

CHAPTER 5
HEALTH FACILITIES AND MEDICAL EQUIPMENT

5 CURRENT SITUATION OF HEALTH FACILITIES AND MEDICAL EQUIPMENT

5.1 CURRENT STATUS OF HEALTH FACILITIES

5.1.1 Number of Health Facilities

The MP state Government follows the national norm on distribution of health facilities, which is based on population.

Table 5-1 Norm on Distribution of DPHFW Health Facilities

	District Hosp.	CHC	PHC	SC
General area / plain area	1 per district	120,000	30,000	5,000
Tribal area / hilly area		80,000	20,000	3,000
Ratio with higher health facility	---	(N/A)	4 per CHC	6 per PHC

Source: 1) Directorate of Public Health & Family Welfare, Government of Madhya Pradesh (2001)
2) Bulletin on Rural Health Statistics in India, Ministry of Health & Family Welfare (1999)

Table 5-2 Distribution of Health Facilities per District in Sagar Division

	Tikamgarh	Damoh	Chhatarpur	Panna	Sagar	MP
Under DPHFW						
District Hospital	1	1	1	1	1	36
CHC	5	1	4	4	9	229
PHC (B-PHC + S-PHC)	18	15	41	15	29	1,192
(Population per PHC)	(66,842)	(72,127)	(35,967)	(56,949)	(69,717)	(50,616)
SC	156	162	186	139	245	8,874
(Rural population per SC)*	(6,409)	(5,470)	(6,398)	(5,347)	(6,090)	(5,306)
Urban FW Centre	1	1	1	1	3	97
Urban Health Post	0	0	0	0	3	80
Postpartum Centre:						
District level **	1	1	1	1	1	39
Sub-district level	0	0	2	0	1	57
Under DMEISM						
Dispensary	28	37	25	14	50	2,316
Under DWCD						
Anganwadi centre	832	756	880	569	1,308	47,433
Private Facilities	14	8	N/A	N/A	N/A	N/A

Note: * Calculated by using Census 2001 population, but urban/rural rate is based on 1991 Census

** Postpartum Centre at District level is in the District Hospital.

N/A: Data not available

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001

2) Directly obtained from the District CMHO Offices of Sagar Division

3) Directly obtained from the Department of Medical Education & Indian System of Medicine

In general, the number of health facilities does not meet the norm. On average, one SC covers 6,409 rural population in Tikamgarh and 5,470 in Damoh. One PHC covers 66,842 population in Tikamgarh and 72,127 in Damoh, more than twice the norm.

5.1.2 Established Health Centres Without Government Building

There are problem not only with the number of the health centres, but many of them lack physical facilities. In some cases, for example, a sub-centre is considered in place when an ANM is assigned to cover an area without any fixed facility. The number of health facilities in Table 5-2 does not show the number of health facilities with government buildings. In MP, 37% of PHCs and 65% of SCs are not provided with government facilities. The situation is the same or worse in Sagar Division as shown in the table below. This means that many of the SCs are not really health facilities since there is no building to be called as such. ANMs or MPWs may work at their homes, at an Anganwadi worker's house, at another village facility, or a rented room. Most of these are not appropriate facilities as places for providing health services. Sometimes ANMs or MPWs have no place to work.

Table 5-3 Ownership of SC Building in Sagar Division

	Tikamgarh	Damoh	Sagar	Panna	MP *
Government **	66.7%	17.3%	25.3%	21.7%	33.2%
<i>Government ***</i>	43.3%	7.4%			
Rented **	31.4%	80.1%			
<i>Rented ***</i>	23.4%	72.8%			
Panchayat Building **	1.3%	1.9%			
<i>Panchayat Building ***</i>	1.4%	4.4%			
Others **	N/A	N/A			
<i>Others ***</i>	23.4%	8.0%			
No building	N/A	N/A			
<i>No building</i>	8.5%	7.4%			

Source: * Annual Administration Report 2000-2001, DPHFW, the Government of MP, 2001

** Data obtained from each District CMHO Office

*** Data obtained through questionnaire survey on SC to ANM/F-MPW working at SC

5.2 CONDITION OF HEALTH FACILITIES

The findings obtained from the field survey conducted by the team members and the SC survey are summarized below.

5.2.1 Target Facilities of the Survey

The facilities for the field survey in each district were selected randomly from the list of the district health facilities. Tikamgarh and Damoh Districts were oversampled since these are the major focus areas of the Study. In case of no building, no person-in-charge for the facility, or a closure of the facility, the nearest facility to the selected facility was visited as a replacement. In some cases access to the selected facility by car was very difficult, and in that case also the nearest facility was visited as a replacement.

The number of facilities surveyed by type and by district is shown in the following table. The detailed list of the facilities is shown in the Supporting Report, Chapter 3, Table 3-1.

Table 5-4 The Number of Health Facilities Visited for the Facility Survey

District	District Hospital	CHC	B-PHC	S-PHC	SC
Tikamgarh	1	3	1	5	17
Chhatarpur	1	1	1	3	3
Panna	1	1	1	3	3
Damoh	1	1	3	5	12
Sagar	1	1	1	3	3
Total	5	7	7	19	38

Besides the field survey, the study team asked all SCs in Tikamgarh and Damoh to complete a questionnaire that included some questions about buildings, facilities, and medical equipment.

5.2.2 Methodology of the Survey

Four interviewers with technical backgrounds were recruited to assist the team members. Two types of questionnaires were used in this survey, one for facilities and the other for equipment. The methodology also included:

- Interviews with key informants of the health facility by using structured questionnaire
- Observation
- Collection and analysis of existing data and drawings
- For the SC survey, a structured questionnaire sent to ANM/MPWs.

5.2.3 Findings

The following are the findings of the survey on infrastructure/building status and general characteristics of different types of facilities. The data obtained from the field survey is shown in the Supporting Report, Chapter 3, Table 3-2.

(1) Public Infrastructure and Building

1) District Hospital

Building condition:

- The District Hospitals in all five districts are mainly reinforced concrete buildings and partially pucca (masonry wall + concrete slab).
- The ages range from 30 to 60 years except the Child and Maternal Hospital in Sagar, which was built 100 years ago.
- The hospitals at Chhatarpur and Sagar have wards on the first floor, while others have wards only on the ground floor. Located at the centre of town, all hospitals have at least compound fencing.

Water Supply

- At all hospitals the running water is supplied by pipes. Bore wells or hand pump are also available at some hospitals. (For open bore wells, it is advisable to set up handrails to avoid possible accidents.)

Electricity

- At all hospitals a power supply is available throughout. At least two generators (around 10 kw. each) are also installed; however, these are inadequate to cover the entire hospital. In the entire MP area, there are regular power-cuts. Sometimes there are also unscheduled power-cuts.

Other Facilities

- All district hospitals have telephones, while none has a computer, NIC terminal or e-mail access.
- All hospitals have septic tanks, and medical waste is disposed of by burning in a pit.

Maintenance and Cleanliness

- Although some District Hospitals have on-going or recent expansion or renovation works, the main buildings are relatively old, and both exterior and interior finishes look damaged. Cleanliness is an issue throughout all hospitals.

2) CHC and PHC

Building condition

- The ages of CHCs and PHCs range from one to 75 years.
- Most of the surveyed facilities are a mixed structure of reinforced concrete with pucca (masonry wall +concrete slab) and have only a ground floor except one S-PHC at Bansakala, Damoh.
- Although for some older facilities, expansion is on the way, structural members seem poor in terms of both reinforcement and concrete works. Despite the existence of a Reinforced Concrete Code, the reinforcement looks insufficient and 'honeycomb' concrete is found in all parts. It seems to be caused by lack of proper mixing or other construction machines, but it would be desirable to strengthen the supervisory services including frequent inspections.

Water Supply

- Some of the surveyed facilities have either bore wells or hand pumps, but others have no water supply, consequently the hand pumps at a distance from the facility (farthest 500m) are used.

Electricity

- Most of facilities have a power supply, but regular power cuts are inevitable. A few facilities are equipped with generators.

Other facilities

- Among 34 surveyed CHCs and PHCs, only three have telephones. Telephones should be provided to enable at least CHCs and PHCs to make telecommunications in the future.
- Most facilities have septic tanks or soak pits. Wastes are burnt in pits.

Maintenance and Cleanliness

- A number of construction defects were found in both exteriors and interiors, even in recently built facilities. Some fitting and glazing works have been left unfinished. Measures should be taken to protect the facilities from malicious mischief.

3) Sub-Centres

Building condition

- The oldest SC among the surveyed facilities was built 50 years ago, while the newest one was built in the last year. In Tikamgarh, 36% of SCs were built before 1981, 49% were built during 1981 – 1990, and 5% during 1991-2001. In Damoh, the figures are 17%, 62% and 57% respectively.
- 65% of SCs in Tikamgarh, 5% of SCs in Damoh, and some in other districts in Sagar have been donated by DANIDA.
- Most facilities are masonry buildings, but two types of roof are found depending on the location and age. In old buildings wooden structures are generally used for the roof, while others are covered with flat concrete or flag stone slabs. With the wooden roof, there is a risk that the roof tiles may become unstable and cause leakage because no roof boards are laid underneath. Concrete slab has also defects since the joints of each element are only filled with mortar, and as a consequence, a waterproofing effect can not be maintained for long.
- In some cases, SC facilities are combined with ANMs' residences or rented by ANMs who are working at home. In Damoh, at least two SCs are functioning in the Gram Panchayat office.
- According to the survey, 39% of SCs in Tikamgarh and 83% in Damoh do NOT have a delivery or labour room.

Water Supply

- Although either bore well or hand pumps are available at most facilities visited, some of them are located outside or far away from the facilities.
- According to the results of the survey, only 28% of SCs in Tikamgarh and 10% in Damoh have a continuous water supply.

Electricity

- About 17% of SCs in Tikamgarh and 10% in Damoh have a power supply.

Other Facilities

- No telephones were found in any SC.
- Some SCs have neither toilets nor septic tanks/soak pits. Wastes are burnt in a pit.

Maintenance and Cleanliness

- Like the other types of facilities, some construction defects were found in plastering, painting and fitting works in even relatively new SC buildings.

ANM/MPW's Satisfaction with Physical Infrastructure of SC

- According to the questionnaire survey, only 24% of ANM/MPW working at SCs in Tikamgarh and 10% in Damoh are satisfied with the physical infrastructure of their SCs.
- The major reasons for dissatisfaction are the poor condition of the toilets and bathrooms, water leakage, old and nonexistent maintenance, lack of weather protection, lack of electricity, and poor location.

(2) Training Centre

The infrastructure and buildings of the training centres was also surveyed. All of them need maintenance work, repair and improvements to the facilities.

1) Tikamgarh

Nursing (Female Health) Training Centre for a 18 month-course (pre-service training) of female MPW/ANM.

- Age: 21 years old (built in 1981 with support of DANIDA)
- Location: on site of District Hospital
- Building structure: Reinforced concrete + Pucca 1, 2 stories
- Floor area: 3,500 square meters
- Facilities: office, lecture rooms, dining hall, kitchen, dormitory (for 34 students), toilets, water supply, electricity, no telecommunication system

A part of the training centre is used for storage of drugs, vaccines and medical equipment.

District Training Centre for in-service training of health workers

- Age: 18 years old (built in 1983 with support of DANIDA)
- Location: Jatara (head quarter of Jatara Block)
- Floor area: Reinforced concrete + Pucca *, 2 stories
- Facilities: office, lecture rooms, dining hall, kitchen, dormitory with bath rooms, toilets, water supply (not in good condition), electricity, no telecommunication

2) Damoh - District Training Centre for in-service training of health workers

- Age: 7 years old
- Location: 3 km away from the CMHO Office, Damoh
- Building structure: Reinforced concrete + Pucca *, 2 stories
- Site area: approximately 2 acres
- Facilities: office, teacher's room, lecture rooms, library, dining hall, kitchen, dormitory (for 30 students), toilets, water supply, electricity, no telecommunication

3) Sagar – General Training Centre

- Age: 19 years old
- Location: adjacent to CMHO office
- Building structure: Reinforced concrete + Pucca *, 2 stories
- Site area: approximately 2 acres
- Facilities: office, teacher's room, lecture rooms, library, dining hall, kitchen, dormitory (for 30 students), toilets, no water supply, electricity

4) Chhatarpur - Nursing (Female Health) Training Centre

- Location: on site of District Hospital
- Building structure: Reinforced concrete + Pucca *, 2 stories
- Floor area: 4,000 sq. m.
- Facilities: office, teachers' room, lecture rooms, dining hall, kitchen, dormitory (for 62 students)

¹ Pucca: Reinforced concrete + masonry wall

5) Panna - District Training Centre (under construction)

- Age: Construction is ongoing under the IPD project supported by UNFPA.
- Location: on adjacent site of District Hospital
- Building structure: Reinforced concrete + Pucca *, one story
- Floor area: 560 sq. m.
- Facilities: office, lecture room, multi-purpose room, library, dining hall, kitchen, dormitory, toilets

(3) Private Health Facilities

The infrastructure and building of private hospitals (nursing homes) in Damoh, Tikamgarh and Chhatarpur were also surveyed for comparison.

The building structure of these is reinforced concrete and two story buildings. Conditions in private hospitals and nursing homes vary; however, these are maintained and equipped better than public health institutions in general. (Supporting Report, Chapter 3, Table 3-3) Cleanliness is much better than in public institutions, but equipment is not sufficient (though better than in public hospitals) in a nursing home in Damoh. The nursing home in Tikamgarh is better equipped than the public institution, but cleanliness and sanitary conditions are almost the same as in the public hospital. The nursing home in Chhatarpur is managed by a business-oriented management and is well equipped and maintained.

5.2.4 Investment Plan

(1) Planning and Budgeting

The main provider of RCH services is the state Government. In the state Government, the Directorate of Health Services, the DPHFW, is responsible for planning and budgeting of construction, renovation, and maintenance works of health facilities, while the Planning Commission is responsible only for the budget ceiling. The Budget is usually drawn up by the former with the full knowledge of requests from the officer-in-charge of rural and urban health facilities as follows.

- CMHO for rural facilities: CHC, PHC and SC
- Civil Surgeon for urban facilities: District Hospital, Urban Family Welfare Centre, etc.

(2) Budget for 1999/2000

In the fiscal year 1999-2000, the state Government appropriated the following budget for civil works in health sector.

- **Major Civil Works:** An amount of Rs. 1,000,000 per district was released to improve facilities for essential and emergency obstetric services through construction or repair of operating theatres or labour rooms, or to provide facilities for water/electric supply in District Hospitals, CHCs, and PHCs.
- **Minor Civil Works:** An amount of Rs. 1,000,000 per district was released for minor repair and maintenance of buildings, particularly for operation theatres, labour rooms, and improvement of water/electric supply.

(3) Responsible Agency for Construction and Renovation of Facilities

The budget 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 following problems sometimes occur:

- The PWD may have other priorities for their work, despite a transfer of funds to the PWD for work on a health facility.
- The Project Team's lengthy briefing and feasibility study stage are inevitable and it could take 10-15 years from inception to inauguration of project. Consequently a newly constructed facility could be outdated.
- To shorten the pre-contract stage, the project manager should develop carefully the *time-line and confirm agreements before initiating construction.*

During construction, close communication is recommended between DOHFW and PWD to monitor progress.

(4) Code and Regulations Related to Construction

The building regulations in MP state are based on the national standards of India.

As far as medical facilities are concerned in surveyed districts, there are no specific codes stipulated by donors since most donated facilities have been designed by local architects.

The actual regulations are mainly divided into three categories: architectural, structural and fire codes.

1) Architectural Code

- National Building Code of India, 1983
- Madhya Pradesh, Rhumi Vikas Niyam, 1984 (Building By-Laws)

2) Structural Code

- Design Aids for Reinforced Concrete to IS
- Plain and Reinforced Concrete Code of Practice

3) Fire Code

Indian Standard, Code of Practice for Installation and Maintenance of Fire Hydrants and Hose Reels on Premises

According to the Seismic Zoning Map of India, most parts of MP state have no or low tremor risk. However, after the Gujarat earthquake in 2001, the Parliamentary Minister announced that the government should pass legislation to make it compulsory for new buildings in high seismic zones to obtain an earthquake-proof certificate.

(5) Construction Costs

Regarding the construction costs, the following information is available.

1) Documents

- Estimating and Costing in Civil Engineering, M.K.S. System
- Schedule of Rates for Building Works for Public Works Department, Engineer-in-Chief MP PWD, Bhopal

2) Average construction costs according to types of structure

- | | |
|---|----------------------|
| ▪ Reinforced concrete structure | Rs. 4,000~4,500/sqm. |
| ▪ Reinforced concrete with steel beams for roof | Rs. 3,500/sqm. |
| ▪ Masonry building with wooden roof structure | Rs. 3,000/sqm. |
| ▪ General worker's wage | Rs. 60/day |
| ▪ Mason's wage | Rs. 150/day |

3) General costs of building materials

- | | |
|---------------------|--------------------|
| ▪ Cement | Rs. 150/kg. |
| ▪ Steel bar | Rs. 15,000/t |
| ▪ Brick (sun-dried) | Rs. 1,000/thousand |
| ▪ Brick (baked) | Rs. 1,400/thousand |

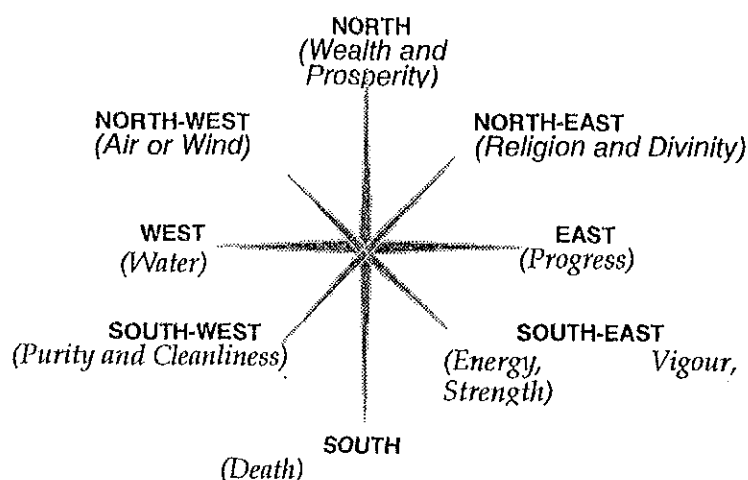
(6) Vastushastra (Hindu Physiognomy of a Building)

Basically, Vastu is derived from "VASTI" which means a place of dwelling. Vastu is a kind of science dating back to ancient times. According to Vastu principles, humans, animals and all substances are made from five basic elements, earth, water, fire, wind, and sky. It is said that giving these elements their proper places in a building brings merit, unifying it with nature.

Following are the five principles of Vastushastra in terms of building design.

- Deciding the direction (Orientation)
- Site planning (Location)
- Measurement
- Scale and proportion
- Finer points of proportion (Height)

Below is the significance of the directions and their effects.



Vastushastra (Hindu Physiognomy of Building)

5.2.5 Maintenance System and Budget Allocation

The Directorate of Health Services under the DPHFW in MP is responsible for maintenance of public health facilities in the state. However, there are no units or technical staff for health facility maintenance under the CMHO or Civil Surgeon and the Directorate.

As mentioned in the previous section all buildings belong to the PWD after construction. Therefore, the maintenance budget is transferred to the PWD. The cost is generally calculated as a fixed percentage of construction costs. Under these circumstances, all health facilities depend on the PWD for maintenance.

Donor supported facilities do not belong to the PWD in some cases, which causes maintenance problem. Since there is no budget for maintenance or technical support from the PWD, these buildings are deteriorating. Among the study area, Tikamgarh has many health facilities and a training centre constructed with DANIDA support, and the PWD never provides maintenance services to these faculties.

5.3 CURRENT CONDITION OF MEDICAL EQUIPMENT

The availability and condition of medical equipment, and supplies of drug and equipment kits were reviewed in the same health facility survey mentioned in the previous section. The detailed findings of the survey are presented in the Supporting Report, Chapter 3, Table 3-5. The study team also sub-contracted a facility and human resource survey to ORG-MARG, to collect data on the availability of more limited equipment and supplies. A gynaecologist in the study team also visited several facilities in Sagar Division and reviewed the availability and appropriateness of medical equipment for providing RCH services at each health service level.

In general, based on the studies mentioned above, none of the hospitals or peripheral health units has all the basic functioning equipment needed to perform the clinical RCH activities they are supposed to according to their level.

(1) Findings in Sub-contracted Facility Survey and Gynaecologist's Study

District Hospital operating rooms are generally deficient, as are delivery rooms. An exception might be the Maternal Hospital in Sagar. X-ray equipment is frequently lacking, malfunctioning, or inadequate. Most pathology laboratories perform only basic tests with the exception of the hospital labs, which do some screening for hepatitis B and HIV, when they have reagents. None of the facilities perform tests for all the RTIs and STDs.

Although Hospitals have delivery tables, their numbers are not always at the recommended level. Almost no peripheral unit has a delivery table. Deliveries are being performed on a simple table, rusty and dirty (usually metal), without stirrups. Scales for weighing adults and newborns are either absent or malfunctioning.

Manual resuscitation devices for either adults or children are lacking, as are delivery forceps (short), suction devices, and heated bassinets for high-risk newborns.

The picture is very similar for consumables and supplies with the exception of vaccines and immunization kits, which were present, in good condition, and properly stored in most facilities. The cold chain has been provided by UNICEF and is working well in all the facilities visited.

None of the facilities visited, with the exception of Maternal Hospital in Sagar, had all the equipment, consumables, and supplies required to attend to normal deliveries, much less complicated ones. In general, based on the both surveys, none of the ????

IUD insertion kits are adequate in less than 15% of the facilities. The same holds true for delivery kits and material for prenatal consultations, including sphygmomanometers, stethoscopes, and strips for assessing the presence of glucose and protein in urine.

Most facilities have the necessary drugs for routine prenatal care, including iron and folic acid (IFA). However, none of the peripheral units had magnesium, tranquillisers, and injectables needed for the treatment of toxemia gravidica, or injectable antibiotics. Nevertheless, these were present at the hospitals. None of the facilities had all the kits that should be available, according to government, at the facilities of a given level, including IFA, Vitamin A, and ORS packets. Over 80% do not have any drugs for the treatment of RTIs and STDs.

Contraceptives, mainly IUDs, condoms, and oral pills are available in all the facilities.

Among ANMs interviewed, 70% reported that the equipment available is not enough, and drugs are not sufficient for 80% of the ANMs.

It should be noted that a few peripheral health units are functioning reasonably well despite their deficiencies, and maintenance and cleanliness are reasonable in a few. Usually the money for these activities comes from a local fund, independent from the government, and the doctor in charge is highly committed and interested in providing the best quality of care possible with scarce resources. Two facilities should be given as such examples, the BI-PHC from Rajnagarh in Chhatarpur and Lidhora in Tikamgarh.

(2) Findings in the Facility Survey Conducted by Study Team

Cold Chain

A deep freezer, ice-lined refrigerator, or cold box is installed in some facilities. Since power cuts occur daily in every facility, there is doubt whether an adequate temperature for vaccine

preservation is maintained. Although ice-lined refrigerators are supposed to maintain temperatures below +8°C even with a 16-hour electrical failure in a 24-hour period, but there is no guarantee of temperature when a power cut continues for more than a day.

Further, it is possible that a refrigerator might not start because of excessive fluctuations; even a wide input voltage range regulator ($\pm 20\%$ 192 V ~ 288 V) would not be able to make up for some fluctuations. The measurement of voltage (often impossible to measure during field work because of power cuts) is shown in Table 3A-5-3-(1)~(5) in the Supporting Report, Chapter 3, Table 3-5, Electric Supply, indicating figures below 190V in several facilities.

The equipment for operating theatres is inadequate even in district hospitals. The worn out equipment might as well never have been installed. There is little or no basic equipment except for some scales, instrument sterilizers, or sphygmomanometers (BP Machines).

1) Comparison of equipment

Table 3A-5-5 (Equipment comparison chart: district hospitals) and Table 3A-5-6 (Equipment comparison chart: CHC, B-PHC) in the Supporting Report, Chapter 3, Table 3-5 show gaps between the norm and equipment available in health facilities. The equipment norms follow those of the World Bank, which funded the Andhra Pradesh Primary Health System Project of 1998-2003. The facilities do not even remotely meet these norms. The machines are in inadequate numbers, and the hospitals, excluding the district ones, do not play the roles appropriate for such facilities. Almost all equipment is overage and there are no maintenance technicians in any facility except for cold chain refrigeration.

2) Drug kits, equipment kits, standard sets, contraceptives, and vaccines

The supply situations can be seen in Table 8-1~8-5 in the Supporting Report, Chapter 3, Table 3-5, which shows the dates of the vaccine reception in each district facilities. The health facilities manage stocks using the stock register. However, they do not manage equipment; some equipment is unused, the whereabouts of other equipment is unknown, and staff simply does not know how to use some equipment. Therefore, the only option is to rely on doctors' memories.

In some facilities, contraceptive distribution is conducted every month, whereas vaccines are distributed every week. No tubal rings are distributed anywhere.

3) Ambulances

Only the five district hospitals and the Hatta CHC in Damoh have ambulances. With the exception of a few CHCs and B-PHCs, there are no other vehicles available in the periphery, resulting that the total number of vehicles available per district ranging from three to five. When available, their utilization is not clear since they are not used to transport patients who are referred from the periphery, nor do staff use them to make house calls. At the peripheral units, patients are not usually transported directly by the unit to the district hospital. Instead, they use private transportation, if available and if they can afford it. Financial resources for petrol are usually enough and can be paid for by the district health authorities from a budget line of the RCH programme.

The only equipment installed in the ambulances are an oxygen mask with cylinder and stretchers to carry the patients. As the road conditions are bad, emergency transportation is almost impossible.

The main trunk line roads are badly damaged, making traffic all the more inconvenient by the half-finished road repairs. And if you make a detour from the main road, you have to travel at 20km per hour over pavement the width of one car, where the road base of sand and gravel is exposed. Moreover running a car on a road with no drainage system or pavement is impossible in the rainy seasons.

4) Communication systems

There is no communication system among health facilities. Telephones are available at district hospitals and some of the CHC and PHC, but making contact with an SHC is impossible. As SHCs have no telephone facilities, such as STD or PCO, one would have to go call a near town to phone the SHC.

Messages are often transmitted person to person by entrusting them to transporters, such as village truck drivers, bikers, or irregular bus drivers. In such circumstances, the reliability of emergency service is questionable. But in cases where medical staff lives in the facility or nearby, emergency treatment is potentially available.

5) Blood bank

Three years ago, the Supreme Court issued an order requiring that blood banks be adequately equipped in order to collect and treat blood for transfusions. Most district hospitals stopped *collecting blood, performing transfusions and sending blood to peripheral units*. All districts hospitals were or are in the process of upgrading their blood banks. In Sagar Division, the blood banks of all district hospitals were equipped by the Government with WHO support, and all have received official certifications except the Tikamgarh district hospital. The Damoh district hospital is waiting for its license.

(3) Availability of Basic Equipment and Supplies at Sub-centres (SCs) in Damoh and Tikamgarh

Results of the Sub-centre Survey indicate that the lack of equipment, drugs and supplies at public health facilities (in this case at SC level) is very serious, with the exception of contraceptives. The situation is particularly serious in Damoh.

Table 5-5 Perceived Availability of Basic Equipment and Supplies at Sub-centres (SCs) in Damoh and Tikamgarh

(Unit: %)

	Damoh			Tikamgarh		
	<u>Adequate and Working</u>	<u>Adequate but Not working</u>	<u>Inadequate</u>	<u>Adequate and Working</u>	<u>Adequate but Not working</u>	<u>Inadequate</u>
Basic equipment for normal delivery	38.1	12.7	49.3	44.7	16.3	39.0
Equipment for ANM/MPW/SC	52.6	8.9	38.5	71.6	24.1	4.3
IUD kit and equipment	<u>Available</u> 77.0			<u>Available</u> 89.4		
Equipment and supplies for immunization	<u>Proper</u>	<u>Improper</u>	<u>Absent</u>	<u>Proper</u>	<u>Improper</u>	<u>Absent</u>
Vaccine carriers	54.3	44.4	1.2	37.7	34.8	27.5
Day carriers	28.0	34.0	38.0	45.8	31.3	22.9
Autoclave	20.8	34.0	45.3	45.2	41.9	12.9
Syringes	48.9	47.7	3.4	53.1	41.8	5.1
Needles	46.9	48.1	4.9	52.0	39.8	8.2
Cotton	26.6	37.5	35.9	43.5	42.4	14.1
Disinfectant	8.9	24.4	66.7	26.2	20.2	53.6
	<u>Adequate</u>	<u>Inadequate</u>	<u>None</u>	<u>Adequate</u>	<u>Inadequate</u>	<u>None</u>
Dai kit	39.7	15.4	44.1	43.3	12.1	44.7
Basic drugs	34.3	47.8	17.9	43.3	44.7	12.1
Contraceptives	88.8	6.0	5.2	90.8	8.5	0.7

Note: All SCs in Tikamgarh and Damoh District were surveyed in the study.

Source: SC Survey in Tikamgarh and Damoh, JICA Development Study, 2001

5.3.2 Purchase of New Equipment

The Joint Director for Medical Administration has jurisdiction over medical equipment in MP and the maintenance of medical equipment.

Each department submits a letter, as needed, to the CMHO, the Civil Surgeon, and the state Government. After the Development and Planning Section makes a proposal, they transmit it to the state Government and receive an approval to secure the funds. Then the approval is sent to the Director for Medical Services. After approval, they will be able to purchase the equipment through L.U.N. (Laghu Udyog Nigam). This L.U.N. is a government agency in charge of procurement. Occasionally the National Mine Department Corporation (a diamond mining company) or a local wealthy individual has donated equipment.

Since there are no more district budgets, district hospitals manage to pay for maintenance from Rogi Kalyan Samiti (R.K.S.) funds. These funds also are used to purchase small equipment, such as analysers and centrifuges. Maintenance of large machinery is provided in 10~15 under an annual contract between the state government and the M/S Conex India Ltd. Bhopal. There is no technical unit for maintenance and repair of medical equipment in the DOHFW or district

hospitals. Actually, except for a few items, district hospitals and CHCs have no need for maintenance since the equipment available is so simple.

Cold chain maintenance has been included in the RCH programme budget in the amount of Rs. 7,415,000 for 2000. There is only a single technician who can repair the ice-lined refrigerators and deep freezers found in district hospitals and some CHCs.

CHAPTER 6
INFORMATION, EDUCATION AND
COMMUNICATION (IEC)

6 INFORMATION, EDUCATION AND COMMUNICATION (IEC)

6.1 CURRENT RCH ADVOCACY AND IEC PROMOTIONAL STRATEGIES

6.1.1 IEC Background

Population communication activities have been prominent in India's history since independence. Significant demographic changes have occurred, but for the most part, what population communication activities have achieved has been to raise awareness. The 1998-99 National Family Health Survey (NFHS-2) reveals that 99% of currently married women knew about at least one modern contraceptive method (in Madhya Pradesh this figure is 97.8%). At the same time, communication activities seem to have failed to reach their potential, as NFHS-2 also showed that only 39.3% of women in the state were using a modern contraceptive method.

The awareness-to-use gap has consistently been a problem for what is called behaviour change communications -- the invention of the new term demonstrates the embarrassing failure or some earlier named "health communication" to achieve its promise. "Behaviour change communication" meant that health communication practice had to become broader, embracing other practices and techniques, and attempting to empower individuals and communities to facilitate voluntary adoption of health-seeking behaviours, which protect, maintain and improve individual and community health and family welfare.

To bridge the awareness-to-use gap, it is also necessary to bridge the "theory" to "practice" gap, seeking new ways to fully implement the claims set forth in the IEC strategy. This will require the development of a new participatory community approach.

6.1.2 IEC Bureau Discussions

The IEC Bureau considers IEC strategy as supportive of the objectives of the Department of Health and Family Welfare (DPHFW), MP: reduce TFR, IMR and MMR. A further objective of the MPHFW is to increase the couple protection rate (CPR), which the DPHFW describes as focusing on reproductive health. Personnel of the IEC Bureau defined the objective of the bureau as informing and raising awareness regarding health and motivating appropriate behaviours. The strategy that it applies to achieve these objectives has as its main components, in order of priority,

- 1) the use of IPC techniques
- 2) group discussions with opinion leaders
- 3) the use of conventional media: cultural programs, folk media, puppet shows, etc.
- 4) print media
- 5) electronic media.

Message development at the district level is based on DPHFW programs and is done by working with a set of intermediaries: male and female health workers, the JSR, Panchayat Raj personnel, the Sar Panch, teachers, NGOs and supervisors, in villages. IEC Bureau personnel reported that these intermediaries, in turn, use input from client populations to refine messages.

For IEC development at the state level, the IEC Bureau prepares creative briefs for the media to be used in a particular campaign. This brief outlines the parameters on which outside

contractors (ad agencies, media production agencies, etc.) develop media. According to state IEC Bureau personnel, district IEC personnel receive guidelines from the state level, but district IEC personnel are then free to develop their own plans and implementation programs.

6.1.3 IEC Bureau Action Plan

DPHFW publications, specifically the 1997-98 Action Plan of the Information, Education and Communication Bureau, spells out this strategy in more detail, referring to it as the Conceptual Basis. This publication recognises the need to bring communities from awareness to use, which it refers to as the "transition in health-seeking behaviour" through revamping the following IEC activities:

- Activities related to health and family welfare IEC both for public consumption and scientific/technical communication
- Activities related to health and family welfare education targeted to the public in general and to adolescents. These activities would also include updating the knowledge of health and family welfare service providers. These latter activities are sometimes referred to as IS (population information services).
- Activities and programmes related to the promotion of community activities in health and family welfare. These would be operationalised through participatory programs and through social mobilisation.

The common thread of these three activities is that they do not just inform, but they also promote action through community organisation. Developing effective community organisations will assist in providing local leadership, which will promote and sustain community health and family welfare action. It is advocated that other related government departments, such as Women and Child Development, Youth Affairs and Sports, Education, Nehru Yuvak Kendra, etc. as well as NGOs be integrated into the community mobilisation process.

A number of activities are proposed to translate the Conceptual Basis into a program of action. These include the Swasthya Mela, Adolescent Education in Primary Health Care, an Orientation Programme for Representatives of the People, Establishment of a Population and Information Centre, Development of a Community-based Monitoring System for IEC Activities, and Orientation Training for IEC Staff.

(1) Swasthya Mela

The Swasthya Mela is a health fair held in villages. It is suggested that because of the large size and relatively low population density of the state of MP, health fairs can be used to expand the reach of communication activities. The mela approach, it is stated, implies active involvement and support on the part of the communities concerned. Furthermore, it calls for the mobilisation of all sources of for counselling and delivery of services to the community. Three of the objectives of the mela relate to health provision while the fourth relates to IEC: to promote community health and family welfare through appropriate counselling. The mela includes these "essential features:"

- It is organised at every gram Panchayat four times a year for two days.
- The first day is used for meeting with Panchayat officials (morning) and with village elders (afternoon). These sessions are used as counselling sessions for village representatives and elders. Door-to-door and mass communication activities are used to inform people of the next day's events.

- The mela is held on the second day. The village Panchayat organises the health check up camp while governmental and non-governmental organisations and individuals handle the technical side. From the government side, there is a doctor, a nurse, Female Health Workers and Female Health Assistants. Village-level support to the team includes Anganwadi workers, trained birth attendants, Jan Swasthya Rakshak (JSR), etc. with assistance from private practitioners as well as female volunteers from the village Panchayat. With the exception of testing salt for iodine content, all services offered relate to maternal child health, with some specific IEC counselling activities. This counselling includes: ante-natal check-up counselling, delivery counselling for already-trained personnel, counselling on new-born care, breast feeding, weaning, ARI, diarrhoea, sanitation and hygiene, safe drinking water, balanced diet, etc., counselling related to family welfare -- spacing, age at marriage, small family, etc.

(2) Adolescent Education in Primary Health Care

The idea behind introducing adolescent education in primary health care is first to broaden the focus of IEC by including this group and second, to reach out to them since they are more likely to be receptive to change in health behaviour than older people are. The objective of this programme is to impart basic primary health, especially RCH, education to adolescents by providing them with the ability to understand their environment, to prioritise health and family welfare issues, to initiate appropriate action to deal with health and family welfare issues. The programmes should also make adolescents into change agents, who are capable of developing an IEC system based on the community and independent of the health and family welfare service delivery system.

The program focuses on youth between 14 and 19 years old. It works through the Ministry of Education in both formal and non-formal modes with input from the state IEC Bureau. A primary health care education package is developed based on a combination of national goals and the felt needs of the community. It focuses on community health action rather than just service utilisation and provides adolescents with the opportunity to initiate actions themselves. In the formal sector there is one session a week which combines classroom lectures, audio-visual shows, demonstrations, field visits and hands-on practice. This formal exercise is combined with community volunteer work. In the non-formal sector, the programme works with the Rajiv Gandhi Shiksha Mission and is integrated into classes held by the Mission.

(3) Orientation Programme for Representatives of the People

The Plan states that elected officials of various kinds constitute an important power group influential in shaping community opinion and behaviour. In MP, the Zilla Panchayat has been made responsible for supervising and implementing health and family welfare activities and programmes in rural areas. Therefore an orientation programme has been designed to: inform officials about national health and welfare program goals, secure their commitment and support for health and family welfare programs, make use of the mass base through the people's representatives for a social audit of health and family welfare activities and to use the power of these representatives to eliminate malpractice.

(4) Establishment of a Population and Information Centre

The Plan suggests the establishment of a comprehensive database on population education at the state level, to ensure that outdated messages are not transmitted to the community. This

database includes information not only on technologies, but also on social and cultural aspects of life, indicators of the health and welfare situation, etc.

(5) Development of a Community-based Monitoring System for IEC Activities

The Plan proposes a system for monitoring reported performance of IEC workers with actual performance as monitored through a post card reporting system in which clients report actual contacts with IEC workers to the IEC Bureau at the state level.

(6) Orientation Training for IEC Staff

This training would be carried out at various levels to orient IEC staff to the new conceptual basis, which the IEC Bureau would apply.

6.1.4 District-level Strategy and Activities

None of the deputy District Extension and Media Officers interviewed showed us a written document, detailing how major district IEC activities fit together into a strategy. However they described at length what activities they were engaged in. A synthesis of these activities follows.

(1) Sagar District

One district, Sagar, reported that its main focus is village-level Mahila Swasthya Sangh (MSS) groups (309 in Sagar District), presided over by a Sar Panch, some of whom are women. Each MSS has about 25 members, with 5-6 trained for health communication activities. The MSS meets as a group about once a month for one or two activities. The purpose for the MSS is to benefit MSS members and the community through "personal contact." A typical MMS community session consists of live bhajan performed by a mandali group, followed by discussions on health topics. The MSS also sponsors a well-baby show. Mothers whose children are fully immunised receive an award, ranging from, for example, Rs. 100 as the first prize. Sometimes at these shows flip charts are shown, demonstrating oral rehydration techniques or discussing aspects of family planning. These flip charts can be very heavy on text. Literate members of the MSS may explain the content to illiterate women or they may be shown mostly pictorial flip charts with little text. Wall posters are put up and pamphlets distributed. Slogans are written on the walls.

Other activities which the IEC district bureau co-ordinates include the Swasthya Mela, at which family planning and maternal-child health issues feature. Contraceptives may also be distributed. These include condoms (which are also available through retail outlets), oral contraceptives, and copper-Ts, which are inserted on site. Visitors are also offered sterilisation counselling, free medical check-ups, free medication, and free oral rehydration salts. Women from 15-45 are said to be well represented and women represent about 60% of those in attendance.

(2) Damoh District

Damoh deputy DEMOs (District Education and Media Officers) stated that their strategy is based on guidelines received from the state level. However, he noted that priorities are established by geographical area, season (diseases) and through monthly meetings.

The strategy for awareness, according to the deputy DEMO, is primarily implemented through health camps on specific issues. The following procedure is followed. First, other concerned

agencies are contacted and areas of co-operation specified. Then the camps are organised. After that, awareness campaigns are implemented at the village, block and district levels through media promotions. At the gram Panchayat level, each Sar Panch and Panch is made responsible for mobilising a ward. MSS (for example) and Panchayat people then visit households, with assistance from Anganwadi, JSR, and Dai, who go door to door, promoting the camp. Announcements are also made at market day and debates on the activity of focus at the camp are held in the schools.

The deputy DEMO reported that there is no needs' assessment strategy and that the needs are established in advance. In defence of this position, he said that the village-level workers already know about the needs, since they have been established in a "free and familiar atmosphere." The workers provide information about options and provide proper guidance.

(3) Tikamgarh District

In Tikamgarh, as in the other districts, there was no evidence of a strategy separate from that already developed for the state. During the discussion, elements of a strategy were mentioned. For example, in the discussion about spacing, the deputy DEMO said that the strategy was to develop awareness by "group discussions through the MSS." There was no evidence of a clear and coherent behaviour change strategy. He said that people were not interested in spacing "because they are illiterate." When we pressed him to explain further, he said that these clients knew "little about health." He said that the IEC personnel felt that they were making small changes in awareness.

What was noted was a series of programs, mostly concerned with training. These include:

1) The Orientation Training Programme (OT)

This focuses on training male and female multi-purpose workers, MSS and Dai (traditional birth attendants, TBA) on techniques of raising awareness. Each of six towns is visited initially for one day, then later for a second day of follow-up. Rs. 300 per group per day is paid to the 15 participants. According to the deputy DEMO, the function of this program is to train people in awareness raising. These people then go to the villages and work with the villagers. This program focuses on: 1) hygiene issues like clean water, nutrition, 2) family planning and spacing methods.

2) Integrated Skills Training, MPWs.

Each year, six groups of 15 female MPW participants each are trained for 12 days at the district training centre. They are paid Rs. 125 per day and given lunch. They are trained in: 1) safe delivery, 2) vaccination, 3) seasonal diseases, and 4) propagation of new ministerial policies and health directives. Based on their knowledge of the clients, the MPWs are expected to educate them on the issues presented at this training by locating the newly married through the Kotwar (village registrar of vital statistics), where people register for 1) marriage, 2) pregnancy, 3) birth, 4) death, even though there is little in the way of interpersonal communication techniques in the training. This training is primarily medical in emphasis.

3) Integrated Skills Training, MSS.

Twenty MSS workers are trained only in health education for a period of two days in 12 sessions. They receive Rs. 10 per day and no travel allowance. They are also trained in: (a) safe delivery, (b) vaccination, (c) seasonal diseases, and (d) propagation of new ministerial policies and health directives.

The purpose of the MSS is to conduct village meetings to create awareness about health issues. In one version of the implementation of this scheme, a female MPW accompanied by a media officer explain government programs and policies to MSS members. MSS members pass this information on to villagers. This seldom happens in practice, as MPWs do not live in the village so programs are never carried out. Mandatory night meetings seldom occur. Even during the day few meetings take place, as people are involved in other activities. One DPFHW representative remarked that removing MPWs or taking action against them would yield little, as they are political appointees. Withholding their rent allowances (meant for village housing) and reporting their non-performance has been tried, but this has all come to naught, according to the same person. As the MPWs see that they cannot be touched, their indifference grows.

Both these programs show major lacunae, which affect the likelihood of their success. Their roles are poorly defined, program implementation is spotty and linkages with other levels of the system do not work well.

4) Community Health Volunteer (CHV) and Village Health Guide (VHG) training.

This two-day district-level camp focuses on provision of RCH IEC, for example, how to combat myths and misperceptions and how to communicate health information, for example, breast feeding, the best possible use of home-available food, safe delivery, etc. They also receive training on survey methodology. For example, a survey on RTIs/STDs was done by having the volunteers go from door to door questioning women. The women were provided with referral cards and were sent to the block hospital where they were given treatment.

5) School teacher training.

These trainings are held for two days with 30 participants in each group six times a year. The schoolteachers receive only a travel allowance. They are trained on: 1) seasonal diseases, 2) nutrition, 3) hygiene, 4) safe drinking water, the use of chlorine for wells, etc., and 5) other health topics

Other IEC activities mentined included debate competitions in schools as well as cultural programs such as bhajan mandali (36-40 per year), puppet shows (90 per year), films (160 per year), dramas (150 per year).

(4) State IEC Bureau/District/Block-Level Organisation

In the vertically integrated system IEC content is meant to pass from the state level to the village. This system does not always function well. The IEC Bureau is the IEC body at the state level. At the district level there are District Extension Media Officers. At the block level there is the Block Medical Officer. At the village level are the Auxiliary Nurse Midwife, the Anganwadi worker, the Multi-purpose Worker (Male and Female), the JSR, etc. IEC officials believe that this system will encourage autonomy at different levels, at the same time having an efficient flow of messages to the target populations, but because of the weakness of the IEC units within the system, this does not happen. District-level IEC personnel's authority is pre-empted by stronger bodies in the system and their power and budget is taken away. By the time the villager interacts with the system, there is very little information transfer. Furthermore, there is very little in the way of exchange of information and expression of villagers' needs' with respect to reproductive and child health. When there is information flow, it is one way.

6.2 FEATURES OF SUCCESSFUL AND UNSUCCESSFUL PROGRAMS

In general, the IEC personnel listed easily quantifiable, discrete events on the success side, the "hard" activities. These are what the IEC system does well. Changing behaviour through long-term interpersonal activities, a "soft" activity, is certainly harder to do and IEC personnel therefore do not cite it as an area of success.

Program successes were generally related to one-day programs, like vaccination campaigns, which had considerable support from sources outside IEC agencies. The IEC Bureau in Bhopal listed three programs as successes: the pulse polio campaign, the Rajiv Gandhi Mission for Iodine Deficiency Disorder (IDD), and the diarrhoea campaign. The synthesis of reasons for these events' successes is shown here. In the polio campaign, they said, targets were achieved. They said that the program was successful for the following reasons:

- Use of a multi-media approach
- Commitment from both government and non-government functionaries
- Good logistics management
- Adequate staff training
- No budget problems
- No transport problems
- Good administrative support (use of and support from other government agencies, Panchayat leaders and Panchayat newsletter)
- Political commitment (use of and support from Panchayat leaders)

The Rajiv Gandhi Mission to create awareness of iodised salt and to ban non-iodised salt and the diarrhoea campaign shared more or less the same characteristics.

Such activities as those discussed above could be called "hard" activities, since they have a strongly quantitative aspect, are held at a specific point in time, and are target-linked. Those which we can call "soft" activities are those which are more qualitative, require continued attention over a long period of time and are target-free. An example of the latter would be changing the perceptions of the women of a village to adopt more spacing methods and to rely less on sterilisation. It is clear that success in the first category is easier to see, since it is implemented at a point in time. It is also easier to measure. Clearly, target-defined activities are easier to implement. Reliance with target-associated activities also affects what happens with IEC, especially when IEC personnel have little control over what is done and what is not done. IEC efforts are pulled away from long-term "soft" activities and concentrated on "hard" activities. The characteristics of successful activities are also easier to achieve for a "hard" activity.

6.3 CONSTRAINTS

There are a number of internal and external factors which affect the efficiency of IEC efforts. Among the internal factors are those which are a part of the system itself. The others are social and economic environmental factors which detract from effective behaviour change.

6.3.1 IEC System Constraints

These are factors which operate at various levels within the IEC system.

(1) Information Sharing

The state IEC Bureau personnel interviewed revealed a need for a higher level of information sharing and exchange. They acknowledged that techniques which have proven effective in one geographical area never have a chance for a broader success, as the use of such techniques is seldom communicated back to the system and to others within the system who might make use of them. "Lessons learned" and "best practices" are thus lost. It is important to develop mechanisms for sharing and diffusion of ideas and techniques.

(2) Organisational Structure

IEC personnel also said that there were far too many bosses and far too few workers. In other words, supervision seemed to them to play a role beyond the needs of the system. Their suggestion was that roles within the system be re-allocated so that there is more equal sharing of work.

(3) Lack of Personnel

At the three project district-level offices which we visited, Sagar, Damoh and Tikamgarh, there is no DEMO, and in one case, the position had been left vacant for twelve years. The IEC work is left in the hands of the deputy DEMOS under the direction of the CMHO, who directs the work of the deputies. So in many cases, the work that the deputies do has little connection with IEC. Furthermore, the district IEC budget is often reassigned to other DPHFW tasks. At the block level, there is no IEC representative and any IEC-related work passes through the BMO. This state of affairs contributes to weakening of the IEC Bureau's effectiveness. One BMO commented that this results in low IEC standards and little work being done.

(4) Poor Distribution of Materials

This same BMO commented that pamphlets are infrequently distributed. This person said that such pamphlets are "generally useless" in part because the language level of the pamphlets is high, the literacy level of the audience is very low and 80% of the women are illiterate. He said that health camp promotion is more effective, with officials making announcements through public radio stations or having banners put up. This is supplemented by sending out health workers to contact people personally to inform them about the camps,

(5) IEC Budget

Most of the budget in MP is spent on salaries. Rs. 1.5 crores, or Rs. 15,000,000 for IEC are allocated by the national government. Tikamgarh District receives 7.1, Damoh 8, Chhatarpur 6.3, Panna 6 and Sagar 12.7 lakhs respectively. In these districts, 80%, 73%, 74%, 76% and 76%, respectively, of the IEC allocation is spent on salaries. The rest is used for program costs. In Tikamgarh District, for example, the yearly amount per capita spent on IEC is less than one-tenth of a rupee per person per year (Rs. 0.071) or about or less than two one-hundredths of one US cent!

The allocated amounts are seldom spent in their totality, however, as government IEC units at both state and district levels are understaffed. For example, in each of the three study districts, Tikamgarh, Damoh and Sagar, there is a position for a District Extension Media Officer, but these posts remain unfilled due to lack of suitable candidates. IEC money allocated for salary is not re-assigned to activities if the salary line item is not entirely used.

Appropriations for IEC are also made at the state level. No figures for recent overall IEC expenditures were made available.

(6) IEC Funding Sources

Within the DPHFW, the IEC Bureau has been made autonomous. This has created a problem in that other bureaux and departments are unwilling to release their budgets for use by the IEC Bureau.

For example, bureaux within the DPHFW, and the Departments of Forestry, Women and Child Development all have their own budgets. Since this is compartmentalised there are no synergies for use of money by the IEC Bureau. If cross-sectoral synergies were created, this would contribute to creating more revenue for IEC. The EC is proposing to create such intersectoral convergence, avoiding some of the budgetary pitfalls of the vertical system.

6.3.2 Community-level Constraints

A successful IEC program will be required to confront numerous village problem areas. These constraints operate in urban areas as well, probably with lesser intensity. They were arrived at through group discussion sessions in several randomly chosen villages in Damoh and Tikamgarh Districts. There were four groups organised in three villages. In one village with two groups, we organised two sessions, one with lower-caste and one with upper-caste women. In two villages, only one session was held. One of these was chosen since it was reputed to contain "scheduled tribe" people. Although these people reported that they called themselves Gond, government information showed them as Sonr, and none of the participants could recall even past generations ever having spoken a language other than Bundel Khondi -- a distinct language variety is often cited as a marker of ethnicity. In all of the villages visited, our interpreter's version of Bundel Khondi was used in communicating with participants.

We find the issues raised to be highly revealing since IEC officers mentioned only some of these as constraints on the functioning of effective IEC practice, i.e., significant behaviour change. There is, of course, a certain amount of interpretation involved in the description of these constraints on our part, but most were either directly or indirectly mentioned by the women themselves.

Following the discussions, responses were organised by what we saw as appropriate classificatory categories. It is clear that some of the issues described may fall in to more than one category, but we tried to place each issue in the most salient category.

Women's lives are severely constricted because of their low level of participation in the educational system. Some of the results of low educational participation include lack of knowledge about issues crucial to their lives as well as a vacuum of personal Power.

The following were problem areas.

(1) Low Literacy

In most of the villages which we visited, more than 80% of the women interviewed were unable to read and write. This means that most printed communication will not reach its intended audience and that communication must be restricted to audio, via radio, or video, via television, or with the most effective form of communication, IPC, at the client level.

(2) Girls' Low Level of Participation in Education

Although the pattern of favouring males for participation in the educational process continues, interviews with these women revealed some interesting developments, among which were changing attitude resulting in changing practices with the current generation of girls, their own children. A large majority of the women in all these groups, most of whom had never attended school themselves, had girl children of their own in the educational system. Girls' participation in education was limited, however. It was believed that girls did not need as much education, since they did not have the same career opportunities as boys did. Nevertheless, the women in one village said that if their daughters had more education, then maybe they could get work other than as bidi makers and day labourers. The women also said that their daughters were not sent to the local secondary school if it required significant travel, unless a daughter could be accompanied by her brother or another trusted male relative. Although this sample by no means representative, in the two villages where boys and girls were sent to secondary school, the boys sent outnumbered the girls sent by a ratio of three to one.

(3) Cost of Education

Education was considered a substantial cost by the women, for both boys and girls. The general perception was that upper-caste children had greater educational opportunities than lower caste children did, for financial and for social reasons. In general, expenditure for boys' education was preferred over expenditure for girls. This preference is reflected in the ratios of boys to girls at the secondary level.

6.3.3 Social and Economic Issues

As these two categories are often linked, no attempt has been made to separate them. Details are described in the Sector Reports 7 (Social Study and Gender Analysis).

- Low marriage age and dowry economics
- Caste-generated social and economic discrimination
- Boy child pressure
- Pressures to keep wages low
- Lack of career opportunities for girls

6.3.4 Health Issues

(1) Permanent-temporary Method Gap

Most women whom we interviewed either had used a single permanent method, tubectomy, while others were waiting for the appropriate time. Few were using temporary methods. There are a number of reasons for this. First of all, for a long time, the term "family planning" was synonymous with female sterilisation, which had a bad name for some time since it was alleged that this practice was not voluntary. When short-term methods were introduced some years ago, poor quality control and insufficient training of practitioners inserting and/or promoting them resulted in uncontrolled side effects, which gave a bad name to these methods and consequently contributed to a preference for sterilisation. At the level of service delivery, many providers still adhere to targeting, even though the target-free approach is supposed to prevail. Inefficiency in pipeline maintenance contributed to low popularity among short-term methods. Frequent stockouts while a woman was using a method discouraged large numbers, resulting in short-term method disaffection. Also, there were demand side-supply side mismatches when client demand for products and services was high, yet supplies were not

available. Provider prejudices may have played a key role in the unpopularity of short-term methods, as most providers preferred sterilisation. Cultural prejudices may have played a role in this as well: women believe that inserting some products, like IUDs, into their bodies, is "unnatural".

(2) Child Spacing

In addition to the predominance of the factors listed above, a number of others play a role in discouraging child spacing. One of these is that society expects that a woman will produce a child within one year of marriage. Another is that women believe that they cannot become pregnant while breastfeeding. Women believe that they should have children in rapid sequence as possible because if they stop having children, having children after a spacing period may not be possible. Providers, along with their prejudice for sterilisation, also have insufficient training in short-term methods and are wary of promoting them.

(3) Need to Pay for "Free" Products/Services Creating Mistrust

Many women complained that medical services, which were supposedly free, were charged for. Among some, this caused suspicion of the government medical system. Examples such as Anganwadi in one village charging pregnant and lactating women for the food-supplement *dalia* and Anganwadi in another village only increased women's suspicions about what the standard practice should be.

(4) Women's Feeling of Neglect by Government Health Services

There is clear evidence from village group interviews that the lower one goes down the caste and class ladder, the worse the situation gets with respect to the level of satisfied contact with government health services generally, and with communication actions in particular. It seemed clear that many of the scheduled caste, scheduled tribe and other backward class women, were, in fact, victims of discrimination and that they, the most in need, received less from the government system than castes and classes above them. This view was clearly expressed in group sessions.

(5) Male Sterilisation Phobia

Discussions among women and men, as well as with IEC staff revealed that there are several widespread myths about male sterilisation. One is that it makes men physically weak. Another is that it is a cause of impotence. One more is that it deprives men of sexual enjoyment. IEC staff members said that people's attitudes about family planning have changed because of mass media exposure and restricted economic conditions, but men's attitudes about sterilisation has not.

6.3.5 IEC Issues

(1) Information Needs

Women often mentioned needs other than RCH as being of high priority in their communities. They frequently changed the subject from reproductive health needs to other needs. One of these was food. Several times the women said that they wished they could eat "more than once a day." Because we interviewed them during a drought, it is possible that more people were mentioning lack of food than might be the case in normal times. However, the mention of eating "more than once a day" occurred several times.

30-35-year-old women in one community stated that they felt that the health service system no longer paid any attention to them. Women in several villages said that they need more information about family planning, that the Anganwadi do not fill this need and that much of the information about family planning comes from television with no follow-up from health workers in the villages. They also said that practically all the information coming from the government health system was about family planning and polio. They said that the information they got didn't address their real needs. Addressing such needs, they said, should have been a part of the health system's response.

Women's comments about the Anganwadi were based on how good a job they felt the Anganwadi in their village was doing. They also said that the Anganwadi only target newly married couples. Only these couples "get something" from the Anganwadi: family planning counselling. What seemed to be going on here was that the Anganwadi had a clearly perceived notion of what she was "supposed" to talk about and that the needs of the women in the village were not necessarily integrated into the communication.

In one village where the issue came up, the women said that they did not always understand the RCH messages which they saw on television. There was no way of determining which messages they were referring to nor whether these were IEC-Bureau generated or not.

In general, the women state that the source for most information about health was their husbands, then after the husbands, they said that they talked with their mothers-in-law. Women placed a great deal of trust in their husbands and believed that he would have information even about "women's matters." In this village, the Anganwadi worker was trusted and respected. The women said that they felt that they could go to her for advice and counselling.

6.4 REVIEW OF STATE AND DISTRICT IEC ORGANISATIONS

This section notes a number of concerns about the functioning of the IEC system at various levels as expressed by IEC personnel and as observed in the field.

6.4.1 Information Sharing

The state IEC Bureau personnel interviewed revealed a need for a higher level of information sharing and exchange. Lessons learned and practices applied in one geographical area are lost, because they never have a chance for broader success. Results are seldom communicated to others who might make use of them. It is important to develop mechanisms for sharing and diffusion of ideas and techniques.

6.4.2 Bureaucratic Reform

IEC personnel also said that there were far too many bosses and far too few workers. In other words, supervision seemed to them to play a role beyond the needs of the system. Their suggestion was that roles within the system be re-allocated so that there is more equal sharing of work. This observation was clear at the village level as well. Where the IEC is needed, it is absent.

6.4.3 IEC District-level Management

At the three project district-level offices which we visited, Sagar, Damoh and Tikamgarh, there is no DEMO, and in one case, the position had been left vacant for twelve years. The IEC work is left in the hands of the deputy DEMOS under the direction of the CMHO, who directs the work of the deputies. So in many cases, the work that the deputies do has little connection with IEC. Furthermore, the district IEC budget is often reassigned to other DPHFW tasks. At the block level, there is no IEC representative and all IEC-related work passes through the BMO. This state of affairs contributes to weakening of the IEC Bureau's effectiveness. One BMO commented that this results in low IEC standards and little work being done.

6.4.4 Little Distribution of IEC Materials

Middle-level DPHFW personnel said that IEC print materials such as pamphlets are infrequently distributed. It was also stated that such pamphlets are "generally useless" in part because the language level of the pamphlets is high, the literacy level of the audience is very low and 80% of the women are illiterate. Health camp promotion is more effective, with officials making announcements through public radio stations or having banners put up. This is supplemented by sending out health workers to contact people personally to inform them about the camps.

6.4.5 Shortage of Personnel

Many of the upper-level IEC posts remain empty. District Extension Media Officer positions in three districts which we are working in are "lying vacant," as the IEC personnel put it. This situation is unlikely to change, in light of the Government of India's (GOI) downsizing efforts.

6.4.6 Lack of Appropriate Information Technology Skills

IEC personnel at both state and district levels stated that they had not received training on up-to-date computer hardware and software which would make their work more efficient.

6.4.7 Medical Provider Domination

IEC personnel believe that they work in a system dominated by medical interests. They feel that medical and health professionals pay little heed to the need for public health communication and assume that it is unnecessary. Another prejudice, often cited, is that "medical people" often assume that "anyone can do IEC," and that others can easily replace those working in the field. In many districts, the IEC personnel are seldom able to do work in IEC as the CMHO under whom they work often assign non-IEC tasks to them. IEC people said that part of the reason for this was that medical personnel supervising them have no understanding of IEC. The IEC personnel feel that these prejudices then become self-fulfilling prophecies as little attention is paid to whom is assigned to work in IEC, and when people are assigned to do IEC work, they are restricted in what they may do, hence little positive results from the process.

6.5 IEC/HEALTH EDUCATION TRAINING NEEDS

The IEC Bureau reported that personnel working in IEC at various levels are trained in a number of different institutions. The IEC Bureau reported that the following institutions in Madhya Pradesh provide training:

- 1) Four Regional Health and Family Welfare Training Centres
- 2) 33 district training centres
- 3) The Academy of Administration in Bhopal
- 4) The National University of Journalism in Bhopal
- 5) The Apex Training Centre in Gwalior

Outside Madhya Pradesh the following institutions have provided training for IEC personnel working in the state:

- 1) The National Institute of Health and Family Welfare in New Delhi
- 2) CHETNA in Ahmedabad, Gujarat and at the national level

In addition, various NGOs have provided training for field functionaries and DANIDA is committed to providing training in IEC management. This will be reviewed below.

When questioned about training needs, the IEC personnel agreed that at state and district levels, management training would be of high priority, while at the grassroots level, training in IPC and participatory approaches would make village-level workers more effective.

(1) DANIDA IEC Training

DANIDA's IEC training is a component of the Madhya Pradesh Basic Health Services Programme (Madhya Pradesh Basic Health Services Programme Document, 1999). The immediate objective of the IEC component is to strengthen IEC through: better planning, improved quality of IEC materials, a more penetrative distribution of such materials, and sharpened interpersonal communication skills of the field staff. The training aspects of this component include: training of IEC managers, upgrading IEC Bureau material production skills, training field staff in counselling and interpersonal communication. Clearly, the training which DANIDA will provide is meant to respond to the most pressing needs of the IEC system.

This training will include:

- sending 5 senior-level state IEC staff to three places for 15 days
- sending 100 district-level IEC staff to two places over 20 days
- one state-level planning workshop
- one district-level planning workshop

The outputs to be expected from this component are as follows:

- 1) Capacity of the IEC Bureau to formulate and execute IEC strategies developed and its sensitivity to women's issues increased.
- 2) Annual IEC Plans formulated.
- 3) The quality of material produced by the IEC Bureau improved.
- 4) Material for large and multi-media campaigns produced by advertising professionals.
- 5) IEC material disseminated through appropriate channels, including mass media.

6.6 REVIEW AND ASSESSMENT OF IEC IN MADHYA PRADESH

RCH IEC activities have been a component of health and family welfare delivery since its beginnings, but 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. 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 DPHFW activities. An effective program would benefit both the clients and the IEC practitioners.

Based on field observations, literature review and discussions with IEC personnel, reform based on finding solutions to the following problems would result in improved IEC effectiveness and achievement of DPHFW objectives.

(1) 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. The IEC worker at the client level is seen now as a dispenser of information, not as a facilitator who can translate and integrate community and individual needs into an effective communication program.

(2) Lack of Knowledge about Community Service and Communication Needs

Little has been done to look at communities with an eye to understanding community service and communication needs on which effective IEC activities can be based.

(3) 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.

(4) Top-down Approach

There has been a failure to integrate local needs into the IEC communication system. The emphasis has been on the dispensing of information rather than on needs-based action.

(5) Failure to Reach Those Most in Need

Group discussions revealed that the quantity and quality of information reaching targeted families seemed largely correlated with the client's location on the socio-economic scale, with poorer and lower caste women receiving less and lower quality information.

(6) Failure to Target Local Audiences

In spite of a strategy which proposes community-level development of IEC, much of what is done is produced at the state level for dissemination down to the clients of the system.

Audience targeting for awareness raising using these methods may be adequate. Behaviour change requires IEC targeted to community cultures and local needs. This has not been done. As in other areas of government, there is a need for IEC decentralisation.

(7) Lack of Family Focus

IEC efforts tend to aim at the community or the individual and miss the crucial link. The tightest communication unit is the family, with the husband and the mother-in-law playing key roles. This family configuration is not sufficiently taken advantage of as a communication channel. The role of the husband and of the mother-in-law has to be taken into account when looking at channels of communication for change. Children in school also offer another important conduit for information to the family.

(8) Print Media Emphasis

IEC activities tend to focus on the development of mass media and especially on print, to the exclusion of IPC. Materials are produced with the whole state in mind; therefore they do not reflect local community needs. They are not in Bundel Khondi (the regional language variety spoken in much of Sagar Division, close to Hindi but not the same language). As the majority of women in the 15-49 age group are illiterate, media resources could be more efficiently used and better targeted through the use of IPC in community language varieties. Not only is less emphasis put on IPC, skills in effective IPC utilisation are low. Village-level communication skills could be improved through the application of an appropriate IPC model, now lacking.

(9) IEC Administrators' Low Skill Levels

In order for the upper IEC Bureau to function as an arbiter of IEC efforts, it is important that personnel who play decision-making roles be well trained in state-of-the-art behavioural change communication and IEC methodologies.

(10) Low Client Confidence in IEC.

Women are reluctant to communicate RCH problems to the health service workers whom they now see. Their reluctance has various sources. In the existing system, Auxiliary Nurse Midwives (ANM) are assigned up to 5000 people whom they are expected to service. 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. Other factors contribute to low client confidence. One of these is that males dominate health services at higher levels. Women feel ill at ease with them and thus reluctant to take the initiative by asking questions. This factor further increases women's exclusion from access to information.

(11) Lack of Sustained IEC Exposure.

Much of what the IEC Bureau is heavily program-focused, for example, a vaccination campaign, or a sterilisation camp. The IEC personnel at the district and lower levels spend most of their time in publicising such events. Long-term and sustained contact through IPC with clients is generally lacking.

(12) IEC Bureau Skills too Widely Spread

The IEC Bureau has been required to be the jack of all trades and the master of none, applying its efforts to each and every DPHFW program. 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.

(13) No Application of an Effective Communication Model

Effective collaboration and integration of the IEC process, from assessment to planning, drafting, pre-testing and production of materials, delivery, monitoring and evaluation, seldom occurs. Particular attention should be paid to IEC pre-intervention and formative research, as well as post-intervention feedback and assessment.

(14) Program-specific Funding Resulting in Little Usable Health and Welfare IEC Funding

Much of the money for IEC activities has already been earmarked for specific programs leaving little latitude for IEC to develop any programs based on needs as defined by the client population. In addition to bureaux within the DPHFW, Forestry, Women and Child Development and other departments each has its own IEC budget. IEC money from some departments is not fully used. With intersectoral convergence, and the pooling of IEC funds, IEC activities could be made far more effective and cost-efficient.

(15) Lack of Understanding of Role of IEC by Medical Providers

In part because of the low level of resources allocated to IEC, medical providers who consider IEC as a low status activity ignore its important role. As mentioned above, if IEC programs were to achieve greater success, the prestige of IEC professionals would increase as well.

(16) Weak Administrative Linkages

The state IEC Bureau is responsible for all RCH IEC activities in the state. The Joint Director in charge of the IEC Bureau has no administrative control over IEC professionals at lower levels of the health and family welfare service delivery system. 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. The authority of district-level IEC staff is weakened since IEC activities are often handled only by deputy DEMOs, acting in place of DEMOs (as in project districts). In one district, it was reported that there has been no DEMO for 12 years. Deputy DEMOs often do little or no IEC work at all, as they are required to perform non-IEC duties for the CMHO.

(17) Failure to Convert Mass Media Awareness Raising to Behaviour Change

Change in Focus from Mass Media In some communities, mass media (primarily television) play an important role in raising awareness (family planning) but the IPC linkages, which can convert this awareness to behaviour change, are lacking. In village interviews, most women reported that day-to-day contacts with health service IEC communicators are rare. This indicates that client-level IPC has been a mixed success. One possible reason for this may be that IEC communicators still see their roles as dispensing information, rather than assessing local needs and then converting this information into effective communication.

6.7 RECOMMENDATIONS

The following series of recommendations should serve as a guideline for the development of some future IEC strategy for the State of Madhya Pradesh. Greater interaction between the health system and the community and heightened interpersonal communication activities are essential to raise the level of behaviour change and bring about healthier, happier lives for families, especially women and children. This will require a local-level participatory approach, wherein community organisation systems closer to women with simple messages designed to

reflect local communication facts are created and sustained. Clearly the focus would be placed on interpersonal communication tied in to and interpreting mass media efforts.

One way this participatory approach could be taken would be to re-define the existing network by dividing the roles at various levels in new ways, as Samarthan has suggested. To leave the ANM free to handle more complicated technical cases, counselling and communication roles could be given to others. In most villages which we visited, the person women trusted most with personal health matters was the dai. Second to the dai was the Anganwadi. Dai are often members of a specific caste but they are respected and used by everyone.

Samarthan suggested that daughters-in-law be recruited to work as Anganwadi or as JSRs. Daughters-in-law can be an important force in the community because they will stay in the community of their husbands' families, unlike daughters, who, if trained, move to the residence of their in-laws. Daughter-in-laws with at least a 10th grade education could be recruited. Daughter-in-laws would have another advantage over unmarried women. As married women, they would be freer to move about the community. Using them as health communicators would give them additional status in the community and thus build the its social capital. With a sense of ownership in the program, these daughter-in-laws could be linked up with the Panchayat system. In many places with only male doctors women clients consult the doctor's wife about medical problem, since they are reluctant to take the problem directly to the male doctor. The wife listens to the client, passes the information on to the husband, who analyses the client's case, and passes it back through his wife to the client. Such wives could be potential recruits as JSR.

The system itself would have to have the following characteristics:

(1) Community Ownership

It would need to give the communities a sense of ownership in the communication process. This would mean that community needs would serve as the building blocks of the communication process and the IEC worker would become a facilitator who could translate and integrate community needs into the communication process rather than a dispenser of MOHFW directives.

(2) Interpersonal Needs-based Communication

IEC professionals would need to be trained on how to learn more about their communities and their needs and how to translate these into effective IEC. This would require that the interpersonal communications' approach applied would result in IEC workers who can both give and receive information.

(3) Women's Empowerment

Women would be given key roles as communicators in the process.

(4) Bottom-up Approach

As emphasis would be placed on the community and its needs through application of this approach, this would obviate the shortfalls of the present system where the information flow often stops short of reaching the client.

(5) Reaching the Poorest of the Poor

With emphasis and empowerment placed at the community level and at the neediest at that level, the problems of these disempowered groups would be alleviated.

(6) Greater Local-level Targeting

Street plays, unlike many of the films shown in villages, can be made to represent the characters with whom the audience is familiar and can vary content and themes according to the situation and the audience. Street plays can make on-the-spot adjustments to dramatic treatment as needs arise. Local RCH information can easily be built into the play and local communication methods used. Players can respond to audience questions after the play. Local RCH content can be integrated and musical content can be adapted to local tastes.

(7) Family Emphasis

Community IEC workers can use the family as a base from which to conduct IEC efforts, involving husbands, mothers-in-law and school children.

Within the DPHFW IEC system, the following changes could be instituted to create conditions facilitating the success of the participatory approach outlined above.

1) Change in Focus from Mass Media and Print to Interpersonal Communication and Local Media.

Improved mass media efforts, in the hands of professional advertising agencies and co-ordinated by the IEC Bureau, would be continued, but the emphasis would be placed on the final link to the client through interpersonal communications. If print media are available and able to be read in villages, they are often irrelevant. Mass media such as radio and television are effective, but as many women in discussion groups mentioned, there is often no one present in the village to respond to questions which they have about the RCH messages that they see or hear. Greater use of interpersonal communication would help to bridge this gap. Television will play an increasing role, but in many rural areas, television is of little use due to power outages. In consonance with the interpersonal theme, the use of bhajan mandali and nukkad watak (street theatre) could serve as important vehicles for village-level communication. These media forms also allow the use of area-specific dialects.

2) Increased Confidence in IEC

With community members offered more ownership and a greater sense of empowerment and with roles within the system re-allocated, it would be expected that the level of trust and confidence in what the government has to offer in terms of health services would increase.

3) More Exposure to IEC

It is essential that the information chain be extended both vertically within the IEC system and horizontally within the community. The greater use of interpersonal communication and trusted community members should help increase exposure.

4) IEC Bureau in a Co-ordinating Role

The IEC Bureau, as a site of professional IEC excellence, should assure that the products of media contracted out, such as for radio and television, as well as all other IEC activities in the state work together to result in effective behaviour change. This would require effective collaboration and integration of the IEC process, from assessment to planning, drafting,

pre-testing and production of materials, delivery, monitoring and evaluation. Particular attention should be paid to IEC pre-intervention and formative research, as well as post-intervention feedback and assessment.

5) Budgetary Convergence

The IEC Bureau develop a plan for accessing these funds along the lines of guidelines now being developed by the European Community to take advantage of funds available in other bureaux or departments.

6) An advocacy Role for the IEC Bureau

IEC is a key to effective change in health behaviour. The MOHFW should take appropriate measures to give this message to all health professionals.

6.8 SOCIAL MARKETING POTENTIAL

6.8.1 Social Marketing Potential

“Social marketing” is used to refer to the sale of contraceptives and other socially beneficial products and services in commercial outlets at subsidized prices. In India, social marketing of condoms appears substantial, with more than 520,000 outlets, but when one looks at actual sales, they are less than one per person per year. Social marketing efforts sell or distribute free about half of all condoms used in the country. This chart shows the major brands, the company which markets them, package size and package price:

Table 6-1 Condoms distributed by Social Marketing

Brand	Company	Package Size	Package Price
DELUX	GOI	5	2
MASTI	PSI	4	5
ZARROOR	DKT	3	3
MOODS (SU)	HLL	4	12
KOHINOOR	TTK	3	12
KAMA SUTRA	J K ANSELL	3	10
MITHUN	JANANI	6	4

Other commodities are also socially marketed. The main other product is pills:

Table 6-2 Pills distributed by Social Marketing

Brand	Company	Package Size	Price
MALA D	GOI	1 cycle	2
PEARL	PSI	1 cycle	5
CHOICE	DKT	1 cycle	7
APSARA	JANANI	1 cycle	4

Discussions with a number of parties, representatives of the Commercial Markets' Strategies Project, the Family Planning Association of India, and Janani reveal that there are several social marketing-related issues which remain to be resolved:

- incentives to commercial participants are insufficient, and several major suppliers have withdrawn from the program
- condoms dominate the social marketing program at the expense of other products, focusing on sales and supply, without taking up the knowledge gap resulting from lack of information about use
- free distribution of condoms results in waste, with evidence that large amounts of freely distributed condoms are not used
- the program is limited in reach and urban-based
- ability to pay has not been converted to willingness to pay
- tight government pricing policies do not permit market expansion
- increasing contraceptive alternatives to sterilization

(1) Offering Incentives to Commercial Participants

Social marketing is implemented by a small number of large, private companies and medium-sized PVOs. Real or threatened pullout by large commercial participants because of limited incentives or change in corporate philosophy has adversely affected the program. Such actions imply that there is a need for a review of private-sector participation incentives and analysis, which would result in a comprehensive strategic solution for socially, marketed product and service expansion. Such a review should also assess the current geographical division among companies. It should also look at the potential for attracting medium-sized players as well, and importantly, at the bureaucratic constraints in program management, which function as a disincentive to commercial players.

6.8.2 Market Expansion

Increasing the overall market can be done in a number of ways, by increasing existing market penetration, by increasing product range and by geographic expansion into new areas.

(1) Increasing Market Penetration

Rural areas offer tremendous scope for expansion of outlets. In most of India, the majority of retailers, including grocers, general stores, chemists, confectioners and other retail outlets, do not stock condoms. Expanding stocking to retailers other than chemists could increase condom availability, while the most likely outlet for other short-term method contraceptives might be chemists. Nutritional supplements and oral rehydration salts could be marketed through food company outlets. Social marketing subsidies as well as product cross-financing *income source generation as well as cost-recovery schemes could be applied to marketing budgets.* Complementarily and partnerships between successful PVO efforts and commercial efforts should be enhanced.

Interviews at the field level suggest that there are several other possible sales agents who are trusted and would have access to customers in villages. Janani is already using the Rural Medical Practitioners (RMP), usually called traditional healers in a scheme as outlined below. It was also suggested that another trusted source for products would be itinerant bangle salesmen. Although dais are also cited as the "most trusted" source for RCH information, they might also work well as sales agents.

FPAI's experience in four districts, Bhopal, Sagar, Vidisha and Raisen, shows that commercial retail outlet expansion is possible, especially when used as a complement to the community-based distribution (CBD) system. Currently, CBD agents are already stocking small retail shop owners and providing products to postal workers and others in the community who can sell these products. Increasing points of sale for contraceptive products would help solve the problem of villagers' need to make purchases in privacy, without everyone in the village being aware of their preferences. Many villagers expressed this concern during a short project survey.

CBDs have been relatively successful in marketing products in FPAI districts. A consequence of this success has been that vendors of other products and services have approached CBD distributors, asking to be piggy backed on to the system, in order to save on sales and distribution costs and to have access to FPAI's market areas. All of this is an indication of a market vacuum. This means that the commercial sector has not maximised its potential and therefore expansion in further retail outlets is a good possibility. Even so, the question about exactly how much room there might be in a commercial retail market remains unanswered. It is likely that there is more room in urban areas than in rural ones, at least for reasons of volume of sales and consumer confidentiality.

Janani, a non-profit social marketing organisation with an office in Bhopal, is an affiliate of DKT International marketing both products and services. It claims to extend traditional social marketing structure by going beyond the urban-based limitations of the market network, to serve rural areas and to incorporate clinical services, by using private sector channels which exist beyond the marketplace.

(2) Broadening Product Range

Increasing the number of places in areas where products are already sold is one way social marketing can expand coverage and contribute to a broader reproductive health approach. This wider product availability will increase client choice and user satisfaction. Client choice and user satisfaction will also be served through increasing product range. FPAI has been socially marketing numerous products in Bhopal, Sagar, Vidisha and Raisen districts, an area contiguous to Sagar Division: condoms, oral contraceptives (OC), oral rehydration solution (ORS), safe home delivery kits, folic acid, chlorine for water purification, scabies medication, fungal infection medication, lice medication, worm medication, first aid boxes.

This range goes beyond what is traditionally marketed. CBDs, oriented on how to market these products, sell them through their network. FPAI reports that these products must be marketed at less than sustainable price levels, as product retail price increases would likely result in substantially lowered offtake. FPAI says that 35-40% of potential users cannot afford to pay for contraceptives and therefore must be provided free contraceptives either through FPAI CBDs or through public sector outlets. The CBDs are flexible enough to be able to establish an informal needs test to identify which persons can pay for the products and which persons cannot. This means that those persons without the ability to pay still receive the needed contraceptives.

The above-listed products fall into categories of items, which can only be obtained in chemists, and items which can be bought anywhere. Many short-term methods (except condoms), such as pills, IUDs and injectables, fall into the former category. Prescriptive short-term methods rank low in availability. Their sale and distribution needs to be expanded rapidly. Although increase in method choice has long been government policy, little priority has been given to

increase method availability through commercial-sector social marketing. Condoms and a broader range of other temporary methods need to be made available in rural areas. And the marketing of products other than contraceptives, such as oral rehydration salts, iron supplements, and iodized salt, needs additional attention. IEC efforts need to be closely tied to product range expansion in order to increase health-improving behavior. They also must be based on solid knowledge of consumer preferences and behaviors as well as audience segmentation evolving into a coherent communication strategy.

(3) Geographic Expansion

Yet another way for increasing overall coverage, in addition to increasing market through greater depth and increasing product range, is to expand geographically. One of the lessons learned by FPAI, however, was that when starting social marketing in a new area, it is important to bring socially marketed and free products in at the same time. Introducing free products first and then trying to bring in socially marketed products showed that they had created buyer resistance, with customers used to free products.

6.8.3 Market Size

When considering a social marketing enterprise, it is important to ask if the overall effect of the social marketing effort grows the total market and not does not just increase the market share for the newly introduced brand. Shrinking the overall market results in fewer benefits for society.

(1) Improving Condom Marketing

Condoms represent a special case. They are contraceptives, but since they are non-prescriptive, they can be sold more widely than other short-term methods. The real size of the condom market is unknown, with 624 M free condoms distributed in 1999/2000, a drop from previous years (GOI). According to the GOI, socially marketed condoms accounted for 478 M pieces. 1999 retail audits done by ORG-MARG showed a different picture, with socially marketed condom sales estimated at 282 M pieces and commercially marketed condom sales at 310 M pieces. Free condoms have a problem, however. Many of them never reach the client and of those that do, clients may use only one-quarter of them. In countries where free distribution is not linked to method targets, use of socially or commercially marketed condoms is frequently higher than use of free condoms.

Of individuals who do use condoms, only 70% are consistent users. The replacement of dry with lubricated condoms has increased product attractiveness and quality, so usage should increase. Associated IEC efforts should inform users of the dangers of less-than-consistent use, including pregnancy and STI/HIV/AIDS, now an increasing threat to health and life in India.

6.8.4 Programme Financial Sustainability

It is likely that social marketing efforts in Madhya Pradesh may have to look at relatively long-term subsidised social marketing since many customers may truly be unable to pay and the government may continue to restrict price increases which would allow social marketers to make a product attractive enough for consumers to buy. FPAI reports that the products which they socially market must continue to be priced at a less than a sustainable price level. It believes that increasing product retail prices would result in decreased offtake, although with

the able-to-pay customer base converted to a willing-to-pay customer base, attractively marketed products may change this picture (see discussion below). FPAI said that 35-40% of potential users cannot afford to pay for contraceptives and therefore would have to continue as part of a free distribution scheme either through FPAI CBDs or through public sector outlets. However, the FPAI CBDs are flexible enough to be able to establish an informal needs test to identify which persons can pay for the products and which persons cannot.

(1) Ability to Pay, Willingness to Pay

However, tighter interpersonal communications' targeting might assist in expanding the market. FPAI has observed that although studies of contraceptive markets show that the level of ability to pay is not matched by willingness to pay -- private expenditure represents 75% of total health expenditure. FPAI has targeted CBD communications to the able but not willing to pay audience, in the hopes of converting them to paying consumers.

(2) Strengthening Program Management

Social marketing activities could be monitored and assessed by a board of advisors consisting of the major participants in the marketing system. This board would be charged with monitoring the performance of products and markets (by geographical and client segment).

6.8.5 Prospectus

As there are already a large number of social marketing players operating in Madhya Pradesh, the availability of products is not the problem. Social marketing organizations mentioned that there are a number of barriers (above) to increasing the amount of socially marketed products in the publicly and privately available health products and services market in Madhya Pradesh, at the same time increasing overall CPR, but many felt that a major obstacles to expanding the size of this market is the lack of a large marketing budgets. Clearly, with both public and private bodies increasing the level of awareness and with increased interpersonal communication on the part of social market sector agents, private individuals and agencies and the MOHFW, more social marketing in Madhya Pradesh would make a major contribution to achieving some of the objectives of the Population Policy of the state.