

ALTERNATIVE APPROACHES FOR DELIVERY OF FAMILY PLANNING, MATERNAL AND CHILD HEALTH SERVICES

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The concept of care to special vulnerable groups has emerged over a period of time. Primarily it merged as a welfare activity provided to groups which were biologically and socially vulnerable. Among the biological factors, period of growth and development during infancy, childhood and adolescence and women during pregnancy and lactation were considered. On the other hand socially deprived groups would include scheduled castes, scheduled tribes, minorities and lately a section of population below the poverty line. Mother and child care emerged as an interest primarily for biological reasons of growth and development and susceptibility to diseases. These groups require additional food intake and special care.

Emergence of Specialities

Mother and child care appeared as a focus of attention even in days when modern medical systems of care were not available. The traditional birth attendants and

the home based remedies provided by grand-mothers to women and children in these age groups are evidence of the same. The speciality of Obstetrics and Gynecology developed early in the history of medical system. Pediatrics as a speciality emerged in developing part of the world around fifty years back with great support and emphasis on the subject of child health by the international agencies such as World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF). In mid 50s, Departments of Pediatrics were established in medical colleges with the idea of providing appropriate educational components in the under-graduate medical education and to develop facilities for treatment of pediatric illnesses.

The concern of pediatricians during those days was primarily to develop their own speciality in the institutional set up. It was later in 1960s and 1970s that the pediatricians started looking beyond hospital care and developed interest in preventive and promotive services which were highly effective and relevant for management of problems of infants, children and adolescents. However, their interest was limited to participation in demonstration centres established as a part of field training centre with the Department of Preventive and Social Medicine.

Maternal and Child Health Care Services

On the other hand, efforts to provide improved care to pediatric age group were being made through creation of cadres of para-professionals on recommendations of the earlier Bhore Committee (1946) and later by other Committees constituted for promoting integrated comprehensive health care to rural masses and introdu

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tion of family planning programme. As such there were two streams of development for mother and child care and these were primarily promoted by health system wherein the responsibility of recruitment and training was taken by experts in public health with partial involvement of specialists in Pediatrics and Obstetrics and Gynecology. This resulted in establishment of centres for basic training of auxiliary nurse midwives/sanitary inspectors/health inspectors throughout the country. Another important element considered crucial and critical by the public health specialists was training of traditional birth attendants (TBAs). Interest of specialists in Gynecology and Pediatrics even in training of the TBAs was marginal. In other words, specialists in the two areas were concerned about improved institutional care to those who were seeking treatment through hospitals and in training of under-graduates and post-graduates, and in research in various aspects of disease problems and their management at institutional level.

Women's Health and Education

It is since last quarter of this century that the two specialists have extended their role and participation in comprehensive health care to children and women in rural areas. As far as women are concerned, emphasis till some time back was again on maternal care. The concept of women's health has emerged even much later. The gender discrimination, the work status and overall socio-economic deprivation of women did not allow women's health to receive special attention. The reproductive health in particular and women's health in general have emerged as focus of attention only during the last one decade. The UN decade of women (1976-85) provided

another dimension to the issues of maternal and child health and women's health and expedited the establishment of national mechanisms for women's development. However, most of the activities related to women development still continue to be positioned in the Ministry of Social Welfare in the Government and as such the welfare image prevails over the development one. This is how we find that there has been gradual and substantial increase in scope of maternal and child health care to women's health and women development.

As far as services to mother and children are concerned, Rosenfield has, even as late as 1985, asked "Where is the M in MCH" (Maternal and Child Health Care). This points out the fact that there was little attention paid to maternal health in comparison to child health care. To sum up, I would like to mention that most of the specialists and professionals involved in areas of maternal and child health in India have primarily been concerned with the health problems of infants and young children. The health status of women of reproductive age group received relatively little attention. This is in spite of the fact that for many years maternal mortality rates have been extremely high in rural areas as well in urban slums in the country.

Integrated MCH Care-Education

Abortive efforts were made by the WHO and Government of India to create greater understanding and awareness of the problems of integrated mother and child care through starting training of Professors of Pediatrics, Obstetrics and Gynecology and Community Medicine in selected centres in the country. Very few medical colleges sponsored and those who

did, sponsored not a team, but one or other specialist and at some times junior faculty members. These were of little help to develop understanding and co-ordination in the training of under-graduates and post-graduates.

Family Welfare Programme and ICDS

With introduction of Family Planning in 1950s, which again was taken up initially as a clinic-based activity, certain services specially of sterilization were made available in clinics established for this purpose. Later on, with adoption of extension approach, para-professionals in primary health centres and sub-centres were involved and an effective support was provided by creating vertical structure in 1966 for this purpose. This included some involvement of specialists from the disciplines of Gynecology and Obstetrics and Surgery for tubal sterilization/vasectomy. Later on another important programme was introduced in 1977 which involved and covered both the mother and child, this was the Integrated Child Development Scheme (ICDS), which had specific focus on children and pregnant mothers in the rural areas basically on aspects of nutrition education, nutrition supplement, immunization and referrals. In this scheme, faculty from Departments of Pediatrics and Community Medicine were involved to a large extent in training, supervision and monitoring. This scheme, however, has been mostly implemented by the Department of Social Welfare at national and state levels.

Efforts for Women Development

Later on a new scheme, namely Development of Women and Children in Rural Area (DWCRA) was started in 1983 as a

pilot programme in 50 centres in the country. This was primarily for income generation, in addition to other services to mother and child. Later another Women Development Programme was started in selected areas to help women organize themselves to receive justice and equity. These two activities were in the Department of Rural Development and Department of Social Welfare, respectively. In other words, Departments which are presently interested in women and children's health and development are (i) Department of Medicine and Health, (ii) Department of Family Planning Welfare, (iii) Department of Welfare/Social Welfare, and (iv) Department of Rural Development. Another department which has been playing consistent role in growth and development of children is the Department of Education, through their efforts to promote early childhood education and care. In spite of these developments over a period of last 50 years, what is the present situation of children's and women's health and development in the country?

Maternal and Child Deprivation and Issues

As far as financial allocations are concerned, it is difficult to look into the components of expenditure incurred on mother and child health care *vis-a-vis* expenditure on other services. In a recent UN report, it has been estimated that one out of three households in the world has woman as its own bread-winner. Similarly, for every woman living in poverty, there are four hungry children. The size of the mother's income has direct bearing on the nutritional health of her children. There is still a continued gender discrimination primarily in the developing part of the world; 2/3 of the illiterate population are women. Nearly

75% of women in the country were illiterate in 1981. Enrolment of girls is also significantly low in comparison to boys in secondary schools. Economic reality often requires that girls help in the field, gather fuel-wood for house and fetch water. As a result many of them drop out of schools to help their mothers. Mother's level of education is one single most important influence on the survival rate of her children and on their achievement in schools. Looking to the above facts, we can conclude that a major transformation in the nutrition and health status of coming generation would occur if girls could go to schools. Nutritional anemia afflicts more than half of all women of child bearing age in developing countries, compared with less than 7% of women of those age groups in industrialised countries. Maternal mortality rates are shockingly high. Life time chances of dying in child birth are one in 38 in South Asia in comparison to one in 6366 in North America. Low level of maternal nutrition combined with frequent child birth are important contributory factors. In India, around 1,25,000 mothers die every year. Major causes of death have also been identified. These include post partum hemorrhage, pregnancy induced hypertension, puerperal sepsis, toxemia, obstructed labor and ruptured uterus and others. Abortion is also an important factor for maternal death specially the illegal abortions. The role played by the rural health services in reducing maternal mortality has not been very significant. This is partly because of the fact that the facilities for management of factors directly associated with maternal death are limited in rural areas and are available only at institutions at district level and above. Under the All India Hospital Post Partum Programme, an effort is now being made to operationalize and provide

some selected services at sub-district level including community health centres.

Gap Between Service Providers and Beneficiaries

Thus, on the one hand the facilities are limited, on the other hand socio-cultural practices, lack of awareness and concerns on part of women themselves and the head of the family, does not permit child bearing mothers and children to reach the institution for such care. They are also not equipped to provide necessary and appropriate care even at home. Therefore, there is a wide gulf between those who require care and those who provide. The medium of communication and channel of transportation are too inadequate for bridging these gaps.

Quality of Care—Certain Aspects

Another important issue in this concern is quality of services. Lack of consistently good quality of service is one of the major complaints against India's maternal and child health and family welfare programmes. Quality of services has its technical and socio-cultural aspects. On the technical side the issues are such as knowledge and professional skills of the service providers, availability of drugs, appropriateness of prescriptions, use of expired and sub-standard drugs, improper and inadequate professional advice and counselling, and errors of facts and judgement on professional matters. On the other hand humane, sympathetic and concerned care from service providers is a mark of service quality.

The very layout in a clinic may reflect quality of care—are women given privacy during examination of treatment? Are there curtains or dividers to assure such

privacy? How long do people have to wait for services? How comfortable are they while waiting? Are people patiently asked about their personal backgrounds and medical histories or are they rudely treated? Are drugs and other services free or are patients charged for items that are supposed to be free? The answers to these questions serve as indicators of quality of services. If they are consistently in the negative, utilization of health services will be very low, for there is nothing more devastating for a service than a report or rumor that it is poor, substandard or life threatening.

Alternative Approaches

It is under these circumstances that we have to look into the alternative approaches for women and child health and development in the national context. A large network for providing health care to these age groups has been developed nationwide. Similarly, a number of vertical programmes have also been started. I am here referring to those programme which are directly related to mother and child health. First and foremost which needs our attention, would be family welfare programme, which started as a population stabilization programme and continues to be so. However, it is professed to be comprehensive and for welfare of mother, child and family. Substantial resources and attention have been paid on this programme at all levels starting from reflected priority in plan documents, allocation of financial resources, identification of manpower, emphasis on monitoring and evaluation, etc. It is a matter of concern that health and family sector outlay during VII Five Year Plan reflected Rs. 3,393 crores for health programmes and Rs.

3,256 crores for family welfare. Over and above this, there is a provision for MCH under the head, family welfare and this comes around 20%. In this context, it may not be out of place to mention, that in the National Health Policy (1983) a set of goals have been laid down, out of which more than 80% are related to maternal, child health and family welfare. Similar goals have also been laid down at the national and international level for children development by the UNICEF and for women development by UNIFEM. At the national level some social indicators have also been identified for women development in the Women's Development Policy.

For planning for the decade of 1990s, it is relevant to ask what was conceptually planned, did it get converted into operational terms? Why inspite of plan provisions, we failed to operationalize the same? Over a period of time new technology has become available for improved health care. Have we been able to use it? Why inspite of support and initiative from international agencies for maternal care, women's health, safe motherhood and for child survival, protection and development, we have not been able to generate sufficient political commitment? Though people now have concern for child spacing and awareness about small family norms, they yet failed to adopt and practice family planning methods?

Certain Assumptions

We have also to make certain assumptions in respect of socio-economic development in the coming decade. Literacy would go up, including female literacy; social backwardness would also get reduced; urbanization will take place; economic imbalances would be reduced; organized

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sector would get strengthened; interest of employers would be in productive workers; small family norms would be increasingly adopted; processes of communication would help demand generation; providers and motivators would become concerned about the quality of care; care by speciality would be in demand; TBA may provide improved care; and facilities of blood transfusion and transport would be available to a large extent and there would be increasing onslaught of medical technology and HIV epidemic.

International Efforts

In a recent document on safe motherhood initiative (1987), a number of direct and indirect programmes have been identified. Similarly, the State of the World's Children-1991 (UNICEF) has also identified specific and support actions for child survival, protection and development. Two major goals under safe motherhood are reducing the number of pregnancies and reducing the risks to pregnancy and child birth from medical factors. Similarly, some of the goals for child survival, development and protection, pertain to reduction of infant, under five, and maternal mortality rates, and severe and moderate malnutrition in under-5 children. In addition there are certain areas which have been identified by both the groups which included status of women, water supply and safe sanitary facilities, women's employment, income generating opportunities, disseminating knowledge for combating hunger and malnutrition, access to information and family planning, women's education with special attention to family and child welfare, universal access to basic education, reduction of adult illiteracy rate, increase acquisition by individual and

families of the knowledge, skills and values required for better living, etc.

Demand Generation

Keeping in view these diverse areas, which are related to overall socio-economic development of women and children, and specific areas for action within the purview of medical and health department, we could divide these into two major groups: Demand Generation and Service Delivery activities. To achieve the goals laid down in the National Policy and to increase demands, we have to organize programmes for demand generation and awareness raising. For this purpose, campaigns are to be launched to change attitudes and behavior towards women and children's health. A number of services have been identified in the country to promote awareness of people about family planning services. However, similar activities for awareness for women's health care, maternal and child health care have been very limited. Various studies have indicated a very high level of awareness of contraceptive methods and it has been reported that the majority of Indians approve of family planning. Similarly, though family planning awareness is almost universal in India, specific knowledge of family planning aspect is quite low.

Poor Knowledge and Skill of Health Workers

The lack of knowledge is quite widespread even among service providers and family planning motivators themselves. Many multipurpose workers are woefully lacking in knowledge about types of contraceptives available, the relative advantages and disadvantages of each one, contra-indi-

cations of each contraceptive, side effects, complications and other matters. Similarly, in a number of immunization coverage evaluations and specific studies on management of diarrhea, multipurpose health workers and even medical officers have been found to be poor in both knowledge and skills to provide these services. Participation of health professionals and multipurpose health workers in demand generation by information dissemination, communication and technical counselling are also very inadequate. The ICMR study carried out on quality of maternal and child health care services revealed abysmally low quality of services provided through primary health centres and sub-centres.

Ineffective IEC

It is understood that awareness creation among general public is significantly hampered by low literacy rates specially among women. Enormous amount of efforts have now been put-in through radio and the print media, television and video on family welfare programmes. Posters, brochures and other printed materials though available in abundant are often wordy, lengthy, poorly laid out and boring. Films, videos, slides and other similar media were often unfocussed in technical aspects as far as messages for specific target audience are concerned. It is also acknowledged that we have failed to recognize that "the most important opportunities for changing attitudes and beliefs and practices occur at points where field workers and users come into contact in clinical setting, through household visits and group meetings".

Poor Image of Health Institutions

"There is no substitute for the image

that consumer receives if staff is not available at PHC, when doctors charge for services that are normally free, when medical supplies are not available, when staff is perceived to be rude or unresponsive to user needs or if staff is not in frequent contact with clients". Demand creation efforts become all the more difficult in respect of rural folks, urban-poor and slum dwellers and other deprived sections of population. In spite of having adopted an integrated service delivery structure that includes mother and child care and family welfare as a vital part of health programme with the Ministry of Health and Family Welfare as the nodal point for the infrastructure, professional staff, and support of peripheral services are not optimally utilized. People are reluctant to visit PHC and sub-centres as point of first contact and referral. Efforts made in this regard of training dais (TABs) as grass root services provider and motivator for family planning programme have also, not given adequate results. So also, the scheme of village health guides has been a dismal failure.

Logistics for Care

Studies carried out on working of grass root level multipurpose health workers have identified various problems faced by them in carrying out multifarious functions ranging from insertions of intrauterine device (IUD), doing immunization, distribution of condoms and pills, preparing rosters of eligible couples, giving injections and providing medication for all sorts of ailments, doing house to house visits, etc. The record keeping and reporting functions of the Multipurpose Workers constituted an onerous job. Logistic support to health units in respect of equipments, instruments, drugs, and other support facili-

ties for providing mother and child care has also been awfully inadequate.

Management Information System

Management Information System which should be a very effective mechanism for identifying problems, allocation of resources and effective supervision and monitoring has not yet been adequately developed. Reporting system seems to be engrossed in gathering statistics that do not have any visible uses for management function. The information gathered hardly helps managerial decision making.

Top-down Approach

The concept of service delivery in India seems to have a top-to-bottom orientation—the central and state governments provide the financial and other resources needed for health and family welfare services and these are handed down to local units and the people. No matter how rich a government is, it would never have sufficient resources to carry out this type of strategy if the people themselves do not exercise self-reliance and mobilize their own resources to meet their needs. People's perception seems to be that family planning and even MCH is of very high priority to the central government and the people are being mobilized to follow this line. However, Maternal and Child Care and Family Planning is not seen as a local felt need. So, higher level governments are expected to provide the resources to meet all programme costs.

Inadequate Co-ordination

Finally, service delivery of Maternal and Child Health and Family Welfare Services

in India is hampered by lack of institutional co-ordination. Within the Ministry of Health and Family Welfare, the different units pursue their functions vertically, often with little co-ordination. There are also co-ordination problems because of the many bureaucratic levels involved at the central, state, district and village levels. As the revised strategy for family welfare goes "beyond family planning" and also covers such areas as economic development, agriculture, women development, employment, education, literacy and community development, the need for institutional co-ordination has become more urgent.

Certain Steps for Effective Delivery of Services

Since the 'Safe Motherhood' initiative in 1987 and adoption of child survival, protection and development plan for the 1990s, it has become imperative that certain specific steps are taken at different levels.

1. In spite of having established Primary Health Centres (PHC) and enlarged its network since 1950s, it has rather been unfortunate that quality of care and coverage of maternal and child health care and family planning has not yet reached its optimum. Various studies have shown that the TBAs involvement and ANMs participation in the activities is not upto the mark.

2. It seems there is limited commitment on the part of the various policy makers and professionals in these areas. There is no reason that maternal and other care is not provided the priority it deserves.

3. Allocation of funds for mother and child care have been specifically worked out under the family welfare budget. In a task force report, it was pointed out the proportion of work being

carried out by the staff in family planning is disproportionate to their involvement in mother and child health care. This needs to be corrected. Increasing allocation needs to be made for these areas at all levels.

4. In a recent report of the Centre for Population and Family Health, Colombia University (1988), it has been brought out that percentage of health component of the total budget was 5.34 in 1984-85. Out of this 16.86% was for family planning. Similarly, of the expenditure incurred on family planning, it was again worked out that 71.2% had gone on contraceptive services. Thus, it becomes evident that the MCH component requires higher allocations.

5. Structure and organization for delivery of health care to women, mothers and children including family planning service deserve rethinking. There have been recommendations to have a National Population Commission which would cover all aspects of population stabilization including those of family welfare. Similarly, Commissions have been recommended for women development as well. Possibility of creating a separate commission for child survival, protection and development at the national and state levels be now considered.

6. The Family Welfare Programme Officers at districts level are also expected to look after the mother and child health. It could possibly be reversed or an additional structure be created for mother and child survival in addition to family planning activities. Presently, posts of Immunization Officers have been created in view of the special focus being given to this programme at all levels. It would be advisable hereafter that such officers are made responsible for integrated mother and child health care activities other than family planning.

7. As is evident, a number of areas of activities in both women's and children's programme as well as for family welfare, pertain to areas outside the Department of Health and as such there is a need for rethinking and reconsideration of creating a new structure which will take into consideration over all activities for status of women and development at state and district levels. Many of the activities towards raising social status of women lie outside the scope of health and family welfare department. As such creating such a body at state and district levels might help in planning and implementation of various activities in this regard.

8. There should be a change in strategy for mother and child care to be provided at all levels. Presently, nearly 80% of deliveries are conducted at home in rural areas and urban slums. The picture may change by the end of this decade. Therefore, simultaneously, we have to work on two fronts—one to encourage establishment of first contact institutions for safe delivery and improvement in quality of home deliveries.

9. Focus of the programme may also be reoriented to adolescent women, primiparas. This would create in due course of time a set of women who had very useful and satisfactory experience with the health services and may like to continue to utilize the services and adopt safe maternal and child health practices. It may also help to focus attention on potential acceptors of family planning. It may seem as if we are neglecting other women for the time being. However, on the other hand we may be creating a satisfied group of young mothers, who would not only adopt health practices themselves, but would become a potential source of information for others in their set up.

10. There is gross inadequacy of data in respect of maternal and childhood morbidities and mortalities. Epidemiological studies have to be encouraged, so as to get the real picture in respect of the disease incidence and prevalence. This would also help us in classifying the country into different areas, which would require specific type of care components and resources. There are areas, where the infant mortality rate is less than 20 and others where it is more than 100. This diversity should make us think of adopting differential approaches for the two different areas. Similar classification could also be done even at the district levels in all the States. If the information in these areas is explicitly available, local areas specific planning could be carried out.

11. Risk approach has been advocated for quite some time. However, this has not yet reached operational level in the field. Neither adequate support has been provided to implement the same nor the concept has been understood and adopted at least at the peripheral levels. Experiments, being carried out recently by Indian Council of Medical Research, have shown its benefit and impediments, which need to be overcome.

12. Decentralization of whole process of health care delivery is an important step for effective implementation of all programmes including mother and child health care programme. Ideally all institutions at district and sub-district level should be controlled and administered by the local bodies. Initially it may seem to be difficult but in the long run such a step is likely to provide responsibility, authority and accountability at local levels.

13. For family planning programme, many motivational strategies have been worked out which include community

based distribution of contraceptives, social marketing and variety of IEC activities. It is essential that in the context of mother and child health care, where accessibility, availability and utilization are equally at low levels, promote similar activities for these programmes as are being carried out for family welfare programme.

14. Monitoring and supervision are key to effective implementation. Major focus of monitoring till today has been oriented towards different vertical programmes. Out of these, major focus has been on sterilization and other methods of contraception. If the monitoring parameters are revised to focus on child care, a significant change can ultimately be expected in the priorities assigned and working pattern of peripheral health workers.

15. It is essential that Pediatricians and Obstetricians take interest in maternal and child health care services at sub-district and peripheral levels. It seems they have been making their sincere efforts to improve institutional care at different levels. However, their involvement and participation in mother and child care services at a sub-district and peripheral level is marginal. It needs total reorientation of the working of Pediatrics and Obstetrics specialists at different levels.

16. Two other essential requirements for successful implementation of mother and child health care programme in the peripheral areas are (i) TBAs involvement through training and motivation, and (ii) orientation and training of female health workers (ANM) and supervisor. The trainings provided are too inadequate for them to get involved. They require skills of communication, supervision, management, team building and leadership; in addition to the technical training. In some areas, link persons have been identified for

around 20 families and they have become nodal points for dissemination of information and motivation. This alternative may also be looked into for effective implementation of various programmes.

17. There is a need for reorientation of under-graduate and post-graduate education in the two respective areas. There should be increasing specialization to provide care to all in different situations, but at the same time specialities of Social Pediatrics and Social Obstetrics should also emerge in the two respective departments.

18. Possibility of having Regional Mother and Child Health Institutes in different parts of the country ranging from four to six may also be considered.

19. In Medical Colleges, the Departments of Obstetrics and Pediatrics should not only help in developing speciality care in their own institutions, but should take charge of all institutions in the district in respect of providing technical and advisory support.

20. Over a period of time it has become evident that state and district level public health officials, though had some training in maternal and child health, had not developed enough expertise to provide thrust and support to activities related to women's health and child care. An effort was made to develop the speciality of Maternal and Child Health by the National Board of Examinations, by instituting a Diplomat qualification in MCH. There is a need for developing this speciality and all district and state level officials looking after these areas should have such qualifications.

21. These developments may need support from educational institutions and the health care system for co-ordinated working MCH officers at the state and

district levels and faculty in Social Obstetrics and Social Pediatrics in the teaching institutions.

22. As per the national health policy, tertiary level institutions must be encouraged through the private sector, while strengthening of the secondary and primary health care institutions be carried out by the State.

23. Lot of interest is being taken by faculty in the medical colleges to undertake research in the two respective specialities. Barring a few exceptions, most of the research seems to be based on institutional care. However, a few comprehensive, longitudinal, field-based studies have been carried out especially in pediatrics. On the other hand, such studies have been very few and infrequent in Obstetrics. Focus has to be on epidemiological and operational research, so as to see that what we propose is operationalized through cost effective and cost efficient methods.

24. Training support need to be provided to peripheral workers and that has to be carried out with effective participation of experts from the system, teaching institutions and management experts. Many of the failures in operationalizing the concepts have been because of poor understanding and management. This needs correction.

25. Successful experiments are being carried out by a number of voluntary organizations, which may provide lot of information for improvization and improvement. Efforts should be made to understand from their experiences and to involve them in identifying innovative alternatives to the present system.

26. Community participation through involvement of organizations such as

Mahila Mandals should be also generated.

In the end it might be worthwhile to mention that women's status, has different parameters of health, education, employment, marriage and children. In a recent publication of Population Crisis Committee (1988), the above four different parameters were considered and again specific indicators under the above four heads were identified. For health, they had identified female infant and child mortality, female mortality in child bearing years, female life expectancy at birth and female/male differential of life expectancy as

indicators of women's social status. This again emphasizes a need for generating sufficient data in respect of women and children's health. National, State and District level surveys need to be carried out to find the real picture and to orient our programmes to the local situation. Great efforts need to be put in by professionals not only in upscaling their knowledge and skills, but to strengthen the facilities at all levels and to play the role of advocacy for obtaining priority to women's health and child care programmes through political and policy making bodies.
