Delivering Reproductive Health Services in Rural Andhra Pradesh. Insights from the Field.

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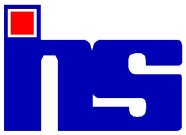

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Printed in Hyderabad, 2003

IHS Library Cataloguing-in-Publication Data
Delivering Reproductive Health Services in Rural Andhra Pradesh. Field Insights: 1st Edition\Prasanta Mahapatra, Samatha Reddy, Mukesh Janbandhu & Pushpalatha.

Includes bibliographic references
1. Reproductive Health Services - India - AP 2. Field Insights-India-AP.
613.94'548 4-dc 21

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Delivering Reproductive Health Services in Rural Andhra Pradesh. Insights from the Field.

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India launched in 1997 the Reproductive and Child Health (RCH) program to meet the total needs of both mother and child. The program covers all aspects of reproductive process, such as care of the young married girls, ante natal care, child birth and care of new born as well as children under 5 years. It includes components to deal with sexually transmitted disease (STD) and reproductive tract infections (RTI). The Andhra Pradesh state in addition drew up a Vision 2020 document setting ambitious health and population program goals. Primary health centres have a pivotal role in RCH program implementation. Medical officers incharge of Primary Health Centres (PHCMOs) are responsible for health care delivery and RCH program implementation. To understand various aspects of the program implementation and gain insights for future action, we organised a three day workshop with 18 PHCMOs. The objectives for these consultations were; (a) to seek creative ideas to improve women and child health status in the state, (b) to elicit opinions, perceptions, and understandings of field health personnel about implementation of programs in their spheres of work, and (c) to explore new and potential programs, so as to improve reproductive and child health in the state. We report here results of these Medical officers group discussions[2].

Methodology:

Each of the 22 District Medical and Health Officers (DMHOs) in the state were requested to nominate five "ideal typical" PHCMOs from their respective districts. The following criteria was suggested to identify the PHCMOs: (a) Comprehensive understanding of RCH services and programs (b) Understanding of Women and Child health problems (c) Effective management of PHC activities (d) Usually resides at head quarters (e) Good communication and managerial skills and (f) Proactive, enthusiastic and dedicated to service. The institute got a list of 110 PHCMOs i.e. five PHCMOs from each of the 22 districts. A random sample of 20 PHCMOs was drawn from this list. All except two participants, one from Khammam and another from Ranga Reddy district, attended the workshop.

The workshop had three main activities, namely (a) Focus group discussions of the PHCMOs (b) deliberations by the PHCMOs as expert groups, and (c) a Policy-Panel discussion. In the three day workshop, six FGDs were organized, in which the PHCMOs had an opportunity to discuss various operational issues. Participants in these small groups were encouraged to raise concerns and suggest recommendations for the effective implementation of the RCH program. In the FGD sessions, the participants were prompted to (a) place themselves in the role of the Governor, the Chief Minister, and / or the Health Minister of the state (b) assume that they have full authority but have to operate within the overall

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[2] Detailed report of the Medical officers Group Discussions have been published as Report Series - RP 19/2002. This paper summarises the key discussions and conclusions arising from them.

socioeconomic environment of the state, (c) collect their life time experience and insights from the field, then (d) ponder how to improve the reproductive and child health services in the state. First, the PHCMOs were organised into two groups, each discussing about Reproductive Health Services and Health Sector Reform. At this time the PHCMOs did not have access to transcripts of ANM group discussions. There after the PHCMOs were provided the full set of transcripts of ANM group discussions (Mahapatra P., Reddy S., Pushpa Latha, Nancy M., 2002). They were organised into six groups of two to three persons each and assigned one of the six ANM group discussions. Their task was to read the transcript, prepare a summary and give their own comments about correctness of assessment by ANMs as well as desirability and feasibility of recommendations made by ANMs. Heavy workload on the ANM, resulting from unmanageable population and area assigned to sub centers, etc. emerged as an important concern in the PHCMO's as well as ANM group discussions. Similarly, non-availabililty of health care professionals was an important concern. Hence the MOs were formed into two groups. One group focused their discussion on Sub center jurisdiction, staffing pattern and male health worker's role. The other group discussed in-depth about various factors contributing to non-availability of health care professionals in PHCs and sub centers.

The PHCMOs were constituted into two expert committees, namely (a) Expert committee on Sub centers and (b) ANM practice guidelines. The two groups were requested to arrive at their recommendations, by consensus. Finally, the plenary of PHCMOs participated in a panel discussion on overall policy towards health sector reform. The commissioner Family Welfare, one of the authors (Prasanta Mahapatra) and the Joint Director, Family Welfare concerned with RCH services, served as panelists.

Results:

Social Reform:

All the participants were concerned about early age at marriage of girls and its adverse effects on health. Early marriages lead to premature maternity and increased maternal complications. There is a need for universal and compulsory elementary education in order to improve population health in general and reproductive and child health status in particular. High priority should be given to secondary education of girls and boys. The high school curriculum should also include topics like sex education, legal age at marriage, etc.

The medical officers highlighted the importance of health education. Certain priority areas for health education in the context of RCH were recommended. These include (a) reassurance about usefulness of Tetanus Toxoid (TT) injections and the fact that the TT injections do not cause abortion, (b) usefulness of hospital delivery to minimise risk on mother and child, (c) usefulness of contraceptives for birth spacing, etc. The ANMs and PHCMOs, informed that many misconceptions exist amongst villagers about early registration and first dose of TT injection. If by chance abortion occurs after TT injection is given, people associate the TT injection with abortion. The PHC medical officers pondered, how to make villagers aware of the importance of TT injection. The participants urged to strengthen the IEC strategies for creating awareness on the above issues.

Role of the PHC:

Discussing about the role of PHC, the medical officers pointed out that there is confusion at every level about the role of the PHC and its staff. As a result people expect many things depending on the context. The participants recalled many expectations from the PHCs. These include, (a) treatment for minor ailments, (b) Monitoring overall sanitation of the villages including inspection and treatment of drinking water sources, (c) implementing disease control program, (d) maintaining birth and death registers, (e) achievement of family planning targets, etc. The medical officers complained that many of the activities carried out these days in PHC are inappropriate. For example, all PHCs are expected to implement all national health programs, irrespective of whether the disease is prevalent in that area or not. There are many overlapping programs for which the PHC staff end up maintaining duplicate records. The participants suggested that such duplication of activity must be avoided while planning at the state level itself and recommended to have area specific health care activities.

Lack of clarity in the role is causing misunderstanding even amongst villagers. People feel aggrieved, if they do not find the doctor in PHC, even if the doctor is on official tour looking after the public health work. All PHCMOs have to travel for different programs. A PHC medical officer is usually away from his out patient service seat for about four months in a year. For example, 20 days for Janmabhoomi program, two weeks each for Family health services campaign and monthly meetings, etc. In addition to this, PHCMOs are sometimes deputed to neighbouring health centers. Therefore, people coming for out patient consultation do not receive care. Some participants felt that PHC role should be confined to public health activities only. Curative services should not be expected. Other participants recognised that in rural areas, many people depend on PHCs for treatment of minor ailments.

The participants recognised that the recent program of designating selected PHCs as round the clock PHCs (RPHCs) has contributed substantial improvement of the facilities and services[3]. Hence participants considered that the existing PHCs should be converted into round-the-clock PHCs (RPHCs). Most of the participants recommended increase in the number of MO's post to facilitate provision of round the clock service. Unfortunately past experience, in this regard has not been encouraging. Additional MO posts had been created earlier in response to the need for reliable services. But these additional posts are the first casualty whenever expansion in PHCs is taken up. New PHCs are created to satisfy people's aspiration, by redeploying additional MO posts. Moreover, regular in-patient services can not be offered only by increasing MO posts. Change over from an out patient set up to full fledged hospital service requires a quantum jump in staffing. The participants suggested that the RPHC should have at least one doctor with diploma in gynecology (DGO), one doctor with diploma in anesthetics (DA) and one MBBS doctor, so that, in case of emergency, caesarian operation can be performed at PHC itself. Alternatively, one MD / DGO must be on round the clock duty in referral hospitals and there should be one anesthetist on call duty. The district / area hospitals should be made accountable for their role as the first referral hospitals. Presently, referral hospitals do not give any feedback and do not maintain any liaison with the

[3] In 1996 Govt. of AP proposed to upgrade 450 PHCs as Women Health Care Centers (WHCCs) with specialist services in gynecology and pediatrics (GO Rt. No. 494 dt.13/3/96). Efforts were made to improve equipment, facilities, staffing and supplies to these PHCs to offer round the clock obstetric service. Additional ANM posts were sanctioned in 2001 (GO Rt. No.338 dt.29/082001). Instructions were issued to organise three shifts duty of staff nurses by redeployment. These RPHCs have come to deliver comparatively better and more reliable services.

PHC staff. Participants suggested to strengthen the staffing pattern and activities of the round the clock PHCs so that they do not have to depend so much on the Area hospitals.

There was a dilemma about provision of in-patient services in the PHC. In-patient services requires sufficient nursing and paramedical staff not usually available in PHCs. On the other hand, PHCs can not afford to restrict their medical services to minor ailments and out patient service alone. There are quite a few day surgery procedures like, Medical Termination of Pregnancy (MTP), vasectomy, tubectomy, etc. that can be performed in the PHC with minimal addition to existing services. For example, the participating PHCMOs suggested during their group discussion, that every PHC should be a family planning service center[4]. The participants pointed out that MTP services are not very easily accessible in rural areas. The participants suggested that MTPs should be conducted free of cost at the government hospitals, because of this many people go for illegal abortions which leads to the death of the woman. The group noted that it is the leading cause of maternal deaths in rural areas. Therefore the participants suggested to have MTP facilities at each PHCs. It is very unfortunate that such an important service like MTP is not provided in PHCs. Some medical officer are taking help form the visiting gynecologists to do MTPs. Having consider all the above issues the consensus opinion among PHCMOs and panelists was that the PHC has three major roles to perform:

(a) Public Health Services

(b) Ambulatory Medical Care, and

(c) Day Surgery, such as MTP, Vasectomy, Tubectomy, etc.

Staffing of PHCs and Job definitions:

The participants expressed concern that the management has failed in deriving the maximum benefit from the presence of additional MOs in the PHCs. Even where more than one MOs were present, the role of each MO was not clearly defined. The issue of staffing and their role in PHC was discussed extensively in the panel discussion. The consensus was that there should be two MOs and a directly recruited Community Health Officer (CHO). The consensus among the group was that, the CHO should have a masters degree in Public Health from a reputed institution and could be made fully responsible for the implementation of various public health and national health programs. The two MOs should focus on curative services. In other words, the CHO would play the role of Program Implementation Officer at PHC. This way, the CHO can take away a lot of the MO's burden of the day-to-day supervision of RCH and other community health activities. The MOs can attend to outbreaks of epidemics and do weekly community visits. The participants also suggested that the two MOs should attend to the OP and the night duty alternately each week. The responsibility of field visits should also be divided amongst the two MOs. In all, the group expressed a need to review the existing staff and recruiting a community health officer per PHC directly. To some extent this arrangement can take care of the problem of non-availability of the health care professionals in PHCs.

[4] In PHCs where there are facilities for conducting vasectomy and tubectomy operations are also called Family Planning Service Center or Sterilisation Service Centers. At present, 793 out of 1336 PHCs conduct sterilisation operations.

Non - Availability of Health Care Professionals (HCPs):

The issue of non-availability of health care professional was also discussed in detail among a group of the PHCMOs who specially focused on this issue. The matter also received a good deal of attention during the course of the panel discussion. To improve availability of HCPs in PHC and at the sub centers, the participants recommended that, as far as possible recruitment for ANMs should be conducted locally i.e. at least at division level. Sub center buildings should have inbuilt quarters with some basic facilities, like water supply, electricity, etc. The target population per sub center should be reduced to 2000-3000 in plain areas and 1000 - 1500 in tribal areas.

At the PHC levels, the group recommended increase in number of medical officers to do duty in shifts. The group suggested increase in the number of paramedical staff and reduction in the number of meetings to be attended by medical officers at mandal and district level. The medical officers suggested a systematic and transparent recruitment, transfer and posting policies to be adopted by the department. The participants remarked that many of the HCPs preferred posting at district Hqrs because of their children's education. All the participants agreed that children's education is the key determining factor for MOs to stay at their Hqrs. Therefore, the participants asked for good residential schools at division level and some quota of seats to be reserved for the children of government employees working in rural and remote areas. The standard of education in high schools at mandal Hqrs should be improved.

Another issue requiring urgent attention is about the role of supervisory paramedical and allied health personnel in the PHCs. For example the PHCMOs were unanimously of the opinion that many persons at this level are underutilised. Their job chart is not clear. These positions are viewed as promotion opportunities, without much attention to their relevance for the PHC's service functions. Many of them are not equipped with required skills. PHCMOs felt that there is a scope for rationalisation of these positions and some redeployment of posts to more desirable functionaries. A comprehensive study to understand the structure of human resources required in the PHC may be required. This should include the paramedical personnel, the middle level persons, the staffing pattern, the essential qualifications of the staff, and recruitment and transfer procedures, etc. The study would help in understanding the mismatch between the skills and the roles of the staff and middle level supervisors in PHCs.

The participants criticized poor management by middle and senior level officers such as the DMHOs, Program Officers. Taking up an example they said, in some districts where the DMHOs have enforced Rs.1000 rural allowance, the Program Officers are issuing certificates even to those MOs who were not staying at the PHC HQ. This has de-motivated many sincere and committed MOs serving at the PHCs.

Strengthening the ANM / Sub center network:

ANMs are expected to play a role in, (a) Family planning (b) Child care (c) Mother care, and (d) National health programs. Presently, she is not able to play her role in any of these areas effectively. The participants shared their concerns and suggested ways to improve her work output. Every one confirmed that the ANMs are overburdened with work. They have a lot of area/population to be covered, which is difficult for her to do alone. While she is able to visit some villages, some others would remain unattended. If her jurisdiction is reduced, then the possibility of her availability to cover all villages will be more. All the participants suggested that, the population coverage for ANM should be reduced to between

2000 and 3000 in plain areas. The sub center area should as far as possible be coterminous with a gram panchayat area or a part of it in case of big panchayats. ANMs should concentrate only on RCH services. She should be allowed to focus on reproductive and child health programs. Male workers should look after the preventive aspects such as, sanitation, water source inspection, etc.

Discussing about the role of sub centers all the participants were of the opinion that the population coverage of a sub center should not be more than 3000. One ANM should be made in-charge for each sub center. The sub center should be located within an existing neighborhood and should be easily accessible to the population with clearly defined geographic area. All the participants said that emphasis should be on early detection and registration of ANC cases, which would help identification of high risk pregnancy cases and timely referral to PHC. Minimum of three ante-natal check ups should be made compulsory.

The participants recommended to avoid the frequent changes in the job chart of ANMs, which at present tend to confuse and disrupt their regular work. The participants also suggested that, overlapping programs, too many meetings, repeated reports should be avoided. Maintaining too many registers and repetition of reports should be curtailed. Instead, a simple and precise reporting system should be followed.

As far as assistant to the ANM is concerned, every one felt that, ANM should be provided with an assistant. The assistant (community health volunteer - male/female) should be 10th pass and help ANM in reporting of health related events in the village and implementing health programs. The participants also expressed a need of trained Dayas in villages, not for conducting deliveries, but to assist ANM during delivery. Daya can be given some incentives. The Daya and similarly male health volunteers chosen from habitations can be paid some honorarium, as in case of the community health worker scheme in Tribal Areas. These volunteers will be expected to report health related events to the concerned ANM and PHCMO. S/he should assist the ANM in organising and delivering health care at the Gram Panchayat level. Construction and maintenance of sub center buildings was an important concern. Many ANMs found it difficult to get rented accommodation in villages. Those, who found rented space, have to put up with a lot of conditions, that are not compatible with their role. For example house owners would not like the ANM to operate ANC or out patient services from their space. Hence construction of sub center buildings was identified as an important infrastructure, by the ANMs. This view was supported by most of the PHCMOs.

Arrangements for minor repairs of sub centre and PHC building should be done at PHC level. Similarly, maintenance of the buildings should be done on a regular basis. The participants pointed out the need to sort out the confusion at the state level, as to, who is responsible for the building maintenance. In few districts it is believed that Panchayati Raj Engineering is responsible for the maintenance, some thought it is R&B's responsibility and few understand that the buildings should be maintained by Andhra Pradesh Health, Medical Housing and Infrastructural Development Corporation (APHMHIDC). Participants suggested that, norms for maintenance of health care institution buildings should be followed while allocating funds for maintenance of the SC and PHC buildings.

Role of MPHA(M):

Discussing about the role of male health workers, the participants agreed that their role is not clear to any one in the system. The participants suggested that there should be one male

worker for every 10000-15000 population and should be primarily responsible for all the activities related to prevention and health promotion. Presently, the MPHA(M) are posted at sub centers. But they are not available at the sub centers most of the time. Although, their job is to be present and help ANMs in conducting ANC camps, they do not attend the camps. ANMs have to carry all the required material on their own and conduct the ANC camps. The participants recommended that the male worker should be working under the supervision of medical officers and should be based in PHCs Hqrs.

Most of the participants suggested that, except in agency areas and malaria endemic areas, MPHA (M) posts should be redeployed and filled up by ANMs. The posts released on account of reorganizing could be used to increase the number of ANM sub centers and there by reduce their population coverage. Some suggested that the supervisor's post is not necessary in PHC. In their place, one PHN and three ANMs should be posted.

Continuing Education:

All the participants expressed the need for training of PHC medical officers. Doctors are not able to manage all cases like obstructed labour, etc. A refresher's training for developing skills in obstetric care and pediatrics should be given to the medical officers to reduce MMR. It came up very evidently in the ANM's group discussion that, medical officers lack skills in conducting MTP. The PHCMOs also agreed with this and asked for training to be organised for MTP. The participants, later learnt that, for the past four months, such training programs are already being organised for PHC medical officers. Two MOs are trained in each batch in conducting MTPs. These training is being provided at 10 different centers located all over AP. But the pace and turnover of existing training arrangement is quite inadequate.

A group of participants prepared contents for a manual on ANM's practice guidelines for common reproductive morbidities. The CSSM manual has covered ANC chapter in detail. The proposed guide will add material on gynecological and obstetrics problems such as differential diagnosis and treatment of vaginal discharge, burning micturition, menstrual disorders like primary and secondary amenorrhoea, irregular menstruation, STD, etc. The group also suggested guidelines for Ante natal checkups and it's importance.

The participants suggested that it would be better, if lab technicians are given training for screening HIV patients. In every PHCs, the lab technician should screen all the STD cases and suspected cases of HIV at-least once in a month.

The participants recommended that the CHWs play a major role in tribal areas and therefore should be trained in managing minor illness. The PHCMOs recognised the importance of CHWs in collecting blood smear for malaria, family planning programs - conduct counseling in tribal languages, etc and expressed the need to develop their skills in these areas.

Balancing allocation between human and material resources:

The ANM as well as the PHCMOs identified that lack of proper equipment, drugs and supplies is a major bottleneck in delivering RCH services. Most of the sub centers do not even have sufficient stationery, BP apparatus, needles and hand gloves. In some places ANMs are buying registers, records and needles with their own money. The PHCMOs complained

that the quality and quantity of supplied drugs is not adequate. Some of the participants mentioned that if they do not have medicines even for minor illnesses they feel embarrassed and loose confidence of villagers. Looking at it from the 'Basic Package of Service' point of view, balancing allocation between human and material resources is important.

Recognising the above mentioned problems an expert group of PHCMOs was constituted to prepare the standard list of equipment, drugs and supplies for sub centers. The group discussed and presented a standard list of essential equipment drugs and requisites. In nutshell, the group suggested 14 essential and 4 desirable equipment for conducting ANC clinics. Similarly, a list of 28 essential and eight desirable drugs at sub centers was also prepared. Injections like Decadron and Avil are considered to be the life saving drugs and must be available at sub centers. The group also recommended a list of nine essential supplies and three desirable items for sub centers. The recommended supplies include; disposable needles, surgical gloves, plasters, etc. The participants recommended that there should be a separate quota of medicines for sub-centers and PHC. They asked for an adequate supply of disposable needles and syringes at the sub center level. The group suggested that the supply should be regular so that ANMs do not have to buy medicines from their pocket. The ANMs also complained and the PHCMOs agreed with them on the irregular supply of disposable syringes, needles, gloves, and disposable deliver kits. The UIP vaccine should be supplied in a small doses to avoid wastage.

Budget for petrol oil and lubricant (POL) should be released in time. Apart from regular pay and fixed tour allowance (FTA) other allowances for ANMs should be paid through demand draft (DD). Some amount has been allotted as contingency. Many of the participants confirmed that they receive the amount quite regularly from their DMHOs. Many participants complained that the money is not sufficient especially if it is a round the clock PHC, because they have to buy medicines with this money also.

Streamlining implementation of health programs:

Inefficient management, poor coordination, distorted objectives and/or ritualistic implementation of programs was pointed out by the PHCMOs and ANMs. Following are some examples cited by the participants.

1. Inefficient management:
   i. During Janmabhoomi program, medical camps are organised but are not effective due to lack of space and privacy. The participants suggested that these camps should be organised separately and not as a part of Janmabhoomi. The medical officers can attend to the ANC clinics and identify the high risk pregnancies.
   ii. Currently disbursement of money requires a certification of income by MRO, along with a white card. The delivery takes place in the PHC. The women do not get money on time because of the unavailability of required documents. The ANMs and the PHCMOs recommended that if the budget is released on a monthly basis and the authority of certification is given to the PHCMOs the money can be disbursed immediately.
   iii. Supply of Disposable Delivery Kits (DDKs) should be made regular and vaccines supplied for Universal Immunisation Program (UIP) should be supplied in small doses to avoid wastage.
2. Poor coordination:
   i. The quota of drugs is inadequate. In addition the supply of existing quota is erratic. Allotted drugs are not supplied in one lot. The PHC pharmacist has to make many trips to get the full quota of drugs. The PHCMOs complained that drugs lay at the DM&HO

office till someone from the PHC collects their quota of medicines. This is the reason drugs are supplied just when the expiry date is approaching.

ii. The ANMs complained that they did not get kerosene amount for the past three to four years. They have to do four to five immunisation sessions per month for which they need to sterilize the needles. The officials at DMHO office say that the money has been disbursed already to MOs. The MOs will sometimes not receive the money. Even if they receive they ask for vouchers and delay the matter. Most of the times ANMs end up using their own gas cylinder for sterilisation.

3. Distorted objectives
   i. The purpose of National Maternity Benefit Scheme (NMBS) is to provide Rs. 500 to pregnant women to have supplementary nutritious food. The participants pointed out that the woman is registered but the money is given only after the delivery is performed. The family planning incentive of Rs.500 is also added to the NMBS money. The total money of Rs.1000 is given only when the women agrees to opt for the family planning operation. This way the family planing targets are being achieved but the purpose of the NMBS is lost.
   ii. Age certificates are viewed as a ritualistic requirement rather than a means of notifying people to follow the legal age of marriage. ANMs in their group discussion raised an issue of false birth certificate to get young girls married at an early age (i.e. 14-15 years to 18-20 years). The Sarpanches and VAO manipulate the age certificates to get votes from them.
4. Ritualistic implementation of programs
   i. The PHCMOs pointed out that they have to implement all types of health programs whether the problem exist or not. Programs like Filaria, Malaria, GE, etc. have to be implemented irrespective of the disease pattern in the area.

Summary & Conclusions:

This qualitative study of Reproductive and Child Health (RCH) program in Andhra Pradesh sought to identify its strengths, weaknesses and gain insights for future action. Twenty “ideal typical” Primary Health Centre Medical (PHCMOs) officers were randomly selected from a list of 110 “ideal typical” PHCMOs nominated by the District Medical & Health Officers (DMHOs). Experience, perceptions and insights of PHCMOs about RCH program implementation was sought through focus group discussions (FGDs), group discussions, and a consensus development process. Quite a few public health insights emerged out of this consultation.

All the PHC Medical Officers felt that education in general and health education in particular is a key input to improve the Reproductive and Child Health (RCH) status. The need for creating awareness on the issue of early age at marriage and its adverse effects on health was highlighted.

Structural changes in the public health care delivery system is required to improve impact of RCH programs. Significant among these are ; (a) clarification and redefinition of the role of PHC, (b) Reduction in population coverage by sub centres, (c) comprehensive review of sub center locations to improve their accessibility, (d) redefinition of MPHA-Male role and their redeployment, (e) continuing education of health care professionals at all levels, (f) improved logistics, and (g) induction or development of managerial skills for program implementation.

Role of PHC should be clearly defined. The participants recommended that the PHC should perform three major roles, namely, (a) public health service, (b) ambulatory medical care and (c) day surgeries. To improve availability of Health care professionals (HCPs) at sub centers, the participants recommended local recruitment of Auxiliary Nurse Midwifes (ANMs). The PHCMOs suggested to reduce the population coverage of a sub center to around 3000 from present 5000. Accessibility of sub centers locations need to improve for better health service delivery. Redeployment and redefining the Multipurpose Health Assistant- Male (MPHA-M) role is recommended.

All the participants expressed need for conducting refresher's training for PHCMOs, ANMs and lab technicians. Irregular and inadequate supply of drugs, equipment and stationary is affecting the health care services. Poor managerial skills at various levels was identified as a major problem in implementing the program.

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Acknowledgments

Funding for this study was provided by the Government of Andhra Pradesh - Commissioner Family Welfare. We are grateful to each one of the Medical Officers who have actively participated in the discussions and helped us with their experiences and insights. We thank the DMHOs who nominated the Medical Officers. We thank our colleagues Ms. Mary Nancy and Ms. Neelima for their support in conducting the Medical Officers workshop. We would also like to thank Ms. Neelam Sawhney, Commissioner Family Welfare for her support and sustained interest in conduct of these workshop.

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