CHAPTER 5
IMPLEMENTATION OF THE REPRODUCTIVE AND CHILD HEALTH APPROACH IN TAMIL NADU

In this chapter, we discuss the implementation of the Reproductive and Child Health approach in Tamil Nadu. As discussed, the RCH programme is qualitatively different from the earlier programmes. In this approach, targets for health workers are no longer prescribed by the central government and passed down the hierarchy but are determined by the workers themselves based on a community needs assessment (CNA) exercise. By shifting more explicitly to identified client needs and involving the community, better quality of services is expected to be offered. The shift to the RCH approach also involves expanding the package of services offered in the programme from the earlier emphasis on family planning.

We first examine the implementation of the community needs assessment approach in Tamil Nadu followed by the expanded service package being offered in the health facilities in rural areas of Tamil Nadu. We describe the quality of services being offered in government programme based on an expanded quality of care framework developed by PAHO and FHI (Finger and Hardee, 1993).

5.1 IMPLEMENTATION OF THE COMMUNITY NEEDS ASSESSMENT APPROACH

The method specific targets were introduced in the mid-1960's after the United Nations Advisory Mission to India recommended "a reinforced programme" and considered the birth rate target of 25 per 1000 to be achievable by 1973. In order to achieve these objectives, the approach of the program was changed during 1966-67 and the program was made "time bound" and "target oriented". Annual targets were fixed for the number of acceptors for different methods of contraception. The responsibility of achieving targets set by the central government – on the basis of the desired decline in birth rate – was in turn passed on to successive lower administrative units such as states, districts, primary health centres and sub-centres. In effect, health workers were assigned quotas to be achieved in order to realize the goal of lowering the birth rate and reducing the rate of population growth.
The target based approach was adopted as it was considered an effective tool to intensify the level of effort of the programme, assess that the programme was moving in the desired direction and place pressure on the workers to increase the couple protection rate. For over 30 years, targets was stressed as it was quantitative, easy to monitor and expected to have a direct link with fertility decline. However, it was found that the decline in fertility was lower than what was expected of the increase in contraceptive use. This was mainly due to the acceptance of family planning by older and higher parity couples, poor promotion of spacing methods to younger and lower parity couples and inflated target achievements reported by the workers (Jain, 1997; Khan and Cernada, 1996; Srinivasan, 1995; Visaria and Visaria, 1995). It was also observed that in the zeal to achieve targets, inadequate attention was given to the quality of family planning services. Health workers often inflated the number of clients motivated by them especially those using spacing methods as it was difficult to verify the cases. The poor association between fertility decline and the increase in contraceptive prevalence rates was partly attributed to this factor. The programme was characterized by poor counseling, lack of informed choice and poor follow up service for family planning acceptors.

The pressure to achieve targets was also resented by the health workers. In the target oriented approach, they were always involved in motivating family planning clients and neglected follow-up care and other services. For those workers who could not achieve their targets their salaries were withheld. An extreme situation was that of workers being suspended for not motivating the prescribed number of family planning clients.

The pressure of recruiting enough cases was so high that health workers had to spend their own money on clients so as to safeguard their jobs. A SHN in Dharmapuri district aged 52 years reported:

"When I joined service 15 years back, my economic situation was very bad. My husband is a farmer and his income is not stable. My family depended on my income for sustenance. But we had to spend several hundred rupees on getting sterilization cases from agents. That period was a nightmare. I had to even recruit my brother's wife and motivated my relatives to fulfill targets"

Sometimes, the situation was so desperate that spouses volunteered to be sterilized. A VHN in Kancheepuram district mentioned that:
"I have undergone sterilization operation. During the year end, I used to be so hassled about not getting enough cases that, my husband offered to get sterilized if I wanted cases."

During the period of targets, other departments like revenue and education were also involved in motivating clients. These officials had considerable authority and influence in the village community as they could, for example, sanction loans, issue caste, income and other kind of certificates. Hence, the villagers feared the wrath of these officials and there was a certain element of coerciveness. These officials also could offer consumer goods – such as pressure cookers, table fans and saris – as additional incentives. This also led to resentment of the health workers as they could not offer monetary incentives like the revenue department personnel could. The coerciveness adopted by the other departments also made the health workers job in the village community more difficult.

VHN's also had to go beyond their service area to recruit cases as the sterilization acceptors in their area have been lured by someone else or there were not enough clients in their area. Stealing, brokering and trading cases was a common practice (Murthy et al., 2002). A VHN in Kancheepuram district reported:

"Once I motivated a client and accompanied her to the hospital and got her admitted. I had just left her alone for a couple of hours when someone else in the hospital claimed her to be his case and took the certificate. All my efforts and money spend was in vain."

Following the persistent efforts by health activists, women's groups which culminated in the recommendations of the ICPD, Cairo, Program of Action, the government of India withdrew method specific targets in order to improve the functioning of the family welfare programme and make it more need-based and client oriented.

Tamil Nadu had been experimenting with the target free approach before it was under consideration at the national level. In 1991-92, the Government of Tamil Nadu withdrew targets for non-health staff in Periyar and Dindigul districts. After a year it was clear that the health staff worked better without competition from other departments. Family planning targets were abolished for non-health staff throughout the state in November 1992. While the debate continued at the national level in June 1994, Tamil Nadu began to reorient the target system to the MCH approach. Family planning targets for health workers were based on the current birth rate of the district, rather than the uniform norm.
At the national level in September 1995, the Government of India abolished targets on an experimental basis in two districts from every state and the entire states of Tamil Nadu and Kerala. These two states became the first target free states as they were already at or near the replacement level of fertility.

The new approach envisage decentralized planning at the sub-centre level, in consultation with the community, to determine annual workloads based on local needs. By shifting more explicitly to identified client needs and involving the community, the government hoped to stimulate better quality services. Expected levels of achievement (ELA), instead of targets, were now to be set by workers at the grassroots level in response to community needs.

Our interest is to examine the changes that have been incorporated in the program after the change in approach and how these changes are being implemented in the field in Tamil Nadu. Our survey has revealed that targets for family planning are no longer prescribed to the field workers but are determined by the field workers themselves based on the birth rates in their service area. The annual work load of the health workers for family planning is based on the birth-order distribution observed the year before. All women who delivered and had three or more children, and 50 per cent of those with two children were assumed to need sterilization. The remaining were assumed to need spacing methods. The workload for other services like immunization, antenatal and postnatal care are similarly determined by the workers based on the number of children and the number of pregnancies in the health workers' service area. The plans are prepared in the month of March and the plan is implemented from April 1 to March 31 of the next year. These health workers have been preparing these plans since the year 1999. These annual action plans prepared at the sub-centre level are then aggregated to form the PHC action plans which in turn form the inputs for the district plans.

In some PHC's the VHN's initially reported that targets for family planning still exist. However, further probing with the medical officers and the statisticians at the block level PHC revealed that the computations are being done by the statisticians and handed to them as the VHN's are not perceived to be competent enough to undertake this exercise.
There is a tendency on the part of the statisticians to inflate the target by 20-25 per cent, so that there is no slackness on the part of the VHN's. One BEE explained that

"Based on the birth rate and population of this area, the sterilization for each VHN works out to be 2.5 – 3 sterilizations every month. To ensure that there is no slackness, the target is set at 4 sterilizations a month. This ensures that the VHN's achieve at least 3. If we set the target as 3, then they will achieve 2."

The CNA manual of the Govt. of India suggests that a household survey to compile the relevant information on determining the service requirements of the area. Also, since such surveys have a high margin of error, the workers should also have detailed discussions with the anganwadi workers, members of the Mahila Swasthya Sanghs and local panchayat members to estimate the felt need for the different needs she provides to the local community. The field survey suggests that the process of decentralized planning is quite different from the one suggested by the Government of India in the CNA manual. The calculations of the targets are based on the birth rates and order of the area and not based on a household survey. Also, the qualitative aspect of assessing the needs of community through a consultative process with important members of the village community is not adhered to. Though some VHN's may be doing it by their own interest and sincerity, it is not formalized and incorporated in the planning process. For instance, there is latent demand for spacing methods and for treatment of white discharge among the community. This is not properly reflected and articulated in the annual plans.

When targets prescribed by them are not met for a particular month, the VHN's have to explain to the medical officers as to why they have not been able to recruit the number of cases. For instance, during the harvesting season women are busy working in the fields and are not willing to undergo the procedure. Those VHN's who are allotted service areas where a sizeable Muslim population resides also face problem of recruiting enough sterilization cases. For not achieving targets at the first instance, they are given verbal warnings by the medical officers during the review meetings. The VHN's give an assurance that they will recruit enough cases in the subsequent months and achieve the target by the year end. In case, the achievement of sterilization cases is less than 70 per cent of the target for the year, the VHN is issued a written memo by the Deputy Director of Public Health instructing the health workers to explain the reason for not achieving the target. Even after this step, the targets are not achieved, then the health
workers lose the increment in their pay. None of the VHN’s interviewed by us had faced this situation. They had somehow managed to recruit enough cases.

The medical officers report that though a written memo is issued no action has been taken against the VHN’s who have not achieved the targets. The purpose of the memo is to keep the VHN’s on the toes and give some recognition to the VHN’s who have achieved their targets. One doctor explained:

“`The VHN’s are the backbone of the health system. They are involved in a multitude of activities and not just family welfare. They might not be getting enough cases for reasons beyond their control - like poor socio-economic development of people. In this case, we cannot penalize the poor VHN. If we do that, then she will get demotivated and all work will suffer’”

In PHC’s in relatively developed areas, it was observed that clients are motivated to use contraception on their own and hence there was no dearth of sterilization cases. Earlier, VHN’s had to motivate the clients with great difficulty and accompany them to hospitals for the sterilization procedure. Now, the clients are themselves motivated to use family planning and avail of the facilities in hospitals themselves. The VHN’s work got reduced to recording the women who had undergone sterilization and submit it to their superiors.

However, in the backward areas where physical and socio-economic conditions are unfavorable, a different picture emerges. For instance the Nachikuppam PHC is located in a hilly, forested area in Dharmapuri district and covers villages which are located as far as 45 kms from where the PHC is located. The VHN’s reported that unlike the plain area, the people in their area are still very traditional and do not want to adopt any method of family planning. The physical conditions and the poor transport connectivity severely restricts their mobility and their interaction with the community is not as frequent as in plain areas. As a result, they are not able to recruit the number of family planning cases they have set for themselves.

Thus, it can be concluded that the system of targets for family planning is very much in place. However, the increase in the desire to have smaller families and the lessened severity of punishment for not achieving the targets have made things simpler for the VHN’s.

In these annual plans, the VHN’s set the targets for early registration of every pregnancy, prenatal care, institutional deliveries, immunization of infants and children, providing
information and counseling and services for contraception. In one PHC in Kancheepuram district, the VHN’s reported that there is a strict target of achieving 100 percent institutional delivery, none of the VHN’s in Dharmapuri district referred to this type of target. Most of the VHN’s reported that the supervisors closely follow family planning achievement while other services get only little attention. A senior SHN offered a different opinion said that

"Since the other services like ANC registration, PNC etc are easy to achieve and coverage is nearly universal. Hence, these do not receive that much attention in the review meetings. It is only for family planning that there are some gaps between the actual performance and targets. Hence, most of the discussion is on this. This gives an impression that family planning gets more importance. This is not so"

The above discussion has revealed that targets for family planning are no longer prescribed to health workers. Health workers determine the workloads for a comprehensive range of reproductive and child health services based on the birth rate, birth order and population in their service areas. We observed that in some PHC’s, the block health statisticians and other supervisors compute the workloads and pass it on to the health workers as workers are not perceived to be competent in this task. Though the CNA Manual prepared by the Ministry of Health and Family Welfare suggests that the needs of the community should be assessed through a qualitative exercise of consultation with panchayat members, members of self-help group and mahila swastya sanghs, it was observed in our field work that this component is missing from the procedure adopted in Tamil Nadu. The procedure of determining workloads is thus, merely a quantitative exercise in Tamil Nadu.

The health workers reported that in the target free approach they are able to deliver other MCH services and offer better quality of care as they were not under constant pressure to recruit sterilization cases. It was noted that supervisors still emphasize on sterilization and there is little stress on spacing and male methods. The number of clients recruited for sterilization are monitored closely by supervisors and any gap between actual and planned performance is severely dealt with. However, in Tamil Nadu where there is a universal desire to control fertility, this situation does not generally arise except in some backward areas like in some pockets of Dharmapuri district. In such cases, health workers are reprimanded in review meetings and warning memos are issued against them. Thus, the mindset developed during decades of target oriented approach still continues and importance is still accorded to family planning, particularly sterilization.
The health department in Tamil Nadu has always laid stress on increasing the coverage of MCH services, even before the RCH programme was launched nationwide and this continues under the new RCH approach. The programme in Tamil Nadu has also introduced certain new services as part of the RCH programme. We now discuss, the provision of these services in the health facilities of Tamil Nadu.

5.2 IMPROVED SERVICE COVERAGE

Implementation of the reproductive health approach requires expansion of the service package offered by the programme. This includes a broader range of safe and effective contraceptive methods as well as incorporating reproductive health services which are not yet available like the management of reproductive tract infections (RTIs), services that address the special reproductive health needs of adolescents and those that recognize the special needs for men. India took an important step in shifting the family welfare programme further toward the reproductive health approach when it initiated the CSSM programme in August 1992. The goals of the programme were to improve the health status of women and children and to reduce maternal, infant and child mortality.

Though good progress was evident in the child survival component of the programme, the progress with the safe motherhood component has been slow. The RCH programme aims to build up on the achievements of the CSSM programme and incorporates two additional components, one relating to sexually transmitted diseases (STDs) and those relating to RTIs. The package of services offered under the RCH programme with respect to maternal health is as follows: antenatal care and early identification of maternal complications, delivery by trained personnel, promotion of institutional deliveries, management of obstetric emergencies, management of RTIs and STDs, improved access to safe abortion services, special services for adolescents and men and promotion of birth spacing methods. In the section which follows, we examine the status of the provision of each of these service in the rural health facilities in Tamil Nadu.

5.2.1 Antenatal Care

Antenatal care (ANC) is the pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home. Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat preexisting and concurrent problems of pregnancy, and provide advice and counselling on preventive care, diet
during pregnancy, delivery care, postnatal care, and related issues. The Reproductive and Child Health Programme recommends that as part of antenatal care, women receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid tablets or syrup to prevent and treat anaemia, and at least three antenatal check-ups that include blood pressure checks and other procedures to detect pregnancy complications (Ministry of Health and Family Welfare, 1997; 1998).

The present study has revealed that the coverage of antenatal services is nearly universal in the study area. The visits of a VHN to a village ensures that a pregnant women is visited three times by the health worker during the course of her pregnancy. The adequate provision of IFA and tetanus toxoid injections also translates into the universal provision of such care to pregnant women. It was also noticed that VHN's provide counseling about the care to be taken during pregnancy and diet to be taken. The signs of risky pregnancies are identified and if found to be in a risk category, are advised to go in for institutional delivery. However, the lack of equipment and other logistics problems prevents the health workers from measuring weights, blood pressure and performing other tests which make the antenatal care effective. In such cases, the women are advised to go to the PHC or other health institutions to get the tests done. Only a small fraction of the women take the pains to go for tests and antenatal checkups.

In a FGD in Dharmapuri district, a mother of a one child mentioned:

"The sister gives us tablets and injections during pregnancy. She also asks us to take green vegetables. She asks us to come to PHC for tests. We generally do not go there because we have to travel for a long time and wait in the PHC. We cannot afford to lose our wages. We go to the doctor only if there is an emergency and not for small things"

A high school educated woman in Kancheepuram district who had visited a PHC for antenatal checkup complained for the superficial and hasty examination done:

"In the PHC, the nurse checks weight and blood pressure. The doctor does not examine us as they do in private clinics. It is better to go to private doctors even if they charge money"

Availability of proper equipment will enable VHN's to offer better services. Basic services can be offered at the door step of the clients and clients need to go to the health centres only for complicated problems.

A VHN in Dharmapuri district reported:

"We would like to offer better services if we are provided with better facilities. It can save the patients a lot of trouble as well"
5.2.2 Promotion of Safe Deliveries

It is well established that giving birth in a medical institution under the care and supervision of trained health-care providers reduces the risk of maternal and infant mortality. Prompt medical attention is possible for those women and new borns who would have otherwise developed serious complications resulting in their death. An important thrust of the Reproductive and Child Health Programme is to encourage deliveries under proper hygienic conditions under the supervision of trained health professionals. The present study in Tamil Nadu has revealed that while most of the deliveries in Dharmapuri district are home based attended to by traditional birth attendants, a greater proportion of deliveries in Kancheepuram district take place in institutions.

A significant reason for the higher proportion of institutional deliveries in Kancheepuram district is the prevalence of strict targets for institutional delivery. The health workers of one PHC of Kancheepuram mentioned that targets for achieving 100 per cent institutional delivery are closely monitored by their supervisors in their district. While on their field visits, health workers counsel women about the importance of delivering in institutions and also about the procedures to follow when labour pains start. However, none of the VHN's in Dharmapuri district seemed to stress on the institutional deliveries to the clients. An important reason for this difference in Kancheepuram and Dharmapuri districts is the quality of supervision. During our fieldwork, we observed that supervisors do not emphasis institutional deliveries to the VHN's in Dharmapuri district. VHN's, we observed, in turn did not emphasize the importance about institutional deliveries to the clients.

In Kancheepuram district, in better interaction of the pregnant women with the health system enables the women to approximately suggest the date of delivery. The advantage of suggesting the approximate date of delivery to the pregnant women is that women visit the hospital in an event they do not have labour pains around the expected date of delivery. There is a perception that in hospitals injections are given to induce labour pains and make the process of child birth easier. Some of the younger women also do not feel confident about delivering at home in the absence of professional help. Some women also do not have elders in the family who can assist them during delivery. These reasons
encourage and contribute to utilization of institutional care for delivery. Higher literacy among women and improved transport connectivity in Kancheepuram district results in higher utilization of institutional care for delivery in Kancheepuram district.

This does not mean that all deliveries in Kancheepuram district are being conducted in health institutions. We have come across pregnant women who have sought the help of a dai even though a health facility was accessible to them. In such cases, we found that the dais who are trusted more than the unknown attendants in the hospital. The dais were considered reliable because the villagers know that the dais have been conducting deliveries routinely. While institutional delivery was preferred by women in Kancheepuram district, women from both the districts face numerous problems in using government health facilities for delivery. We now discuss the problems faced by women in utilizing public sector facilities for delivery.

Problems faced in utilizing government health services

As discussed, the lack of functional sub-centres makes the government health system physically inaccessible to most villages. Most of the VHN's stay in the nearby town and their interaction with the village community in Dharmapuri district is only about once a month. The health workers are not reachable when a woman has labour pains, especially when she has pains during odd hours. Most PHC's function for only a few hours a day and the services of doctors and health workers are not available for the rest of the day and especially during odd hours at night.

Though all Primary Health Centres in the study operate from government buildings and are well equipped they are open for only a few hours a day in the morning. The PHC remains locked for most of the day. One women said: *Are we expected to deliver only when the doctor is there in the PHC!* It is not surprising that some PHC's conducted only 12 deliveries in the year 2001, thus averaging 1 delivery a month.

The doctors in the PHC's are also seen as incompetent and not trustworthy. One woman narrated the following incident:

"A woman from our neighbouring village went to the doctor in the PHC with labour pains. The doctor examined her and told her that it will take another 2-3 days for delivery and sent her back. She delivered twins some 200 meters outside the PHC on the road side in full public view. The twins died immediately after birth. What kind of a MBBS doctor is he who cannot recognize labour pains. All the
villagers gathered and protested. What is the use? Things got back to "normal" and another similar incident happened again also.

Incidents such as these have made the villagers apprehensive about approaching the PHC for health services. They are willing to travel long distances and spend money and get the services of private or government hospitals rather than the PHC’s which is in the village itself. Women who have delivered at the PHC report of shabby treatment meted out to them and of money demanded by the staff. The rate for conducting a delivery in a PHC is Rs. 500. Women are also shouted at and sometimes hit by the attendants when they do not "behave properly". One woman recalled:

"When I was groaning in pain during labour, the sister asked me to shut up. I was having severe pain and called for the sister. She slapped me and told that when I was enjoying with my husband, did I not anticipate such pain. I will never go there again for anything."

A more favorable picture emerges about the quality of services provided by PHC’s in Kancheepuram district. It is observed that there is a VHN is resident in many PHC’s and her services are available round the clock. In the villages where the PHC is located, most of the deliveries which take place in the PHC. Women also report that the environment in the PHC is more friendly than in a hospital. Relatives are allowed to be beside the patient to take care of her and bring home made food. In a hospital, relatives cannot accompany women to the ward and there is also some verbal and physical abuse of patients in such a setting. The money charged by the ANM in a PHC is also much lower than in a hospital. However, the utility of such PHC’s is limited to the PHC village.

The VHN’s justify charging money for delivery as they do not receive any equipment or supplies like gloves and cloth from the PHC. They have to purchase them from their own money. Also, since they perceive to be doing a “dirty” and difficult job they feel that it is not wrong to take money from clients. One VHN in Dharmapuri district opined -

"Even the patient’s mother would not have touched her in that state. I did all the cleaning and served her. Even it was a difficult delivery. Had she gone to a private hospital, they would have done a cesarian and given her a bill of Rs. 12,000. Even in GH, it would have cost them at least Rs. 1000."

It should be noted that PHC’s play a limited role in providing care for delivery in Tamil Nadu. Inspite of the large number of PHC’s and their wide geographical coverage, PHC’s account for only 5-6 per cent of rural deliveries (Athreya and Chunkath, 1999).
Only 52 per cent of the PHC’s in Tamil Nadu were conducting deliveries and the average number of deliveries conducted by all the PHC’s in TN per month averages 3.1. If we take only the PHC’s which are conducting deliveries, the average work out to only 6 deliveries a month in a PHC (4404 deliveries in November, 1999 and 1404 PHC’s total). This implies that the government taluq, district and teaching hospitals are catering to most of the demand. While these hospitals should be catering to the more complicated cases, these are burdened by the normal delivery cases which can be easily managed at the PHC level.

In this regard, it should be noted that the performance of the PHC’s in Kancheepuram district is better than in Dharmapuri district. Of the 7 PHC’s surveyed in each district 5 PHC’s in Kancheepuram district had an ANM residing in the PHC and conducting deliveries regularly while it was 2 in Dharmapuri district.

Most of the women in villages having neither a PHC nor a SC wanting institutional care go to the Government Hospital located at the taluq headquarters as it is perceived to have good facilities and open round the clock. The transport connectivity to the taluq headquarter is also better than to a PHC village. However, the treatment of patients in such facilities is also very poor in both the districts surveyed. It costs a woman upwards of Rs. 500 to have a delivery at the government hospital. The staff demand a tip for each service performed by them and non-payment results in shabby service and bad treatment. A woman who went for delivery told:

"There is a charge for everything. If you keep paying them, then they treat you properly. Otherwise they behave cruel like pricking the injection very painfully and removing the stitches as if they are removing it from a cloth. Even if they remove the stitches from a cloth like that, it will tear"

It is widely known that going to a government hospital involves considerable expenditure and if a woman does not have money with her, she would prefer delivering at home rather than approach a government hospital. A mother of a patient narrated the following incident:

I took my daughter to the Government Hospital for delivery. The sisters there asked for money. When I paid them Rs. 100 (she was very poor and this is a huge amount by her standards), she threw the money on my face and told that unless I am able to organize Rs. 500, they won't allow my daughter and the baby to go. I came back to my village (20 kms away), pawned my jewellery and paid them and brought both of them back.
Similarly, another woman who had gone for delivery and also planned for post-partum sterilization recalled her experience:

"The sisters demanded money from my husband. He had only Rs. 50 with him that time and he offered it to them. They abused him in the most filthy language and told that I would not be allowed outside if he did not pay more money. He borrowed money from some friends paid them and brought me back home without the sterilization operation. My husband did not want to be further harasseed there"

There were other instances where clients motivated to undergo sterilization are not going to the hospitals because they do not have enough money. It is reported that patients spend more than the Rs. 135 which is given as compensation money for sterilization on tips. Moreover, this money is given much later after the clerk has his share of the money. Thus, unless a woman has enough money, they do not approach the hospitals for services.

Apart from the constant pestering for money at government hospitals, women who have availed of services speak of abysmal conditions there. A woman who had gone for a delivery and post-partum sterilization reported

"The toilets are in terrible state. The wards are also very dirty. There were no lights. My husband got a tubelight fitted near my bed when he saw me lying in the dark. Does the government not have enough money even to provide a tubelight in a place visited by hundreds of patients. Moreover, we are provided beds only on the day of the operation (tubectomy). After that we have to spend 4 - 5 days (the post-operative period) on the floor."

The behaviour and attitude of the staff of hospital towards patients is also very hostile. They are always scolding the patients and shouting at them making the environment very tense. A high school educated woman who had gone for delivery and post-partum sterilization to the hospital mentioned:

"The six days I spent in the hospital was a nightmare. The staff kept shouting apart from asking money for everything. If we had to spend so much money, I could have spent more in a private clinic and got better treatment"

Women in Dharmapuri district and in certain remote pockets of Kancheepuram district consider the process of child birth to be a very normal event and do not feel the need to seek professional assistance for it. The harassment and expenditure involved in hospitals
seems to strengthen this belief. The most typical answer to a question as why hospital services were not used for delivery is that "It was a normal delivery". The other typical response is: "Everything went on smoothly at home and I did not feel the need for going to a health centre or hospital". This attitude of rural women is illustrated by the comment of a scheduled caste woman:

> I went to a nearby town (4 kms away) carrying a sack of paddy to the mill and came back. I cooked a meal for a large gathering for the festival and mopped the floor of the house. I then delivered this child (in her arm). It was as simple as that. Why do we need to go to a hospital for that. I was back to work the next day.

Sugathan et al., 2001 report a similar finding about this "lay-health" culture. The field work conducted suggests that women have been conditioned to accept this "lay-health" culture as there is not much choice for them. Women who are to deliver would like to use the facilities of a health clinic but the monetary and other costs mentioned above are rather too high for persons who are at the bottom of the economic and social ladder. As these costs are high they consider the process of child birth as a normal, everyday event that does not require medical intervention. Added to these costs is the procedures that they are not familiar which are employed when women deliver. These two factors result in their rationalising pregnancy and delivery as normal events in a society. The experiences of women in general are used to offer justification for not visiting the government clinics that they are entitled to. Given the conditions and treatment meted out to patients at government health facilities and the belief among villagers that the process of child birth is a normal process not requiring any sophisticated assistance, an elderly health worker rationalized their behaviour:

> "A young girl would be more comfortable delivering at home in the presence of elders in the family and the dai who is familiar in the village and has conducted probably her grandmother's delivery also. In hospitals and health centres, family members are not allowed near the patient and she is terrified to be alone during the process. Also some procedures like enema is not liked by village women. This is apart from the harassment at hospitals and demands for money".

It should be noted that promotion of safe deliveries is the most basic of services even under the earlier MCH and the subsequent CSSM programme. However, the increase in the proportion of institutional deliveries is not as easy as achieving universal immunization. Increasing institutional deliveries requires that health facilities remain operational throughout the day and night and for 365 days a year. In vaccination a missed opportunity can be taken care of but in a complicated delivery lack of facilities would be
disastrous. It is important that in case of complication in a delivery help should be available without much loss of time. In case, facilities are not available for a complicated delivery a referral mechanism should be in place. The current strategy of fixed day clinic - once a month in each village will not increase institutional deliveries and the management of obstetric emergencies.

The successful provision of the expanded package of services and the orientation towards clients' needs is dependent on the successful provision of facilities for institutional deliveries. Once, the health system is able to provide universal institutional delivery by placing health facilities which are functional during most part of the day and have staff on call during emergencies and staff is courteous and have orientation for quality of care, the health system can then build upon these success and provide additional services.

We noticed in our field work that the proportion of institutional deliveries is higher in Kancheepuram district compared with Dharmapuri district. Higher literacy and better economic status stimulates women to access institutions for deliveries in Kancheepuram district. A higher proportion of sub-centres and PHC's with resident health workers in Kancheepuram district (discussed in detail in Chapter 6) facilitates the use of institutional services for child birth. Better transport facilities also increases mobility and the utilization of services. Moreover, VHN's also emphasize on institutional deliveries to their clients in Kancheepuram district unlike Dharmapuri district.

5.2.3 Postnatal Care
The health of a mother and her newborn child depends not only on the health care she receives during her pregnancy and delivery, but also on the care she and the infant receive during the first few weeks after delivery. Postpartum check-ups within two months after the delivery are particularly important for births that take place in noninstitutional settings. Recognizing the importance of postpartum check-ups, the Reproductive and Child Health Programme recommends three postpartum visits (Ministry of Health and Family Welfare, 1998). The Tamil Nadu government has issued guidelines of five postpartum visits at intervals of 1 day, 3 days, 7 days, 15 days and 30 days after delivery. The infrequent visits of the VHN to the villages does not permit her
to stick to this prescribed schedule. Nevertheless, postnatal care is offered during the field visits of the VHN.

5.2.4 Management of Obstetric Emergencies
Timely availability of emergency obstetric care prevents maternal mortality and morbidity. The complications of pregnancy such as anemia, hemorrhage, obstructed labour and sepsis are major causes of maternal mortality and morbidity. If these complications are detected early and managed appropriately maternal mortality and morbidity can be reduced substantially.

However, even if women with complications arrive at a health care facility, they may not receive the care they need quickly enough to save their lives. Health facilities in many less-developed countries including India do not have an efficient system to make sure that emergency cases are seen promptly. This is often due to the inability of facility staff to recognize obstetric emergencies. Shortages of skilled attendants at health care facilities mean that women receive substandard care at the moment when they most need high quality care. Health facilities often are not well equipped with sufficient supplies, emergency medicines, essential equipment, and blood required to ensure a safe delivery. Lack of medical protocols to guide health care providers and effective supervision also affect quality of care.

Under the RCH programme, FRU’s identified under the CSSM programme but not made fully operational are to be strengthened and made functional. This is to be done by appointment of contractual staff, provision of surgical interventions, blood transfusion and anesthesia and improved supply of drug and medicines.

As mentioned, the VHN’s identify high risk pregnancies during their field visits. The women are advised to go in for institutional delivery – either government hospital at the taluqa headquarter or private hospital depending on the resources available with the family. Whether the women are able to comprehend the seriousness of the problem and make arrangements to go to the hospital during labour is open to question. Most PHC’s do not have the facilities to handle these cases (anesthetist, operating theater, facilities for blood transfusion etc). Moreover, as PHC’s are operational only for a few hours a day, their ability in handling emergencies is further eroded. Unlike the PHC’s, taluq hospital
have adequate facilities to handle obstetric emergencies. Most villages have informal arrangements to transport patients to hospitals in emergencies even during odd hours.

5.2.5 Management of Reproductive Tract and Sexually Transmitted Infections.

Reproductive Tract and Sexually Transmitted Infections are a major health problem around the world. Community based studies (Brabin et al., 1998; Koeing et al., 1998; Wasserheit et al., 1989) have shown the high prevalence of RTI's and their grave consequences among women. The ICPD PoA and the spread of the rapid spread of the HIV / AIDS epidemic have emphasized the urgency to manage RTI's as part of the primary health care. An important component of the RCH programme is the control and management of RTIs. In this section, we analyze the efforts made by the government of Tamil Nadu to integrate the treatment of RTIs in the primary health care system.

In order to address the problem of RTI's, STD/ RTI clinics have been started and held once a week in 10 PHC's in Dharmapuri District and 15 PHC's in Kancheepuram district. In other PHC's, one day STD/RTI camps are held once a year on rotation basis at every sub-centre.

Clearly, the duration of the camps affects the provision of services and the camps have not been able to address the wide spread problem of RTI among women effectively. About 100 women avail of the services of a typical STD/RTI camps while about 20- 30 women attend a typical weekly STD/RTI clinic in a PHC. The prevalence rates of RTI's is high - 25.1 per cent of the currently married women in Kancheepuram district and 48.4 per cent in Dharmapuri district have symptoms of STI/RTI (IIPS, 2001). Many women do not avail of these services because of lack of knowledge of such camps and/or of the opportunity cost of seeking services.

A medical officer in charge of a PHC reported that the because of infrastructural and manpower constraints, only syndromic treatment of the problem is offered to patients instead of a complete treatment of the problem. Also in resource-poor settings, it is very difficult perform a clinical diagnosis. The additional load of the STD/RTI clinics is being handled by the existing staff. Counseling and follow-up services that is crucial for the
The medical officer of a PHC in Dharmapuri district where STI / RTI clinics are held stated:

"In treating STD cases, counseling is very important. Patients also need to be told about the importance of treating the spouse and asked to bring their partners. Because of the nature of the ailment and associated shyness, many people drop out of the treatment after getting some relief. Apart from my clinical treatment, counseling and follow up activities is important. As the staff is already burdened with existing responsibilities, this activity gets sidelined. Complete treatment is thus not provided."

The MO of the PHC mentioned that the patients start queuing up for the clinic about an hour prior to the start of the scheduled time. He felt that the time could be effectively used for counseling if there is some audio-visual equipment which can replace individual counseling to some extent. He had requested for such equipment with the district authorities but because of budgetary constraints, it was not sanctioned. There are also reports of shortages of specialized equipment like focusing lights, examination tables and consumables such as gloves and regents.

Because of budgetary constraints and that the drugs for RTI treatment are expensive, patients coming for the clinic are given treatment for only 2 weeks duration and asked to return for reexamination. However, many women drop out during the process. Follow up on patients who have visited the clinic to ensure that their infection is completely cured and also persuading the spouse to come forward for treatment is an important component of the treatment of RTI’s. However, this is not possible because of manpower shortages. The MO admitted that in such a situation where women drop out of treatment and their spouses are not treated resulted in a situation where the infection would resurface after a couple of months. He helplessly said that whatever treatment given to them at present is a waste. Because of this many doctors are disinterested in providing treatment to begin with.

VHN’s on their field visits also get numerous requests for medication for white discharge. As these medicines are expensive VHN’s do not carry them and are therefore unable to give them the required treatment. Even in some PHC, medicines are given for 2 days only whereas a minimum of 2 weeks treatment is required. So VHN’s recommend
their patients to go to a private practitioner instead of wasting time in the PHC. Such situations are rather anomalous. On the one hand, these workers work for the government health service. Since they understand the necessity of treatment in such cases, they are compelled to refer such cases to the private sector because of the inability to provide these services.

An efficient referral system is important for the effective treatment of serious cases of RTI's which cannot be handled at the PHC. However, the taluq and district level hospitals are not yet geared for this. According to one MO, he does not refer serious cases of STI to the hospitals because the patients will be turned out there also. Instead of wasting their time and putting them to further harassment, he gives them the best possible treatment in the PHC itself. He admits that this is sometimes not enough but is the best possible solution under the circumstances.

The STI clinics at the PHC’s are held on a day of the week after the out-patient hours. The clinic is generally between 11:30 a.m. to 1:30 p.m. We observed the functioning of one such clinic during our survey. On the day we earmarked for observing the STI clinic in Kaveripattinam PHC in Dharmapuri district, the lady doctor who is supposed to attend to female patients was deputed for some other assignment outside the PHC. Since women patients had come for the clinic, the male MO volunteered to attended to the female patients instead of sending them back and disappointing them. In the consultation room, men and women were lined up on either side of the table. The doctor was attending to the patient in turns. There was neither visual nor auditory privacy. It is very likely that patients would not be able to describe their problems in detail to a male doctor and presence of other people especially of the opposite sex (see also Bang and Bang, 1996). Such ad-hoc arrangements do not reduce the burden of STI/RTI in Tamil Nadu. This indicates to us the casualness adopted by the health centre in treating STI / RTI patients.

It was reported that very few men come for treatment in the STD camps and clinics. In the one year since the start of the STD clinic, nearly 1000 people have taken treatment in the PHC of which only 200 were men. In another STD camp held at a sub-centre, no man turned up for the camp while around 40 women received treatment. An explanation for the low male turnout according to the VHN’s is that the health inspectors do not
publicize the camp among the men. As men have a better status in the family and have more disposable money with them, they seek treatment from private providers. Another reason for the men not to attend the STI camps is that there is no privacy and men feel that they will be identified as having sex with other women and perhaps take treatment outside the local area. On the other hand, women are culturally conditioned to bear suffering especially in case of "shameful" diseases like STI / RTI's. The doctor explained that most of the women patients come for treatment at an advanced stage when the women have no other options other than to take treatment. Even after they come, the women do not reveal their difficulties and mention that they have lower abdominal pain. Only after probing, do they hesitantly explain the difficulties like white discharge and painful urination. In their study of gynecological disorders in Maharashtra, Bang and Bang (1996) reported that women with white discharge often say that they are having weakness. Inexperienced doctors generally fail to take the clue and prescribe vitamin tablets. Doctors need to understand the subtler meanings of the terms women use in the region. Sensitization of doctors and health workers in these subtler aspects of communication is vital in the effective treatment of these diseases.

The Tamil Nadu government initiated provision of RTI services that are sorely needed in rural areas. Annual RTI camps at the sub-centre level and weekly RTI at selected PHCs have been started to provided treatment for RTI to the rural population. However, these initiatives have been ad-hoc arrangements and have not been able to meet the huge demand for such services. To offer widely available services throughout the year, it is necessary that the health workers are trained and equipped to offer these services. RTI services do not have the support of effective referral services, insufficient manpower and lack of adequate equipment which affects the quality of services provided.

5.2.6 Access to Safe Abortions
Aborting an unwanted pregnancy is recognized as a woman's basic right. India liberalized abortions in 1972 by the passing of the MTP Act which permits termination of pregnancies when the continuation of the pregnancy would result in grave injury to the child's or mother's physical or mental health or due to the failure of contraceptive methods. The Reproductive and Child Health Programme has reiterated its commitment to strengthening abortion services to ensure that all women desiring abortion of unwanted pregnancies should have easy access to safe and hygienic abortion services.
Despite the increase in access to safe abortion services, majority of the 6-7 million abortions conducted annually continue to be done in unsafe backstreet facilities by untrained providers (Chhabra et al., 1994; Khan et al., 1999a).

In Tamil Nadu, abortion services are available in government facilities only when the woman agrees to undergo a sterilization procedure after abortion. The rationale of such a condition according to one medical officer is:

"The very fact that a woman needs an abortion is that she is having an unwanted pregnancy. If we do not persuade to do sterilization now, she will need another abortion after a couple of months. This is not good for her and also puts pressure on the health system. Hence, abortion services are offered to women only if they agree to undergo tubectomy”

Such perceptions about abortion are rather common among health professionals. However, the RCH programme that is expected to provide spacing methods to women has not expanded this service coverage. Women who wish to space births or who want to postpone child bearing have not been provided with suitable choices in terms of contraception. For this reason alone, women who do not wish to stop child bearing have little option but to resort to abortion when they conceive. Additionally, linking up abortion with sterilization violates the very basic reproductive rights. And the RCH programme, in fact, strives to provide such rights to women of Tamil Nadu.

In a multi-state study, it was found that the pressure to undergo sterilization for clients seeking abortion is strongest in Tamil Nadu and perhaps the reason why abortion services are provided only on the day sterilizations are performed (Khan et al., 1998a). The VHN's also reported that government doctors generally discourage women from getting abortions. Surgeons disqualify cases based on medical reasons: anemia and pregnancies that are over 10 weeks are the primary reasons for not conducting an abortion. Doctors engaged in pre-operative screening attribute additional medical reasons, including symptoms of fever at the time of registration, minor ailments, conditions of the woman's heart and lungs, and obstetric history. However, there are also non-medical reasons like the eagerness to get back to their private practice and also to divert cases to the government doctors' private practice.

One VHN reported that such rejections results in frustration of women who travel long distances and wait for long time to avail services. Moreover, it damages the reputation of
the VHN in the local community who refers cases there and sometimes accompany women to these facilities. One medical officer who was sympathetic to the needs of the woman reported that the results of the pathological tests conducted before abortions are not always reliable. The doctor mentioned that rejecting cases based on the basis of these laboratory tests is not justified. Such findings are also reported in a study of abortions in Coimbatore district (Laxmi et al., 2002).

Abortion facilities are available only in government hospitals and in PHC's only on days there is a special camp. Because of limited options available in the government sector, and the associated shame / guilt associated with the procedure, women prefer a private provider and undergo abortion with few difficulties. The VHN who are the first contact of the public health system with the community are also aware of such problems and refer women to appropriate private providers depending on the “paying capacity” of the woman. It should be noted that most of the private providers are not registered to provide abortion. In certain instances, they are not even qualified doctors and are just registered medical practitioners with good standing in the community. Laxmi et al., (2002) reported that VHN had good contacts with providers of abortion and referred and accompanied pregnant women to these providers.

All VHN's in Kancheepuram mentioned that women in their service area approach them for abortion with intention to get sterilization. These women are then referred to the government hospitals for abortion. The VHN's have never faced the situation of a woman requiring only abortion services. Probably, these VHN's are not reporting the facts as they might have tacit understanding with the private providers of abortion who might be offering monetary incentives for cases brought in by the VHN (Laxmi et al., 2002).

In one of the focus group discussions among VHN's in a PHC of Kancheepuram district, we asked whether abortion services are available for those women who are not willing to undergo sterilization. There was a disagreement among VHN's as to whether only abortion services (without sterilization) were available in government hospitals. While one group of VHN's claimed that such services were not available, the others claimed that such services were introduced recently in government hospital. However, none of the VHN's had ever known of any client utilizing the services of government
hospitals only for abortion. When this issue was discussed with the medical officer, he clarified that in urban areas, government hospitals entertain such cases as instances of pregnancy outside marriage are common. In rural areas, women requiring abortion services implies that they do not want any more children and hence it is better to motivate them for family planning so that the women can be saved of the trouble of subsequent unintended pregnancies and also reduce the pressure on the health system.

It can be concluded that safe abortion services are yet to be provided in the government health facilities in Tamil Nadu. Further, abortion services are available only to women who are willing to undergo tubectomy. In the absence of services in the government health facilities, women seeking abortion are forced to seek the services of untrained, illegal provider – often quacks – which exposes the health and life of the women to grave risk. Confidentiality and anonymity – which are important service attributes sought by women seeking abortion are not provided in the government system – further forcing women to resort to the private sector. In the absence of widely accessible, spacing methods (discussed in detail in section 5.2.9), providing abortion services with conditionalities mentioned above violates the basic tenets of the RCH approach i.e., gaining control of one's reproduction and violation of her reproductive rights.

5.2.7 Services for Adolescents

Adolescents constitute a large segment of population which is of special significance for the RCH status of the population at large, more so because adolescents will shortly join the reproductive age group. In rural areas of Tamil Nadu, the age group 10-19 years constitutes 19.5 per cent of the population or about 6.8 million persons (IIPS, 2000). The special needs of this segment have not been addressed in the past. This group has important health and information needs, particularly with regard to nutrition, sexuality and reproduction. Though the RCH programme has recognized the importance of catering to the needs of this important group, the package of services for adolescents has not been properly defined. The RCH Programme “Schemes for Implementation” of the Ministry of Health and Family Welfare states that a committee of experts has been constituted in the Department of Family Welfare to work out appropriate package of programmes for this group.

As part of the RCH programme, the Tamil Nadu government has started a the distribution of prophylactic iron and folic acid tablets to adolescents. All adolescent girls
are given these tablets once a week by the health department. This is in addition to the iron and folic acid tablets which are given to pregnant women as part of the antenatal care package. This objective of this intervention is to prevent anemia among adolescents many of whom are known to be anemic (Gopalan, 1992) and better prepare them for later motherhood. This initiative of the Government of Tamil Nadu was started when our field work was under progress (January, 2002). Therefore, it was not possible to assess the effectiveness of this scheme.

Adolescence is a time in which individuals explore and develop their sexuality. The habits and attitudes they acquire during this time may become life time habits that can result in diseases many years later. As future adults and parents, it is imperative for health planners to consider their health and development a priority, and address it in a holistic manner – from a physical, psychological and social perspective (Mamdani, 1999). Little attention had been given till recently to the sexual health and development of this group in the national programme. As the Indian culture prohibits premarital sexual activity, the needs of sexually active unmarried adolescents are rarely considered.

There is a lack of awareness among adolescents on important issues related to reproductive health issues and sexuality. They must also be equipped with skills and abilities to utilize this information for preventive behaviour, and to enhance their decision making skills. The imparting of these skills, known as Life Skill Development also incorporates gender sensitization for adolescent boys. As part of the school health programmes, school girls in Tamil Nadu are provided information about hygiene, physiological changes and sexuality. Periodically, meetings are also organized in villages for adolescents where they are also exposed to issues relevant to them. But the coverage of such meetings is very poor and a vast majority of the adolescents are left out.

A medical officer of Dharmapuri district reported:

"We talk to adolescents in schools during the school health programme. I also talk to adolescents in meeting organized in villages. May be 50 -100 members may be attending. Only a small fraction of adolescents are covered. Even for those who are covered, a couple of meetings are not enough to get the desired behavioral changes. Persistent efforts through a variety of media can only meet the objective. I do not have the resources for this purpose"
5.2.8 Services for men

The Family Welfare Programme has not given sufficient attention to men in the recent past although they are key actors in the family welfare activities and decisions. There is a growing realization that unless men are catered to, programme effort will have limited impact (Bhalerao et al., 1984; Terefe et al., 1993; Wang et al., 1998; Raju et al., 2000). The RCH programme seeks to actively involve men in the programme (MOHFW, 2000). A basic tenet of the reproductive health approach is that reproduction should be based on joint decision making between husband and wife. Even though pregnancy is borne by women, the responsibility for planning or averting births and for parenthood should be shared by men and women. Hence, couples should be in a position to select the most appropriate method for them at different stages of their reproductive and family lives. This entails giving information about male contraceptive methods as well as female contraceptive methods, and dispelling fears which have accumulated about male methods such as vasectomy. A major problem underlying unmet demand has been men’s resistance to family planning, both for themselves and their wives.

The second round of the National Family Health Survey has reported that the use of male methods in Tamil Nadu is significantly lower than the national average. The percent of eligible couples protected by male sterilization in rural Tamil Nadu is 0.9 compared with the all-India figure of 1.9. Similarly, the percent of eligible couples protected by condoms in rural Tamil is 0.7 compared with the all-India figure of 1.6. Further, despite an increase in the percentage of eligible couples using modern contraceptive methods in rural Tamil Nadu from 45.5 to 47.6 between the two rounds of the NFHS, most of the increase has been due to the increase in female sterilizations. In fact, the proportion of couples protected by male methods has decreased—male sterilization has declined from 2.3 to 0.9 and the use of condoms from 0.8 to 0.7.

As in the other predominantly illiterate and backward northern states, there is a misconception among the people in Tamil Nadu that sterilization makes a man weak and incapable of performing hard labour. As the man is the bread winner in the family, any incapacitation of him even for a few days will affect the family adversely. It is believed that as women are not working, they can stay at home and recoup after undergoing tubectomy. There are no concerted efforts to remove these misconceptions. Moreover, not many government health institutions offer vasectomy procedures on a regular basis.
except during some special drives. The female health workers also report that it is the health inspectors responsibility of educating and motivating men to accept male methods. However, this task is not being done by them.

A VHN reported in Kancheepuram district reported:

"The VHN’s cannot approach men to do motivation work (to accept vasectomy) or distribute condoms. This work needs to be done by the health inspectors. They do not do this work."

In one PHC of Kancheepuram district, VHN’s reported that there were targets for male health workers to recruit vasectomy acceptors. There was an attractive incentive of one wrist watch for the health inspector who recruited the prescribed number of acceptors. However, it appears that this proposal was not implemented. The Deputy Director of Health Services also admitted that there are no special efforts to involve men in the programme and the status is the same as before the RCH programme was launched.

The performance statistics shows that only a handful of vasectomy procedures are being performed in any particular PHC during a year. Of the 70 PHC’s in Dharmapuri district, 15 PHC’s did not have a single vasectomy acceptor in the year 2000-01 while 26 PHC’s has less than 10 vasectomy acceptors. In 3 PHC’s, there we more than 100 vasectomy acceptors in that year. In these PHC’s, facilities for no-scalpel vasectomy are available and there are related IEC and motivational efforts. More importantly, the medical officer in these PHC’s has taken special interest in promoting vasectomy and has been able to percolate this interest down the hierarchy in his PHC. Thus, if facilities and attention are directed towards men, an encouraging response is obtained from them. These efforts should be replicated in other regions to encourage the participation of men.

The utilization of health services by women (like institutional deliveries) also depends on the discretion of the men of the household as women have limited decision making power and disposable cash. It emerged from the focus group discussions with clients that an important hurdle in woman utilizing institutional health services is the indifferent attitude of men. For instance, a woman cited that during her delivery, she developed complications and started to bleed profusely. She was lying in a pool of blood but her husband did not bother to get transportation to take her to hospital. The family could easily afford the expenditure to hospital but the indifferent attitude of her husband
almost cost her life. Some neighbors brought the local VHN who then transported her to the hospital and saved her life. But the baby could not be saved.

The VHN who took her to the hospital told:

"The life of a woman is taken for granted. They do not value the life of a woman and her health. Only if the family members cooperate will the woman can seek proper health services and have good health. If the poor woman had died, it would have not made any difference to her husband. He would have married another woman."

It is also observed that the utilization of health services is lower among women than among men. As discussed, women seek treatment for RTI's only at an advanced stage when it cannot be ignored further. The men on the other hand, seek treatment at a much earlier stage. A medical officer of a PHC in Dharmapuri district said:

"Men generally have some cash with them and take treatment for STI's at an early stage. They generally go to some private doctor or take some medicines from a chemist. Women tend to suffer in silence. Since they do not have money with them and since other family members don't care, they don't take medical attention immediately. When the problem becomes so severe that it cannot be ignored, then women approach the VHN or come to the PHC."

These findings on the differences in the health seeking behavior of men and women have been corroborated by other studies (Raju et al., 2000). Though research has shown that male members in a household are important for maintaining health in general and reproductive health of women in particular, little is known as to how men can be better involved in improving the health status of women. In addition, family members in general also need to understand that women as distinct individuals can decide on matters relating to reproduction. An important reason for non-acceptance of contraception is the opposition from family members. Though some women are highly motivated to adopt sterilization, they do not undergo sterilization because of opposition from family members especially the elder females in the household. As the government programme has not targeted men and the elder population, they have not developed a favorable attitude towards the use of contraception.

The lack of support of men contributes to the non-acceptance of sterilization by women. Sterilization requires the woman to be away from the household and requires considerable support from other family members for child care and other daily chores.
On probing as to why women do not accept contraception inspite of non wanting children, a mother of three children in Kancheepuram district replied:

"I do not have any support at my home to take care of my children when I am in the hospital"

Another woman in Dharmapuri district said:

"In case I am indisposed after operation what will happen to my children. The men are not responsible and will not take care of the children. In fact, we have to earn to take care of the children. They spend all their money on drinking"

Thus, persistent IEC efforts are required to sensitize husbands and other family members to the problems faced by women and elicit favorable behavior from them. However, there are no programmatic efforts directed towards them to change their behaviour.

5.2.9 Promotion of Spacing methods

In India, a reason why women give births in rapid succession is the limited use of spacing methods. Births that occur in rapid succession depletes the health of the mother and contributes to increased maternal morbidity and mortality (Merchant et al., 1998; Winikoff, 1983; Royston et al., 1989). In India, the government programme has emphasized sterilizations till recently. Though, promotion of sterilization is a useful strategy for fertility control and also contributes to reduced infant and maternal mortality by reducing higher order births, it has no effect on spacing of births. Even in the demographically developed states such as Kerala, mothers often do not space their births. We now discuss the use of spacing methods of contraception and the problems women face in accessing such methods in Tamil Nadu based on our field work.

The general pattern of family planning adoption found in the villages of both Dharmapuri and Kancheepuram district is of sterilization after 2 – 3 children. The degree of son-preference is not as high as in the northern states. Women who have low socio-economic status accept sterilization even after 2 female children. There are very few users of spacing methods. The private sector is the dominant source of spacing methods for these few users of spacing methods. The health workers of the area where focus group discussions were conducted reported that there were only about 10 women who were using spacing methods in their service area of about 5000 people and they were from the more affluent households near the towns.
The second round of the NFHS has also reported that the use of spacing methods in Tamil Nadu is much lower than the national average. The percent of eligible couples using modern spacing methods in rural areas of Tamil Nadu was only 2.0 per cent compared with the all India average of 4.5 per cent. Further, inspite of an increase in percent of eligible couples using modern contraceptive methods from 45.5 to 47.6 per cent in rural Tamil Nadu between the rounds of the NFHS, the use of modern spacing methods has declined from 6.0 to 2.1 per cent. Thus despite the increased emphasis on the birth spacing in the Reproductive and Child Health Programme, the use of spacing methods continues to be low, especially in the rural areas.

During the focus group discussions, it was emphasized by the women that they have limited knowledge of spacing methods. They expressed fear about using these methods. Instances of complications arising as a resulting of use of spacing methods have also reinforced the fear of using the methods.

A related factor for not using spacing method after the first child is the cultural practices prevailing in the villages. Women in the area stay for considerable duration (nearly one year) in the mother’s place after the birth of the child. During this period there is limited contact between the couple and the chance of conception is limited. The women do not feel the need to use spacing method during this period.

Programmatic factors are also responsible for non-use of spacing contraceptive methods. We observed that the average frequency of visit of a health worker to a particular village is about once a month in Dharmapuri district and once a week in Kancheepuram district. In the case of more remote villages and in hamlets, the contact between the village community of the health worker is less frequent. During these visits – considerable time is spent by the health worker in reaching the village and all activities (viz., immunization for children and pregnant women, treatment for minor ailments, distribution of IFA tablets and family planning counseling and motivation) are conducted during the limited time she spends in the village. In such a situation, it would not be possible for the VHN to dispel the apprehensions and doubts women have about spacing methods. Hence, the ignorance of the methods and the fear of the methods continues. Moreover, since the women have no direct acquaintance who has used such methods, they cannot also gather
information about them. This, however, is not the case for sterilization. As a result, there is less mystery surrounding sterilization than spacing methods.

It is surprising that even in Kancheepuram where the contact of the village community with the health system is better, the use of spacing methods is very low. In this district, visit of the VHN to the villages is more frequent and many women (especially in the PHC villages) go to the PHC for antenatal checkups. Inspite of better contacts, like in Dharmapuri women do not have enough information about the methods and have misconceptions about the use of such methods. To be fair, some VHN's seem to be promoting such methods but they are not persistent enough to overcome the inhibitions women have about these methods. One woman in Kancheepuram district said in a FGD:

"VHN told me after my first child to use IUD or Oral pills as frequent child bearing makes a woman weak. I did not use IUD as I did not know about the method and was afraid to use it. VHN gave me oral pills. I took the tablets from the VHN but did not eat it. I lied to the VHN that I am taking the pills. Then after a few months, I became pregnant again. My husband told me that taking pills will cause health problems."

Unfortunately, the service statistics do not reflect such clients and the usage of spacing methods in such statistics is inflated. A VHN in a PHC of Dharmapuri district reported:

"On paper I have 30 users of OP. But there are only 10. Even these are not eligible women. They are very old. There are none who are very young and with no or 1 child."

From our survey it is clear that greater and more consistent efforts are required on the part of the health workers to remove the fear of side effects. This requires substantial effort to dispel the misconceptions. Discussions with the deputy director of health services (the head of the PHC system in the district) also revealed that there are no special efforts to renew spacing methods.

The focus group discussions also revealed that women space their children by using traditional methods like rhythm, withdrawal and abstinence. The role of culture in spacing of children cannot be underestimated. The FGD's revealed that women were interested in spacing their children but modern methods were not promoted by the RCH programme. There is an urgent need for popularizing spacing methods among women of Kancheepuram and Dharmapuri districts.
While the clients’ perceptions of the government health services were obtained in an FGD environment, it was not possible to get an insight into the sensitive topics like abortion. However, an investigator who has worked extensively in the health sector in the region, reported that there are many instances of abortion (predominantly conducted by backstreet and private providers) among women who have had unusually long gaps between children without any use of contraception. Such women were not probably not keen on expressing their experiences in a group environment. It should also be noted that Tamil Nadu has the highest rate of induced abortion in the country – 5.2 per cent of pregnancies compared with 1.7 per cent for all India average (IIPS, 2000). As spacing methods are not available to women, they have to resort to abortion to space their births. A 19 year old mother of a 6 month old child feared that she might have conceived again. She said:

"I should have used some method to avoid conceiving so soon. I will have an abortion if the conception is confirmed"

We also observed that there is reluctance on the part of the health workers to promote spacing methods. Sustained use of spacing methods requires more frequent contact with the village community for resupply of methods, checking for any side effects and ensuring that there is no discontinuation of methods. The workers feel that in the resource scare environment in which they operate promoting spacing methods is not viable as there would be frequent instances of discontinuation. They felt that focusing on motivating clients for sterilization would be a better strategy in this scenario. This is probably related to the legacy of the target era.

Even in the Government hospital where women go for delivery, mothers have not been counseled about the use of spacing methods. This is to be considered as a missed opportunity for the health system to impress upon women the use of spacing methods. When sufficient number of women use such methods, other women will gain confidence to use the method. For instance, though sterilization is a complicated and time consuming process – involving hospitalization for a week, leaving family alone for the period, surgical procedures and the other difficulties– it is still considered a “simple” process by women in reproductive ages. Women are not afraid of sterilization as almost every second eligible women is sterilized. They see these women leading normal lives and hence the fear is dispelled.
To sum up, it is evident from the above discussion that promotion of spacing methods in government health facilities of Tamil Nadu is virtually non-existent. The low frequency of contact between health workers and the village community do not permit enough interaction to dispel fears, resupply contraceptive supplies and ensuring that there is no discontinuation of methods. In such a situation, health workers tend to focus on pushing sterilization to minimize any wasted efforts in promoting spacing methods. We also noted that women are not counseled about spacing methods even in government hospitals and PHC's which reflects the low importance accorded to spacing methods in the programme. The users of spacing methods source it from the private sector and are restricted to urban areas and the more affluent villages near towns.

It is clear from the section on improved service coverage, presented above that there has been limited effort by the Tamil Nadu government to expand the service package under the RCH approach. Tamil Nadu has achieved near universal coverage of antenatal and postnatal services much before the launch of the present RCH approach and this continues into the present programme. The facilities to manage complications during delivery are also not satisfactory. The initiative of the government to build sub-centre buildings, functioning of PHC's round the clock and emphasis on the promotion of institutional deliveries – as in some PHC's of Kancheepuram district – would result in higher proportion of institutional deliveries and better management of obstetric emergencies. The family planning methods available under the government programme are still limited to sterilization, particularly female sterilization. There have been no consistent efforts to promote spacing and male methods of contraception. Abortion services are not available easily to women seeking these services in government health facilities. Further, this service is available only if a woman agrees to undergo tubectomy after the abortion. The health department in Tamil Nadu has started to provide services for RTI treatment in its rural health facilities after the launch of the RCH programme. This initiative has faced serious teething troubles and has not been able to meet the huge demand for the treatment for RTI among men and women in rural Tamil Nadu. The government programme has not yet begun to address an important segment of the population – adolescents and men. Though the Indian population policy places high emphasis on meeting the needs of this group, it remains to be implemented in the government health institutions in rural Tamil Nadu.
5.3 QUALITY OF CARE

Quality, in health care, is defined as a program attribute that relates to whether the “right thing is being done and whether it is done well” (Aday et al., 1993). Issues of quality of care have become central in debates about family planning and provision of reproductive health services (Bruce 1992; Simmons 1992). Quality refers to providing services that address the reproductive needs of women in a way that upholds their rights and enables them to gain control over their reproductive capacity. The main objective of the family welfare programme in India till recently has been the reduction of fertility through the aggressive pursuit of method-specific targets. As is well known, the programme has been promoting only sterilization while other methods have been sidelined. This strategy has neglected client choice and quality of care. A reason for non-achievement of program objectives has been the poor quality of family welfare and health services provided through the public health care facilities (Government of India, 1992; MOHFW, 1997). This has also been identified as the principal reason for the underutilization of public health facilities (CORT, 1995; Khan et al., 1999; Roy et al., 1999).

Following ICPD, Cairo, the government of India shifted its policy emphasis from achieving demographic goals to meeting the reproductive needs of individual clients. These changes have reinforced the importance placed upon the quality of services in the government’s new service delivery strategy. In this section we examine the quality of services provided in the rural health centres in Tamil Nadu. In her pioneering work, Bruce (1990) defined the concept of quality in family planning and identified six elements of quality. These six elements include choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms and an appropriate constellation of services. Subsequently, the Pan-American Health Organization and Family Health International has developed a quality of care framework in the broader context of Reproductive and Child Health. (Finger and Hardee, 1993). We use this framework to examine the quality of care provided by rural health centres in Tamil Nadu. These element of quality of care in the framework developed by PAHO and FHI include:

1. Accessibility and availability of services.
2. Availability of basic facilities and essential supplies
3. Choice of methods
4. Information to Clients
5. Technical Competence
6. Client provider interaction
7. Continuity of services and
8. Appropriate constellation of services, including treatment for sexually transmitted diseases and MCH care.

This broadened framework is more suitable for the rural health centres as it considers the reproductive and child health in totality while Bruce's framework was restricted to quality of care in the provision of contraceptives. The broadened framework developed by PAHO and FHI explicitly considers the accessibility and availability of health services which are important components for the rural clients in Tamil Nadu. Without the availability of these services, quality of care has little relevance for those who seek the services of health workers. Similarly, for example, accessibility can be a major factor in villages where people are isolated because of rough terrain and poor transportation networks.

Figure 5.1
The quality of the service experience – its origins and impacts

Programme Effort
- Policy / Political Support
- Resources Allocated
- Programme management/ Structure

Elements in the Unit
- Accessibility and availability of services
- Availability of basic facilities and supplies
- Choice of methods
- Information given to clients
- Technical Competence
- Interpersonal relations
- Follow-up / continuity Mechanisms
- Appropriate constellation of services

Impacts
- Client knowledge
- Client Satisfaction
- Client health
- Contraceptive Use:
  - Acceptance
  - Continuation

Adapted from Bruce (1990).
The figure 5.1 depicts the relationship between programme effort, the elements of the quality of care and its impact on clients. Quality of care is related to the policies, resource allocation decisions and management tasks that precede the delivery of services. For instance, the choice of methods available to clients depends on the policy of the state and the resources allocated by it. Though the government may on paper promote a particular method, the health machinery working on the ground must be in a position to offer the services. Thus, choice of methods also depends on the programme and management structure. The client does not usually see the apparatus and the background work that goes into the provision of services. She is however able to experience the eight aspects of services which ultimately impacts her knowledge, satisfaction, contraceptive use and health.

The elements of the quality of care are not entirely discrete. The elements are interrelated and as discussed determined by common background factors and program policies, operations management styles and resource limits. As a result, there are overlaps in the discussions which follow on the quality of care with the preceding discussions on various aspects of the management of the RCH programme. For instance, the element on availability of basic facilities and essential supplies overlaps entirely with our earlier section 6.1 on infrastructure and logistics management to be discussed in the next chapter. Hence we have omitted this aspect in our subsequent discussions. We have tried to minimize the other overlaps. We now discuss the findings on quality of care of reproductive health services provided in Tamil Nadu with respect to each of the elements.

5.3.1 Accessibility and Availability of Services

The geographical accessibility of health facilities is an important determinant of the availability and utilization of health services. Communities which are better accessible to main roads report better levels of outreach by health workers and better health outcomes (Blaikie, 1975; ICMR, 1991; Khan et al., 1999). The location of health facilities within the village also determines the utility of the health centre. The location of health centres at the periphery of the village as is common in India (Iyer et al., 1999) not only results in
poor utilization but also discourages health workers from residing in the health centre itself.

The presence of medical personnel especially that of the doctor is central to the availability of doctors. Studies have reported that doctors are not always on duty and that they spend only a fraction of the mandated hours providing services (Singh and Kumar, 1998; Murthy, 1999; Ravindran, 1999; Roy and Verma, 1999). Client access is also heavily influenced by clinic timings – whether these hours are convenient to clients and whether these stated working hours are actually observed by the staff. Studies have generally reported that government clinic timings were unpredictable (Ravindran, 1999). In their review of the quality of care in the Indian family welfare programme Koeing et al., (2000) report that the reliability of opening hours appears to diminish as one moves to a lower level facility (i.e., from PHCs to sub centres) which tends to be poorer in infrastructure, equipment and supplies, staffed by a provider who is less likely to be resident, and less likely to be motivated since the services she can offer are limited given the inadequate resources. In the section which follows, the discussion the availability and accessibility of services in sub-centres followed by the situation in PHCs based on our field work in Tamil Nadu.

a. Sub-centres

As mentioned, most of the sub-centres are in rented buildings in both districts. The rented sub-centre buildings are barely functional as rental allowances given to obtain a sub-centre building are meager. Such VHN’s stay in nearby towns and commute to their service areas to provide services. The interaction between a particular village and the VHN is for a few hours every month in Dharmapuri district and few hours every week in Kancheepuram district. The VHN is out of reach of her clients during other times.

Even for sub-centres operating from government owned buildings, some VHN’s do not reside in the sub-centre. As their families reside in nearby towns and have children studying there, these VHN’s have not shifted their residences here and still commute to their service areas. As residence in sub-centre is more strictly enforced for those operating from government buildings, these VHN’s ask the local dai or their relatives
stay in the sub-centre so that it does not appear to be locked when supervisors come for visits.

A sub-centre typically caters to 7-12 villages in Dharmapuri district and 3-5 villages in Kancheepuram district. In the non-sub-centre villages especially those in the rented buildings, it is found that people hardly know about the existence of the sub-centre. Although a sub-centre is supposed to cater to the surrounding villages, the sub-centre at most caters to the population of the village of its location. Just as in the case of a sub-centre, most of the patients visiting a PHC are also from the PHC village. In some remote areas, some villages could be as far as 8 kms from the sub-centre. In such areas, the utility of a sub-centre if any is restricted to the village of its location.

It is also observed that in some cases the location of the sub-centre is far from ideal and is located at a distance from the main settlement. For example, the Nalaganagotapalli sub-centre under Kamandhoddi PHC of Dharmapuri district, the sub-centres is located in a remote village rather than the main village which is well connected to the neighboring villages. In other instances like Jakeri sub-centre under Kelamangalam PHC in Dharmapuri district, though the PHC is located in the main village, it is located in an inconvenient location in the outskirts of the village. In such cases, the accessibility of the sub-centre is considerably reduced. The Deputy Director of Health Services in Kancheepuram district explained the procedure of determining the location of the SC:

"The policy of the government is that it will bear the cost of the construction of the building but expects it to build out of the land donated by the community. In most cases, the land is in the outskirts of the village near the graveyard. If the government is willing to buy the land, then it could get a better location"

He further elaborated that

"The location of the sub-centre also discourages the VHN from staying in the sub-centre. Her reluctance is also understandable. I cannot strictly enforce VHN's to stay in sub-centres without taking into considerations these factors. We have to take a humane approach in dealing with the staff. I would not like any of my lady family members staying in that situation"

b. Primary Health Centres

Though all PHC's operate from well equipped government owned buildings, inconvenient hours of operation and non-availability of staff hamper the quality of services provided by the PHC. The morning out-patient hours are from 8 – 11:30. Most
medical officers turn up to work only by 9 a.m. expect on occasions when a higher
authority is scheduled to visit. Though, an out-patient clinic is supposed to be operating
in the evenings also, most PHC's do not conduct this clinic. The exceptions were the
upgraded PHC's and 24-hour PHC's which had more than 2 doctors and had in-patient
beds. Even in a 24-hour PHC only an ANM and not the medical officer who is available
for 24 hours. The medical doctor attends to the morning and evening out-patient clinics
and is available only during emergencies.

It is observed that most of the patients visiting a PHC are from the village in which the
PHC is located and villages in the radius of 3 to 5 kilometers. Typically, a PHC caters to
about 50 to 80 villages in a radius of 15 to 20 kms. The residents of villages at further
distances from the PHC's either do not know of its existence or avail of alternative
health services. Many travel to the taluqa headquater which have private doctors and a
government hospital. The government hospital is operational for longer duration (not
during morning hours only) and is perceived to be more accessible than a PHC. The
taluqa headquater is generally better connected to the villages than the PHC village and is
another reason for people to prefer the hospital.

During FGD's with the clients in a village located at about 8 kms from a PHC, we
discussed the location of the nearest PHC. None of the women was aware of its location.
The panchayat president of the village was asked about the non-utilisation of the services
of the PHC by the village. According to him:

"Though the taluqa headquarter is 15 kms away, we have 5 buses a day directly
to the place. To go to the PHC, people have to change 3 buses. After taking so
much pain, people reach the hospital late or doctor is absent. So people have so far
not opted to go to the PHC from this village. The GH is always open and even if
treatment is not available there, there are number of private doctors available
there"

Accessibility and availability of services is a function of not only the location of health
facilities but also the operational aspects of a health centre. Both these factors go
together in determining the utility of a health centre. In order to improve the utility of
PHCs, it needs to be ensured that the health facilities remain operational for the
prescribed duration and the doctors are available during that time. In Tamil Nadu, the
good transport networks and bus services enable people to reach towns easily to avail
health facilities. However, in those regions where terrain and other factors restrict the
mobility of the population, the PHC's and SC's remain the only source of health care available to them. Hence, the operational aspects of the rural health centres need to be streamlined and strengthened. Improvement of roads and bus services will also improve accessibility and utilization of health services.

5.3.2 Choice of methods

Information about choice of methods is an important aspect of the quality of care. People have different needs in different phases of the life cycle and the preferences vary with several socio-cultural characteristics. Though the government is supposed to provide a range of contraceptive services, female sterilization dominates the contraceptive method mix. The second round of the National Family Health Survey reports that female sterilization accounts for 83.9 per cent of the current use of contraceptive in rural India. The corresponding figure for Tamil Nadu is higher, at 91.5 per cent.

As discussed in the section of the promotion of male methods, it is female sterilization which almost exclusively dominates the method mix. There are only a handful of vasectomy acceptors in each district. There are only a few PHC's having facilities for performing vasectomy procedures in each district. Also, it is widely believed that vasectomy operations make a person weak. As the man is the bread winner of the family, the risk of becoming incapable of performing work even for a few days is not taken in the case of men. As women are primarily home based and at best only supplement to man's income, women come forward to accept sterilization as it is believed that the family can be sustained even if the woman is indisposed for a few days.

Promotion of spacing methods require frequent contact between the client and providers for restocking and solving problems with the use of methods. In the absence of frequent contact discontinuation and drop outs of users tend to be high. As discussed earlier, the frequency of contact between health workers and clients is low. Even when the frequency is relatively higher as in Kancheepuram district, the interaction between the provider and clients is not private and long enough to resolve problems involved in the use of spacing methods.
Another reason for the predominance of sterilization is the focus of the programme managers on sterilization in the era of method specific targets. As the service data on spacing methods can easily be manipulated by health workers, the supervisors have been giving more importance to sterilization for programme evaluation.

Pressure to accept sterilization epitomizes lack of choice. As discussed in an earlier section, abortions are performed in government hospitals only if the client agrees to undergo a tubectomy procedure. The medical officers feel that it is a gentle way to coax women to accept sterilization rather than have another unintended pregnancy and perform another abortion. However, women seek abortion services because they do not have access to birth control methods particularly spacing methods. For instance, a woman aged 19 years conceived a few months after delivering her first child. She reported in a FGD:

"I had my first child 6 months back. Now I have conceived again. I want to get an abortion but the sister (VHN) says that in government hospital abortion and operation are done together. I do not want to get operation as I want another child. I do not know what to do now? (where to get abortion). If I had known about a spacing method, I would not have to face this situation."

5.3.3 Information to Clients

To make choice of the clients effective and informed complete and correct information is critical. Information also helps in improving acceptance of methods and their continued use. Information has several levels viz. information about possibilities of controlling fertility, information on existence of various methods, information on advantages and disadvantages including side-effects and complications of the methods, information on how to use the method, information on where to get the methods and information on what to do if the method is not suitable or causes problems.

Our survey shows married couples aware that fertility can be controlled and in fact are motivated to control it. However, the knowledge of the methods other than sterilization is lacking. In our study in Dharmapuri district, it was observed that the health workers do not tell their clients about spacing methods. In Kancheepuram district, though some of the VHN’s seem to be telling their clients about these methods, it is not sufficient and persistent enough to overcome the apprehensions clients have in using these methods.
Apart from the information about contraceptive methods, it is essential for the community to know about the services available in the different health facilities, the time of availability and the responsibilities of different staff. During our field work, we found that people lack basic information about health services provided. Such information would not only improve the utilization of health services but also increase the accountability of the health personnel. In the absence of such information confusion prevails and health personnel take advantage of the situation. For instance, we found that though out patient clinics are supposed to be conducted in evenings also, most of the PHC's do not conduct it. Some PHC's also charge Rs. 1 as outpatient registration charges though it is not sanctioned. Only government hospitals are supposed to charge this. Because of the lack of information, some personnel take advantage of the situation and deceive people for monetary benefits.

By preparing a citizen's charter on health services, displaying them prominently in every health facility and publicizing this through the mass media could help in bridging the information gaps. There should also be an effective grievance redressal mechanisms so that shortcomings in services provided is taken care of.

5.3.4 Technical Competence

Technical competence is one of the key elements of quality of care. Important indicators of technical quality of care include providers' complete and accurate knowledge of methods, procedures, and reproductive health care, as well as acceptable clinical practice of family planning and reproductive health service delivery (Koeing et al., 2000). Health programs have an implicit assumption that by employing "qualified" staff it is assuring technical quality of service. However, it does not happen so in reality because of two main reasons. The qualification requirements do not necessarily imply that the staff may be competent in performing specific tasks. For instance, a doctor may not be trained to perform an abortion or even insert an IUD. Also, the nature of training may be that "qualified" persons are not necessarily capable of performing certain tasks. Secondly, some aspects of the technical quality may be poor not because the staff lacks technical competence but because they lack the equipment, the time or simply they do not bother to follow the norms and management is not willing/able to do any thing about it. We now discuss the technical quality of services by the health system in Tamil Nadu based on our field work.
Some of the instances reported by women indicate a lack of adequate technical competence on the part of health personnel. For instance, one woman reported that the medical officer in a PHC misjudged the timing of her delivery resulting in grave problems for the woman. She reported:

"I started to have labour pains and my family members rushed me to the PHC. The doctor examined me and told that it would take another 2-3 days for labour and asked me to come afterwards. Hardly I walked 100 meters from the PHC that I had severe pains and delivered the baby on the road in full public view. What kind of a doctor is he?"

In case of another woman in Kancheepuram district, we observed that a woman was on oral pills continued to breastfeed her child. It was clear that the provider of the oral pills did not verify the acceptor’s suitability for the methods before recommending it. Such cases indicate that adequate attention is not given to the procedures to be followed in case of recommending a method of contraception.

We also came across instances of contraceptive failure in Dharmpuri district. A woman who had undergone the sterilization procedure conceived after a couple of months. She mentioned that she had to get the baby aborted and suffered immense health problems and mental agony because of this. She had filed a case against the doctor in court and spent a lot of money in the lengthy litigation processes. She bitterly mentioned:

"The doctor has a very good reputation. How can we (poor and illiterate) take on these big people. I have spent 10 years and so much money. We could not do anything to them. We should console ourselves by attributing it to our fate"

Several women complained of back pain, pain in the lower abdominal region, becoming tired easily and weight gain after sterilization. Though we could not attribute these problems to sterilization or due to some preconceived notions women have about sterilization, it is necessary that women be counseled about the after effects of sterilization which reflect the lack of technical competence in the services provided.

We observed that the injections are administered by non-disposable syringes. It is important that adequate attention be paid to sterilize them properly before reusing them. No allowances or facilities are provided to the VHN for this purpose and is expected that VHN’s do this exercise at home out of their own expenses. In such a situation it is doubtful whether these are done properly. A VHN in Dharmpuri district reported:
"We have to sterilize the needles by keeping them in boiling water for 20 minutes. Doing this everyday involves a sizeable expenditure for us. We do not get any allowance for this. Though I do this procedure, I know many colleagues of mine who do not follow this strictly"

Not sterilizing the needles can lead to serious problems for women who are injected medicines through these needles. There is also the threat of HIV/AIDS being transmitted through these needles. In order to avoid such problems, the Tamil Nadu government introduced the practice of using disposable needles by charging a user fees of Rs. 2 per needle. This procedure was introduced towards the end of our field work in Tamil Nadu. We noticed that clients did not have any difficulties in paying this small user fee.

In the absence of adequate equipment like instruments to measure blood pressure, weighing scales and other kits to perform simple tests, we noted that the diagnosis done by the VHN's in their field visits is approximate at best and there is considerable scope of error. This aspect of the technical quality of service is, however, good in the PHC's and government hospital.

One of the important reasons of the poor technical quality of care is that there are no protocols, manuals or guidelines, and when they are there, they are not followed. In PHCs such technical guidelines are not available. Most of the work is conducted in a routine manner and any improvements is due to the personal intervention of the doctor-in-charge. Preparation of Quality Assurance Manuals and Guidelines can help introduce quality consciousness among the health personnel. Firstly, the medical officers have to be trained and sensitized to this issue and this can then pass it down the hierarchy. Close supervision and support is necessary to ensure that the quality guidelines are adhered to by the health workers.

5.3.5 Client Provider Interaction

"Client-provider interactions" refers to the interpersonal exchanges between a client who receives health information and services and the clinic-based or outreach health providers who offer these services. In the early 1990s, attention to improving the quality of care of family planning services highlighted the need for client-centered services, including courteous treatment of clients and greater clarity of the information imparted
to them (Bruce, 1990). The emphasis on the importance of positive client-provider interactions in family planning and other reproductive health services gained even more ground after the ICPD, Cairo and the Cairo +5 assessment exercises (Ashford and Makinson, 1999). Sound client provider interaction is now characterized not only by courtesy and clarity, but also by more listening and less “telling” on the part of the provider; encouragement of the client to ask questions and seek clarification; attention to sexuality and gender issues; discussion of contraceptive methods’ side effects; inquiry about the client’s risk of sexually transmitted infections (STIs), including HIV/AIDS; and other features (Murphy et al, 2000).

As part of our study, we observed the interaction which takes place between clients and health staff as we were interested the nature of the client-provider interaction in the government health system in Tamil Nadu. We now describe the client-provider interaction takes place at different places which include:

1. In the villages, during the field visits of the VHN.
2. Primary Health Centres
3. Government Hospitals

a. Client Provider Interaction during field visits

We accompanied VHN’s on their field visits to observe their work and the client-provider interaction which takes place. In this section, we describe a typical field visit of a VHN and the events which transpire therein.

Generally, VHN’s reside in a town and commute to their service areas. The field visit of the VHN we describe in this section is aged 48 years stays in a town about 15 kms from the PHC. Her service area lies midway between her residence and the PHC. We observed that the sub-centre is in a rented building which was a small room with a collapsed roof. The VHN was initially reluctant to show us the sub-centre but our persistence resulted in her showing the ramshackle building. There are 13 villages in her service area. Some of the villages are along the highway while others are about 7-8 kilometers along a kaccha road from the highway.

VHN’s generally restrict their field visits to immunization days which are on Wednesdays in Tamil Nadu. VHN’s generally recruit an assistant usually a dai to carry the vaccine
box and do other petty jobs during the immunization day. The assistant is paid Rs. 50 per month – which is paid to the VHN as assistant allowances. The VHN complains that nobody is willing to work for such a small amount and they put in more money from their pocket to keep the assistant working. They also spend their money on the assistant’s expenses like bus fare and food. One of the assistant’s responsibilities is to fetch the vaccine box from the PHC and wait for the VHN in a pre-designated place along the highway. The VHN meets her in that place and they together start their village visits. On a typical immunization day, the VHN covers 3 – 4 villages in a particular direction.

After reaching the village, she goes to the ICDS centre if there is any, or sits in a central location. She asks a local woman for a mat and spreads her vaccine carrier, records and other bags and ask her assistant and other women present there to mobilize all pregnant women and women with small children. In a few minutes, she is surrounded by a number of women with babies in their arms. She starts to immunize the children and notes the name in her notebook. To administer injections to women, she takes them inside a house. She gives pregnant women with IFA tablets. She comments that IFA tablets are never in short supply while there is severe shortage of other medicines. While administering these injections, she also enquires about the health of the women. In case of any minor ailments, she gives them a few tablets and instructs them the procedure of taking these medicines. In the case of others, she asks them to consult the doctor in the PHC, government hospital at the taluqa headquarter or to a private doctor depending on the profile of the woman. The VHN adds for some problems, (for instance, a skin problem) there is no point of referring them to the PHC or government hospital when they also cannot attend to the difficulties. It is better to tell them to go to a private doctor so that time and effort is saved. She also has a informal link person (ICDS worker, dai or an educated person) in each village with whom she keeps a few strips of vital drugs she should dispense with, in case someone in the village requires. The VHN restocks this supply during every visit.

The VHN also carries some injections which is not provided by the PHC. She administers these injections on patients on payment of additional fees (Rs. 10). During these visits the VHN provides health education – about cleaniness, personal hygiene and about the diet to be followed during pregnancy. For high risk pregnancies (like short stature, anemic women, foetus with wrong orientation and very young women), she
advises them to go in for institutional delivery (government hospital or private depending on the resources of the family). She also counsels women with 2 or more children to go in for sterilization.

It should be noted and stressed that in this situation there is no privacy or one-on-one counseling. The VHN tells us that in socio-cultural milieu of these villages, there is not much importance attached to privacy. Everybody knows about everyone else. Also in the constraints in which VHN operate, they say it is not possible maintain privacy as they are told in the training sessions.

The villages are separated by distances of between 3 – 5 kms and she mostly covers them by foot. Some villages are skipped because they are too far away. The VHN says that the effects of aging are showing on her and she is not able to walk long distances as before. After visiting the villages scheduled for the day, she leaves for her home during the late afternoon (3 – 4 p.m.).

Client Perceptions

The behaviour of the health workers with the clients varied with the personality traits of the worker. While some workers we observed empathized with the problems faced with the clients, others seemed to be indifferent to their concerns and a few were harsh and rude in their behaviour.

One of the important complaints women have against the VHN is that she does not make house to house visits. One woman in Kancheepuram district said:

"The sister comes to the balwadi centre and asks all of us to come there. It would be better if she comes to our house and provides the service"

An important aspect in the treatment of sensitive topics such as reproductive health and family planning is inadequate privacy between the provider and client. The absence of house-to-house visits by the VHN and the provision of services in a group implies lack of privacy. When a VHN was enquired about the need for privacy in discussing sensitive topics, she mentioned:

"These things are very normal in the villages. Here everyone knows about everyone else. Nobody is bothered so much about privacy. Moreover, with the constraints in which I operate, it is not possible for one-to-one counseling. It is simply not workable"
Some women also feel that there is too much constraints on time which restricts women to come out with their problems. A woman reported:

"She comes to our village for such a short period of time. During that short time she to do so many things. There is hardly any time to listen to our problems. If she devotes more time to us, then we can come forward to express our health problems. She is always in a hurry to go back."

It is a custom in the villages where the study was conducted to offer gifts to government and other visitors who come to the village. Some villagers complained that some VHN’s demand gifts. A woman in Dharmapuri district said:

"As a respect we give some farm produce to the VHN and other visitors to the village as a mark of respect. She (the VHN coming to the village) demands something or the other when she comes here. Last time she took away the only jackfruit in my farm which I planned to sell in the market."

It is also perceived that the VHN caters to children, young mothers and pregnant women. An old woman reported:

"She does not seem to be interested in our problems. I have asked her to get a medicine for my rashes for so long but she does not seem to care."

As mentioned, the frequency of contact between the community and the VHN is much less in Dharmapuri district because of the nature of settlements and the poor transport connectivity. This poor contact is the most important source of dissatisfaction among women in this district. A woman in a FGD told:

"She comes here about once a month. Sometimes, it can be once in two months also. We also do not know when exactly she comes. On the day she comes, if we go out of the village, we have to wait for another month to see her."

A woman in a remote hamlet which is located 2 kilometers from a nearest road reported:

"She comes to the next village but rarely comes to our village. We understand that our village is out of the way. We also fall sick and require her services. At least, if we know when she visits the nearest village, we can go there."

b. Client Provider Interaction in PHC’s

In this section, we describe the events that transpire in a PHC between the time a patient enters and leaves the health facility. A patient first goes to a hospital worker to get an out patient slip with a payment of Rs. 1. The slip contains a serial number, name, age and sex
of the patient. The patient then waits to see the medical officer conducting the out-patient department for the day. The typical waiting times for seeing the doctor varies from 30 minutes to one hour. A hospital worker manages the queue of patients in front of the doctor's room. The interaction with the doctor is quite brief and there is little privacy. Persons in the queue have already entered the consultation room while the earlier patient is being examined. A study has calculated that the average time of consultation between the medical officer and a patient is only 2.78 minutes in the PHC's of Tamil Nadu (Government of Tamil Nadu, 2003). In our survey, we also observed that the average time of consultation between the doctor and the patient in the PHC is around 3 minutes. The doctor writes the prescription in the outpatient slip and explains the treatment to the patient. He then signals the next patient to take a seat.

In case the patient requires a injection or a dressing, she goes to the ANM's room where the required procedure is administered. Otherwise, the patient goes to the pharmacist to obtain the medicines. It is the duty of the pharmacist to explain in details the procedure of taking the medicines to the generally illiterate patients. Again, the way this duty is being carried out depends on the personality traits of the pharmacist. While some pharmacist explained the procedures to the patients politely most of the pharmacists just handled over the medicines to the patients. Patients are given medicines for 2 days and are told to return if required.

In one instance, the doctor did not turn up for duty. The pharmacist dispensed medicines for all the minor ailments. It so happened that the PHC did not receive any serious cases on that day. In case a serious patient had come to the PHC, the pharmacist explained that they would have asked the patients to go the government hospital.

Client Perceptions
One of the important complaints against the service provided by the PHC is the unavailability of doctors and other staff. Also, the doctor turns up late and by the time the doctor arrives, the queue of patients becomes too long. As the doctor is in a hurry to get back to his private practice, patients are not given adequate attention. One woman in Dharmapuri district reported in a FGD:

"On several days the doctor is not available. He asks about the problem we are facing and writes a prescription. He does not do any examination"
Another problem faced by the clients in the PHC's is the charging of illegal user fees. For instance, clients are charged Rs 5 for an injection and Rs. 30 for an intravenous drip. Even the charging of outpatient slips for each client at Rs. 1 is illegal. While the larger government hospitals charge an outpatient fee, the PHC's have followed this practice under this garb. Clients are unaware that this practice is illegal. A VHN reported that a fraction of the proceeds go to the medical officer while the remaining is used for miscellaneous items of expenditure incurred in the PHC.

The small size of the PHC and its informal nature (compared with the larger government hospital) makes it more patient friendly. A client who had recently gone for delivery in a PHC of Kancheepuram district told:

“The ANM in the PHC is very friendly. Relatives can stay by the side of the patient and get her home food. I felt better in the PHC. In the government hospital, there are so many rules and restrictions. It is very frightening there.”

c. Client Provider Interaction in Government Hospitals

During the FGD’s with clients we also came to know about the experiences women undergo during their visits to the government hospitals. As discussed in an earlier section, women are treated shabbily by the support staff and nurses in government hospitals. Corruption, in particular the demand for money, lay behind most of these incidents.

A woman who had gone to a government hospital for delivery and post-partum sterilization reported:

“There is a price for every service. Rs. 20 for enema, Rs. 100 to tell whether it is a boy or girl to relatives outside, Rs. 50 for removing stitches. Apart from that the watchman takes Rs. 5 for every visitor who comes to visit every time. Apart from that at the end of the stay we have to give them Rs. 300 – 350. The price can be higher if the new born is a son.”

Another woman added:

“If we do not pay they behave very badly with us and talk to us in foul language. I and my newborn are at their mercy for the duration we are in the hospital. It is better to pay them and get out safely than to confront them.”

Apart from the demands of money, patients visiting government hospitals are treated shabbily. A woman reported:

“All the staff – from the ayah to the head nurse - is shouting and talking very rudely to the patients. The ayah will ask you to get up from the bed fast to change...”
It is common for women to be physically abused in government hospitals. A woman recalled:

"I was groaning in pain and screamed for help. The nurse came at leisure and asked to me shut up and stop making a fuss. Because the pain was so intense, I could not stop shouting. The sister slapped me and left"

Another woman mentioned:

"The woman in my next bed was shouting and crying for help and the sister came slapped her. Though I was in pain, I was scared and kept my mouth shut"

Harassment is not restricted to patients but also to the VHN’s from the PHC’s. A VHN who accompanied a client to the hospital for abortion reported:

"I was not in my uniform and did not carry my I-card. When I wanted to enter the ward, the watchman asked me to pay up and then enter. No amount of pleading could convince him and I had to pay to enter the ward. If this is the fate with us, imagine the fate of the poor patients"

Such harassment was not reported in the case of doctors. It appears that this harassment occurs with out the knowledge of doctors or they are helpless to do anything to prevent such occurrences. A women who had recently gone to a government hospital for delivery told;

"The sisters behave properly when the doctors are on visit. After they go away, they are back to their rude behaviour"

Another women reported in a FGD:

"The doctors there (in government hospital) are all very young and meek. It is the ward boys and nurses who are rough and call the shots there. The doctors cannot challenge their carte!"

Women reported that doctors generally remained aloof, distant and indifferent to their problems. The doctors do not explain the treatment given to patients nor did they answer questions or reassure patients or their relatives. They consider patients to be ignorant and incapable of making decisions.

5.3.6 Continuity of Services

In light of the high rates of method-related complications and associated reproductive morbidity, client follow-up represents an important component of high quality services
During our field work, we tried to ascertain the follow-up services provided to the clients. It is observed that follow-up activity though given importance does not take place as per schedule. It is stipulated that post natal women and women who have accepted a family planning method are followed up as per a prescribed schedule. For instance, a woman who has given birth should be visited by the health workers on the 1st day, 3rd day, 7th days, 15th day and 30th day after the delivery. However, follow-up care takes place during the field visits of VHN's to the villages. This activity is clubbed with other services such as immunization, antenatal care and treatment of minor ailments.

In the event that a woman develops side effects and is unable to get in touch with the VHN (which is generally the case), she is forced to make alternate arrangements or approach a private sector. A woman in Dharmapuri district, aged 28 years, having undergone a sterilization procedure faced intense pain in the abdominal region. She had to go to a private doctor in the town as the VHN was not available.

Women face considerable opposition from home in order to use a method of contraception. The visits of the VHN till she accepts a method and her disappearance later is a big let down for these women. Lack of follow-up services means that women discontinue the use of contraception. If a complication occurs, there are no backup services.

Similarly another woman in Kancheepuram district, aged 21 years started taking oral pills to space her children. After a week she began to feel uneasy. Since the VHN was not available to dispel her fears and attributing the ailment to the consumption of oral pills, the woman discontinued taking them. Later when the VHN diagnosed the problem and asked her to start taking oral pills again, the woman said:

"My family members advised me against taking the tablets. They said who would be responsible if you fall sick again. Will the sister take care of you?"

5.3.7 Appropriate Constellation of Services
The government family welfare programme in India, set in the context of primary health care, is ideally suited to provide the appropriate constellation of services. The PHC system is supposed to provide MCH, disease control, and treatment of minor injuries
and ailments. The functioning of the PHC's is supported by taluka and teaching hospitals which provide referral services.

In the outreach activities of the female health workers, family planning services are offered within the context of a wide range of services. In fact, all possible health services like ANC, immunization, post natal care, treatment for minor ailments, motivation for family planning, referral activities for other complications and health education are offered during the visit of a health worker to a village. However, the lack of equipment and supplies with the VHN hinders the services provided by the VHN’s. The shortages of basic drugs and antibiotics forces VHN’s to refer even simple cases to the PHC or other hospitals.

The recently introduced RCH programme has listed services that are to be provided to the rural population. These services are to act as a support not only for the family planning programme but also for better Reproductive and Child Health in the villages. In the RCH package, in order to reduce maternal mortality and morbidity, abortion services are to be included. However, abortion services are not yet provided even for those women who have reported unwanted pregnancies.

In the context of the RCH programme with a broadened service package, it is observed that many services are yet to be provided. As mentioned earlier, abortion services are yet to be made accessible for those in need of it. Services for adolescents and men are still in their nascent stages and limited to a few pioneering PHC’s. Treatment for RTI’s are available only during annual camps and at weekly clinics in some PHC’s.

Our study has shown that the quality of services provided by the government health system in rural areas needs considerable improvement. Although health facilities are physically accessible in most instances, problems arise because of limited hours of operation and non-availability of health personnel. Most sub-centres are non-functional because the VHN is not resident in the sub-centre and most PHC’s operate only during morning out-patient hours. Our findings indicate that in their outreach activities health workers concentrate mainly on antenatal care, immunization and promotion of female sterilization. Spacing and male methods are not promoted in the programme and only a handful of users of these methods exist in the rural areas of the study districts. The
limited interaction between health workers and women results in limited information exchange between them. Clients have misconceptions about the use of methods and side-effects. Clients have limited information on the services provided in health facilities and their rights. The ignorance of clients encourages providers to take advantage of the situation and provide insufficient service and of poor quality. Limited interaction between health workers and rural population also results in poor follow up care. In case of complications after delivery, sterilization or contraceptive use - health workers are not accessible and women have to fend for themselves and take resort to the private sector often at considerable cost. Our survey indicates that technical competence is lacking among health workers. Several instances of wrong diagnoses, contraceptive failures, non-adherence to prescribed clinical procedures which emerged from our survey indicate inadequate technical competence among health workers. The client-provider interaction was noted to be poor – often shocking – in the health institutions of Tamil Nadu. Clients are badly treated, demands for bribes are common and instances of physical harassment have also been reported. The treatment of patients was noted to be particularly bad in the government hospitals. However, the nature of client provider interaction depended on the personality traits of the provider and some providers seemed to empathize with the patients. Our observations on the quality of services provided were similar in Kancheepuram and Dharmapuri districts. However, a greater proportion of sub-centres and PHC’s in Kancheepuram district had a resident health worker which increased the accessibility of services. The smaller number of villages to be covered by a VHN in Kancheepuram district and better transport facilities resulted in better interaction of health workers with the village community which translated to better follow-up care.

5.4 CONCLUSION

The RCH approach envisages a shift in the focus of the programme from family planning to meeting the reproductive health needs of the population by providing a broad range of high quality RCH services. The programme is to operate in a target free environment where the needs of the community are the inputs for the planning of the programme. From the analysis of the implementation of the RCH approach in Tamil Nadu, it is clear that the drastic change envisaged in the policy has not been reflected in the grassroot level health institutions. Though targets are no longer prescribed to health workers, the procedure adopted in Tamil Nadu does not capture clients’ needs properly
and is a mechanical exercise. Moreover, family planning and particularly female sterilization is still given importance over other services. A number of components of the expanded service package is not yet provided in the government health facilities. Access to spacing methods, safe abortion, services for men and adolescents are not easily available in health facilities. Though services for RTI treatment have been started, it has not been able to cater to the huge demand for this service adequately. The inadequacies in the health infrastructure and poor staff attitudes towards clients contribute to the low utilization of institutional services for childbirth. Though, the RCH programme emphasizes quality of care and client satisfaction, the quality of services provided in government health facilities is not satisfactory. The most serious aspect of the quality of services is the poor nature of the client-provider interaction.

An important reason for the inadequate implementation of the RCH approach is that while the policy envisages a drastic change in the functioning of the programme, it has not been matched with commensurate inputs to the programme. The programme faces serious constraints with respect to infrastructure, equipment, and vehicles. The programme also has insufficient manpower who are oriented to the RCH approach and are equipped with the necessary clinical and interpersonal skills to provide necessary services which are of high quality. We now discuss the managerial constraints involved in the implementation of the RCH approach in Tamil Nadu.