CHAPTER 10

ISSUES IN REPRODUCTIVE AND CHILD HEALTH (RCH)

10 ISSUES IN REPRODUCTIVE AND CHILD HEALTH (RCH)

Constraints and problems in improving reproductive and child health (RCH) in the target area, particularly in Tikamgarh and Damoh District are drawn and analysed based on our study on current situation of RCH in Sagar Division. Base on these analyses, district master plan for improving RCH was developed (Chapter 11 & 12).

10.1 POLICIES AND PLANS RELATED TO RCH

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

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

These policy frameworks and plans are already mentioned in Chapter 4.

10.2 ISSUES IN REPRODUCTIVE AND CHILD HEALTH (RCH)

10.2.1 Reproductive and Child Health INdicators

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

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

The followings are summary of major reproductive health indicators from available secondary information[1] and survey results of our study.

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

(1) High Fertility and Unmet Needs of Family Planning

<State of Madhya Pradesh>

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

<Tikamgarh and Damoh Districts>

Based on Rapid Household Surveys (RHS) conducted under the RCH Programme and Census1991;

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

Table 10-1 Available Indicators of Fertility and Family Planning

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

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

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

(2) High Maternal Mortality Ratio

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

<State of Madhya Pradesh>

- An estimated MMR of the state is 498 which is unacceptable level. In the CSSM Programme, the state was categorized as one of the six priority states due to high MMR.
- According to the results of the survey of causes of death in the rural areas carried by the Registrar General of India in 1993, major causes of maternal death are haemorrhage and fever during pregnancy, anaemia and toxaemia of pregnancy (70%), followed by abortion and related complications and puerperal sepsis.
- About 40% of pregnant women do not receive any antenatal care (ANC). There is big difference in percentage of women received ANC between the rural and urban areas (45% in rural areas and 11% in urban areas)
- Delivery not attended by any trained person is 24%.

<Tikamgarh and Damoh Districts>

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

Table 10-2 Available Indicators of Safe Motherhood

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

Note: * 540 (428~653) for India in NFHS-2 (1996-1998)

** Medical doctors, nurses, ANM, female MPW, trained TBA (Dai)

*** percentage of delivery attended by TBA (Dai)

Source: 1) Sample Registration System (SRS)

2) Compendium of India's Fertility and Mortality Indicators 1971-1997 based on the Sample Registration System (SRS), Registrar General, India, 1999

3) *Rapid Household Survey, RCH Programme, 1998/1999*

4) National Family Health Survey (NFHS-2) 1998-99

(3) High infant Mortality Rate

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

<Tikamgarh and Damoh Districts>

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

Table 10-3 Available Indicators Related to Childhood Mortality

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

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

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

(4) High Prevalence of STIs/RTIs

<State of Madhya Pradesh>

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

<Tikamgarh and Damoh Districts>

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

Table 10-4 Available Indicators of Morbidity of STIs/RTIs

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

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

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

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

High Fertility and Unwanted Fertility

Major causes are;

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

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

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

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

High Maternal Mortality and Morbidity

Major causes are;

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

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

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

(4) **Unattended delivery** mainly due to

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

(5) **Ill-attended delivery** mainly due to

- inadequate knowledge and skills of ANMs/MPWs and Dais
- insufficient equipment and supplies
- lack of EOC and EmOC
- lack of referral system

(6) **Lack of functioning referral system** mainly due to

- lack of qualified health staff
- insufficient facility and equipment
- lack of transport support for referred patients and emergency cases
- lack of communication system between health workers, PHC and CHC.
- lack of management capacity.

(7) **Low access to and poor quality of postnatal care** due to

- low coverage (low accessibility and low availability) by ANMs/MPWs
- inadequate knowledge and skills of ANMs/MPWs
- shortage of equipment/supplies
- lack of referral system
- lack of knowledge and awareness of population on health of pregnant women
- low social status and education level of girls and women

High Infant Mortality and Morbidity

Major causes are;

(1) **No reduction of neonatal death** in the past decade mainly due to

- non-availability of high-risk newborn care
- low nutrition status of pregnant women

(2) **Prevalence of chronic malnutrition** mainly due to

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

(3) **Diarrhoea, ARI (acute respiratory infection), Malaria and others common diseases are not well controlled and treated** mainly due to

- lack of caretakers' knowledge about infectious diseases and its causes
- lack of sanitation and poor access to safe drinking water
- inadequate knowledge of health providers about proper treatment of these infectious diseases
- shortage of drugs for treatment

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

<u>High Incidence of STIs/RTIs Symptoms</u>

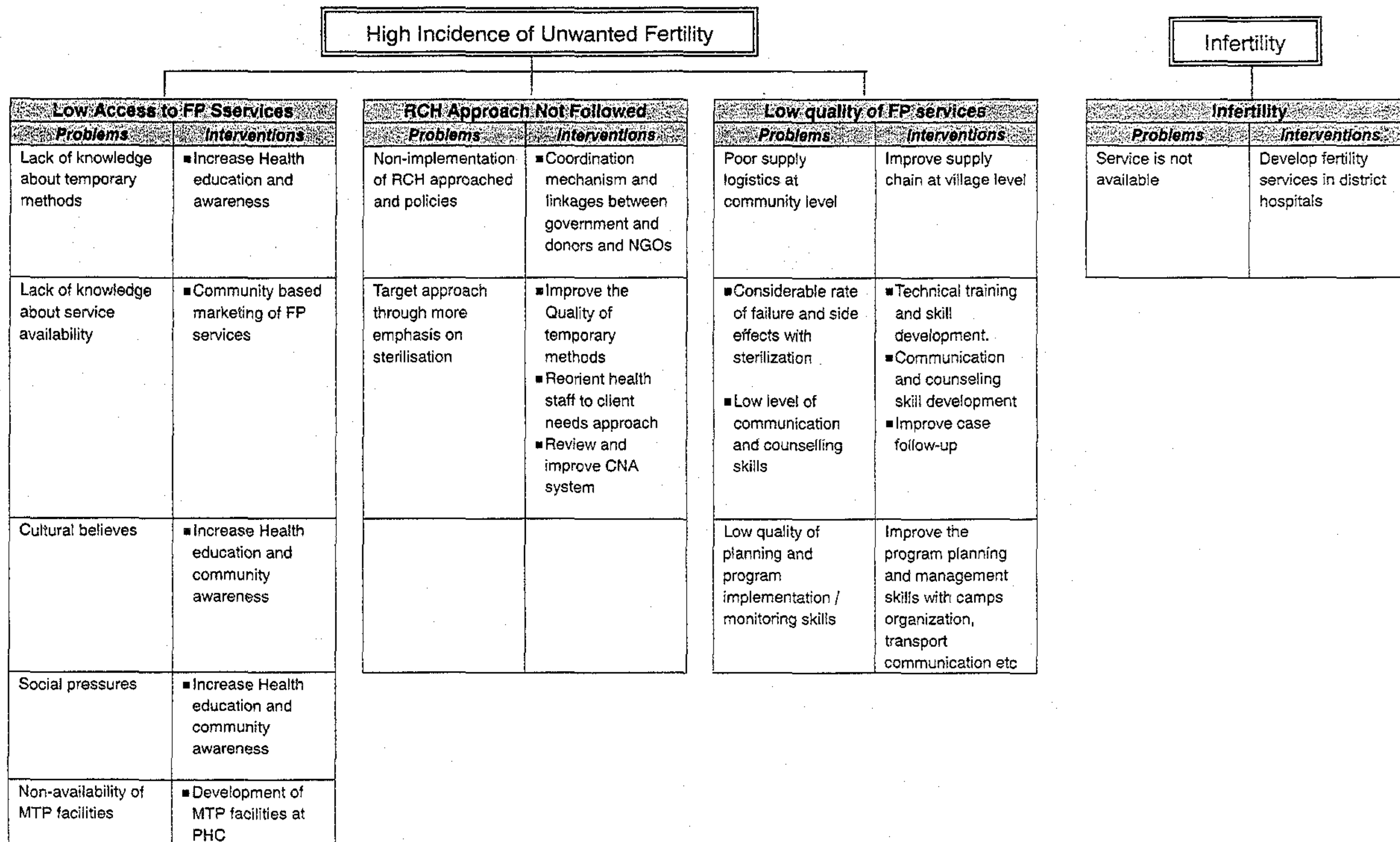
Major causes are;

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

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

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

Table 10-5 Problem Analysis: Problem and Solution Trees for High Incidence of Unwanted Fertility (and Infertility)



High Incidence of Unwanted Fertility

Low Access to FP Sservices

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

RCH Approach Not Followed

Problems	Interventions
Non-implementation of RCH approached and policies	▪ Coordination mechanism and linkages between government and donors and NGOs
Target approach through more emphasis on sterilisation	▪ Improve the Quality of temporary methods ▪ Reorient health staff to client needs approach ▪ Review and improve CNA system

Low quality of FP services

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

Infertility

Infertility

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

Table 10-6 Problem Analysis: Problem and Solution Trees for High Maternal and Neonatal Mortality

High Maternal and Neonatal Mortality

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

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

Induced Abortion	
Problems	**Interventions**

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

Unattended Delivery	
Problems	**Interventions**

Ill-attended Delivery	
Problems	**Interventions**

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

Induced Abortion	
Problems	*Interventions*

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

Unattended Delivery	
Problems	*Interventions*

Ill-attended Delivery	
Problems	*Interventions*

Table 10-7 Problem Analysis: Problem and Solution Trees for High Infant Mortality

High Infant* Mortality Rate

Prevalence of chronic malnutrition

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

Diarrhea, ARI, Malaria and others are prevalent, and not well controlled and treated

Problems	Interventions
Lack of sanitation, poor access to safe drinking water	▪ Increase water sources and toilet ▪ Provide health education on sanitation
Lack of knowledge of infectious diseases of care takers	▪ Provide health education on major infectious diseases prevention and control ▪ Increase family awareness of infectious diseases
Lack of knowledge of infectious diseases of health service providers (including AWW)	▪ Train health providers on major infectious diseases ▪ Train health providers on interpersonal communication skills
Lack of supplies including medicines	▪ Improvement of logistics management of supply

Inadequate protection from vaccine preventable diseases

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

* Children above 6 weeks old and below 1 years old

Table 10-8 Problem Analysis: Problem and Solution Trees for High Incidence of STI/RTI Symptoms

High Incidence of STI / RTI Symptoms

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

10.3 CATEGORIZATION OF THE PROBLEMS IN RCH

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

A. Problems and constrains in RCH service delivery system

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

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

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

C. Social and cultural factors which hinder RCH improvement

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

D. Poor management in health administration and health programme

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

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

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

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

10.3.1 Health Care Delivery System

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

1) Distribution of health facilities providing basic RCH services

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

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

a) Sub-centres (SCs)

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

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

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

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

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

b) Sector-PHCs

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

c) Block-PHC / CHC

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

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

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

2) Availability of RCH Services at Health Facilities

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

Table 10-9 Services Offered at the Health Facility in Sagar Division

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

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

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

The major reasons of these are;

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

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

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

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

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

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

<u>Referral services for EmOC</u>

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

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

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

  In the whole Damoh district there are only two health units to refer patients to: the District Hospital and the Hatta CHC. Doctors and nursing staff working in the other 13 PHCs outside of that Block do not have any technical support or a facility to refer patients to any other than the District Hospital. Even Hatta CHC does not provide emergency obstetric services. It has neither functioning operation theatre nor staff.
- Lack of specialists even at district hospital; no anaesthetist in Damoh district. No specialists at lower level.
- LHV/ANM's knowledge on warning signs of a situation that requires immediate intervention (means requires refer of the patient to the higher level) since it puts at risk the life of many women and their babies is very limited. Findings in our study show the absence of referral to the health facility in many life-threatening cases.

<u>**Non-emergency referral services**</u>

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

c) No MTP / abortion services at PHC Level

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

d) No diagnosis and treatment of RTIs/STIs

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

e) Postpartum care

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

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

f) Limited IEC activities

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

10.3.2 Quality of RCH Services

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

a) ANM / MPW / LHV

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

<Training of ANM / MPW / LHV>

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

<F-ANM Training Centre >

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

<Selection of ANM trainees>

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

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

b) Male-MPW Training

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

c) Dais

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

<Dai Training>

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

(2) Human Resource Availability and Distribution

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

(3) Physical Condition of Health Facilities

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

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

(4) Lack of Equipment and Medical Supplies

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

(5) Technical Issues in Sub-programme

a) Sterilization

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

b) Family Planning

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

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

<Method of Family Planning>

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

c) Nutrition (Anaemia)

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

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

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

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

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

2) Problems in IEC in Madhya Pradesh

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

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

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

10.3.4 Social Factors and Traditional Habits

1) Discrimination by Caste

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

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

2) Age at Marriage / Pregnancy too early

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

3) Gender Issues

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

4) Girls' Education

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

10.3.5 Poor Management and Implementation of RCH Programme

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

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

(2) Capacity of District and Block Level Health Administration

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

(3) Inter-sectoral Coordination

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

(4) Better Communication is Needed at All Levels.

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

(5) Lack of Supervision System and Capacity

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

(6) Decentralization and Community Participation (Health committee)

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

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

- An urban health committee, one of these standing committees, has two permanent health technical staff within the committee, i.e. Health Officer and Health Inspector[2]. Therefore, technical support from Additional CMHO Civil Surgeon is not significantly needed and is limited to minimum on ad-hoc basis. In other words, health committees in ULBs may have better technical capacity in implementing projects and programmes compared with the one in PRIs of rural areas. Activities of health committees of ULBs include sanitation in the cities and IEC in urban slum
- PRIs and ULBs needs technical support from and Health

(7) Supporting System for Delivering Services is Poorly Operated

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

(8) Partnership with NGOs/Private Sector

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

(9) Supervision

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

(10) Decentralization and Panchayat

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

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

CHAPTER 11

DISTRICT MASTER PLAN FOR IMPROVEMENT OF REPRODUCTIVE AND CHILD HEALTH

11 DISTRICT MASTER PLAN

This master plan is for Damoh and Tikamgarh districts, and was developed within the frameworks of state population policy and state health strategies. It is recommended that the plan should be integrated into a comprehensive district health plan, and implemented in coordination with other state health activities.

The district master plan consists of overall goal, objectives, strategies and priority projects. The priority project is explained in the next Chapter of this report (Chapter 4).

11.1 PLANNING FRAMEWORK AND GOAL FOR DISTRICT MASTER PLAN

11.1.1 Policy Framework

As already described in Chapter 4 and 10, the1994 International Conference on Population and Development (ICPD) in Cairo marked a turning point in the approach that the Government of India (GOI) enunciated for its population and health programmes. In line with the Programme of Action adapted at the ICPD in Cairo and the Government of India (GOI) espousal of a policy supporting provision of quality services to meet the full range of reproductive health needs of women and couples, it adopted integrated RCH approach and the "target-free reproductive health approach." Method-specific targets were discouraged nationwide in April 1996.

The Reproductive and Child Health (RCH) Programme was begun in 1997 combining several Programmes that had previously been vertical in line with the Action Programme adopted in ICPD Cairo. The target free approach was adopted, which changed its name in 1998 to the Community Needs Assessment Approach (CNAA) to emphasize the positive side of the new orientation.

Under these circumstances, GOI issued its National Population Policy in 2000. The Government of Madhya Pradesh also establish the State Population Policy in 2000. These are the major policy frameworks for RCH programme and the district planning to improve RCH in the target districts, Tikamgarh and Damoh District.

The mission of State Population Policy is ***"improving the quality of life of people in the state by achieving a balance between population, resources and environment."*** This mission is to be accomplished by achieving the main objective: reaching a TFR of 2.1 by 2011. Sub-objectives including increasing contraceptive prevalence through women's and couple's informed and voluntary choice, reducing infant mortality rate (IMR), reducing maternal morality ratio (MMR) and reducing morbidity of RTIs/STIs through integrated approach with emphasis on women's empowerment. Specific objectives are set up for more than 20 items in these four fields as shown in the Table below.

Draft National Health Policy 2001 affirms close relationship between population stabilization and achieving better health standards, and addresses to reduce the unmet needs for basic and reproductive health services. It also says "The synchronized implementation of these two policies will be the very cornerstone of any national structural plan to improve the health standards."

Table 11-1 Specific Objectives of Madhya Pradesh Population Policy

	Current	2005	By 2011
Reduction in Fertility (TFR)			**2.1**
Increase the use of modern contraceptives	42%	55%	65%
Reduce unmet need for contraception		By half	By 90%
Increase in male sterilization acceptors	2%	7%	20%
Increase the use of spacing method among young married couples	---	---	At least 50%
Increase in the average age of marriage	15 years		18 years
Increase in the age of the mother at the birth of her first child	16 years	20 years	21 years
Increase in the gap between the first and the second child		3 or more years	
Motivate couples with two or more children for terminal contraceptive methods			
Adjusting service delivery to regional variations			
Reduction in Maternal Mortality (MMR)	**498**	**330**	**220**
Increased registration of first-trimester pregnant women and provide a full range of ANC services to all pregnant women		70%	90%
Increased proportion of institutional deliveries	15% in 1995	25%	50%
Increased participation of trained TBAs in assisting delivery		75%	90%
Creation of sub-centre pregnancy testing facilities		by 2003	
Creation of block-level EmOC and MTP, and prevention and treatment of RTI facilities		50%	100%
Reduction in Infant Mortality (IMR)	**97 in 1997**	**75**	**62**
Reduction in Child Mortality (U5MR)	**120 in 1997**	**90**	**65**
Total immunization coverage		70%	90% by 2009
Increase ORS use	40%	80%	90% by 2009
Reduce incidence rate of ARI		50% reduction	75% ↓ by 2009
Introduction of ARI treatment		In all block level institutions	
Creation of appropriate facilities for treatment of diarrhea		All SCs	
Ensure children's receipt of Vit.A		50%	90% by 2009
Provision of Other Services			
Prevention of transmission of STIs			
Provision of quality services to infertile couples at the district level		By 2005	
Universal primary education		By 2005	
Completion of elementary education (girls)		30% of girls	50% of girls

Source: Madhya Pradesh Population Policy 2000, Government of Madhya Pradesh

11.1.2 State Health Strategies

As mentioned in Chapter 2

, the DOHFW has contracted a consultants group for developing the mid-term state health strategy, and it is undergoing at present. However, the DOHFW has already developed a basic state health strategy as described below to push implementation of population policy on forward, since it is critical issues which needs immediate action for the development of the state of Madhya Pradesh.

In the above mentioned state health strategy, "Convergence", "Implementation", "Micro-planning" and "Monitoring" are raised as the Key Word of the strategic approach with "40 points activities."

Key Word

(1) Convergence: This means the optimum utilization of existing resources (both human and financial) and avoiding the duplication of activities of various agencies. It also means uniformity of content and effort in training of health workers, and public-private-NGO partnership.

(2) Micro-planning: In rural areas, 20% villages will be covered in the first year, 40% in the second year, and the remaining 40% in the third year. Similarly, in urban areas the slums will be covered. The forth and fifth year would be used for consolidation.

(3) Implementation: To ensure effective implementation of the programmes/projects, it should be ensured that ANMs are in the position and sessions are carried out regularly. The detailed district plan will be developed based incorporating the outcomes of micro planning. Health insurance will be experimented.

(4) Monitoring: A detailed HMIS will be developed including incorporation of GIS package into HMIS, simplification of input format, and carrying out concurrent surveillance.

The following are the family welfare activities to reduce TFR (40 points activities):

1) Assessment of service need for primary health care.
2) Eligible couple survey complete.
3) 100 % vital registration of marriage, pregnancy, births, and deaths.
4) 3 ANC check-up to all pregnant mothers along with two does TT, 100 IFA and complete check-up.
5) Nutritional supplement to all pregnant mothers in AWW.
6) 100 % delivery by trained personal ANM.
7) Weighing of all new born and referral to hospital of LBW babies.
8) Referral of all complicated deliveries to CHC and their follow-up.
9) DDK to all pregnant mothers in last trimester.
10) 100% full immunization of infants and children no drop out.
11) 100% vitamin A distribution to children 9 months to 3 years.
12) IFA small distribution to under five children.
13) Growth monitoring of all children under 6 in AWW.
14) Registration and treatment by ORS of all diarrhea cases under 5 years.
15) Registration and treatment by Co-trimoxazole of all ARI/common cold cases under 5 years and

appropriate referral and follow-up of ARI cases.

16) Provision of referral system by community for high delivery cases.
17) Clint segmentation of all eligible couple in a separate diary and work out CPR of the area. Ensure that 70 % couples are covered by some or the other contraceptive.
18) All PNC to be followed up till first year regularly every months. And provided with contraceptive.
19) All newly wed couples must receive Condom/OP.
20) All PNC cases screened for RTI and counseled for IUD and insertation according to their wish.
21) Cover all PNC with some or the other contraceptive till 3 years of age.
22) Maintain CC/OP/IUD insertation register separately and regular record keeping.
23) All cases have been two and more children must be counseled for NSVT/CTT/LTT. If they are resistant proper counseling by peers/PRI/MSS/Religious and opinion leaders.
24) MSS must be formed and meeting are held regularly.
25) Group meeting with all the SHG regularly every month.
26) RTI/STD treatment.
27) Group meeting regularly with eligible couples in each mohalla.
28) Slogan and wall writing.
29) TB and leprosy cases to be given regular treatment.
30) All fever cases blood slide to be taken and pre-presumptive treatment of malaria given.
31) Campaign for environmental sanitation.
32) All wells must be disinfected regularly every week.
33) All Infant deaths, Maternal deaths must be notified and investigated.
34) Any epidemic of VPD must be reported within 24 hrs. and containment majors taken.
35) Surveillance of Polio, VPD and diarrhoeal disease.
36) Regular weekly ANC/PNC clinics at SHC.
37) Regular visit of health supervisor alternate week for supportive supervision and IEC.
38) School health of all school in area once in a year.
39) Meeting with community once in a month and presentation of statistics.
40) Health Mela for mothers and babies every three months.
41) Gender issues.
42) Adolescent Health.
43) Gender based violence.

Swasth Jeevan Sewa Guarantee Yojana (Rajiv Ghandi Mission for Community Health)

The state scheme of Swasth Jeevan Sewa Guarantee Yojana (Rajiv Ghandi Mission for Community Health) was launched in 2001 in MP. This mission programme also emphasises decentralised planning and management in health sector and revitalisation of the village health committee as a core mechanism for community participation in their own health care.

11.1.3 Overall Goal and Targets of District Master Plan for Improvement of Reproductive Health

The National and State Population Policy suggest that plan for implementation of the policy should be developed at district level taking consideration of local needs. The district master plan will cover reproductive and child health areas which are included in the current RCH Programme, but not other less priority areas in India such as women's cancer, menopause, etc.

Performance of the RCH programme currently implemented nationwide is moderate in Madhya Pradesh, and limited in Tikamgarh and Damoh District. One of the issues at district level is that the reproductive health approach is not well understood by district officers, politicians, health staff and general population.

Based on the policy frameworks and the situation at district level, the overall goal for the district master plan for improvement of reproductive and child health is proposed as ***to improve health status of all women and children through a Reproductive and Child Health (RCH) approach contributing to population stabilization in the target districts.***

As indicated in Table 11-1, the Government of Madhya Pradesh set quantitative goals in the State Population Policy. In the District Master Plan, quantitative goals for TFR and IMR are set according to the State Population and Policy. However, to set quantitative goal for MMR is difficult since district level data is available only at one point (1991) and quality is questionable. Since the period of the Tenth National Five-Year Plan will be 2003 – 2007, the goal in 2007 are also set.

Table 11-2 Quantitative Goal for District Master Plan

	MP *			Tikamgarh			Damoh		
	Current	2005	by 2011	Current	2007	by 2011	Current	2007	by 2011
Fertility (TFR)			2.1			2.1			2.1
Maternal Mortality (MMR)	498	330	220	1,178	---	---	856	---	---
Infant Mortality (IMR)	97 in 1997	75 (71 in 2007)	62	132 in 1991	80	70	123 in 1991	75	65

Source: * Population Policy of Madhya Pradesh, MP, 2000

11.1.4 Socio-economic Frameworks in 2007 and 2010

(1) Population

Based on the population projection of Case 2 where the assumption of decreasing in TFR to 2.1 in 2011 is adopted, population framework is set shown below. In Tikamgarh population will increase 12% in 2007 and 18% in 2011. In Damoh, it will be 11% in 2007 and 17% in 2011.

Table 11-3 Population Projection in 2007 and 2011

	Sagar div.	Tikamgarh	Chhatarpur	Panna	Sagar	Damoh
Population ('000)						
2001*	6,636	1,203	1,475	854	2,022	1,082
2006	7,314	1,334	1,628	940	2,227	1,184
2007	7,416	1,353	1,653	953	2,258	1,199
2011	7,823	1,427	1,750	1,004	2,380	1,261
Annual Growth Rate (%)						
2001-2006	1.97	2.09	2.00	1.94	1.95	1.82
2006-2011	1.35	1.35	1.45	1.32	1.34	1.28
Annual Live Births ('000)						
2001-2006	105	20	22	14	32	16
2006-2011	95	16	19	13	31	16

Note: *Actual
Source: Census of India 2001

(2) Literacy Rate

Literacy, one of indicators of development in a society, forms an important input in the overall development of individuals enabling them to comprehend their social environment and respond to it appropriately. The literacy rates are projected based on the current trend in India from 1991 to 2001 as shown below.

Table 11-4 Literacy Rate * in 2007 and 2010

(Unit: %)

		Sagar div.	Tikamgarh	Chhatarpur	Panna	Sagar	Damoh
1991**	Male	55.4	47.5	46.9	46.3	67.0	60.5
	Female	27.5	20.0	21.3	19.4	37.8	30.5
	Total	42.4	34.8	35.2	33.7	53.4	46.3
2001**	Male	73.2	68.8	65.5	74.0	80.0	75.0
	Female	46.7	41.0	39.4	47.8	54.5	47.5
	Total	60.8	55.8	53.4	61.6	68.1	62.1
2007	Male	79.8	77.0	75.0	80.3	84.3	81.0
	Female	56.1	51.6	50.4	56.9	62.3	56.7
	Total	68.7	65.1	63.5	69.2	74.0	69.5
2010	Male	83.3	81.2	79.8	83.6	86.6	84.1
	Female	61.5	57.6	56.6	62.1	66.8	61.9
	Total	73.0	70.1	69.0	73.3	77.3	73.6

Note: *The population of seven years and above only is classified as literate and illiterate.
** Actual
Source: Census of India, 2001

(3) Economic Growth

The Ninth Five Year Plan 1997-2002 of India set its main objective as 'Growth with Social Justice and Equity'. According to the Ninth Plan, one of the specific objectives is to accelerate

the growth rate of the economy with stable prices and the GDP growth target of 6.5% per annum is established after detailed examination. In addition, the growth rate of the GDP after the period of the Ninth Plan is estimated at 7.7%. The growth rates of the GDP of the state of Madhya Pradesh were lower than that of India during the period of 1993-99. Taking into consideration these conditions, the GDP of the State is estimated as shown below.

Table 11-5 GDP at Constant Price of 1998-99

	1993-94*	1998-99*	2006-07	2007-08	2011-12
GDP (billion Rs.)	731	907	1,319	1,386	1,690
Annual Growth Rate (%)	-	4.43	4.79	5.08	5.08

Note: *Actual

Source: Estimate of State Domestic Product of Madhya Pradesh 1993-94 – 1998-99, Dir. of Economics & Statistics, MP

11.2 OBJECTIVES AND STRATEGIES OF THE DISTRICT MASTER PLAN

11.2.1 Objectives and Strategies

Based on the current problems and issues in RCH and the RCH Programme in Tikamgarh and Damoh, which are described in Chapter 10, the District Master Plan address three objectives and several strategies to achieve them.

Overall Goal

To improve health status of all women and children through a Reproductive and Child Health (RCH) approach contributing to population stabilization in the target districts.

<Quantitative goals>

Reduction of TFR: 2.1 by 2011 in both Tikamgarh and Damoh District
Reduction of MMR: 50% reduction in 2010 in both Tikamgarh and Damoh District
Reduction of IMR: 80 in 2007, and 70 in 2010 in Tikamgarh District
75 in 2007, and 65 in 2010 in Damoh District

Objectives

(A) To improve the access to high quality RCH services

(B) To promote effective and efficient RCH service delivery through improved management

(C) To encourage women's empowerment and improvement of women's quality of life

Vision in 2010: In 2010, the followings are achieved according to the objectives.

(a) Management capacity at block level and district level is strengthened:

- *District and block health office (CMHO and BMO offices) develop their plan for* improvement of RCH for implementation of effective services with participation of all stakeholders including other departments, PRIs, NGOs and the community.
- BMO offices implement the plan efficiently, and supervise and monitor the activities for better implementation and planning based on the analysis of performance, health information data and field visits. CMHO office supervises and monitors BMO offices.
- *To support these CMHO and BMO office tasks, improved health management* information system becomes functioning by introduction of computers in each BMO office and CMHO office.
- BMO office works as a focal point of all service and political levels and partners within the block to coordinate and provide support to health and health related activities. BMO office works as a link to CMHO/District for the lower level in the block.
- *Close coordination mechanism between health administrative structure and health* committees within the political structure (Panchayat and Urban Local Body) is established and become functioning.

(b) First referral unit (FRU) and referral system become functioning in all blocks:

- CHC is established in all block with adequate building/facilities, equipment and human resources.
- CHC fully functions for the entire block as a core health institute. About a half of CHCs provides full range of essential and emergency obstetric care including blood transfusion.
- Referral system, particularly for emergency obstetric care, functions in all block. Referral system between CHC and District Hospital also fully functions.

(c) High quality RCH service delivery system is established in all block, then in the district:

- All SCs have basic building/facilities and equipment and all basic RCH services are available, and 85% of population is accessible to SCs within 4km distance.
- All existing PHCs have adequate building/facilities and a medical doctor posted provides integrated RCH services including EOC and non-surgical EmOC, and MTP.
- In remote areas, out-reach services are available regularly.

(d) Increased demand for and utilization of RCH services:

- Access to high quality RCH services is enhanced by community participation
- Village health committee is established in all village
- Operation and management committee for SC is established by the representatives of village health committee members for all SCs.

Strategies

Objective (A) To improve the access to high quality RCH services

<Increase of coverage of RCH services>

A1. Improve infrastructure (health facilities and equipment) to facilitate availability of high quality of health services and emergency obstetric care.

A2. Increase adequate (quality) coverage by field staff (Enhance field activities in villages)

A3. Fill the vacancy posts at PHC, CHC and District Hospital.

A4. Implement functioning and adequate referral systems

A5. To provide basic infrastructure in order to improve communication and accessibility

<Improve quality of RCH services>

A6. Increase knowledge and skills of health service providers

A7. Increase number and proximity of EOC and EmOC services and MTP service provision

A8. Improve availability of drugs and medical supplies

A9. Build up user- fee structures for proper utilization of services

<Increase knowledge and awareness and behaviour change of population on RCH>

A10. Strengthening of IEC and Introduction of BCC

A11. Encourage voluntary health activities at community level (Social and community mobilization and involvement)

Objective (B) To promote effective and efficient RCH service delivery through improved management

B1. Improve management capabilities of health administrative organization and Panchayat

B2. Increase linkages between and within governments, programmes, NGOs and private sectors (to enhance linkage between different levels and to encourage collaboration between different sectors)

Objective (C) To encourage women's empowerment and improvement of women's quality of life

C1. Promote and encourage women's empowerment

C2. Improve women's quality of life

11.3 INTERVENTIONS BY OBJECTIVES AND STRATEGIES

11.3.1 Improvement of Access to High Quality RCH Services

(1) Increase of Coverage of RCH Services

Lack of emergency obstetric care is notable in the health system. The most important issue here is to change the state policy focusing on Dai training to ensuring skilled attendance during childbirth.

(A1) Improve infrastructure (health facilities and equipment) to facilitate availability of high quality of health services and emergency obstetric care.

<Necessary Interventions>

- Review SC catchment areas and reallocation of catchment areas.
- Construction and upgrading of SC building adequate to provide RCH services.
- CHC upgrading to provide necessary services as FRU.

(A2) Increase adequate (quality) coverage by field staff (Enhance field activities in villages)

<Necessary Interventions>

- Develop a supervisory system of the health services provided by the ANMs and LHVs at the SCs and villages.
- Create / develop sustainable linkages among field health workers to ensure that the Health Professionals (doctors and nursing staff) are always informed correctly and in a timely fashion.
- Create mechanisms to ensure that the field nursing staff and supervising doctors have means of transportation to visit all the villages under their responsibility.
- Train doctors and nurses in EOC: in service competency-based and learner-centred training with special emphasis on referral protocols and use of the partograph of Friedman.
- Improve the planning capabilities of the local authorities and physicians-in-charge in order to:
  - Improve the better distribution of workload among field staff
  - Design of training, development of human resources and reward mechanisms
  - Ensure the availability of supplies

(A3) Fill the vacancy posts at PHC, CHC and District Hospital

Redesigning of standards of human resource allocation to each service level of facility. Posting doctors with training in some specific area and aesthetician but not specialist to CHC and PHC should be considered.

(A4) Implement functioning and adequate referral systems

<Necessary Interventions>

- System Development

- Design a EmOC delivery system
    - Health facility at no more than 1 hour from every settlement (usually PHC)
    - Equipped and staffed to attend to most cases of EmOC
    - Upgrade hospital to receive and treat most severe cases (intensive care, equipment, supplies including blood)
    - Assess the impact of "Maternity Houses" for villages very distant from any well-equipped and staffed PHC or where transportation is not available.
- Training
    - Train of doctors and nurses in EOC and EmOC
    - In-service competency-based and learner-cantered training with special emphasis on abnormal ANC and delivery, including use of suction device and surgical and anaesthetics procedures according to basic qualifications
- Transport system (see A5)
- Communication system (see A5)
- Motivate institutional delivery

(A5) <u>To provide basic infrastructure in order to improve communication and accessibility</u>

<Necessary Interventions>

- Transport system
    - Vehicles should be available at the all health facilities
    - Work with the community to implement a fund for transportation of emergency cases
    - Improve and maintain trunk roads
    - Construct and improve access roads to health facilities
- Communication system
    - Implement telecommunication devices in every community and health facilities. these devices.
    - ANMs should also be provided with communication devices.
    - Involve Gram Panchayat and health committees to equip communication devices at AWCs

(2) Improvement of Quality of RCH Services

(A6) <u>Increase knowledge and skills of health service providers</u>

<Necessary Interventions>

- Training
- Clarify and re-design a standard of services provided by each health service providers (health professional and field workers) including health providers under the ISM (Indian System of Medicine).
- Reorient Community Needs Assessment Approach (CNAA)
- Establish policy that all medical officers should manage EOC and basic EmOC.
- Assess expansion of availability of safe abortion by adopting simple technologies, e.g. manual vacuum extraction.

- Implement policy of non-discrimination (by caste) in work of health system.
- Modify medical school curricula or create a competency residency required for DoPHFW medical officers
- Modify ANM and Nursing school curricula
- Provide reorientation seminars / workshops on CNAA and RCH to all health officers, health professionals and health workers, and provide training on IPC and counselling skills
- Provide refresher training to LHVs, ANMs and AWWs.
- Improve ANM and AWW skills in educating & counselling on temporary methods (Family Planning)
- Train doctors and nurses in all PHCs on EOC and EmOC
- ANMs to stabilize patients prior to referral and to know and teach danger signs
- Train health professionals and health workers on diagnosis and treatment of RTIs/STIs
- Equip training centres

(A7) Increase number and proximity of EOC and EmOC services and MTP service provision

<Necessary Interventions>

- Re-design service delivery system according to the design of the training and the viability of staff, transportation, etc. in order to implement the delivery of services in an effective and efficient manner.
- Review and assess adaptation of simple technologies, e.g. manual vacuum extraction by nurses and LHVs.
- Assess the catchment's area of SHC (not population based norm but based on actual accessibility by community)

(A8) Improve availability of drugs and medical supplies

<Necessary Interventions>

- Implement State Drug and Medical Supply Management Policy
- Establish district logistics system
- Improve health officers and storekeepers capability in logistics management
- Train storekeepers and health workers on drug and medical supplies management

(A9) Build up user- fee structures for proper utilization of services

<Necessary Interventions>

- Establish uniform fee structure, allowing for no payment by the poorest.
- Strengthen RKS at hospital and block level.
- Eliminate extra-charging in hospital, specifically individual caretakers' soliciting fees.
- Establish emergency transport system at community level not dependent on individual's ability to pay.

(3) To Increase Knowledge and Awareness of Population on RCH

Low utilization of services is big problem in MP and in Tikamgarh and Damoh. This is mainly because of lack of knowledge and awareness of population on RCH or lack of behaviour changes in health care seeking behaviours.

Extensive efforts of IEC activities and introduction of BCC is needed to increase use of services.

(A10) <u>Strengthen EIC (education, information and communication) and introduce BCC (behaviour change communication)</u>

<Necessary Interventions>

- Training of communication skill
  - Train health professionals and health workers on IPC (interpersonal communication) skills, counselling and providing of health education
  - Strengthen IEC Bureau and district IEC activities review and reform the bureau / target local needs and family / provide skill training / strengthen district level IEC planning and activities
  - Integrate some IEC activities with DWCD IEC activities, particularly the topics regarding the gender issues and women empowerment
- RCH mass media campaign
  - RCH mass media information on danger signs in pregnancy, benefits of safe delivery, institutional delivery (safe motherhood)
  - Include basics of child nutrition, immunizations, key disease symptoms and care in RCH mass media campaign (child health)
  - RCH mass media campaign on temporary methods, age at marriage (family planning)
- Awareness of symptoms of disease, modes of transmission, and possibility and source of treatment (RTI/STI)
- Organize Panchayat, health committee, SHGs to increase community people awareness, to enhance health promotion activities and to monitor health status of the community, women and children.
- Introduce social marketing for basic drugs and contraceptives
- Provide family health education through school and peer education
- Provide family health education to adolescent groups in collaboration with WCD programme.
- Sensitise people on symptoms of disease, modes of transmission, and possibility and source of treatment

(A11) <u>Encourage voluntary health activities at community level (social and community mobilization and involvement)</u>

<Necessary Interventions>

- Strengthen capacity of VHC
- Establish health committees for SHG

- Organize and strengthen SHGs and women's groups for community health activities and voluntary works.
- Design and implement interventions with NGOs and SHGs.

11.3.2 Improvement of Management Capabilities of Health Administrative Organization and Panchayat

(B1) Improve management capabilities of health administrative organization and Panchayat

The RCH programme already exists and being implemented since 1997, however, the performance is moderate in MP and limited in Tikamgarh and Damoh District. There are many problems found in the implementation: insufficient planning, no proper records on budget and expenditure, poor quality of training, no planed and coordinated building construction and provision of equipment, lack of supervision, lack of quality data available, no data sharing, etc. All these are related to lack of management capacity.

In the framework of decentralization policy, the district and block level need capacity building for effective service delivery and efficient programme/project implementation.

The first thing to be done is to re-orient RCH programme, since most of health personnel including district officers do not fully understand the concept of RCH. Reorientation of RHC programme and CNAA is the must for improving RCH status through the programme.

The other important role of block is described in the next section.

<Necessary Interventions>

- RCH programme management
  - Provide reorientation seminars / workshops on CNAA and RCH to all health officers and implementation of policies.
- Capacity building (Training)
  - Train officers in the district and block level on management capacity
  - Improve planning capacity of district and block level officers and improve linkage between planning and budgeting
- Supervision and monitoring
  - Development of monitoring and evaluation systems towards increased supervision and program management at each level: Standardization, Development of supervision protocols, and Training on them.
  - Provision of supervisory transportation
- Development of supporting systems for better management
  - Development of communication system between health care levels
  - Systems improvement/development in finance, personnel, inventory of equipment , and drug supply logistics (partly covered in HMIS)
  - Improve HMIS at state, district, block level and PHC/SHC level
  - Feedback of data and information from field to district and block level

officers and planning committee for better planning and monitoring
    - Promote data and information sharing through HMIS
- Health administrative structure, Panchayat structure and health committees (see *Figure 2*)
    - Clarify role/function and demarcation of health administrative structure and Panchayat structure on delivery of health services
    - Strengthen Panchayat and health committees' capability to identify their health problems, conduct micro planning and organize health activities
    - Organize Panchayat, health committee, SHGs to monitor pregnant women and advise on delivery
- GIS cell development at the state head quarters.

(B2) Increase linkages between and within governments, programmes, NGOs and private sectors

<Necessary Interventions>

- To enhance linkage between different levels and to encourage collaboration between different sectors,
- Strengthen interdepartmental committee and information sharing mechanism at the district and block level.
- Integrate child health services in collaboration with AWWs including child growth and nutrition
- Support to small local NGOs with material and orientation programmes on RCH policy and implementation.
- Explore and test strategies for private sector care for EmOC and health education (Operation Research)

11.3.3 Encouragement of Women's Empowerment and Improvement of Women's Quality of Life

The low status of women is one of the reasons for low health status of women and children. The imbalance of sex ratio clearly shows the discrimination of women in health care. Poor accessibility to information on health and health care, depending on decision making on their own health to others (husband and mother-in-low), and care for women always comes last after the other family members' dare. Women's empowerment activities should be incorporated with RCH programme/projects together with gender awareness campaign.

(C1) Promote and encourage women's empowerment

<Necessary Interventions>

- Increase gender awareness at all levels
- Support economic employment of women's groups and SHGs (Self Help Groups)
- Enforce legal age of marriage and elimination of Dowry discrimination and harassment

- Increase girls' and women's access to education (formal and informal) and achievement of education.
- Provide vocational trainings to girls
- Strengthen legal enforcement on minimum wages

(C2) Improve women's quality of life

<Necessary Interventions>

- Reduce women's workload, particularly the disadvantaged women's overwork
- Introduction of new/alternative technology: new cooking fuel and improved oven, introduction of flourmill
- Increase the number of common water supply system in the community, etc.

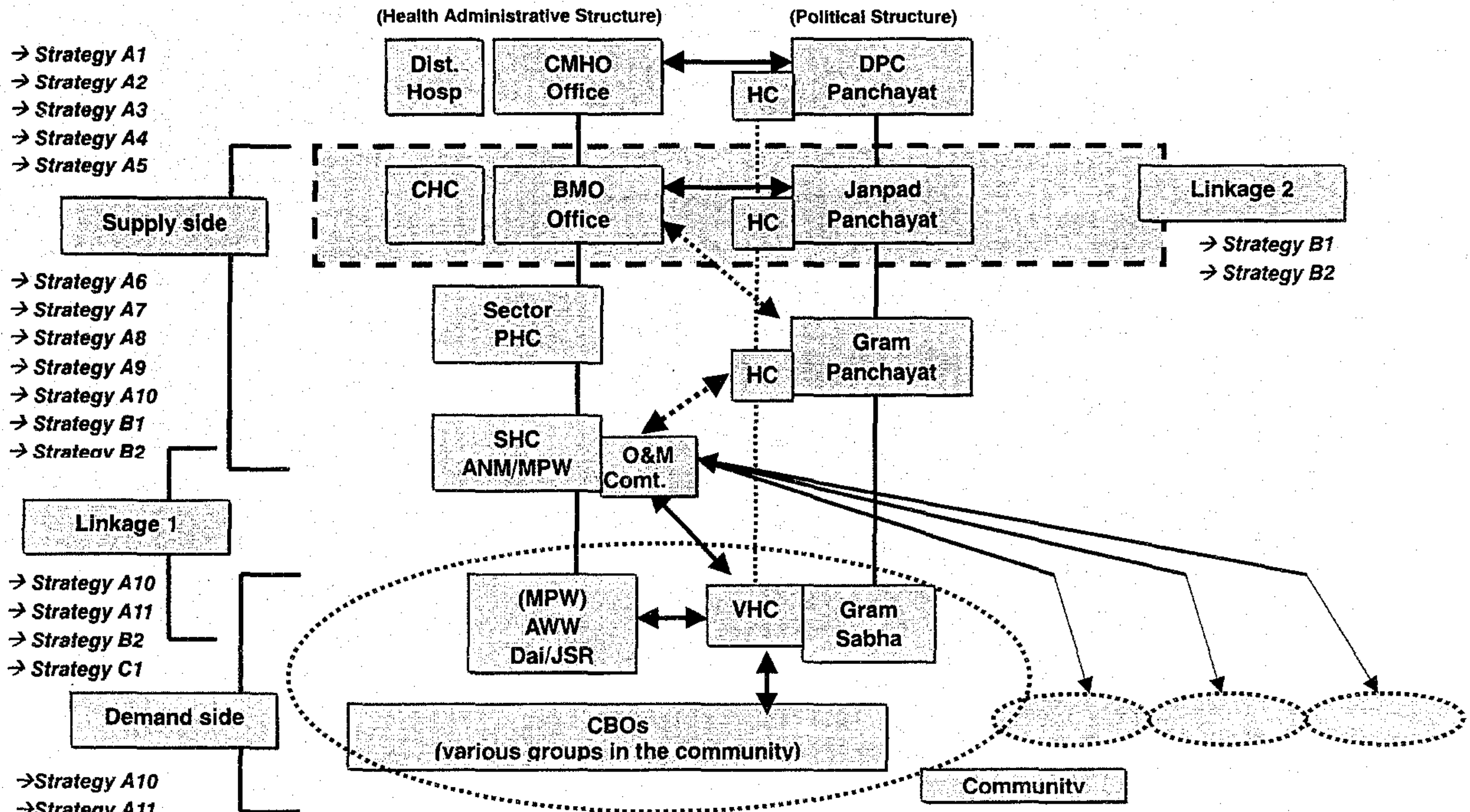

Figure 11-1 Strategies and Structures of Health Administration and Panchayat

(HC: health committee, CAB: community advisory boar)

11.4 STRATEGIES FOR IMPLEMENTATION

The implementation of these projects, the team also develop the strategies for implementation, which provide the methodology of effective implementation of the projects in compliance with decentralization and democracies.

(A) Establishment of block level as a nodal spot, aims at linkage of all level organizations to attain sustainability of RCH service delivery with effectiveness and efficiency (See Figure 10-1)

Community participation contributing to people's ownership of programmes is essential for sustainable field activities and encouragement of own decision on RCH. Furthermore, people's involvement may bring reduction of cost and enhancement of effectiveness on programmes. Amount of budgets of community level organizations, however, is deemed to be inevitably limited even in the near future and is not enough for employment of sufficient permanent staff for overall arrangement and implementation of RCH programmes because these organizations, which are the basis of community participation, have rather small population.

In short, community is crucially important, but has not enough resources and capability for implementation of RCH programme. This situation shows that intensive support to community level organizations is indispensable.

On the other hand, neither the Madhya Pradesh State government in Bhopal nor the district government is far from community geographically and mentally. Furthermore, decentralization proceeded in recent years requires the state government to delegate the authority and responsibilities to local governments.

Therefore, intermediate function linking between community and upper-stream such as state and district is required for the sake of effective and efficient implementation of RCH programme.

As shown above, one of crucial issues for implementation is linkage of all level organizations concerned because of long distance between the state and community, and complicated administrative structure including PRIs. As for implementation of RCH programme, block level among these is to be emphasized on account of close to community where programmes are implemented, as well as provision of administrative function and health facility to some extent

in comparison with community level.

(B) Stepwise extension of implementation area and activities of RCH programmes, aims at focusing on the first success in the initial stage of implementation, and inspiring people concerned by exhibiting initial successful precedent in the consecutive extended stage.

This strategy is applied in such a manner that efforts will be concentrated in a selected pilot area in order to examine designed systems and projects how they function, then to improve them, and to attain the first success in the initial implementation stage. In the following stage for the extended area, lessons learned in the initial stage are applied for the redesign of the project plan.

The community leaders and groups in the initial stage target areas should be involved in the extension stage for motivate and guide communities in new areas.

In the state strategy, it recommends a phased manner implementation in which 20% villages of a selected district is coveted in the first year, 40% in the second year, and another 40% in the third year. The study team also recommends a phased manner implementation, however, the target area(s) covered in each year is different.

Since project implementation for system strengthening and development needs to select one consolidated administrative area (cluster) in which a target health system exists and all the level of services from the village to CHC (or B-PHC) are available so as to developed system can be evaluated in the health system. In this regards, administrative "block" under district is the most proper unit to implement projects, and one health administrative block is covered in the first year, other two to three more blocks in the second year, and the all blocks in the third year.

This does not mean to put huge amount of resources in a small area, but emphasize implementation of well-designed projects and systems with practical operation and management plans also considering necessary resources based on the pilot project implementation. The pilot project should be replicable to the entire district.

Proposed Blocks for the pilot Implementation

As a demonstration block for the first step, Hatta block in Damoh and Bardevgarh block are selected according to the following criteria.

- The block has CHC
- The block has willingness to improve RHC services by themselves
- In the block, women's group activities and SHGs activities are more active than other blocks
- The CHC in the block is near to the district head quarter for close supervision and monitoring of the project, and for referring patients to the district hospital for blood transfusion if necessary.