2 CURRENT SITUATION AND ISSUES OF REPRODUCTIVE AND CHILD HEALTH (RCH)

Constraints and problems in improving reproductive and child health (RCH) in the target area, particularly in Tikamgarh and Damoh District are drawn and analysed based on our study on current situation of RCH in Sagar Division. Base on these analyses, district master plan for improving RCH was developed (Chapter 3 & 4).

2.1 POLICIES AND PLANS RELATED TO RCH

The followings are important policies and national- and state-level strategies and plans/programmes related to population and reproductive health, which are the frameworks of district plan for improving reproductive health. Another important policy is decentralization policy which is common for all sectors, and closely related to how to implement the policies from administrative management and democracy point of view.

- National Level: Ninth National Five-Year Development Plan 1997/98-2001/02
  National Population Policy 2000
  National Health Policy 2001 (draft)
  RCH Programme
- State Level: State Population Policy 2000
  State Mid-term Health Strategy
  State Policy on Women 1995
  State Nutrition Policy 2000

2.1.1 National Level

(1) ICPD in Cairo and Population Policy of India

The 1994 Cairo International Conference on Population and Development (ICPD) marked a turning point in the approach that the Government of India (GOI) enunciated for its population and health Programmes. In line with the Programme of Action adapted at the ICPD in Cairo and the Government of India (GOI) espousal of a policy supporting provision of quality services to meet the full range of reproductive health needs of women and couples, GOI adopted **integrated RCH approach** and the **target-free reproductive health approach,** and Method-specific targets were discouraged nationwide in April 1996. The Reproductive and Child Health (RCH) Programme was begun in 1997 combining several Programmes that had previously been vertical.

In 2000, National Population Policy were issued, the mid-term and the long-term objectives of which are to bring the TFR to replacement levels (2.1) by 2010, and to achieve a stable population by 2045. In the policy, 14 national socio-demographic goals to be achieved by 2010 are formulated. The major strategies themes are as follows, where needs, decentralisation, convergence, women's empowerment, intra- and inter-sectral coordination & collaboration.

- Decentralised planning and programme implementation
- Convergence of service delivery at village levels
- Empowering women for improved health and nutrition

- Intensified effort on neo-natal care
- Meeting the unmet needs for family welfare services
- Specific measures to under-served population groups (urban slums, tribal communities, hill area population and displaced and migrant populations, adolescents) and men
- Diverse health care providers and collaboration with NGOs and the private sector
- Mainstreaming Indian System of Medicine and Homeopathy
- Contraceptive technology and research on RCH
- Providing for the older population
- Information, education and communication (IEC)

(2) The Ninth National Five-Year Development Plan and RCH Programme

Overall goal of health sector in the Ninth National Five-Year Plan (1997/8-2001/02) is **to improve the health status of the population by optimising coverage and quality of care,** and it emphasizes that the efforts will be directed to improve functional efficiency of the health care system through:

- Creation of a functional reliable HMIS and training, and deployment of health manpower with requisite professional competence.
- Multi-professional education to promote teamwork.
- Skill upgrade of all categories of health personnel, as a part of structured continuing education.
- Improving operational efficiency through health services research.
- Increasing awareness of the community through health education.
- Increasing accountability and responsiveness to health needs of the people by increasing utilization of the Panchayati Raj Institutions in local planning and monitoring.
- Making use of available local and community resources so that operational efficiency and quality of services improve and the services are made more responsive to user's needs.

<Family Welfare>

For the area of family welfare the following specific objectives, strategies, direction of programmes and efforts which should be intensified are set, where also importance of local needs, decentralisation, community participation, intra-/ inter-sectoral coordination and collaboration are stressed.

Objectives

(a) To meet all the felt-needs for contraception

(b) To reduce the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility

Strategies

- To assess the needs for reproductive and child health at PHC level and undertake area-specific micro planning

- To provide need-based, demand-driven, high quality, integrated reproductive and child health care.

Direction of the programme

- Bridging the gaps in essential infrastructure and manpower through a flexible approach and improving operational efficiency
- Providing additional assistance to poorly performing districts identified on the basis of the 1991 census
- Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives
- Promoting male participation in the planned parenthood movement and increase the level of vasectomy

Efforts will be intensified to enhance the quality and coverage of family welfare services through;

- Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of parishioners of ISM&H
- Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management
- Involvement of tries, organised and unorganised sectors, agriculture workers and labour representatives.

<RCH Programme>

Based on these objectives and strategies, the all vertical programmes related to women's and children's health of the 8th Plan was integrated into one Reproductive and Child Health (RCH) Programme based on the concept of reproductive health adopted in ICPD in Cairo. The programme is supported by World Bank and other donor agencies. The concept is to provide **need based**, **client centred**, **demand driven**, **high quality** and **integrated** RCH services for effectiveness and efficiency of the programme.

Since the "target free approach" caused a misconception of RCH approach and made confusion of activates in the field, it changed the name in 1998 to the "Community Needs Assessment Approach (CNAA)" to emphasize the positive side of the new orientation.

As indicated in RCH programme guideline and MP population policy, essential services covered by RCH programme are as follows.

The RCH services for women	The RCH services for children
- Safe motherhood, including antenatal, natal and postnatal care - Nutrition, specifically concerning anaemia - Adolescent reproductive health - Family planning - Abortion - Care for RTIs and STIs. * *The Programme also recognizes gender issues as important to women's health.*	- Breastfeeding and nutrition - Essential newborn care - Control of Acute Respiratory Infection - Control of Diarrhoeal Diseases - Control of Vitamin A deficiency - Immunizations

(3) Draft National Health Policy 2001

In 2001 GOI drafted a new National Health Policy (NHP-2001) that has not been finalised yet. It referred to a close relationship between population stabilisation and achieving better national health standards, and addresses to reduce the unmet needs for basic and reproductive health services. It also referred that "the synchronised implementation of two policies, population policy and health policy, will be the very cornerstone of any national structural plan to improve the health standards."

It emphasizes a more equitable access to health services across the social and geographical expanse, and the approach recommended is to increase access to a decentralised public health system. The policy includes major 23 policies including implementation of public health programmes through local self-governing institutions and increased access of women to basic health care.

(4) Decentralisation

Decentralization is one of important national policies in India. The GOI encourages decentralised governance through Panchayat Raji Institutions (PRIs) in rural area and urban local body (ULBs) in urban area to enhance bottom-up planning, and community participation in implementation and monitoring of government schemes. It is closely related to how to implement policies on the ground responding to local needs.

2.1.2 State Level

Under the national policy frameworks and plans mentioned above, the Government of Madhya Pradesh (GOMP) took several state initiatives. A state-specific population policy established in 2000 is the most important policy framework for a district plan of improvement of reproductive health. Recognizing existing of gender inequity throughout women's life which adversely effect women's health and quality of life and development of the state, The GOMP issued a state policy on women in 1995 to address gender issues and to rectify gender inequity. Furthermore, in 2001, the GOI issued nutrition policy to improve nutrition status of women and children.

The GOMP is the first state to conduct elections for PRIs immediately after the Constitutional Amendment. It encourages decentralization in the health sector to implement the policies through bottom-up planning responding to local needs and community participation.

(1) State Population Policy

At the same time of issuing of National Population Policy, State Population Policies are also issued based on the National Population Policy. In Madhya Pradesh, State Population Policy established in 2000. Its mission is **"improving the quality of life of people in the state by achieving a balance between population, resources and environment."** This mission is to be accomplished by achieving the main objective: **reaching a TFR of 2.1 by 2011.**

Sub-objectives to be achieved through integrated approach with emphasis on women's empowerment are as follows. Under these four areas, more specific objectives are set about more than 20 items.

(a) increasing contraceptive prevalence through women's and couple's informed and voluntary choice

(b) reducing infant mortality rate (IMR)

(c) reducing maternal morality ratio (MMR)

(d) reducing morbidity of RTIs/STIs

Key policy initiatives are identified as follows:

- creating an environment conducive to a planned family and creating demand for family planning and reproductive health,
- increasing collaboration with Panchayati Raj Institutions, the private sector and the non-government sector in community mobilization and programme implementation,
- improving the management of the family welfare programme to achieve excellence in meeting the needs of clients,
- developing appropriate implementing structures

To strengthen political support, ensure inter-sectoral coordination, and institutionalise integration at district level and below, the following new mechanisms will be put in place:

- State Population and Development Council (SPDC)
- State Population Policy Implementation Committee (SPPIC)
- District Population and Development Coordination Committee (DPDCC)

In December 2001, the GOMP appointed a new commissioner specifically responsible for population and family welfare bedsides the commissioner health. The new commissioner came out with a new initiatives consists of four guidelines and 40 points activities to promote the implementation of State Population Policy (see Chapter 3).

(2) Madhya Pradesh Mid-Term Health Strategy

The Government of Madhya Pradesh (the government of MP) does not have any mid- or long-term state vision or strategy for the health sector except the budget plans included in the State Ninth Five-Year Plan. The budget plans usually follow the National Five-Year Plan. Actually most of the major health programmes in the health sector are the National Programmes.

The DOHFW of MP is currently developing a comprehensive mid-term state health strategy and strategies for the next ten years. A team of international and national consultants was contracted to review the health sector and develop the detailed state mid-term health strategy. Prior to development of detailed strategy, the GOMP formulated basic strategies[1].

(3) State Policy on Women

State Policy for Women issued in 1995 have made serious efforts towards redressing gender inequity. The Empowerment of women to take control of all aspects of women's life is fundamental to sustainable development. The empowerment of women, women's economic, social and cultural development and progress in all sectors are priority areas for the development of MP.

[1] Verbal information. The document was not ready when the study team left India.

The main goals of the MP Policy for Women are:

(a) Ensuring the survival and protection of female life

(b) Ensuring the fullest participation of women in Civil Society and strengthening their role in decision making

(c) Increasing self-confidence and enhancing the status of Women

(d) Empowerment of women to enable them to take the fullest advantage of developmental efforts in all fields

(e) Affirmative action to ensure women's full participation in economic activity

(f) Ensuring the visibility of women in all walks of life

(g) Bringing about sensitisation and attitudinal change in the larger society on the women's question

(h) Prevention of atrocities and acts of violence against women.

(4) Nutrition Policy 2000

Programmes and activities against malnutrition, particularly in women and children, are also mainly implemented by the Department of Women and Child Development (DWCD) but not by the Department of Health and Family Welfare, and State Nutrition Policy also prepared and issued by the DWCD in 2000. The aim of the policy is to reduce malnutrition with the following targets to be achieved by year 2003.

(a) To reduce the level of moderate malnutrition by 15% and the serious malnutrition by 10% for children under 5 years of age.
(b) To reduce the cases of low birth weight by 10%.
(c) To eradicate blindness caused by lack of vitamin A.
(d) To reduce anaemia, caused by lack of iron, in pregnant women by 20%.

The strategies to achieve the aims are:

- Political resolution and public awareness
- Implementation by the PRIs and LUBs (Decentralisation)
- Special attention on the below poverty line and Tribal families
- Multi-regional efforts and inter departmental co-ordination
- Attention to young girls
- Monitoring nutrition
- Establishment of a state nutrition cell
- Targeting families

(5) Other policies on health sub-sector

The DOHFW of MP drafted several sub-health sector policies in 2001 with support from DANIDA. Among these, the MP Drug Policy and MP Training Policy (In-service Training) are closely related to implementation of RHC programme and improvement of RCH service delivery. However, these policies have not been finalised yet by the government of MP.

<MP Drug Policy (draft)>

MP Drug Policy in 2001 drafted by the DHFW with assistance of DANIDA covers a wide range of areas including availability (selection, procurement, distribution and stock control), financing, quality assurance, rational use, and drug and therapeutic committee.

The followings are the major contents of the draft policy that needs immediate review and finalisation by the GOMP and implementation on the ground.

- Establishment of a State Drugs and Therapeutics Policy Advisory Committee (SDTPAC)
- Review and yearly revision of a Essential Drug List for Madhya Pradesh (EDLMP), use of the EDLMP, and implementation of generic name policy
- Establishment and setting-up of an autonomous corporation (Madhya Pradesh Medical Supplies Corporation: MPMSC) for procurement, distribution and stock management of drugs and medical supplies.
- Introduction of centralized bulk purchase
- Establishment and maintenance of quality assurance and control system under the State Drug Controller including GMP
- A cost-effective and efficient distribution from regional warehouses to district stores by MPMSC
- Delegation of responsibility and financial power from the GOMP to the District Health Committee to make arrangements for distribution of drugs and medical supplies
- Establishment of uniform systems, procedures, records and forms regarding stock management of drugs and medical supplies
- Rational use of drugs and setting of therapeutic committee at each hospital
- Development of a Standard Treatment Guidelines

<Health Sector Training Policy (draft)>

Having recognized the inadequate competence levels and skills of the health care providers is the one of the crucial factors for low performance and effectiveness of health care, the GOMP has drafted the health sector training policy based on the training needs assessment.

The policy emphasizes the strengthening of training systems and institutions. It also emphasizes that training will be integrated with the health system as a sub-system of health system and will be reorganized with strong vertical and horizontal linkages with training institutions and service organizations.

Other policy directions and strategies includes necessity of well-designed integrated in-service training programmes (from multiplicity training programmes and programme specific training to integrated training programme), improvement of training environment (improvement of physical infrastructure, training of trainers and developing competence of trainers), training research and development (developing effective training approach such as problem-solving approach, area-specific approach, distance learning and involvement of NGOs, and evaluation of training and its impact)

The policy objectives are;

(a) Develop and establish an efficient and effective training system, and ensure its effective management
(b) Increase the training capacity of the existing system at all levels, including training the district level
(c) Create an environment that will promote the efforts of developing and testing alternative training approaches in search of the most appropriate and area-specific training strategies
(d) Enhance the training competence of trainers, enabling trainers to acquire high quality training skills and develop confidence in performing the roles of trainers, researcher and consultant most effectively and efficiently
(e) Promote training and health services research, including evaluation of training and its impact
(f) Promote participation of trainers in problems solving and could help health providers in solving problems or testing alternative strategies for service delivery

The following implementation mechanism is recommended;

- Establishment of a Departmental Training Committee at the state level
- Establishment of a training management cell within the human resource development wing of the DHFW, and introduction and maintenance of Personnel Management Information System (PMIS)
- Reorganisation of all health institutions:
    i) all the training institutions will be brought under administrative, financial and technical control of the State Institute of Health Management and Communication (SIHMC)
    ii) the SIHMC gives support and supervision to the Regional Family Welfare Training Centres (RFWTCs)
    iii) the RFWTCs will be responsible for providing administrative, financial and technical support to the District Training Centres (DTCs) and Family Welfare Training Centre in its jurisdiction
    iv) the DTCs will report to the respective RFWTC
- Development of Field Practice Demonstration Area to organize community based training by each HFWTC/DTC

(6) Decentralisation

Madhya Pradesh was the first state to conduct elections for Panchayat Raji Institutions (PRIs) immediately after the Constitutional Amendment. Since then the government of MP has promoted decentralisation through PRIs in rural areas and ULBs (urban elected local bodies) in urban areas. According to the Panchayat Raji Act of 1993, MP officially transferred authority and responsibility for policy making and programme implementation in 18 sectors including health to the Zilla Panchayat.

In the health sector, there is little decentralisation to date. Rogi Kaliyan Samiti (patients welfare society), India's cost sharing scheme, is cited by the DOHFW as a successful

example of bottom-up planning and decentralised management. Decentralisation in the political structure is emphasised; however, technical support and co-ordination with the health administrative structure and staff at each level (district, block and community level), which is essential for better operation of decentralised governance, has received little attention.

2.2 CURRENT SITUATION AND ISSUES OF RCH

As described in the population policy, issues in reproductive health are **(1) high fertility and unmet needs** of family planning, **(2) high maternal mortality ratio, (3) high infant mortality rate (IMR)** and **(4) high prevalence of STIs/RTIs.**

Madhya Pradesh is ranked as one of low performing states regarding reproductive health status. Total fertility rate (TFR), maternal mortality ratio (MMR) and Infant mortality rate (IMR) are unacceptable level and more than half of children are malnourished. In general, the reproductive health status in the target districts for the Study is worse in Tikamgarh district, and similar or slightly better in Damoh district than the state average according to reproductive health indicators.

2.2.1 Reproductive and Child Health Indicators

The followings are summary of major reproductive health indicators from available secondary information[2] and survey results of our study.

(1) High Fertility and Unmet Needs of Family Planning

<State of Madhya Pradesh>

- The Total Fertility Rate (TFR) has been gradually declining from 1972 to 1996 (5.7 → 4.1), however there is still big gap between the present TFR and 2.1, the TFR to be achieved by 2011 indicated as a goal in the State Population Policy.
- There is a big difference in TFR between urban and rural areas (urban 2.6, rural 4.4 in 1996). While the TFR has decreased to almost the same as that of India in recent years, reduction in the TFR in rural areas is a little during the same period.
- The biggest contributing factors to population increase are early-marriage and early pregnancy.
- In the rural areas, the age-specific fertility rate (ASFR) for the age group 20-24, which is the highest among all reproductive age groups, remained unchanged on the whole for the 15 years from 1981 to 1996. This contributed most to population increase in the rural areas.
- The age-specific marital fertility rate (ASMFR) in rural areas had a similar trend to the ASFR in rural areas.
- CPR has been gradually increasing from 1991 to 1998 (36.6% → 44.3%), mostly by increase of sterilization (6.4 points) and only 0.7 points increase in modern non-surgical methods.

<Tikamgarh and Damoh Districts>

Based on Rapid Household Surveys (RHS) conducted under the RCH Programme and

[2] Census of India 1991 and 2001, National Family Health Survey 1 (NFHS-1), National Family Health Survey 2 (NFHS-2), Rapid Household Survey 1998, etc.

Census1991;

- The estimated TFR is 0.5 points higher in Tikamgarh district than that of the state, and almost the same in Damoh as that in the state.
- The annual growth rate of population of the last ten years is higher in Tikamgarh district and lower in Damoh district than that in the state.
- Couple Protection Rare (CPR) is slightly higher in Tikamgarh district, and lower in Damoh district than that in the state.
- Unmet need for family planning is lower in Tikamgarh district and strikingly higher in Damoh district than that in the state.

Table 1 Available Indicators of Fertility and Family Planning

	Tikamgarh	Damoh	MP	India
Total Fertility Rate (TFR)	5.04 [1)]	4.14 [1)]	4.1* [2)]	3.4* [2)]
Annual population increase rate (%) (1991-2001) [3)]	2.49	1.88	2.06	1.95
Ideal number of children [4)]	na	na	2.9	2.7
Percentage of women with living two children wanting another children (%)	27.2 [5)]	27.2 [5)]	38.8 [4)]	23.0 [4)]
Couples Protected Rate (CPR) (%)	45.5 [6)] (36.1**)	41.6 [6)] (38.5**)	44.3 [4)] (37.9**)	48.2 [4)] (36.1**)
Unmet needs for family planning (%)	12.7 [6)]	34.8 [6)]	16.2 [4)]	15.8 [4)]

Note: * 3.31 for MP and 2.85 for India in NFHS-2 (1996-1998)
** Sterilization

Source: 1) Estimated (Calculated by the study team based on Census 1991 and SRS)
2) Compendium of India's Fertility and Mortality Indicators 1971-1997 based on the Sample Registration System (SRS), Registrar General, India, 1999
3) Census of India 2001, Government of India
4) National Family Health Survey (NFHS-2) 1998-99
5) JICA Study Team
6) Rapid Household Survey, RCH Programme, 1998/1999

(2) High Maternal Mortality Ratio

There is little reliable data on maternal mortality ratio (MMR) of the state and the districts. According to NFHS-1 and NFHS-2, maternal mortality ratio of India is 424 in 1991 and 540 in 1998. Although there is no statistically significance between 424 and 540, MMR may be tend to increase during this period. This may be the same in the state of MP.

<State of Madhya Pradesh>

- An estimated MMR of the state is 498 which is unacceptable level. In the CSSM Programme, the state was categorized as one of the six priority states due to high MMR.
- According to the results of the survey of causes of death in the rural areas carried by the Registrar General of India in 1993, major causes of maternal death are haemorrhage and fever during pregnancy, anaemia and toxaemia of pregnancy (70%), followed by abortion and related complications and puerperal sepsis.
- About 40% of pregnant women do not receive any antenatal care (ANC). There is big difference in percentage of women received ANC between the rural and urban areas (45% in rural areas and 11% in urban areas)

- Delivery not attended by any trained person is 24%.

<Tikamgarh and Damoh Districts>

- There is no reliable data on district maternal mortality ratio.
- According to the RHS, about a quarter of pregnant women received ANC at least once in Tikamgarh district, and half in Damoh district.
- According to the RHS, about 70% of delivery is not attended by any trained person in both Tikamgarh and Damoh districts. There is a large gap between rural and urban areas (54.0% in urban areas and 24.8% in rural areas in Tikamgarh district; 40.6% in urban areas and 26.7% in rural areas in Damoh district)

Table 2 Available Indicators of Safe Motherhood

	Tikamgarh	Damoh	MP	India
Maternal mortality ratio (MMR)	1,178 [1)]	856 [1)]	498 [2)]	408* [2)]
Percent of births whose mothers received ANC at least once (%)	23.0 [3)]	49.0 [3)]	60.8 [4)]	65.1 [4)]
Percent of births whose mothers were assisted at delivery by trained person** (%)	29.4 [3)]	29.1 [3)]	76.3 [4)] (46.7***)	76.7 [4)] (35.0***)
Institutional delivery	21.5 [3)]	8.5 [3)]	19.8 [4)]	33.6 [4)]

Note: * 540 (428~653) for India in NFHS-2 (1996-1998)
** Medical doctors, nurses, ANM、female MPW, trained TBA (Dai)
*** percentage of delivery attended by TBA (Dai)

Source: 1) Sample Registration System (SRS)
2) Compendium of India's Fertility and Mortality Indicators 1971-1997 based on the Sample Registration System (SRS), Registrar General, India, 1999
3) Rapid Household Survey, RCH Programme, 1998/1999
4) National Family Health Survey (NFHS-2) 1998-99

(3) High infant Mortality Rate

<State of Madhya Pradesh>

- The IMR decreased from 1972 to 1998 on the whole (135 → 94). The difference between the IMRs of the state and India, however, increased in the 1990's compared with the1970's, especially in rural areas.
- There is large difference in IMR between urban and rural areas (IMR is 57 in urban areas and 99 in rural areas; NNMR is 33.2 in urban areas and 68.2 in rural areas).
- The PNMR of the state showed a rapid decrease since 1990. The urban PNMR of the state has been nearly the same level as that of India in recent years.
- The rural and urban NNMR stagnated during 1972 and 1997 (68.7 → 64.0).
- In the state, 2/3 of the IMR is contributed by the NNMR and 1/3 is from the PNMR.
- Coverage of immunization is quite low (percentage of children 12-23 months who received all vaccination is 55%), particularly in rural areas (less than half).

<Tikamgarh and Damoh Districts>

- There is no reliable data on childhood mortality of districts except Census 1991.
- The IMR in both districts in 1991 is higher than that of the state.
- Coverage of immunization is lower in both districts. The coverage in rural areas is very low.

Table 3 Available Indicators Related to Childhood Mortality

	Tikamgarh	Damoh	MP	India
Infant mortality rate	132 [1]	123 [1]	94 [2]	71 [2]
Neonatal mortality rate	na	na	64.0 [2]	46.1 [2]
Under 5 mortality rate	187 [3]	194 [3]	120 [4]	95 [4]
Percentage of children who received All vaccinations (%)	17.3 [5] (U: 39.5 R: 13.0)	27.2 [5] (U: 32.0 R: 26.3)	22.4 [4] (U: 41.2 R: 17.0)	42.0 [4] (U: 60.5 R: 36.6)
Percent of births whose mothers Received two or more TT (%)	47.8 [5] (U: 52.7 R: 46.9)	38.7 [5] (U: 61.1 R: 34.3)	55.0 [4] (U: 73.7 R: 49.8)	66.8 [4] (U: 81.9 R: 62.5)

Note: "U" and "R" in the table means "Urban" and "Rural" resoectively.

Source:
1) The Madhya Pradesh Human Development Report 1998, Gov. of MP
2) Compendium of India's Fertility and Mortality Indicators 1971-1997 based on the Sample Registration System (SRS), Registrar General, India, 1999
3) Census of India 1991
4) National Family Health Survey (NFHS-2) 1998-99
5) Rapid Household Survey, RCH Programme, 1998-1999

(4) High Prevalence of STIs/RTIs

<State of Madhya Pradesh>

- About 40% of interviewed married women reported some symptom of STIs/RTIs.

<Tikamgarh and Damoh Districts>

- About 40% of interviewed married women (age between 15-44) reported some symptoms of STIs/RTIs in both districts.
- A quarter of interviewed men (age between 20-54) reported some symptoms of STIs/RTIs in Tikamgarh districts, and 4% in Damoh district.

Table 4 Available Indicators of Morbidity of STIs/RTIs

	Tikamgarh	Damoh	MP	India
Percent married women reported at least one syptoms (%)	36.0 [1]	40.5 [1]	40.7 [2]	35.5 [2]
Percent married women reported at least one syptoms (%)	24.2 [1]	4.3 [1]	na	na

Source:
1) Rapid Household Survey, RCH Programme, 1998/1999
2) National Family Health Survey (NFHS-2) 1998-99

2.2.2 Cause and Problem Analysis on the Four Major Issues in the Reproductive Health

Cause and problem analysis on the four major issues in the reproductive health area, high maternal mortality, high Infant mortality, high unmet needs of contraception, high morbidity of STIs/RTIs, is done based on our findings in the study on current situation of RCH in Sagar Division. The problems and possible interventions discussed are simplified in the Tables 5 - 8.

High Fertility and Unwanted Fertility

Major causes are;

(1) **Early pregnancy** due to
- social/family pressure and cultural habits
- inadequate knowledge of new couples on FP and FP methods and sources of them
- low social status and education level of girls and women

(2) **Low access to FP services** mainly due to
- lack of knowledge of availability and sources of FP services
- non-availability or shortage of contraceptives at community level
- social/family pressure and traditional belief
- inadequate/partial knowledge of population on FP and FP methods
- low social status and education level of girls and women

(3) **Poor quality of FP services** mainly due to
- inadequate knowledge and skills of ANMs/MPWs and doctors including communication and counselling skills
- lack of supervision system of health staff for assuring quality of services

Non-availability of services about infertility
- This is not the cause of the high fertility, however, infertility is tragic because much stigma is attached to it, and the many women are suffering from social and family pressure. Many of them lose their social standing and are divorced.

High Maternal Mortality and Morbidity

Major causes are;

(1) **High risk pregnancy** is mainly due to
- early pregnancy
- short birth spacing
- too many children
- low health and nutrition status (especially anaemia) of women

(2) **Poor quality of induced abortion** mainly due to
- unwanted and mistimed pregnancy
- lack of accessibility to quality MTP service at PHC level
- use of illegal provider who provide poor services
- lack of knowledge of population on risk of illegal and traditional abortion
- low social status and education level of girls and women

(3) **Low access to and poor quality of** ANC mainly due to
- low coverage (low accessibility and low availability) by ANMs/MPWs
- inadequate knowledge and skill of ANMs/MPWs
- shortage of equipment/supplies
- lack of referral system
- lack of knowledge and awareness of population (particularly husbands) on health of pregnant women
- low social status and education level of girls and women

(4) **Unattended delivery** mainly due to
- low coverage (low accessibility and low availability) by ANMs/MPWs
- lack of advise by ANMs/MPWs during ANC
- lack of knowledge and awareness of population on health of pregnant women and delivery
- financial constraints in paying for services by health workers/professionals
- cultural beliefs and habits
- low social status and education level of girls and women
- caste segregation.

(5) **Ill-attended delivery** mainly due to
- inadequate knowledge and skills of ANMs/MPWs and Dais
- insufficient equipment and supplies
- lack of EOC and EmOC
- lack of referral system

(6) **Lack of functioning referral system** mainly due to
- lack of qualified health staff
- insufficient facility and equipment
- lack of transport support for referred patients and emergency cases
- lack of communication system between health workers, PHC and CHC.
- lack of management capacity.

(7) **Low access to and poor quality of postnatal care** due to
- low coverage (low accessibility and low availability) by ANMs/MPWs
- inadequate knowledge and skills of ANMs/MPWs
- shortage of equipment/supplies
- lack of referral system
- lack of knowledge and awareness of population on health of pregnant women
- low social status and education level of girls and women

<u>High Infant Mortality and Morbidity</u>

Major causes are;

(1) **No reduction of neonatal death** in the past decade mainly due to
- non-availability of high-risk newborn care
- low nutrition status of pregnant women

(2) **Prevalence of chronic malnutrition** mainly due to
- lack of caretakers' knowledge about nutrition
- cultural habits of feeding children

- low nutrition status of pregnant and nursing mothers
- poverty (difficult to feed children with adequate nutritious food)
- inadequate knowledge and skills of ANMs/MPWs and AWW in providing nutrition services and health education
- inadequate knowledge and skills of ANMs/MPWs and AWW in providing child growth monitoring services and education

(3) **Diarrhoea, ARI (acute respiratory infection), Malaria and others common diseases are not well controlled and treated** mainly due to
- lack of caretakers' knowledge about infectious diseases and its causes
- lack of sanitation and poor access to safe drinking water
- inadequate knowledge of health providers about proper treatment of these infectious diseases
- shortage of drugs for treatment

(4) **Inadequate protection from vaccine preventable diseases** mainly due to
- low coverage (availability and accessibility) of routine immunization services
- lack of knowledge of care takers
- weak in maintaining cold chain at peripheral level.

High Incidence of STIs/RTIs Symptoms

Major causes are;

(1) **Lack of general population's knowledge of symptoms, potential for treatment and modes of transmission** mainly due to
- low availability and poor provision of information/information sources on RTIs/STIs to general population
- lack of strategic IEC activities on STIs/RTIs

(2) **Lack of services for diagnosis and treatment** mainly due to
- lack of trained service providers
- lack of laboratory capacity
- lack of equipment for diagnosis
- lack of medicine for treatment

(3) **Insufficient coordination with RCH programme and AIDS control programme at district level** mainly due to
- no government strong initiative on this component
- insufficient awareness of health administrative staff and politician on importance of control of STIs/RTIs and possible AIDS crisis

Table 5 Problem Analysis: Problem and Solution Trees for High Incidence of Unwanted Fertility (and Infertility)

High Incidence of Unwanted Fertility

Low Access to FP Sservices	
Problems	***Interventions***
Lack of knowledge about temporary methods	▪Increase Health education and awareness
Lack of knowledge about service availability	▪Community based marketing of FP services
Cultural believes	▪Increase Health education and community awareness
Social pressures	▪Increase Health education and community awareness
Non-availability of MTP facilities	▪Development of MTP facilities at PHC

RCH Approach Not Followed	
Problems	***Interventions***
Non-implementation of RCH approached and policies	▪Coordination mechanism and linkages between government and donors and NGOs
Target approach through more emphasis on sterilisation	▪Improve the Quality of temporary methods ▪Reorient health staff to client needs approach ▪Review and improve CNA system

Low quality of FP services	
Problems	***Interventions***
Poor supply logistics at community level	Improve supply chain at village level
▪Considerable rate of failure and side effects with sterilization ▪Low level of communication and counselling skills	▪Technical training and skill development. ▪Communication and counseling skill development ▪Improve case follow-up
Low quality of planning and program implementation / monitoring skills	Improve the program planning and management skills with camps organization, transport communication etc

Infertility

Infertility	
Problems	***Interventions***
Service is not available	Develop fertility services in district hospitals

Table 6 Problem Analysis: Problem and Solution Trees for High Maternal and Neonatal Mortality

High Maternal and Neonatal Mortality

High Risk Pregannacy		Induced Abortion		Ante Natal Care		Unattended Delivery		Ill-attended Delivery	
Problems	***Interventions***	***Problems***	***Interventions***	***Problems***	***Interventions***	***Problems***	***Interventions***	***Problems***	***Interventions***
1. Pregnancy too early (<19 yr) ▪ Early marriage ▪ Social pressure	Social develop/ Campaign that should include at least ▪ Promotion school attendance by girls ▪ H. Education ▪ Life skills development	1.Unwanted and mistimed pregnancy	Increase the provision of FP services and contraceptive distribution at the community level *(→ see FP)*	1. Low (%) of Receivers Too little coverage by ANM ▪ Not informed about pregnant women ▪ No transport ▪ Lower castes segregation ▪ Too large coverage area ▪ Lack of motivation and commitment	▪ Improve Planning of ANM work by BMO and PHC ▪ Increase the supervision by MD of PHC ▪ Increase transportation means of ANM ▪ Increase coordination with AWW etc. in the community. ▪ Increase planning of human resources ▪ Increase motivation through supervision and reward scheme	Limited access: ▪ Cultural beliefs (see before) ▪ Lack of awareness/ health education ▪ Lack of advice by ANM during ANC ▪ Caste segregation ▪ Financial constraints ▪ Lack of coverage by field staff	▪ Review of SHC catchment area ▪ Health education ▪ Training of providers ▪ Cost of delivery to be free *(→ see ANC)*	▪ Lack of knowledge and skills of providers ▪ Lack of planning ▪ Lack of transportation and equipment supplies ▪ Lack EOC ▪ Lack of EmOC ▪ Lack of referral mechanisms	▪ Training of providers ▪ Increase management capability ▪ Cost of delivery to be free ▪ Supply equipment ▪ Provide transportation *(→ see ANC)*
2. Pregnancy too late (>40 y) Not Important Issue		2.Use of illegal providers because of: ▪ Low availability of MTP ▪ Financial pressure ▪ Social pressure ▪ Boy preference	▪ Increase the availability of MTP services ▪ MTP services free ▪ Increase of awareness of gender ▪ Social environmental change by BCC /awareness campaign	2. Low quality of service provided by ANM ▪ Low identification of high risk ▪ Lack of knowledge ▪ Lack of skills ▪ Lack of equipment	Pre-service and in-service training				

High Risk Pregannacy	
Problems	*Interventions*
3. Spacing (more than 2 years of inter genesis interval) <u>Not very important issue</u>	Heath education in schools and in village
4. Too many children (TFR>= 4) ▪ Male preference (Gender) ▪ High infant mortality	▪ Health Education in schools and village ▪ Increase of social status of women (See approaches separately) ▪ Decrease Infant/ Child mortality. (See approach separately

Induced Abortion	
Problems	*Interventions*

Ante Natal Care	
Problems	*Interventions*
3. Lack of referral system ▪ Distance to FRU is too long ▪ Lack of communication tool ▪ Lack of transport and cost	▪ Upgrade CHC equipment and staff. (MDs and ANM trained in emergency obstetrics and managing of complicated cases) ▪ Implement tele communication system ▪ Development of community fund for transportation ▪ Available vehicles at HF ▪ Upgrade hospital to receive severe cases ▪ Create blood banks
4. Lack of supplies (medicines: IFA, Vit A, etc.)	Increase planning capability

Unattended Delivery	
Problems	*Interventions*

Ill-attended Delivery	
Problems	*Interventions*

High Risk Pregannacy	
Problems	*Interventions*
5. Low health status ▪ Nutrition/Anemia ▪ Workload ▪ STDs / RTIs ▪ Other conditions	▪ Improve local development ▪ Increase women's literacy, social status and economic condition ▪ H. Education ▪ Increase prev & treatment of chronic Illnesses and deficiencies ▪ Increase treatment of STDs

Induced Abortion	
Problems	*Interventions*

Ante Natal Care	
Problems	*Interventions*
5. Limited Access to ANC ▪ Cultural beliefs ▪ Low empowerment ▪ Low literacy	▪ Increase H. education ▪ Increase ▪ empowerment ▪ Increase school attendance

Unattended Delivery	
Problems	*Interventions*

Ill-attended Delivery	
Problems	*Interventions*

Table 7 Problem Analysis: Problem and Solution Trees for High Infant Mortality

High Infant* Mortality Rate

Prevalence of chronic malnutrition	
Problems	***Interventions***
Cultural habit hampers providing proper diet to children	▪Promote exclusive breast feeding ▪Provide health education on nutrition, particularly on weaning ▪Increase of public awareness of nutrition ▪Strengthen nutrition programme
Lack of knowledge and awareness of child nutrition of care takers	▪Provide heaith education on nutrition ▪Increase family awareness of child nutrition ▪Strengthen nutrition programme
Lack of knowledge of child nutrition of health service providers (including AWW)	▪Train health providers on child nutrition ▪Train health providers on interpersonal communication skills
Poverty (Financial) : low economic status to have sufficient food	▪Strengthen vitamin A distribution programme ▪Encourage SHG activities for income generation ▪Organize and promote community (Panchayat) activities to increase availability of nutritious food (home gardening, etc.)
State policy: nutrition issues is not addressed within the health system	▪Policy change to integrate all primary health care activities for children at primary health care facilities and community level (→ IMCI approach)

Diarrhea, ARI, Malaria and others are prevalent, and not well controlled and treated	
Problems	***Interventions***
Lack of sanitation, poor access to safe drinking water	▪Increase water sources and toilet ▪Provide health education on sanitation
Lack of knowledge of infectious diseases of care takers	▪Provide health education on major infectious diseases prevention and control ▪Increase family awareness of infectious diseases
Lack of knowledge of infectious diseases of health service providers (including AWW)	▪Train health providers on major infectious diseases ▪Train health providers on interpersonal communication skills
Lack of supplies including medicines	▪Improvement of logistics management of supply

Inadequate protection from vaccine preventable diseases	
Problems	***Interventions***
Low coverage of immunization due to poor planning	▪Improve access to immunization services through better planning ▪Strengthen routine immunization of DPT, BCG, TT ▪Improve coverage of Measles Immunization through campaign
Lack of knowledge of care takers	▪Provide health education on major infectious diseases prevention and control ▪Increase family awareness of infectious diseases
Irregular supply of vaccines	▪Improve logistics management of vaccine supply
Weak in maintaining cold chain at peripheral level	▪Improve logistics management of vaccine supply ▪Train health workers on cold chain maintenance

* Children above 6 weeks old and below 1 years old

Table 8 Problem Analysis: Problem and Solution Trees for High Incidence of STI/RTI Symptoms

High Incidence of STI / RTI Symptoms

Problems	*Interventions*
1. Lack of knowledge of symptoms, potential for treatment, and modes of transmission	1. Health Education ▪ By ANMs in visits ▪ Mass media for creating awareness ▪ Peer education
2. Lack of Services for Diagnosis and Treatment Due to: ▪ Lack of trained providers ▪ Lack of laboratory capacity for diagnosis ▪ Lack of equipment for diagnosis ▪ Lack of medicines for treatment	2. Expand Services to Diagnose and Treat ▪ Modify pre-service curriculum to develop skills in syndromic management, provide in-service training ▪ Develop laboratory capacity at B-PHC level ▪ Provide equipment for diagnosis (light and speculum) ▪ Provide medicines at all levels for treatment of symptoms according to protocols

2.3 CATEGORIZATION OF THE PROBLEMS IN RCH

All the problems in RCH and RCH programme reviewed are collected and categorized into the following four cross-cutting issues, which are very common categories in the assessment of health services delivery and health programme. The summary description of problems and constrains in RCH are given by these issues in the following sections.

A. Problems and constrains in RCH service delivery system

- Inadequate Coverage (Accessibility and actual availability) of RCH Services
- Poor Quality of Services

B. Lack of awareness and knowledge of RCH and RCH service and behaviour change among general population

- Lack of awareness and knowledge of population on health and nutrition of women (particularly, pregnant women) and children
- Lack of awareness and knowledge of population on needs of preventive health care and FP, and availability and source of RCH services.
- Lack of behaviour change of population in spite of having awareness and knowledge at individual level

C. Social and cultural factors which hinder RCH improvement

- Social pressure and cultural habits which obstacle women's and children's health
- Early marriage and early pregnancy
- Difficult access to information on RCH for adolescents
- Social and cultural habits which hinder the use of RCH services
- Husband's decision making on receiving health care
- Limited mobility of women (limited within the village in rural area, in general)
- Low literacy rate in women and girls
- Caste segregation

D. Poor management in health administration and health programme

Inefficiency and ineffectiveness in health care system due to poor management are fundamental issues.

- Lack of clear demarcation for role of health administrative office and Panchayat/health committee, and lack of close linkage between health administrative structure and political structure (lack of communication mechanism and supporting system to the health committee and community from health administrative office within) the decentralization policy
- Poor coordination and communication between service level (district, block and sector and community) and other health related sectors (particularly, Department of Women and Child Development, Department of Medical Education and Indian System of Medicine, and Department of Panchayat and Rural Development)
- Poor and week establishment, operation and use of health sub-system, such as health referral system (particularly emergency referral system), health management information system (including vital registration system, health personnel information

system and health financial information system), communication system between different health service level, supervision and monitoring system, drug supply logistics management system

- Week in super vision and monitoring
- Week in use of health information and epidemiological data in planning and monitoring
- Week linkage of health service delivery system and community system, or health care provider and community people

2.3.1 Health Care Delivery System

(1) Coverage of (Access and Availability) of RCH Services

1) Distribution of health facilities providing basic RCH services

In the capital of each district there is a district hospital that is the main reference centre for the whole district. Actually, except Sagar district, it is an only one referral facility and hospital for about 1 million population besides a few private nursing homes and clinics. At the peripheral level, there is a network of health facilities, administratively organized under the block medical officer.

It is, in fact, impressive the number of health structures in Sagar Division, over 1,000 in total. However, each health facility covers population much more than the norm. The number of S-PHCs is small and it covers about two to three time of the population.

a) Sub-centres (SCs)

- **Availability and ownership of the SC building:** The number of established SCs given to us does not show the number of health facilities with government building. 32.7% and 82.8% of SCs in Tikamgarh and Damoh District are not operated in government health facilities. This means that most of the SCs are not really health facilities since there is no building to be called as such. 17% of SCs in Damoh District and 61% of SCs in Tikamgarh District have no labour room. 7% of SCs in Damoh District and 18% in Tikamgarh District have no building and usually health workers are not there for providing services.

  ANM or MPW works at their house, at an Anganwadi worker's house, at another village facility or a rented room. Sometimes the room rented is only a small storage for keeping some medical equipment and drugs.

- **Catchment area of SC:** Population covered per sub-centre (SC) is about 5,500 ~ 6,500 on average. However, the SCs do not cover whole population in the catchment areas for providing RCH services, since it covers 4~8 village (sometimes more than 10 villages) in the wide area including isolated areas, and only one ANM or F-MPW cannot cover the entire catchment area by field visit.

  Usually the location of SC is based simple population norm. The issue of access, easy reach and manoeuvrability for the ANM and other factors are not greatly considered in setting up the SC. According to our GIS study, there are only 54% of the population within the 2 km access to the SC, even within 4km only 69% in Damoh. This is almost the same in Tikamgarh; only 51% of the population is located within the 2km, 67% within 4 km.

- **Location of SC in the village**: 54.6 % and 28.7 % of SCs in Tikamgarh and Damoh District are NOT located in the centre of the village. This causes low awareness and utilization of the SC services by villagers, poor relationship with community people and insecurity of living in the village for ANMs/F-MPWs.
- **Station of ANMs/F-MPWs for SCs**: Many of ANM/F-MPWs assigned to SCs do not stay in the assigned village: about 28% of ANM/F-MPW in Damoh and 44% in Tikamgarh District live outside of the village. Where there is a government owned building half of which is for the ANM's residence, the ANM is more often present in the community.

b) Sector-PHCs

- The number of sector-PHC is very small and it is difficult for them to supervise all SCs under them.
- Even though the number of sector-PHC is very small, they are under-utilized.

c) Block-PHC / CHC

- Every block has a block-PHC or a CHC. However, there is no specialist at block-level, which makes PHC/CHC difficult to function as a first referral unit.

d) Health facilities under the Department of Medical Education and Indian System of Medicine (DMEISM)

- There are some clinics at SC level where an Ayurvedic or a Homeopathic doctor is working: 37 in Damoh district and 28 in Tikamgarh district. However doctors and staffs are not enough trained in RCH and CNAA.

2) Availability of RCH Services at Health Facilities

The table below are the summary of availability or accessibility of RCH services by service level.

Table 9 Services Offered at the Health Facility in Sagar Division

H. Facility / Service	Hospital	CHC	B-PHC	S-PHC	SC	Field /Home Visit	AWC /AWW
Safe Motherhood							
Antenatal care	A	A	A	A	A	A	
Blood test anaemia	A	L	L	L	NA	NA	
Blood test malaria	A	L	L	L			
Urine test	A	L	L	L	NA	NA	
Normal delivery	A	A	A	A	A	A	
Normal newborn care	A	A	A	A	A	A	
High risk newborn care	L/NA	NA	NA				
Postnatal care	A	A	A	A	A	A	
EOC/EmOC (non-surgical)	A	NA	NA	NA	NA	NA	
Caesarean/EmOC	A	NA					
Blood transfusion	L	NA					
Adolescent Reproductive Health	NA	NA	NA	NA	NA	NA	
Service for Infertile Couples	L	NA	NA	NA	NA	NA	
Abortion							
M.T.P.	A	L	L	NA			
Complicated abortion	A	L	L				
Family Planning							
FP counselling	A	A	A	A	A	A	
Pill	A	A	A	A	A	A	A
IUD	A	A	A	A	A		
Condom	A	A	A	A	A	A	A
Surgical female sterilization	A	L	L	NA			
Surgical male sterilization	A	L	L	NA			
Complication of FP	A	L	L	NA			
RTIs/STIs							
Sympt. diagnosis RTI/STIs	A	L	L	L	NA	NA	
Lab. Diagnosis RTI/STIs	A	L	L				
Treatment for RTI /STIs	A	L	L	L	NA	NA	
Child Health							
Immunization M & C.	A	A	A	A	A	A	
Nutrition supplementation							A
Child growth monitoring	A	A	A	L	L	L	L
Distribution of Vit. A	A	A	A	A	A	A	A
Diarrhoea	A	A	A	A	A	A	A
Fever	A	A	A	A	A	A	A
ARI	A	A	A	A	A	A	A
IEC Activities	L	L	L	L	L	L	L

Note: A - Available in most facilities of the mentioned type.
L - Available but limited in some facilities of the mentioned type, or level and contents of services are limited
NA - Not available in the mentioned type of facility.

RCH services, which should be available and provided, are actually not available or availability is very limited. Particularly, access to and availability or essential obstetric care (EMO) and emergency obstetric care (EmOC), the crucial components of reproductive health services for reducing maternal mortality and morbidity, are very limited.

The major reasons of these are;

- Inadequate technical and communication competence of health personnel (doctors, nurses, ANMs/ MPWs and health educators) for provision of necessary RCH services at each service level
- Shortage of trained doctors for provision of integrated RCH services
- Frequent absence of ANMs/MPWs when needed at SCs because there is no government facility where she may reside or the ANM has too much territory to cover by visiting the community
- Some of doctors and health staff working at S-PHC and B-PHC do not stay in the community since poor living standard, infrastructure and environment. Therefore, provision of 24 hours services is difficult.
- Inadequate managerial competence of programme managers, supervisors, medical/health officers and field health workers.
    - Not well organised field visit and out-reach services and insufficient coordination among field health providers
    - Poor linkage of health providers and community
- Shortage or lack of appropriate physical facilities and equipment
- Shortage or lack of medicines and medical supplies

a) Essential and emergency obstetric care (including neonatal care) at first referral level is available only at District Hospital

- The most curtail component to reduce maternal mortality is access to and availability of EOC and EmOC. However, availability of EOC is limited and EmOC is almost none at peripheral facilities and primary health centres. The District Hospital is the only government facility that can provide the services in the district.
- The RCH activities in the villages in the Study area put emphasis on five cleans in delivery attended by a trained TBA (Dai).

  Possibility of incidence of a situation that needs EmOC always exists with all pregnant women. It is well known that the establishment of ANC, EOC and EmOC together with effective referral system is essential to reduce maternal mortality and neonatal death remarkably.

  It is also well-known that TBA training does not give much impact on reduction of maternal mortality (1~3% reduction). The TBA training is essential, however, attendance of delivery by a health professional (a trained ANM/F-MPW, a nurse-midwife or a medical doctor) and institutional delivery need to be promoted furthermore.

b) No functioning referral services (system) in the district

<u>Referral services for EmOC</u>

- The emergency referral system is not functioning. The system needs three sub-systems; (i) health facilities where a patient is received and treated by trained

specialist (doctor) for 24 hours, (ii) transport system (readily available transport) to link all levels of health care and community, and (iii) communication system to contact to all levels of health care. Management capacity to operate the systems is essential. None of them are available in Tikamgarh and Damoh Districts.

- The CHCs are defined as a first referral unit (FRU) at block level. All former block level PHC were supposed to be upgraded to CHCs, however, in reality, many are not functioning as FRUs yet. No building and facilities for providing EmOC and equipment at CHC level. The number of specialists is not sufficient to assign them to all CHCs.

  In the whole Damoh district there are only two health units to refer patients to: the District Hospital and the Hatta CHC. Doctors and nursing staff working in the other 13 PHCs outside of that Block do not have any technical support or a facility to refer patients to any other than the District Hospital. Even Hatta CHC does not provide emergency obstetric services. It has neither functioning operation theatre nor staff.

- Lack of specialists even at district hospital; no anaesthetist in Damoh district. No specialists at lower level.
- LHV/ANM's knowledge on warning signs of a situation that requires immediate intervention (means requires refer of the patient to the higher level) since it puts at risk the life of many women and their babies is very limited. Findings in our study show the absence of referral to the health facility in many life-threatening cases.

Non-emergency referral services

- The referral system is essentially non-functional. Existing beds are under-utilised.
- LHV/ANM's knowledge on warning signs of a situation and symptoms which needs higher level of care is very limited.

c) No MTP / abortion services at PHC Level

- Services that are only available at the district hospital or a CHC where there is a woman doctor are not services that are available to rural women. If Madhya Pradesh is serious about decreasing maternal mortality due to abortion, MTP must be provided by trained ANMs/LHVs. In neighbouring Bangladesh, LHVs have been performing MTP safely for more than 20 years.
- National law currently prevents the state from training the LHV/ANM/MPW-F in this procedure. It should be reviewed and changed.

d) No diagnosis and treatment of RTIs/STIs

- Many women cannot receive diagnosis and treatment of RTIs/STIs.
- Diagnosis and treatment of RTIs and STIs are neglected. ANM training in their diagnosis and treatment is minimal. Even at the block level, one hears that they have never had a case, suggesting they do not know how to recognize one.
- Given the prevalence of symptoms reported in recent surveys, the level of diagnosis is well below the prevalence of these diseases.

e) Postpartum care

- Postpartum care to date has been badly neglected.
- ANMs are required to register pregnant women and provide them with antenatal care and any delivery care they may require or request short of EOC. However,

there are no guidelines for visiting women in the postpartum period and their care. This is a prime time for counselling on family planning methods - an opportunity to provide information on the full range of methods, both temporary and permanent, in an unhurried manner - as well as on breast-feeding, nutrition during lactation, and immunizations.

f) Limited IEC activities

- Although IEC is very important to give correct information on RCH to beneficiaries, and create needs and motivate them to access and utilize services, this component is very weak in RCH.
- IEC activities at present and health staff's undersigning on IEC are to distribute printed leaflets or put posters on the wall. Health staffs are not trained in interpersonal communication skill or training is not adequate.
- IEC has not been effective in producing the desired results partly because of weaknesses in the application of an effective behaviour change (health communication, IEC) process.

2.3.2 Quality of RCH Services

(1) *Health Service Provider's Competence and Skills for Providing Quality Services*

a) ANM / MPW / LHV

- ANMs and LHVs do not attend to cases of abortion, RTI/STI, chronic illnesses and nutrition.
- ANMs seem to conduct relatively few deliveries, although this is supposed to be one of the crucial tasks of the ANM: 25% never attended the delivery, 49% attended in the past week, 13 % in the past month, and 13 % in the past 6 months.
- 83% of ANMs/MPWs/LHVs never encountered sepsis puerperal, 67% never encountered obstructed labour, eclampsia, complicated abortion, and half never encountered postpartum haemorrhage. In this case, the types of frequent situations/medical conditions that ANMs/MPWs/LHVs have never encountered lead us to believe that chances are that they were not able to recognize them.
- ANMs/MPWs/LHVs' advice to clients are not adequate and appropriate during ANC and postnatal care and after delivery: they do not motivate clients well to have three times ANC, institutional delivery, postnatal care and family planning.
- It is important that clinical staff know when to refer patients to the health facility, particularly in the case of Sagar Division where transportation is not easily available. However, ANMs/MPWs/LHVs have limited knowledge on warning signs of a situation that requires immediate intervention.
- Of the 17 crucial tasks of the ANM described a guideline, 15 are related to IEC. However, the ANM is taught nothing about Communication during her training.
- Too many activity and task: In fact, it seems that every new activity places an additional burden on the ANM, who already has numerous responsibilities that go well beyond providing health services and education. For example, every February-March, the ANM is expected to visit every household in her catchment area to update the Eligible Couple Register.

<Training of ANM / MPW / LHV>

- The problems mentioned in above and other low performances in ANM/MPW/LHV's work are mainly because of insufficient pre- and in-service training and lack of follow-up of training and supervision.
- The syllabus for ANM training was designed by the Indian Nursing Council in 1977 and updated in 1986 but not since. Training consists of courses in sciences and health. The texts and manuals used are similarly outdated and lacking in important information about recent developments.
- The trainers receive little material or training to advance their knowledge about changes in the national health programme or health care.
- Notably absent from the syllabus of the ANM training is any course on communication skill, although one of the major responsibilities of the ANM is health education in home visits and while providing primary health care.
- Required further training was referred by 67% of ANMs/MPWs, yet almost none was able to specify in what subjects was this training necessary.
- In-service training conducted under the RCH programme never cover all health staff due to financial limitation.
- The in-service training covers too many areas in limited period. Therefore, only one to three hours are spent for each subject, which is not sufficient to improve quality of services provided by ANMs/MPWs/LHVs.
- The training through practice is badly needed.

<F-ANM Training Centre >

- Tikamgarh has an ANM Training Centre (ANMTC) while Damoh does not and has to rely on getting trainees from the Sagar district ANMTC. (Nevertheless, it is not recommendable to increase the number of ANMTCs until the state manages to make the existing ones effective.)
- The Tikamgarh ANMTC has filled only three of seven staff positions. The post of principal was filled for about a year and a half when the school was first founded in the early 1980's. Since then it has remained vacant, and a tutor is assigned as acting to handle administrative responsibilities as well as training. The school is using the 1977 syllabus. The materials and teaching aids are old and in disrepair and often inappropriate, and the tutors, who were not selected for their training skills and received no TOT to develop them, do not receive regular in-service training (their last in-service was in 1997 or 1998).
- ANMTCs are lacking an effective strategy for recruiting good candidates.

<Selection of ANM trainees>

- There is a fundamental flaw in the approach to selection of ANM trainees. The selection is treated as a strategy for decreasing unemployment, rather than a part of the process of assuring qualified health care providers. Candidates must be registered at the unemployment office of the Ministry of Labour, and that office advertises the training, receives applications, and participates in the selection (along with the CMHO, District Collector, and a couple of others).
- ANM training is just as crucial as the training of nurses and doctors and should be accorded equal importance. This requires a rethinking and redesign of the

recruitment and selection process. Recruitment needs to be more rationalized also. It also needs to be more aggressive since ANMTCs in general do not fill all their trainee positions. In Tikamgarh, for example, there are 35 students filling 60 positions. The situation is similar in the Sagar district ANMTC.

b) Male-MPW Training

- There are ten MPW (male) Training Centres in MP, each of which has an annual admission capacity of 60 trainees. The eligibility criteria are the same as for ANMs, ten pass. Their training also follows an outdated syllabus developed by the Indian Nursing Council, the materials and trainers are similarly out of date, the facilities for the men are generally in poor condition, and all resources are inadequate.
- Problems in in-service training are the same as for ANM/F-MPW.

c) Dais

- The GOMP should re-examine the role the Dai should realistically play and formulate its goals, expectations, and work plans accordingly, recognizing that Dai training will not achieve a goal of having one trained dai in every village, and training dais will do little to bring down the maternal mortality rate.
- In Madhya Pradesh it has been also the case but with a particularity: over 93 % of Dai belong to the Basor caste, a scheduled caste with high untouchability by the other castes. These means that they are often called not to conduct the delivery of the newborn, but rather to deliver the membranes only. The delivery had been previously conducted by a relative.
- Despite all the efforts placed on training Dai in safe delivery procedures, 17% percent of them never performed a delivery, about 1/3 only performs 2 deliveries a year, and only about 1/3 conducts between 1-4 deliveries /month.
- The number of deliveries performed per year does not ensure enough practice to conduct safe deliveries. Moreover, in a large number of cases the Dai is called only after the baby is born and just to deliver the placenta. In fact, over 20% of all Dai in Sagar Division have faced these cases.
- Less than 15 percent of Dai recognised at list 2 dangerous sings of pregnancy. Regarding postnatal care the lack of knowledge is even more marked. Only 15% of Dai mentioned any signal of puerperal sepsis as a reason for referring women to the health facility
- In 57% of deliveries, new mothers are not told to go to the health facility for postpartum follow up, or are told to go only in the case of some problem. Note that postpartum complications, such as bleeding or vaginal discharge are only mentioned by 7% of Dais.
- Regarding the umbilical cord, after cutting it with a sterile instrument, over 90% of Dai don't treat it at all.
- One of the programmes tried in other countries is one of encouraging Dais and family members to conduct deliveries in the SC or PHC. These health centres should be dai-friendly and women-friendly places where all feel welcome to come and learn at any time. Operations research should test dai-friendly and woman-friendly PHCs.

<Dai Training>

- PHCs have been given targets for Dai training. When they meet their target, they cease to train, leaving Dais in the community attending births but not receiving training or sterile supplies through the government. Targets should be eliminated, and the policy should be changed to require that all dais in the coverage area should be trained and have access to sterile supplies.
- Training of Dais is mainly conducted at the PHC and focuses on normal delivery. Although the presence of intense bleeding in the postpartum is a frequent cause of maternal mortality, it should be noticed that the percentage of Dai that received training in postnatal care is very low.
- There is no training of Dai in the treatment of malnutrition, emergency obstetrical care and treatment of complication of abortion, despite the fact that these are main causes of maternal deaths during delivery. Moreover, training in counselling in RTI/HIV/AIDS is basically nonexistent, although frequently women have complaints related to RTIs.
- In 95% or more of the cases, training was provided less than 5 years ago with the exception of family planning. In this last case 60% of the trained Dai received training between 5 and 10 years ago.

(2) Human resource availability and distribution

- No special doctor (gynaecologist and paediatrician) and anaesthetist except for district hospital. Nurses and doctors are in short at hospital and at block level.
- Even at hospital, special doctors and anaesthetists are not sufficient to provide quality services. No anaesthetist in Damoh District.
- Very little number of lady doctor at rural facility
- There is one GP (general doctor) per rural primary health centre (S-PHC) and more in B-PHC on average, however, many doctors assigned to sector level and block level do not stay in the location.
- Medical doctors at S-PHC and B-PHC are not functioning much partly due to lack of equipment and supplies, and low utilization of population.
- Too many doctors in B-PHC per the number of the patients.
- According to the staffing norm, HA/LHV and ANM/F-MPW is not much in short. Male MPW is also in short a bit.

(3) Physical condition of health facilities

- The problem is not only the number of facilities, building availability, their inaccessibility in short time, but the lack of adequate physical conditions in most of health facilities. Many buildings and facilities are decaying and ill maintained.
- The budget for construction and maintenance of health facilities is transferred to the Department of Public Works (PWD), which is responsible for implementation of construction, renovation, and maintenance works. After completion of the construction works, the facilities belong to the PWD. The PWD may have other priorities for their work, despite a transfer of funds to the PWD for work on a health facility. The construction project team's lengthy briefing and feasibility study stage are inevitable and it could take 10-15 years from inception to inauguration of the project. Consequently a newly constructed facility could be outdated.

- During construction, close communication is recommended between DOHFW and PWD to monitor progress.
- Poor quality of construction works
- Poor cleanliness and hygiene at health facilities
- Facility design: According to the beneficiary survey, many client women concerned about privacy at health facilities during consultation. New design for SC is needed since the current design has only one room for a waiting area plus examinations. There should be a separate private examination room.

(4) Lack of equipment and medical supplies

- Lack of equipment is seen at all health facilities, which make difficult to provide quality health at the each service level.
- At SC, 70% of ANMs/MPWs say that the equipment available is not enough, and drugs are not sufficient for 80%.
- CHC is not able to function as a FRU (first referral unit) due to lack of equipment.
- The standard list of equipment of Madhya Pradesh is not available and no inventory system at district level.

(5) Technical issues in sub-programme

a) Sterilization

- Facilities that perform tubectomies report that they keep a woman in the hospital for 7-10 days after a traditional tubectomy because she would experience wound infection at home. This serves to decrease availability of the service since only sites that have a laparoscope and personnel trained on the laparoscope can perform tubectomies.
- If the woman is given good post-op counselling and perhaps clean gauze or Band-Aids to take home, she should be able to avoid post-operative infection and not have to spend such a long time as an indoor patient. Elsewhere in the world, it is common for a woman to return home after resting a few hours following the operation, and this is the practice at Surya clinics in Madhya Pradesh.
- Medical Officers who perform sterilizations should be thoroughly retrained in mini-laparotomy technique and counselling clients for post-operative care.

b) Family Planning

<*Concept of RHC: client needs oriented family planning based on informed* choice>

- There is very clearly that there is little understanding of the concept. Then the concept needs to be turned into systems. Staff need to have goals and objectives for which they are held accountable. There are many alternatives to the current system of reporting and holding staff accountable for such quantitative targets as new acceptors by method.
- The current "needs assessment" procedures for developing an annual target, in fact, do not take the community into account in any way except to count its members and calculate what their "needs" will be based on formulas developed at higher levels.

<Method of Family Planning>

- Family planning is virtually synonymous with female sterilization.
- Providers need to receive refresher training in temporary methods and how to counsel clients properly about them.
- More attention needs to be paid to involving men in family planning. Probably a more successful scheme than that of the M-MPW for educating village men is needed.
- Family planning clients need to be given clear, complete, and accurate information about each method, including instructions on how to use the method, its advantages and disadvantages, possible side effects, and danger signs that require immediate attention. Information on side effects is the most neglected during counselling.
- ANMs, who have the greatest responsibility in the area of IEC and counselling, receive no training on counselling and communication in their pre-service training.

c) Nutrition (Anaemia)

- ICDS & Distribution of IFA (Iron and Folic Acid) tablet: The Indian programme to decrease iron deficiency anaemia in pregnant women through distribution of IFA tablets and food supplementation during pregnancy has had very limited impact. Additionally, the cost for national supplementation in India has been estimated at $93 million well beyond the reach of the national health system.
- Feeding programmes for under-fives and women of fertile age should expand to include a focus on not just food supplementation. They should place greater emphasis on teaching proper nutrition using participatory methods.

2.3.3 Lack of Awareness and Knowledge of Population on RCH and RCH Care

1) Lack of Awareness and Knowledge of Population on RCH and RCH Care

One of the notable problems in RCH is under-utilization of services. The reasons for this may not simple and several factors are complicated. Even though the services are available and accessible, partly because of lack of awareness and knowledge of population on available services and importance or need of health care, they do not access to services.

- Lack of awareness and knowledge on RHC service resource and availability.
- Lack of source of information on RCH for adolescents.
- Husband's intention is still respected for health care.
- Approach to husbands and family is needed.
- ANMs and AWWs should train groups of women to recognize the danger signs in pregnancy, labour, and postpartum and the need to seek immediate help and where to go, since most of delivery still attended by relatives or mother-in-laws.

2) Problems in IEC in Madhya Pradesh

- IEC has not been effective in producing the desired results partly because of weaknesses in the application of an effective behaviour change process. Such a process should include assessment, planning, drafting, pre-testing and production of materials, delivery, monitoring and evaluation. Much of this is done for mass media at the state level, but tailoring of generic messages to the specific needs of

client population, primarily through interpersonal communication, fails to achieve its potential. The result of these weaknesses has been ineffectiveness at the level of the client.

- Observation of this ineffectiveness by others in the health establishment has in turn reduced the prestige of IEC professionals and placed them on the sidelines of DOHFW activities. An effective programme would benefit both the clients and the IEC practitioners.
- The followings are the problems in IEC sector:
  - (a) Community disenfranchisement: At present, communities feel that they are merely the receiving vessels for IEC information. They have no sense that their needs are taken into consideration in the IEC process, neither as a community nor as individuals.
  - (b) Women's disenfranchisement: As point 1 indicated, communities feel left out of the communication process. Women are even further marginalized from the IEC process than the general community.
  - (c) Top-down approach
  - (d) Failure to reach those most in need
  - (e) Failure to target local audiences:
  - (f) Lack of family focus
  - (g) Print media emphasis
  - (h) IEC administrators' low skill levels
  - (i) Low client confidence in IEC: Women are reluctant to communicate RCH problems to the health service workers whom they now see. Most ANMs regard their jobs as target-based, counting numbers of immunisations and antenatal service contacts, etc. and often do not have time or neglect the counselling role. ANMs are also generally members of castes higher than those of their women clients, so clients feel excluded. Without an atmosphere of trust and confidence, clients are reluctant to share their RCH concerns.
  - (j) Lack of sustained IEC exposure
  - (k) IEC Bureau skills too widely spread: Greater efficiency would be achieved if the Bureau were to assume a co-ordinating role of quality assurance, supervising IEC activities sub-contracted to advertising agencies and media production groups.
  - (l) No application of an effective communication model
  - (m) Programme-specific funding resulting in little usable health and welfare IEC funding
  - (n) Lack of understanding of role of IEC by medical providers
  - (o) Weak administrative linkages: DEMOs, their deputies, and Block Medical Officers (BMO -- who has no IEC background) work in near isolation with few linkages with others in the system.
  - (p) Failure to convert mass media awareness raising to behaviour change:

2.3.4 Social Factors and Traditional Habits

1) Discrimination by Caste

- The work of the AWWs and the ANMs/MPWs is sometimes hampered by casteism.

- The recruitment of AWWs and the ANMs/MPWs needs consideration of caste group.
- The ICDS Programme and the DOHFW should establish a policy that there will be no discrimination on the basis of religion or caste in any of their services.

2) Age at Marriage / Pregnancy too early

- Social and family pressure does not allow individual will of young generation on the age of marriage and having children. Social environmental change through social mobilization is needed.
- Intensive advocacy efforts aimed at increasing age at marriage are needed, as well as enforcement of the Child Marriage Restraint Act that sets 18 as the minimum age for girls. Additional efforts in girls' education and increasing their economic empowerment is needed to give girls productive alternatives to early marriage.
- Information on benefits of later marriage to family and society should be widely disseminated.
- The Child Marriage Restraint Act should be enforced and known more widely.

3) Gender Issues

- There is still strong boy preference.
- Decision maker on household issues including access to health care is usually man.
- Major information source on health care for women is their husbands.

4) Girls' Education

- Perhaps the most important step that can be taken to improve women's health and status and the health of children is to increase girls' school enrolment and retention. The role of education in decreasing fertility is also indisputable. In every country there exists a negative correlation between fertility levels and women's education.
- While the GOI and GOMP are to be commended for the progress made to date, efforts must be redoubled.

2.3.5 Poor Management and Implementation of RCH Programme

(1) Lack of Understanding of RCH Concept by the Health Staff at District Level and below District Level.

- The concept of RCH is to provide need based, client centred, demand driven, high quality and integrated RCH services. The concept of RCH is not still fully understood by health officers and health staff, particularly at district level and below the district level as already described.

(2) Capacity of District and Block Level Health Administration

- Capacity of health administrative office and health administrative staff in planning, implementation, and monitoring is very weak. Health administrative capacity at district and block level should be strengthen. This is the key for implementation and management of programme in effective and efficient manner.

(3) Inter-sectoral Coordination

- In the public sector several different units deliver health services and health education. There is no structured coordination system for effective and efficient service delivery within the limited resources.
- Coordination with DWCD and Panchayat in nutrition programme and child growth monitoring is weak.
- Coordination with the Department of Medical Education and Indian System of Medicine in providing RCH services is none.
- Fixed MCH day should be set once a month in village instead of Immunization day.
- NGOs are generally more effective at health education than service delivery, while the IEC Bureau of the government is very weak.
- The government and donors should test innovative strategies to increase NGO participation in promotion of women's and children's health. Two such strategies that have been successful elsewhere are described in this report.

(4) Better Communication is Needed at All Levels.

- Personnel from blocks of the same district are operating with different conceptions of what their objectives are. For example, in one district, out of five BMOs sampled, only three knew that they had an annual target of training 30 JSRs. In another district the ANMTC had gone 15 years without learning about the syllabus update in 1986; they continue to use the 1977 syllabus. These are serious communication deficiencies that make it impossible to create the kind of spirit needed to turn around the performance of the state system of health care.
- Better systems for communication should be developed throughout the state health system.

(5) Lack of Supervision System and Capacity

- In spite of training of health staff, performance is not improved remarkably. One of the major reasons is lack of follow-up training and supervision after training.
- Capacity building on supervision and establishment of supervision system is needed.
- Regarding LHV, who should supervise ANMs in the SCs receive little more than an abbreviated repetition of the original ANM training. This represents a lost opportunity to develop new skills that are needed for the new responsibilities that the LHV will assume, the most obvious being supervision, also micro-level planning for development of a needs based work plan to be taught to ANMs, adult education for expanding the technical skills of ANMs, and communication techniques for giving group educational and consultative sessions during community visits. Supervision currently amounts to little more than collection of reports.

(6) Decentralization and Community Participation (Health Committee)

- Village health committee is rarely functioning.
- Rural Health committees were supposed to be organized at each level of PRIs. Communication and interaction between health committees of higher and lower

levels are seldom confirmed. Moreover, functions of the health committees at each level are, in reality, very limited.

- An urban health committee, one of these standing committees, has two permanent health technical staff within the committee, i.e. Health Officer and Health Inspector[3]. Therefore, technical support from Additional CMHO Civil Surgeon is not significantly needed and is limited to minimum on ad-hoc basis. In other words, health committees in ULBs may have better technical capacity in implementing projects and programmes compared with the one in PRIs of rural areas. Activities of health committees of ULBs include sanitation in the cities and IEC in urban slum
- PRIs and ULBs needs technical support from and Health

(7) Supporting System for Delivering Services is Poorly Operated

- Drug and medical supplies logistics system and management are relatively poor.
- HMIS (health management information system) is not well operated.
- Lack of human resource development plan.
- Lack of training in management for health administrative officers at district and block level.
- Registration system for vital statistics is not fully functioning.

(8) Partnership with NGOs/Private Sector

- NGOs are generally more effective at health education than service delivery, while the IEC Bureau of the government is very weak.
- The government and donors should test innovative strategies to increase NGO participation in promotion of women's and children's health. Two such strategies that have been successful elsewhere are described in this report.

(9) Supervision

- Lack of Supervision
- PHCs are supposed to be responsible for supervision of SCs, however, there too many SCs under the them and no structured supervision mechanism.

(10) Decentralization and Panchayat

- In health sector, decentralization has not happened much. Rogi Kaliyan Samiti (patients welfare society), India cost sharing scheme, is given by the DOHFW as one of successful examples of bottom-up planning and decentralized management. Decentralization in political structure is emphasized much, however, technical support from and coordination with health administrative structure and staff at each level (district, block and community level) are not discussed much so far, which is essential for better operation of decentralized governance.
- What authority will be devoted, to which level, and how and by when is not clear in the process of the decentralization in health sector.

[3] Health Inspectors have some technical expertise. Health Officers are either recruited from Medical Doctors (MBBS) or promoted from Health Inspectors. The creation of the posts of these health professional staff are based on Municipal Corporation Act 1956 and Municipal Act 1961 (amended in 1992).