	83.5
No women doctors available	50.0
Local *dai*** advised against it	70.0
Mother-in-law says 'No'	64.8
Symptoms are 'normal' signs of pregnancy	61.5
Previous experiences highly discouraging	77.2
Superstitions and beliefs	52.8
Involves a lot of expense	100.0
No follow-up is done by health staff	82.2
Who will look after household chores?	77.7

*FRU = first referral unit; **dai* = traditional healer

prolapse. The *dai*, who was a young trainee of her own mother-in-law, became nervous at the unexpected sight and asked the relatives to take her to the Primary Health Centre or the district hospital immediately. Both were about 20 miles distant.

The family did not have any transport of its own and so the husband went to ask one of the local residents to lend him his tractor. After about 30 minutes the woman was put onto the tractor and her ordeal began. As the tractor was passing slowly along the bumpy roads, the woman was in great pain and almost unconscious. It was the rainy season and the muddy roads were water logged and slippery. At one spot the tractor's huge tyres got stuck in a big hole and could not be moved. The woman was carried by her husband to a nearby village and had to be laid down under a tree. Fortunately, the local *dai*, who was also accompanying them, knew someone in that village and the woman was taken to their house.

While the husband went looking for help to get the tractor moving, the women of the household called the local village *dai*. She was an elderly woman with vast experience of conducting deliveries. She took command of the situation and asked the women to prepare for the delivery. She first inserted the hand back into the womb and then manipulated the position of the foetus, and within minutes the child was delivered. Unfortunately, the little girl was cyanosed, but the *dai* revived her somehow. By this time, the tractor was ready again and both the mother and the baby girl were taken to the district hospital. They reached there at about 0200h and were received by a hospital cleaner. A nurse was called and both were admitted. The baby was recovering but the condition of the mother was deteriorating. She had lost a large amount of blood and was semi-conscious. The nurse asked that she be taken to an Apex hospital, which was 45 miles away. The child was left with the *dais* and the mother was taken to the Apex hospital in a hired jeep for blood transfusion. After three days' struggle, she was discharged from the hospital.

The baby girl was given cow's milk and had to survive on it as the mother was too weak to nurse. We discovered later that the child died after three days. Unfortunately the parents could not be contacted as they had left the village.

Knowledge and attitude of health staff

The provider : client ratio indicates high pressure on the healthcare staff in the state of Rajasthan. On average, a nurse has to look after the health needs of more than 5500 persons, and a doctor cares for the health needs of more than 3000 (Central Statistical Organization, 1992). When rural facilities alone are considered, the situation is even worse, since more than 70% of the health staff confine themselves to health institutions in urban areas leaving only 25–30% to bear the burden of providing health services in rural areas.

According to a facility survey of FRUs undertaken in 1996 the population covered by each FRU is 152 000 on average (Indian Institute of Health Management Research, 1996). Thus, a high load of general patients and ante-natal and post-natal care cases exert a tremendous pressure on paramedical and medical personnel. The situation becomes graver with the effects of other resource constraints. The study revealed that cases involving caesarean section, APH, PPH, blood transfusion, paediatric emergencies, eclampsia, severe anaemia and abnormal presentation are referred to the next level because of lack of facilities at the FRU level to manage these complications. Health personnel also lack adequate training, both technical and managerial, to let them function effectively.

A large number of women complained that the paramedical staff had a general tendency to treat poor rural women with a high degree of indifference. Some went to the extent of saying

that they are very rude and discriminate between rich and poor patients. Hence they avoided paramedical staff even when they had serious problems. They also observed that the higher the level, the more difficult it is for an illiterate rural woman to get proper attention. Therefore the best option was to manage without health services as much as possible.

Doctors were usually reported to tend to discriminate between private patients and the others who visited them in the government dispensary only. It was a common observation of many women and their husbands that their treatment and quality of care improved soon after they made a visit to the doctor's private clinic. The rich, who could afford to pay his fees at the private clinic, always managed to get better care including accommodation at the hospital if needed. The nurses were less privileged as far as private practice was concerned as the local *dai* was preferred by the community as she was a local and available 24 hours a day. The indifference towards the poor, insensitivity towards a woman in pain, lack of efficiency in managing complications and the unsympathetic attitude of health staff were some of the deterrents to using the referral services. A large number said that even if the advice of the referral service was followed, it would not prove to be of any use as the doctor was not at the health centre most of the time.

No woman doctor available

Most of the rural posts for doctors in India, especially in the state of Rajasthan, are filled by men because of the non-availability of female doctors. Moreover, female doctors are hesitant to accept rural postings because of reasons such as safety, education of children and non-availability of basic amenities. The conservative rural community does not feel comfortable consulting a male doctor for gynaecological problems. Unless it is a question of life and death, no man would be permitted to examine a woman or manage any complications.

There are some communities where the custom of *purdah* (the veil system) is very strictly followed; many deaths occur simply because women cannot be shown to a male doctor. One such incident was narrated by a Rajput woman whose sister-in-law died due to ante-partum haemorrhage.

Lad Kanwar had recently married Sumer Singh of Jharana village, in Jaipur district. As her sister-in-law was without a child even after three years of marriage, Lad Kanwar was under pressure from her in-laws to give them a grandchild as early as possible. She conceived soon after her marriage at the age of 17. She was a healthy girl and was provided with good care during her pregnancy. In spite of this, something went wrong and she started bleeding in the seventh month. Her family contacted a nurse who asked that she be taken to the hospital immediately. The Primary Health Centre did not have a woman doctor and since it was late in the evening, they decided to take her to the Apex hospital the next day. During the night, the bleeding became severe and she slipped into unconsciousness. This was noticed quite late as everyone was sleeping. They rushed her to the hospital where unfortunately no female doctor was on duty. Although the doctor on duty insisted on attending on her, the family did not allow him. She was taken to a private hospital where the female doctor declared her dead.

Several reasons were given by the women for the preference for a female doctor. One of them was that a female doctor, being a woman herself, has better understanding of the women's problems and hence had an empathetic attitude towards them, whereas a male doctor usually lacks that empathy. Unlike the West, where most of the gynaecologists are male, in the closed Indian society it is considered indecent to discuss such matters with any male and that is the reason why women do not go to them.

Local *dai* advised against it

In rural communities, TBAs enjoy tremendous privileges and are highly respected. They are consulted for every matter related to the health of a woman, especially for matters related to pregnancy and delivery. It was found that many women do not visit the referral unit because the local *dais* advised them against it. Actually, some *dais* are skillful in manoeuevring the child in extremely difficult birth situations and others try to follow their practices. Thus cases of obstructed labour, breech or twin deliveries are also not referred by them. We contacted the TBAs to also find out more about why they

do not refer the risk cases, and the following issues emerged:

- The TBAs, prior to being trained, used to deliver all kinds of cases without being aware that some of them could be risk cases. The concept of the high-risk case was introduced to them through training and they were also trained to identify such women from their villages. However, it proved to be beyond their comprehension that low weight, weakness, paleness, first delivery, contracted pelvis and so on were dangerous and could cause harm to women and children. So they did not refer such cases.
- Another reason for the low referral rate was that if they referred more cases, it meant loss of income to them.
- A further reason for lower referral was the indifferent attitude of the sub-centre staff towards these trained TBAs. The TBAs are not considered as part of the health system and because of that they do not receive serious attention from the paramedical staff. When TBAs tried to seek the support of auxilliary nurse midwives (ANMs) while conducting deliveries it was often denied. After several such experiences they stopped referring even really high-risk women with abnormal presentations such as breech or twins.

Mother-in-law says 'No'

Just like the TBA, the mother-in-law is another very highly influential member of the Indian rural community. She is the key person who takes some of the major decisions in the family. This includes the decision related to her daughter-in-law's fertility, such as how many children she should have, when and whether she should undergo tubectomy, etc. She is usually the sole person in charge of the care of her daughter-in-law during the special days of pregnancy, but ironically she is often very unsympathetic towards her needs. A common remark of a mother-in-law to a daughter-in-law's need for any special pregnancy-related care is often along the lines of, 'I have borne eight (or more) children and never ever visited a doctor! What is so special about your deliveries?', which puts an end to it. Almost 60% of women complained about their mother-in-law's attitude in this regard.

In any emergency or problem, women were asked to consult the local *dai* or the *ojha* (traditional healers who also practise black magic etc.) for the treatment, as mothers-in-law usually had tremendous faith in these traditional healers. Sometimes, even if the husband is willing to take his wife to the hospital or a doctor he has to comply with the wishes of his mother and take her to a local *dai* or traditional healer. In the male-dominated societies of rural India, a man could be teased and taunted for being very soft towards his wife and for exhibiting extra care and concern. Thus, sometimes nothing but his ego prevented the husband from helping his wife to get good care.

'These are normal signs of pregnancy'

Pregnancy is a much-desired state for a married woman in India. Although it brings with it certain discomforts and emotional stress, these are generally accepted by women as welcome signs of pregnancy and motherhood is looked upon as a blessing. A very large number of women opined that giddiness, oedema, nausea, anaemia, stomach ache etc. were normal signs of pregnancy and, therefore, did not require any medical intervention. They also said that some have this problem to a greater degree, in terms of both frequency and intensity, than others but they only indicate that everything is normal. Indeed, absence of these symptoms was often greater cause for concern. We often had pregnant women in their first trimester in our Maternal and Child Health (MCH) clinics with complaints like 'Why do I not feel like vomiting?', 'Why do I not feel the loss of appetite?' etc. Sometimes they would want the doctor to confirm that they really were pregnant. To some of them, it was quite unnatural not to feel these things and still be pregnant.

To some extent, these beliefs seem to be harmless but problems arise when the real risks are also taken casually. Often these women are so enthusiastic about bearing children, especially their first and second, that they just fail to perceive any complication serious enough to need specialized care. As pregnancy advances the enthusiasm declines but tolerance increases. It was revealed during the focus group discussions that women consider it to be inappropriate and also indecent to complain about the discomforts of pregnancy and women are often rebuffed by the elderly ladies of the community for any show of weakness.

Previous bad experiences

The decision not to go to the next level of referral in many cases was based on past experiences of the women and their family members. It was the experience of more than 150 women that they tried to use the referral service on the advice either of the TBA or the sub-centre nurse but were highly frustrated by their treatment at the FRU. First, no preference is given to referred cases; they are not given any priority even if the case is serious. The woman and the attendant have to wait till the doctor or the nurse is free from whatever other work they are busy with. Second, the arrangements for waiting patients and their attendants are far from satisfactory. There is no proper waiting space or furniture. Drinking water, tea etc. are not usually available on hospital premises. After waiting long hours for admission, when the case is attended the attendants have to camp outside the hospital to look after the patient.

None of the rural hospitals have canteens and, therefore, arranging the clinical diet prescribed for the patient or the ante-natal or post-natal care case is very difficult. Buying food from private eateries is not advisable and is also very expensive. All these troubles are nothing compared to the kind of treatment received at the referral centre. One woman, Mangi, from Baniyana village in Dausa described the experience of her previous pregnancy:

When her labour pains started, the village *dai* tried to conduct the delivery, but could not succeed. After trying for several hours, she asked the family members to take Mangi to the hospital. (Incidentally, we were there and observing the entire process. We took her in our vehicle to the post-partum centre at the district headquarters, which was 25 km away). On reaching the hospital, they found that there was no nurse or doctor available. After about half an hour, a nurse came and examined her and said that there was still time. As there was no bed, she was asked to lie down on a small bench. She remained there the whole night and nobody attended to her. In the morning, the nurse again examined her and said that she must have had false pains and the delivery would not occur within 48 hours. Her family hired a jeep and brought her back. She delivered the same evening and the same local *dai* conducted the delivery.

Many other women had similar experiences, which included rough and inefficient treatment, long waits, highly uncomfortable resting places, no drinking water etc. Such experiences compelled them to conclude that it was the *dai* ultimately who would come to their assistance. Why not use her services rather than wasting time, money and energy in trying to get specialized care which never comes? Another woman, Shyama, again from Dausa, described the following incident:

She was in pain and her family summoned the ANM, who was staying in the same village. (The ANMs prefer to conduct deliveries at home rather than the health centre). The *dai*, who was in touch with the woman all through her pregnancy, had informed the family that it was going to be a twin delivery and so it would be better to call a nurse. The nurse also knew all along that she would be expected to conduct the delivery but, when the time came, she insisted that the *dai* should be called as she would not be able to manage it all by herself. The *dai* was out of the village and the nurse refused to attend, fearing that if something went wrong she would be held responsible. Ultimately, the mother-in-law and an aunt conducted the delivery while the nurse remained an observer. They never contacted her again for any help.

Superstition and beliefs

To the people of rural India, health complications are as much a moral as a physical crisis. In their conception the roots of illness extend into the realm of human conduct. As a consequence, they look for relief in rituals and reassurance as well as in mundane medicines. As a rule, they first approach a traditional healer, an *ojha* or a *dai*, and follow all their advice and prescriptions. According to their faith, the healer must serve as a link between mortal man and the supernatural. Only as a supplement or an additional effort do they visit medical personnel and take Western medicine. Usually, they do not believe that one can influence the course of events simply by the exercise of technical skills and so do not seek medical assistance.

For the same reason, the advice for the referral of a pregnant woman is not taken very seriously. Although, with increasing education and media exposure, such beliefs are changing, a large number of superstitions still prevail in rural communities. A pregnant woman is usually not permitted to go out after sunset in village communities, as it is believed that evil

spirits become active during the night. It is also believed that these spirits can be incited to cause harm. It is held that they look for a human body that can be easily overpowered, and a woman during pregnancy is a most appropriate prey.

For the same reason, pregnant women are also not allowed to pass by cemeteries, ponds, peepul trees, etc. It is interesting to note that, on the one hand, the peepul tree is considered to be very auspicious and is worshipped and on the other, it is believed that the spirits of dead people rest on it. A pregnant woman is also advised not to contact any woman without children, especially one who is declared to be sterile. Some others who are believed to be 'possessed' likewise must not be contacted by pregnant women.

All these beliefs make it practically impossible for a rural woman in trouble to reach the appropriate services. Sometimes an ANM who is not married or does not have children is not contacted for any maternity assistance as she is not expected to appreciate the condition and its implications for a pregnant woman. Such beliefs and prejudices are very strong among rural people, especially if they are illiterate and are not exposed to the media.

A lot of expense is involved

Although there are both rich and poor people in rural communities, spending on health is generally considered to be a waste by both categories. The average *per capita* income in India is US $320 per annum. The one reason for not using referral services, which all interviewees agreed upon, was that of the financial implications. This concerned almost everybody—the women, their husbands and their mothers-in-law.

To a family of average income, referral meant an extra expense of about Rs 2000–10 000 (about US $50–250) depending upon the conditions when the referral is made and the place of referral. When a woman is asked to go to a health service centre (which may be 10–15 miles away) arranging the transport itself would cost her family something between RS 500–1000 (about US $25). Once she reaches the centre, the expenses on the various laboratory tests and medication come to about RS 500–1000, at the least. To this is added the expense of food and beverages consumed during the hours when the patient and family members are waiting for the doctors, test reports and so on. When after spending about 1500 rupees or so, the woman is asked to come again for the follow-up, the family decides not to go again.

If the patient is admitted, approximately RS 150 per day are required towards the board and lodging expenses for the attendants. Once the person is admitted, there are other expenses—for medicine, clinical tests and other investigations such as sonography. Besides these direct costs, there are indirect expenses in terms of the wages lost during the period of referral. Those who cannot afford hospital treatment, even once, simply stay, at home.

No follow-up is done

When the patient returns home after spending a considerable sum using the referral service, usually no one from the health system comes to enquire about her. With family planning activities, some care can be expected but a regular maternity case is the last priority of the health staff. On the contrary, when a local *dai* is dealing with a case in her village, she goes back to the woman quite often to enquire about her and safeguard her well being.

A woman under the supervision of even the best doctor or nurse is highly unlikely to be visited by them at her home. Thus, a local *dai* is preferred to the doctors and the nurses by rural communities. A *dai* would not usually attend to a case that has been under the supervision of a doctor as the doctors instruct patients to avoid this. This lack of coordination also leads to non-utilization of the referral services.

Who will do the household chores?

For a rural woman the day begins at 4a.m. After the morning ablutions, she attends to whatever cattle the family owns and milks the cows, buffaloes, goats etc. Then she lights the fire with wood and cowdung cakes in four or five places. On one is put a big vessel to cook cattle feed. On another, she puts water for bathing for the whole family. The third has *dal* or *curry* for the family's lunch. The fourth is for boiling milk. A fifth could be for preparing *ghee* (clarified butter).

After setting things going, she leaves for the fields, where she will attend to the crops. It

depends on the season whether she will water them or cut them or do the sowing and so on.) She comes back at about 8a.m. and feeds the cattle, bathes the children and takes a bath herself after she does the washing, cleaning etc. Then she cooks for the family and after feeding the family and taking her own meal, she sends her children to school and her husband to work. At about 10a.m., she again goes back to the fields, taking the cattle along with her for grazing. She returns at about 5p.m. with firewood, prepares dinner, attends to the cattle and feeds the family.

These are some of the major functions performed routinely by a rural woman. There are numerous other household activities which keep her occupied more than 18 hours a day, like making cowdung cakes for burning, grinding cereals and pulses, making butter and preparing buttermilk etc. If she falls sick or is away for some reason family life is totally disrupted. Therefore, she is seldom able to be away from home. Her presence in and around the family becomes so indispensable that neither she nor others can think of her going away unless there is an emergency or an unavoidable reason. In such circumstances, going away to use a referral service and staying there for treatment is unthinkable.

Conclusion

Referral is highly under-utilized by rural communities in Rajasthan. This study establishes a third reason for maternal deaths occurring from inadequate utilization of obstetric care services. Apart from patients attending late and coming from a distance, the third aspect of high maternal mortality could be that they never come at all!

For a variety of reasons, women in rural areas of Rajasthan do not make use of referral services. The reasons are mainly social and economic in nature and reflect on poor case management both by the family and the health sector. The overall resource constraints within the rural health service delivery system make it difficult for healthcare staff to provide quality services to the referred cases, while poor infrastructure, such as the conditions of roads and transport services, causes undue delays and high expenses for users of the referral services. In spite of the professed objective of the system to provide good quality obstetric care, the FRUs are not well equipped to cater for obstetric emergencies such as caesarean sections, blood transfusions, retained placenta, cord prolapse, APH, PPH and paediatric emergencies. Attitude and behavioural problems, arising from inadequate training, and an unfavourable provider:client ratio, adversely affect the utilization of the referral services. This study also suggests that the problem of referral could be termed a 'family problem,' in part, at least—the mother-in-law and the husband, the two key decision-makers with regard to the woman's health and fertility-related issues, are to a great extent insensitive to her health needs. (Many husbands in rural communities do not remember how many times their wives have conceived!). This insensitivity sometimes arises from widespread ignorance but in a large majority of the cases it has some selfish motive; they do not want to take the burden of the innumerable responsibilities the woman otherwise shoulders, or they do not think it worthwhile spending time and resources on 'routine problems' related to pregnancy. On top of everything else, women themselves do not give adequate attention to their own health problems. On the whole, investing in health is not a priority issue for rural people as they view health complications much as a moral as a physical crisis and they look for relief in rituals and reassurance by traditional healers. Only when these fail do they go to a specialized healthcare facility.

Recommendations

Considering the magnitude and the diverse nature of the problem, the process of referral of pregnancy-related complications needs very special attention. First and foremost, the referral units need to be equipped with adequate facilities so that healthcare staff are able to provide the desired services. Only after the availability and the accessibility of obstetric care facilities have been improved can the community be expected to come forward to use them. Healthcare staff need to be given intensive technical, as well as managerial and behavioural, training and they should also be able to undertake counselling as and when needed. There is a need to develop an empathetic attitude in medical and paramedical staff. TBAs are an indispensable part of the rural health system and need to be given a defined role in healthcare delivery.

Family members, especially mothers-in-law and husbands, need to be made aware of the risk signs of pregnancy and should be more sensitive towards the health needs of women, particularly, during pregnancy. An Infromation, Education and Communication programme especially designed to target key people in the community and implemented under skilled supervision could help to bring about the desirable change. Women should also be encouraged to realize and understand their own needs and to find ways to fulfil them. To increase uptake of referral, public interest groups and opinion formers, should also be kept fully appraised of its importance.

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