Emerging Issues in Reproductive Health

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The government of India has decided to introduce target-free approach in family planning. But whether this change in the language of discourse also implies a change in the dominant mind-set focused on fertility control, remains a moot question.

HEALTHWATCH, an informal network of non-governmental organisations, social activists, researchers and policy analysts interested in health issues, was formally launched in December 1994. In the wake of government of India's (GOI) decision to discontinue method specific targets in family planning and the introduction of target-free approach, HealthWatch interfaced with the government on initiating a nationwide discussion on the target-free manual and the new reproductive and child health programme proposed to be launched across the country. In the first national meeting of HealthWatch held in Ahmedabad on March 25-26, 1996 it was decided to convene a series of regional consultations over a period of one year. The main focus of these consultations was as follows:

(1) to study ground-level implications of the 'target-free approach' (TFA) and the reproductive and child health (RCH) initiative from a woman's perspective;
(2) to examine and evaluate the new performance indicators developed by GOI, particularly those in the TFA manual;
(3) to develop a concrete response to the challenges, strengths and limitations posed by the GOI's shift in population policy and health care delivery, particularly with regard to the process of planning, implementation, monitoring and accountability systems;
(4) to examine the experiences of the non-governmental organisations (NGO) in women's health in order to draw relevant lessons for the delivery of government health services; experiences of involving women in planning implementation and monitoring programmes; and
(5) to expand and strengthen the Health Watch network and formulate region-specific plans of action for advocacy at the state-level.

Eight regional meetings were held between June 1996 and January 1997. Nodal agencies identified in the Ahmedabad meeting constituted their respective planning teams for each region and took full responsibility for convening the meetings and preparing the reports.[1] Efforts were made to invite NGOs, social activists, researchers, government officials, training institutions, representatives of the auxiliary nurse midwives (ANM) union and medical professionals. This note draws upon the reports of the eight regional consultations which were held between June 1996 and Janurary 1997.

Feedback on the Manual on Target-Free Approach

Participants at all the regional consultations strongly felt that the Target Free Manual does not hang together and is self-contradictory. A mission statement or a preamble should be included where the fundamental principles of the new approach are spelt out. The rest of the manual needs to be screened for consistency. It would be appropriate to treat the current document as a draft, which could be modified in the light of experience and feedback.

Adapting the national manual to suit each state would enable the government to respond to the enormous diversity in the country. In this context, it was suggested that GOI convert the manual into guidelines to be adapted to the needs of each state/region. In some of the regional meetings the efforts made by the government to disseminate the manual through state-level workshops were noted with appreciation. However, many district level groups, representatives of ANMs and some officials said that they were seeing the manual for the first time. Many of them found it difficult to comprehend and some wondered how this manual really marks a departure from the earlier system; in particular, the summary fax sheet of information which is being sent by each district to GOI. All the meetings called for efforts to make the manual more user-friendly.

The following specific recommendations were made:

– Widespread dissemination of the manual, translation into regional languages, block level and district level workshop for dissemination;
– Awareness creation among officials, service providers and the community on the use of the manual; the shift it signals in India's health and family welfare programme preparation of local models of component implementation systems, information that needs to be collected and disseminated enabling service providers to understand the logic behind the new system – these were considered as being essential for effective implementation;
– Concretisation of "community participation" through specific implementation strategies to involve village level/urban groups, women's collectives and panchayat representatives;
– Spelling out methods and indicators to be used to assess work quality, output and outreach of the PHCs. Formation of a technical group to develop detailed formats and processes for quality assessment;
– Developing a feedback system to get regular information on the effectiveness of the manual, its impact on the quality of service and the attitude of officials and service providers.

Women's Health and Proposed RCH Programme of GOI

At the outset, it is important to note that the TFA approach was often confused with the RCH programme. Given that the two initiatives were launched simultaneously many participants from the government and the non-governmental sector wanted to know whether the TFA approach was a precursor to a good RCH programme or whether the system would continue to focus on fertility and efforts to control or regulate it. Issues surrounding mortality, morbidity, child health and survival and the like are all linked to the goal of fertility reduction. In short many participants wondered whether or not there is likely to be a change in the basic mind-set of planners, policy-makers, service providers and donors. The language of discourse has changed but has the basic population control mind-set changed? This apprehension was articulated in all the regional consultations.

Another concern that was voiced related to the fact that, despite official protestations to the contrary, the main thrust of the erstwhile family planning programme and the proposed RCH programme is primarily aimed at women in the reproductive age group. Almost all the meetings reiterated the importance of a good and reliable primary health care system for women, men and children. The importance of a special women's health programme was recognised, not as a parallel or a vertical programme, but one that is woven into the primary health care. There was a consensus over this and in particular on the need to empower women to take charge of their basic health care, with efficient, effective and sensitive health

delivery system which treats them with dignity.

At one level, policy documents addressing education, income, employment, violence, etc, argue that women are not "autonomous" decision-makers and that social status, values, customs and religion determine their lifestyle, the choices they make and so on. At another level, the policy documents dealing with family planning, assume that women are "autonomous" and sometimes portray women as perpetuators of the population problem and the vehicle for transmission of STD and HIV/AIDS. In recent times immunisation drives have started focusing on both the father and the mother in order to ensure that children are brought into the health centre at the appropriate time. Yet, when it comes to family size, child survival, maternal health (nutrition, spacing, age at first pregnancy) women are seen as autonomous agents. This fractured world view was noted with concern.

Given the dominant mind-set among service providers and administrators where emphasis is largely placed on fertility control (with infertile women becoming effectively invisible), women are unable to seek care for gynaecological illnesses that are not directly related to pregnancy. This is understandable because the public health workers at PHCs are perceived to be callous, insensitive and often intimidating. This is specially so for abortion services. Further, the quality of care rendered by the service providers changes according to the social and economic status of women. Unmarried women have even less bargaining power and are forced to seek such services in the private sector. Despite guidelines to the contrary, in many public clinics consent of the husband is sought. Similarly, there are no services for occupational health problems, domestic violence/abuse and mental health. Older women past their reproductive stage have almost no place to go. Given such complex social and economic constraints on the care of reproductive health of women, the following issues were reiterated for an effective RCH programme at the meetings:

– Safe child bearing with appropriate health care services, including treatment for infertility;

– Safe, effective and affordable family planning methods with a focus on encouraging informed choice;

– Care of gynaecological morbidity – identification and treatment of problems facing women from adolescence to old age;

– Safe sex without fear of disease;

– Access to safe and affordable abortion services;

– Mechanisms to respond to victims of violence and abuse at home and in the community with special focus on mental health;

– Mechanisms to address health problems arising due to occupational hazards.

Some concrete recommendations concerning the RCH programme were also made:

– Provide services of a gynaecologist on a weekly basis in every PHC, and at assured and regular (monthly basis) intervals with wide publicity at the sub-centre level;

– Provide privacy for women to speak out their problems, for internal examination and for confidential discussion /counselling;

– Devise ways and means to monitor reproductive health services with a view to fine-tune design and delivery systems, enabling the system to respond to emerging needs of women. It is important to recognise that women are not likely to come forward in the initial phase but as and when they gain confidence in the health delivery system, the demand for a range of services is bound to change;

– Provide or build basic laboratory facilities, toilets and private rooms for women in all health centres;

– Provide effective communication system and transportation for critical cases at all PHCs. They should have special labour rooms and should function 24 hours with doctors working in shifts. The ANMs should be provided with basic essentials such as first-aid kits and gloves.

– Communicate to people effectively the link between the HIV/AIDS and RTIs and STDs. The latter increase the risk of acquiring HIV/AIDS. As of now HIV/AIDS programme is seen as a parallel initiative of the government with little link to the RCH or family planning programmes. Continuation of such a fractured approach will be counter-productive. The close relationship between sexual health, sexual practices, sexually transmitted diseases, reproductive tract infections (including tears, cervical cancers) and so on need to be communicated effectively. In the long run an effective RCH programme must encompass education and awareness about HIV/AIDS.

The Target Free Manual assigns the responsibility of health care and family planning primarily to the ANMs. Given the existing work load, training received, capabilities, support structures and supervisory system, the participants at most of the regional meetings expressed concern over the ability of ANMs to do all that is expected of them. MPWs seem to have been absolved of primary responsibility. All the regional meetings called for concerted efforts to end this imbalance. Serious efforts need to be made to clearly spell out the roles and responsibilities of all service providers – ANM, MPW, PHC doctors and so on. Health workers who have been trained for almost four decades to work for targets cannot make a quick transition without intensive training, orientation, capacity enhancement and support system put in place.

Specific Recommendations on ANMs

The participants of the regional consultations were aware of the plight of the grass roots health workers. The ANMs are the fulcrum around whom revolve all changes. Research and experience of grass roots workers have shown the dismal state of affairs in the position, social status and capabilities of ANMs. The TFA manual assumes that the ANMs are independent and confident planners. It was recognised that the ANMs function under difficult circumstances, and being women from disadvantaged classes, are vulnerable both socially and as women. They have little bargaining power, most of them are stationed in villages far away from their homes and cannot take advantage of family support in times of need. They are required to travel extensively in a cluster of villages and have little security or comfort. They work with poor infrastructure at the sub-centre, while they are held responsible for its performance. ANMs typically take care of women and children and are seen by the community as someone just above the traditional 'dai'.

On the other hand, MPWs tend to be seen as 'doctors' even though they do the same amount of curative care as the ANMs. They are mostly malaria workers who chlorinate wells, collect TB slides and so on. While MPWs have a higher status in the health delivery system and in society, ANMs share the entire burden of grass roots implementation of family planning services, child survival and safe-motherhood initiatives. In this context the following recommendations were made:

– The role and the status of the ANM need to be substantially strengthened. Her responsibilities should be commensurate with her training and capacity. It was suggested that the ANMs be assigned the task of taking care of family health in general and women's reproductive health and child care in particular. Maintaining a family health register and building long-term relationships with the community will enhance her effectiveness and social status.

– In order to enable the ANM to carry out her responsibilities efficiently, she must be backed by more curative care oriented sub-centre than what exists now. She must be trained to recognise gynaecological morbidity (including STDs, RTIs) and in case she cannot treat them all, be able to refer the women to PHCs with the confidence that they will be treated promptly, properly and

with dignity. This is vital to strengthen her linkages with the community and build her confidence.

– ANMs must have team support from the MPWs. Outreach work should be done by the now defunct community health volunteers (CHV), instead of having ANMs travel long distances. Many groups felt that the CHV scheme needs to be revived.

– ANMs must be motivated with avenues for professional recognition and advancement. A system which stagnates field-workers with little recognition and/or lack of possibility for advancement breeds indifference and discontentment.

– Effective strategies need to be worked out with NGOs and other government programmes to break the isolation of women workers. Building networks of women workers to enable them to relate to each other as women could help the system create informal support structures for the grass roots workers. Finding effective, region specific strategies for community involvement through women's groups, health forum and the like has to be built into the TFA strategy.

– The training system needs to be revamped with efforts to provide regular refresher programmes, with focus on reproductive health. The training sessions should also become forum for sharing experiences and discussing problems and opportunities to recuperate and renew energy and enthusiasm.

– ANM is expected to collect a large amount of information and fill out innumerable registers and forms. Most often she does not know why she is collecting the information and does not relate it to her tasks. Collecting a limited amount of information with knowledge of its relevance to her day-to-day work will transform the process from a meaningless mechanical exercise to one that lends meaning to her work. Using the information while collecting, relating it to the performance and problems will enhance the quality and texture of the MIS system. It will also enable the system to minimise over-reporting and bogus data.

– If the ANM is to be the first and the most accessible link between the people and the health system, she must be given the necessary tools, both medical and human, to sustain that position effectively. To this end each ANM and the MPW should cover a population of 3,000 instead of 5,000 in most regions and less in mountainous and remote areas; it must be compulsory for them to reside near the sub-centre (which should be located within a habitation and not be isolated). Frequent transfers should be avoided and efforts made to ensure that the ANM has a long enough tenure to build rapport and a relationship with the community.

– The supplies of drugs and other equipment/ supplies should be streamlined. Provision of sub-standard drugs leads to a loss of confidence in service providers, and this should be tackled urgently.

Specific recommendations on MPWs:

– To eliminate discrimination in status, role and responsibilities, salary, privileges and facilities of male and female health workers, there should be a common recruitment policy, duration of training and equal sharing of responsibilities and burden of work.

– MPWs should educate men in families and communities about family planning, STDs, AIDS and the causes of reproductive tract infection (RTIs) and their relationship to sexual hygiene and practices of men. Child survival, safe motherhood and a host of issues that influence family health, should also be part of the tasks of the male health workers. Experience of many NGOs have shown that insensitivity of men to frequent child birth, good nutrition for women before and after child birth, child rearing practices, and sexual health compound the problem in our society. Even a little bit of sensitisation of men makes a significant difference. The TFA initiative and the RCH programme should recognise that women do not have the autonomy to act, even if they have the information. Support of men will greatly enhance effectiveness of IEC activities that are today directed towards women.

– To carry out the above responsibilities, MPWs should be given intensive training in child survival and safe motherhood (CSSM), immunisation, reproductive health issues and be made aware of male role in the determination of the sex of a child.

– All vacancies for MPWs should be filled immediately.

Involving Women's Groups in TFA Strategy and RCH Programme

The overwhelming consensus of participants in the regional consultations was that, women's groups/collectives will have to play a key role in order to ensure that women's needs are recognised and met adequately. Almost every government programme calls for formation of women's groups. In some areas the situation is quite alarming, with departments competing with each other for the formation and control of women's groups. In some other areas successful initiatives in groups formation for awareness or credit are under pressure to "take on" another agenda. has compelled many NGOs and act groups to initiate a debate on "compet claims on women's groups and the im of such initiatives on the ground. necessary to have separate "groups" education, health, water and so on? thrift and credit groups form the basis issue-based mobilisation?

It is unrealistic to expect women's gr to be formed for each programme – educat health, public distribution system, protec of forests/common property resources, w sanitation and so on. The answer to dilemma could be creation of issue-base task-oriented platform of women which m at regular intervals. A group of two or t women could be trained and oriented to the role of facilitators for health. Sim forum for education could train another nucleus of two or three women to en them to facilitate discussions on educa and literacy related issues. This is boun reduce the competition between minist and programmes for an exclusive wom group.

While the above idea was seen as alternative, some regional consultati focused on the need for full-fledged wom groups. In this context four key questi were identified:

– If the RCH programme envisages wom participation through groups, how will s groups be formed, who will be respons for their formation?

– What are the pre-requisites for a w functioning women's group?

– What are their rights and responsibilit Will they be involved in planni implementation, monitoring and evaluati Will the health care service providers made accountable to these groups? ANMs expect and demand support from groups?

– What sort of linkages would have to developed between women's groups, he workers and officials?

In order to ensure effectivity, the requisites for a well-functioning group w have to be identified carefully. To this the following issues were conside important:

(1) Conceptual understanding of issues have to be fostered through training regular interaction of groups/forum

delivery system which treats them with

(2) Clarity about the resources that the women's groups/forum will have at their command. Availability of resources – including a meeting place and fund for emergencies will determine the real "status" of the group/forum in the community.

Catalysing the formation of women's group or creating a village-based platform for women's health requires strategic planning, transparent and accountable management systems, highly motivated and committed functionaries, appropriate training programmes, opportunities for periodic reflection and self-evaluation, resource support and a host of qualitative inputs that enhance the capabilities of the catalysts and the members of the forum. Effective decentralisation and autonomy of decision-making at the village level for village-based activities; at the panchayat level for activities at that level, at the taluk/mandal/block level for activities at their level, could create an environment for effective parti-cipation in the community-based groups/forum.

Relationship between NGOs and the Government

Most of the regional consultations started by exploring the history of GO-NGO collaboration in health and family welfare. Over the years the focus of voluntarism has shifted from charity to welfare to development. Historically, voluntary organisations functioned as catalysts for change and worked among the people as partners in struggle, change and development. However, in more recent times, there has been a split between voluntarism and NGOs. Today many NGOs see themselves as implementers of programmes and projects. While many of them retain a social change perspective, availability of ample funds from the government and from the donor agencies has gradually transformed many NGOs into contractors, executing projects. The expectation from the funders (government and donors alike) is that NGOs will be more cost-effective, reach the unreached and deliver services more efficiently and in a humane manner. While there is a tremendous variation between NGOs in effectiveness, commitment and outreach, there is also a great deal of scepticism about the NGO sector. This is evident within the government, among donors and in the media.

The dominant perception in most meetings was that the government continues to perceive NGOs as contractors, who can be given financial support to deliver services. While large number of NGOs do not have major problems with government's perception, those NGOs and social activists who are involved in mobilisation and advocacy work, are uncomfortable with this image. They see themselves as:

– partners in development and social transformation,

– link between the people and the government, to foster mutual understanding;

– partners in planning, implementation, monitoring and evaluation of programmes meant for the poor;

– conscience-keepers of the society, mobilising people to demand their entitlement, assert their rights;

Coming to the TFA initiative and RCH programme in particular, the following recommendations were made in the regional consultations:

– NGOs, researchers, training institutions and social activists can be partners in communicating the paradigm shift and bringing about a change in the dominant mind-set.

– Some NGOs can effectively participate in designing and conducting training of service providers, officials, trainers of other NGOs;

– NGOs can help develop monitoring and evaluation systems as well as develop support systems for field workers (ANMs in particular);

– NGOs can also take on consultative status at the district and block level for decision-making on location and infrastructure of sub-centres, PHC and so on;

– NGOs can also take the responsibility for formation of women's groups which take up issues related to the RCH programme;

– NGOs can be involved in and also take the responsibility for IEC activities, rural women's health melas, outreach programmes, campaigns and so on;

– NGOs can help develop alternative monitoring systems and work with service providers to implement them.

The overriding concern expressed in the regional consultations was the lack of sustained dialogue with government. While some NGOs and the HealthWatch network were invited to organise the NGO consultations in the wake of the TFA initiative, there has been very little information sharing during the planning phase of the RCH programme. NGOs are invited to participate after a programme has been finalised, leaving very little room for dialogue on the main thrust or focus, the content and the processes initiated. Donors eager to encourage the participation of the NGO 'stake holders', have also not shared their proposals. As a result, the consultative process on RCH was based on little information on the actual project being negotiated by GOI with donors. A hope was expressed in all the consultations that the initiative like the RCH programme, will create an environment and enabling conditions for sustained and meaningful dialogue between the GO and the NGO sector.

Note

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1 The eight regions were: (a) Karnataka and Andhra Pradesh, (b) Punjab, Haryana and Himachal Pradesh, (c) Uttar Pradesh and Bihar, (d) West Bengal and Orissa, (e) Tamil Nadu and Kerala, (f) The north-eastern states, (g) Gujarat, Rajasthan and Madhya Pradesh and (h) Maharashtra and Goa.