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Integrating Reproductive Health in Health Programmes in India

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In the International Conference on Population and Development held in Cairo, Egypt, in September 1994, 179 states formulated a Programme of Action (POA) which focused on meeting the reproductive health needs of individuals rather than on achieving demographic goals of countries. The recommended objectives at this conference were:

- Economic growth with sustainable development;
- Universal Education (specially for girls);
- Gender equity and equality;
- Reduction in infant, child and maternal mortality; and
- Universal access to reproductive health services.

Reproductive health services thus imply the enabling of individuals, both males and females, to decide freely and responsibly, the number, spacing and timing of their children. For this they must have the information and the means to attain the highest standard of sexual and reproductive health. Reproductive care, therefore, includes family planning (FP) counselling, contraceptive information and services; safe delivery and post-natal care; infant, and women's health care; abortion; treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs); and counselling on human sexuality, reproductive health and responsible parenthood.

To achieve the objective of universal access to reproductive health services, all the participating countries were urged to make reproductive health services available through the country's primary health care system. The Government of India (GOI) strongly supported this approach, and committed itself to introducing reproductive health in its family welfare (FW) programme.

Indias Family Welfare Programme

The Indian Family Welfare Programme, initiated in 1952 (then called Family Planning Programme) has helped India bring down the total fertility rate of 6 in the 1950s to 3.4 in 1993-4. During this period the Infant Mortality Rate declined from 146 to 79, and Maternal Mortality declined from 8 to 4.2 per 1000 live births. India has established an impressive primary health care infrastructure consisting of Community Health Centres (1 CHC per 100,000 population), Primary Health Centres (1 PHC per 30,000 population), and Subcentres (1 SC per 5,000 population). The National Family Health Survey (NFHS) carried out in 1993 found that slightly more than 40 percent married women were using some method of contraception, over 60 percent pregnant women had received Tetanus Toxoid during pregnancy, and over 60 percent children were fully immunized against vaccine preventable diseases.

However, one of the weaknesses of this programme has been its relentless pursuit of the fertility reduction goal, using such means as contraceptive targets and cash incentives. It took quite some time for the government to admit that these means had not only failed to produce the desired impact on fertility, but consequently they had also caused a neglect of quality of services to clients. To remedy this situation, the GOI recently decided to adopt the reproductive health approach for delivering family welfare services and took the critical step of removing method specific contraceptive targets from the programme.

Contents of Reproductive Health Approach

The Cairo conference had articulated the need to adopt a broader and more holistic approach to family planning that would link demographic concerns with improving the health of women, including their reproductive health. At the programme level this meant providing high quality, client centered reproductive health services which included family planning, treatment of reproductive tract infections and measures to reduce infant and child mortality.

India has identified the essential package of reproductive health services to be provided through the Family Welfare Programme. This package includes:

- Prevention and management of unwanted pregnancies;
- Services to promote safe motherhood;
- Services to promote child survival;
- Nutritional services to vulnerable groups;

- Prevention and treatment of RTIs and STDs;
- Reproductive Health service for adolescents;
- Health, sexuality and gender related counselling; and
- Establishment of an effective referral system.

Four out of the eight services included in the package are already available in the national programmes (see Table 13.1). In an evaluation of these, the issues of increasing access, improving their quality and ensuring client satisfaction need to be addressed. With regards to the remaining four services which are yet to be introduced, there are questions about their feasibility and cost-effectiveness which need to be answered.

Table 13.1: Essential Reproductive Health Services (RHS) Package

Essential Reproductive Health Package	Primary Health Care: Services Available
<i>1. Prevention and management of unwanted pregnancy</i> Family Planning: Terminal methods Spacing methods	Available Available
<i>2. Prevention and management of RTIs and STDs</i>	Not available*
<i>3. Child survival</i> Immunization ORT for Diarrhoea ARI management	Available Available Available
<i>4. Safe motherhood</i> Ante-natal care Safe-delivery Post-natal care	Available Available Available
<i>5. Safe abortion</i>	Available**
<i>6. Reproductive health services for adolescents</i>	Not available
<i>7. Sexuality & gender Information, Education & counselling</i>	Not available
<i>8. Effective referral systems</i>	Not available

* Management of RTIs and STDs is restricted to the CHCs and the District hospitals.

** Exist but not uniformly available.

Constraints in Introducing Reproductive Health Approach

A review of India's Family Welfare Programme carded out in 1995, found three constraints which were likely to come in the way of its adopting the reproductive health approach. These were:

- Non-availability or poor quality of certain services;
- Inadequate equipment and supplies at the PHCs and SCs;
- Gender bias and low status of women in service provision

Some services like emergency obstetrical care and treatment of RTIs were not available through the Primary Health Centres and Community Health Centres. Routine service like Ante-Natal Card (ANC) was reduced to registering mothers' names and giving them Tetanus Toxoid (TT) and 100 tablets of Iron Folic acid (IFA). In case of family planning, most women were not screened for contraindications before providing them with contraceptive methods. Often they were not even told about the possible side effects because the health workers feared that women may refuse to accept any method if they were told about the side effects. Follow up of acceptors and after-care in case of side effects, was also found lacking.

Health functionaries blamed many of their problems that led to poor quality of service on lack of equipment and inadequate medicine supplies. A facility survey carried out in 1992 by the Indian Council of Medical Research had found that 40 percent of the centres were poorly equipped. About 25 percent of the medical and paramedical staff positions were vacant. Health workers were not able to reach many villages because of a lack of transport and poor road conditions. Under such conditions, the package of reproductive health services would be difficult to deliver.

Gender bias was the third constraint identified, which could make delivery of reproductive health package an uphill task. Due to the gender bias, girls get lower priority in schooling, women have less access to health services, and they get lower quality services. Since the success of the reproductive health approach hinges on the extent to which women have access to health services, a programme designed to reach them must pay special attention to reducing the barriers faced by women. These may include steps such as recruiting female outreach workers and doctors, providing support to women vis-a-vis their families and making women and their health needs, more visible (Koenig and Gillian 1992).

This paper describes our effort to introduce elements of the reproductive health package through Subcentres and PHCs, in the Parner block of Ahmednagar district in Maharashtra. The experiment is currently being carried out by the Directorate of Health Services in collaboration with the Foundation for Research in Health System, an NGO, that is funded by the Ford Foundation. The experiment has been planned in two phases. In phase I, attention was to be focused on the existing services in terms of improving their access, quality and utilization. In phase II, the feasibility of introducing new RH services within the existing system, were to be studied. This paper describes findings from Phase I of this experiment.

Access and Quality of Reproductive Health Services

In phase I, we first identified the constraints that affected the access and quality of the existing RH services. To identify the constraints, data was collected from Parner block, the experimental block in Ahmednagar district.

Ahmednagar district is one of the largest districts in the western state of Maharashtra in India. It has a population of 3.3 million distributed across 1535 villages in 13 blocks. About 13 percent of the population is urban and 87 percent rural. The population has a sex ratio of 946, literacy rate of 50 percent and about 31 percent of the population falls below the poverty line. Ahmednagar is predominantly agricultural and is well-known for its sugarcane plantations and sugar factories.

Parner, the experimental block, is situated in the western region of the district adjoining Pune district. This block has a population of 2.1 lakhs spread over 131 villages. Of these 131 villages, 7 are PHC headquarter villages, 38 are Subcentre villages and the rest are 'Other' villages. The population has a sex ratio of 1016, a literacy rate of 46 percent and about 52 percent of the population falls below the poverty line. The entire block is a rural area. Almost all the (130) villages have electricity and at least one source of safe drinking water supply. However, the block with an annual rainfall of 566 mm marginally below the 575 mm for the district, is prone to severe droughts. Health services to the block are available through government and private sources. The former is constituted by 7 PHCs, 1 Rural hospital, and 38 Subcentres as mentioned earlier.

In January 1994, a survey was carried out, using a sample of 1023 married women of reproductive age, selected from 40 randomly selected villages of Parner block. Out of a sample of 40 villages, 24 villages had either a PHC or a Subcentre located in them, while 16 villages had no government health facilities. Information related to ANC and Child Care was obtained from 624 mothers with the youngest child less than 5 years of age. Information on family planning

practices was collected from 1023 married women. This data was analysed to answer three specific questions:

1. What were the barriers to Reproductive Health (RH) services coverage?
2. How good was the service delivery process?
3. How good was the technical quality of the RH services?

The barriers were defined in terms of client's background variables, which are known to affect their health seeking behaviour. These were:

- Education of the women (Literate or Illiterate);
- Economic status of the family (Poor, Not poor);
- Social status (Belong to Scheduled castes/ tribes, other castes);
- Residence village by type (PHC/SC or Other).

The family's economic status was classified as 'Poor' if it lived in a Katchcha house, had no water source near the house, had no electricity and no possessions such as a bicycle and radio. Using this definition, about 62 percent of households were classified as 'Poor'.

Barriers to Services Coverage

In this block, the coverage rates of the existing RH services were found to be high. Antenatal care registration was nearly 80 percent; Full immunization rate among children was 81 percent; and family planning was practised by about 59 percent couples. However, when these coverage rates were examined against the barrier variables (education, income, caste, and village type), some interesting findings emerged (Table 13.2). First, ANC registration was found to be more sensitive to barrier variables.

Table 13.2: Barriers to RH services coverage

	Percent ANC Registered	Percent Children Fully Immunized	Percent Couples Using FP Methods
<i>Place of residence</i>	85	83	57
PHC/SC villages (673)	69	76	61
Other villages (350)			

Mother's education:	74	73	64
Illiterate (405)	84	85	55
Literate (618)			
Economic status:	78	80	59
Poor (689)	83	83	58
Not Poor (334)			
Social status:	82	84	61
SC/ST (328)	79	80	57
Other Castes (695)	80	81	59
Total			

ANC registration in PHC/SC villages was much higher than that in 'Other' villages. ANC registration and immunization rates were also sensitive to the education of mothers. But these did not vary much by social or economic background.

Family planning use however, was higher in 'Other' villages and among illiterate women. In these groups Family Planning meant sterilization since use of spacing methods was just about 2 percent. A higher sterilization rate among them probably indicated they could be more influenced with incentives and target pressures. In PHC/SC villages, 9 percent women reported using spacing method. They also reported 'Doing something (methods unspecified) to avoid pregnancy'.

Thus, one significant finding of this survey was that immunization and sterilization services were reaching the 'Other' villages but the ANC services did not do so to the same extent. This was because ANC services were provided only at the Subcentre clinic, while immunizations were provided at the village level camps, once a month. At these camps pregnant women got Tetanus Toxoid and Iron tablets, but nothing else.

Immunization camps were usually held at public places in villages such as school buildings or even temples. Pregnant women, specially very young women felt shy and hesitated to come to these crowded' camps. Therefore, women reported their pregnancy only when ANMs visited them at home. If the ANM did not visit the household, a pregnancy in that home was not registered even if the women knew about the care needed during pregnancy. Therefore, next we assessed how well the services were being delivered to women living in remote villages, and women belonging to different socioeconomic groups.

Quality of Service Delivery Process

Quality of service delivery was assessed using four indicators. These were:

- Home visits by ANMs in previous three months;
- Duration of home visits and satisfaction of the women with the amount of time spent;
- Clients told about spacing methods;
- Clients informed about contraceptive side-effects.

About 51 percent women reported that ANMs had visited them in the previous three months. ANMs were expected to visit 50 households per day and cover all the houses in their area, once a month. They could complete this task only if they spent less than 5 minutes in each house. The ANMs made only 50 percent of the expected number of visits, but they did not necessarily spend more time in the homes they visited. According to the women a majority of these visits (64 percent) were of five minutes duration or less. Only 36 percent visits were of some-what longer duration.

However, over 75 percent of the women who reported ANM visits, were satisfied with the amount of time the ANMs spent with them. They sympathized with the ANM's work-load. Many women commented that as ANMs were required to visit too many houses, it was all right if they did not spend much time in each house, but they also said that these visits should be regular.

Another aspect of the delivery process we investigated, was whether the women were told about spacing methods, whether they were given option of using spacing methods, and whether they were told about the possible side effects of all methods. Women who had not accepted sterilization were asked if the ANM had told them about different spacing methods. Forty-three percent of the women said that they were told about at least one spacing method. But when asked about which method the ANM had recommended for use, 4 percent responded that they were recommended sterilization, 18 percent were recommended spacing methods, 22 percent were advised to adopt either one, and 56 percent were not recommended any method (Figure 13.1).

A majority of the acceptors (55 percent) were not told about possible side effects of the method they were adopting. Among IUCD and Pill users however, 80 percent were told about the side-effects because these users were more educated. ANMs said that they did not usually tell women about the possible side-effects because it discouraged women from accepting any method.

From this data it appeared that in a majority of cases, the health workers decided the appropriate contraceptive method for the client rather than allowing them to

make that decision. They also decided whether the clients should be told about the side effects. The factors they used in these decisions seemed to be not just the number of children the women already had, but also some other variables of their background such as where they lived, their education etc.

This analysis showed that ANMs visited the 'Other' villages less frequently. When they visited these villages they could spend less than five minutes in most of the houses (82 percent), as they had very little time at their disposal. This may be one important reason why ANC registration in 'Other' villages was rather low.

The ANMs also did not recommend the use of spacing methods in these villages to the extent that they did so in PHC/SC villages. The reason for this, the ANMs explained was that if women living in remote villages suffered from any side-effects of the spacing methods they could not reach the health centres easily. Also, maintaining a regular supply of Oral Pills to these women was a problem.

Another significant finding of the survey was that families belonging to socially under-privileged groups reported fewer ANM visits as compared to other castes. Some of them alleged that because ANMs belonged to higher castes, they avoided visiting the houses of Scheduled Caste families. Such complaints were frequently heard by investigators during the survey. However, ANMs denied any such bias on their part. They implied that members of these communities, who are politically sensitive, make such allegations specially against government functionaries, to gain political influence in their community.

Data also showed that ANMs visited the educated women more often than the uneducated, perhaps because the educated women, who usually came from economically better off families, were at home, while the illiterate and poorer women were in the fields when the ANMs visited them.

Thus, the quality of service delivery process seemed to depend very much on client characteristics. Next, we examined the technical quality of these services and how it was affected by the provider's abilities and client characteristics.

Technical Quality of Services

The technical quality of FW services was assessed using the indicators shown in Table 13.3. For mother care we selected the indicator of delivering a complete package of ANC services (TT, IFA, abdominal examination, monitoring blood pressure and urine for sugar and albumin). Over the years, ANC has come to mean only giving TT and Iron Folic acid. Services such as monitoring pregnant women for high risk conditions, providing medical attention when needed and

counselling them are getting less and less attention. In the experimental block we found that only 46 percent of the pregnant women had received the full pack-age of services.

Table 13.3: Selected Indicators of the Technical Quality of Family Welfare Services

Indicators	Percentage
Complete ANC check-up	45.8
Delivery by trained persons	50.8
Immunization drop-out rate	14.4
Immediate breast feeding	22.0
Experienced Contraceptive side effects	38.5
Treatment of side effects at Government centres	46.7

On all technical criteria, except immunization, the programme showed less than 50 percent achievement. The immunization dropout rate reflected the system's failure to provide the measles vaccine before the child had already suffered from measles. It also included a few cases of adverse reactions to immunization, but these were about 2 percent. In family planning, the technical quality was assessed by side-effects reported and the percentage of women availing of treatment for side-effects at the government health centres. Nearly 39 percent acceptors of sterilization reported side effects. Though the nature and severity of those side-effects were not probed, nearly 70 percent reported taking medical treatment for them and half of them had gone to the government health centres for treatment.

As discussed earlier, health workers had no fixed rule for giving information about side-effects. They claimed that they made this decision based on the women's education level. The data however, showed no such pattern. It appeared that some workers told about the side-effects and others did not. Perhaps those who felt the pressure to complete acceptor targets did not talk about side-effects. But the data clearly showed that those who were told about side-effects sought treatment more frequently than those who were not told. Thus, workers by withholding this information from the clients seemed to be negatively influencing their help-seeking behaviour.

ANMs gave two reasons for the poor technical quality of ANC care. One was the lack of equipment and supplies. More than half of the Sub-centres did not have the equipment for antenatal care, such as blood pressure apparatus, weighing machines and urine test reagents. Though the ANMs had some theoretical knowledge about ANC services, half of them lacked in skills due to non-practice.

The second reason given was that women did not like to come for ANC visits. They, being poor and illiterate, did not understand the importance of ANC services.

In our block, the bottleneck seemed to be access to services and not education or poverty of women. When we analysed the percentage of women receiving the full benefits of ANC by education and the type of village they lived in, the type of village showed a more significant effect than education Table 13.4.

Table 13.4: Effect of Women's education and Place of Residence on Probability of Receiving ANC Package of Services (Percent Received Full Package of Services)

Place of Residence	Education	
	Literate	Illiterate
PHC/SC villages	30	12
'Other' villages	7	5

Access to service thus emerged as a strong variable affecting both the quality and quantity of services received by women. However, health workers tended to blame either the supplies or the women themselves for the lacuna in the service delivery.

At the village level, the FW services were delivered through the Multi-purpose camp (or Mother and Child Protection camps or MPC) held in every village with more than 1000 population. At any given camp, services were provided to 25-30 children who came for immunization, 5 to 6 pregnant women who came for TT and 1-2 cases of IUCD insertions. Though these MPCs were meant to cover a wide range of FW services, including treatment and counselling, in practice they had become immunization sessions. Very often, only ANMs were available to handle the entire case load, and they could spend less than 5 minutes per case. In order to increase the women's access to RH services we felt that these MPCs should provide better quality services.

Thus, this analysis helped to show that in order to introduce reproductive health services in the existing programme, three aspects of the programme needed strengthening. These were:

1. Improving access of 'Other' villages to the ANC services;
2. Improving the technical quality of ANC services; and
3. Modifying service delivery process to enhance women's access.

We tried to overcome the above mentioned constraints by taking steps to increase the access of women to the services, specially the ante-natal care services, through the strengthening of the ANC component of the MPCs and scheduling of the MPCs to coincide with the weekly market day and bus timings. For improvement of the quality of services, we supplied equipment and made check-ups by the medical staff at these clinics mandatory. To highlight the health needs of women, the MPCs were scheduled in one fixed, central and acceptable public place where women could come without any hesitation.

The remainder of this paper describes in detail the steps taken to strengthen these three aspects of the existing programme and their effect on the provision of reproductive health services.

Implementation of Steps

The five initial steps taken were:

1. Systemizing work routines of workers and supervisors;
2. Increasing contribution of male workers;
3. Making women and their health needs visible;
4. Examination of High Risk Cases and Delivery by Trained Persons; and
5. Training and providing logistic support to workers.

(a) Systemizing Work Routines of Workers and Supervisors

As a first step it was decided that full range of ANC services will be made available at the village i.e. at the MPCs, so the women from 'Other' villages need not go to Subcentres for those services. To implement this decision, the work-schedule of the workers and the supervisors needed to be designed such that at each of the MPCs both male and female supervisors and male and female workers could remain present. Female workers and supervisors would take care of ANC cases and women's problems while male workers would give immunization to children.

In the earlier work-schedules, supervisors could not remain present at all camps because 2-3 camps were scheduled on the same day at the same time. Most of the camps were organized in the third week of the month, which led to unnecessary clustering of camps. After studying this problem, we proposed revisions in the camp schedules in which the original camp days were retained, only the weeks

were changed such that the camp days were spread uniformly over the month and no two camps were held on the same day. This planning was in fact done by the PUC staff. District officers facilitated this process by ensuring that all workers or supervisors were allotted more or less a uniform amount of work.

(b) Increasing Contribution of Male Workers

Earlier, the male multi-purpose worker and the male supervisor were not given specific roles in the village level camps. They were expected to carry the vaccines, fill the cards and generally help to gather children for immunization. But the responsibility of providing immunizations was carried out by the ANM. In the new schedule, the male workers were given the specific responsibility of weighing children, and recording information on the health card. Attendance of the male supervisor and male multi-purpose worker was also made mandatory. The regular presence of male workers and supervisors was meant first, to reduce ANMs' work-load so that they could pay more attention to women, and second to pave the way for gradually getting men to these camps for advice on contraception and STDs.

(c) Making Women and their Health Needs Visible

In the earlier system most women felt shy to come to the camps because these were held in public places with not much of privacy. They therefore waited for the ANMs home-visits which were not regular. In each village our effort was to make a space available where women could be examined with privacy. We were told that it was not possible to get rooms that were large enough in all the village. But when we persisted, we were able to get such rooms in Panchayat buildings, where secluded corners for the camps were created using curtains. ANMs and LHVs could comfortably examine the women and spend an adequate time with them.

Health workers were apprehensive about using the Panchayat building because they thought the women-would feel shy to come to a place where many men may be present. Initially, that was a problem but the male workers and supervisors were able to get the men to leave the place during the camp. They also used that time to explain to the male village leaders the importance of a medical check-up during pregnancy and of treating problems that women suffer from. Thus, using a visible place like a Panchayat building was a strategy we adapted to make women visible and to create support groups for them from among women who attend the clinic.

(d) Examination of High Risk Cases and Delivery by Trained Persons

Some steps were taken to see that women with high risk factors could be examined by a doctor. Getting the PHC doctor to visit every camp was impractical. But they could be expected to come to Subcentre camps once a month, if they were given vehicles. Each PHC doctor was looking after 6-7 Subcentres. They thus required a vehicle for one week in a month. Since at least one vehicle was available for 2-3 PHCs, schedules were worked out so that these PHC doctors could share the vehicle time among themselves and could attend the Subcentre clinic once a month. This arrangement could function only if the vehicles were in working condition.

The project therefore provided funds for the maintenance of vehicles if needed and a fund for petrol to ensure that the Subcentre visits were not cancelled for lack of petrol. Doctors were informed that they could rent a vehicle, if need be and the project would cover that expense. This system is in operation for over a year but no doctor has asked for funds for this purpose. However, only five out of seven doctors have been visiting Subcentres regularly.

Initially the doctors did not expect women to come to the Subcentres for examination. Over time, they found that women not only came but waited until the doctors examined them. Doctors also responded to this demand. In one or two PHCs where doctors are not able to attend Subcentre clinics, it is planned to get private doctors on a contract basis.

Through this step, deliveries by trained persons are expected to increase since most pregnant women will have a sufficient number of contacts with the health system and an opportunity for education and referral.

(e) Training and Providing Logistic Support to Workers

To rectify the problem of lack of working equipment and supplies, ANM kits were procured for each ANM. The kit consists of a rexin bag, blood pressure apparatus, fetoscope, stethoscope, adult weighing machine, infant weighing machine and a measuring tape. The cost of this kit along with one curtain and dari (thick sheet) was about Rs. 4800 per Subcentre. All ANMs were supplied with Uristix worth Rs. 50 per Subcentre. Medicines, vitamins, vaccines and FP supplies were supplied by the PHCs.

An important aspect is to ensure continuous supply and maintenance of equipment. Two project assistants, who made regular visits to the Subcentres and to village level camps made a note of shortages or breakage in equipment. They also ensured repairs of this equipment. If there were shortages in supplies,

the project staff would bring it to the notice of the PHC doctor or the DHO, if the health workers did not. The project assistants did not function as supervisors but they provided a communication link between the field workers and PHC or District level officer.

ANMs were given on-the-job training in practical aspects of ANC, by the district training team. Re-orientation training by the district training team is carried out every six months.

Initial Impact

After the health staff's work-schedules were reorganized, the health workers themselves worked out a system of sharing work at the modified MPCs. Under this system LHV and ANM gave ante-natal and FP services (IUCD, Oral pills and Condoms). ANMs also gave the vaccination while IUCD insertion was done by the LHV. Both the LHVs and ANMs gave health education while examining the women. All high risk cases or doubtful examination findings were rechecked by the LHV and the women were also asked to come to the Subcentre to see the doctor on a specified day.

For vaccination, children were first seen by the male worker. He weighed them, and from the immunization card noted the due immunization dose on a small chit. Mothers took the child and the chit to the ANM who then gave the dose. Mothers then came back to the male worker to collect the updated immunization card. This system streamlined the flow of work and ensured that there was no overcrowding or confusion in the camp. Male supervisors gave health education. This revamping and remodelling of the camps generated a lot of enthusiasm and the ANMs got support from other sources in the community for conduction of these camps. For example, the CHVs, Balwadi teachers and even some community members helped ANMs with simple tasks like weighing, measuring height and giving IFA or Vitamin A. These camps had become visible and therefore they had to be held regularly. This as well as the fact that the days and timings were prominently displayed in the village created a positive pressure on the health workers to maintain the camp schedule.

Outcome of the Interventions

A month-wise analysis of the data (Table 13.5) at the end of year one of the experiment showed gradual improvement in the attendance at the camps. The month of April, was an exception because the staff after writing reports and completing the paper work required during the month of March usually relaxed in April. Therefore, there was some laxity in holding the camp. Though none of

the camps were cancelled during this month, non-availability of the staff for the full duration of the camp was responsible for a lower attendance of women.

Table 13.5: Overall performance of ANC component of the camps (February 1995 to January 1996)

	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.
<i>ANC registered</i>												
New	167	119	66	104	150	135	122	81	83	109	86	54
Old	NA	124	75	150	120	212	264	116	210	116	112	110
< 16 weeks	37	68	45	80	67	72	55	59	59	53	44	30
<i>Services given</i>												
Phy. Examination	167	243	141	254	270	347	386	197	293	225	208	164
Blood pressure	167	242	141	254	236	347	248	197	293	225	206	164
Urine test	16	57	140	254	270	347	204	197	293	225	206	164
TT	142	215	140	228	248	244	176	275	169	154	91	
IFA	135	240	140	254	270	74	223	159	293	225	206	128
H. Risk diagnosed	39	52	53	31	81	76	82	56	53	40	52	39

*Uristix could be supplied only by April 1995.

*B. Pr appartus out of order at Parner PHC; Uristix, TT and IFA in short supply in the month of August 95.

*TT and IFA in short supply in August and September 1995 and January 1996.

*In the month of December 3 MPCs under Bhalavani and 5 under Parner PHC were cancelled because of the Pulse Polio Programme. The Beneficiaries were requested to avail of the services at the PHCs.

On the whole camp performance has shown a steady improvement. According to the staff, earlier the pregnant women had to be called to the camp, but now they have started coming on their own. The attendance at all the camps has also increased. The earlier attendance of 3 to 4 pregnant women has now increased to a minimum of 15.

Analysis of the services received by the beneficiaries revealed that the coverage of the full ANC service package has reached almost 100 percent. It has also been found that ANMs applied the high risk criteria rather rigorously, and hence almost one third of the pregnant women were labelled as high risk. The next step

in the project was to insist on a follow-up of these cases, work out a feasible schedule for follow-up and obtain information on the status of referral.

Discussion and Conclusions

To integrate the reproductive health approach with the country's FWP is undoubtedly the most feasible mode of achieving the objective of universal access to reproductive health services. As mentioned earlier most of the services included under the new approach such as family planning, antenatal care and immunization are already included in the FWP

During the survey in Ahmednagar, the current FWP was found to have major weaknesses in service delivery like inaccessibility to the community due to physical location, or because of the inefficient work schedule or system of working; a disproportionate emphasis on selected services; and poor quality because of poor skills of the providers and lack of working equipment. Our own experience in Ahmednagar district indicates that certain minimal inputs in the form of availability of working equipment, a rational and feasible work schedule and support to the field level workers, go a long way in establishing an efficient system whose range can at a later stage be broadened to include the reproductive health services which are not already available.

In the next phase of the project other components of essential reproductive health package such as those dealing with RTIs and STDs, abortion services, and information, education and counselling will be included. Integration of this approach in the FWP will need the backing of a very strong and effective referral system in place.

Integrating the reproductive health approach in the FWP would require a change in the manner in which the package of services is devised, delivered and monitored. This has to be done without compromising on the quality and access of the existing services. The Ahmednagar experience indicates that strengthening of the existing FWP services creates a strong foundation, which can perhaps be built upon to include the whole range of recommended services at a later stage.

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