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

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The Government of India has accepted the strategy of primary health care like many other countries, which has been reflected in the National Health Policy document. The policy has identified MCH services as needing priority attention.

The Seventh Five Year Plan envisaged providing antenatal care to 65-70% of pregnant women, two doses of tetanus toxoid to 100% women and 80% deliveries to be conducted by Trained Birth Attendants. The available national statistics indicate that the targets have not been achieved. The results of evaluation study conducted by Indian Council of Medical Research indicated that the quality of antenatal, intranatal, postnatal, neonatal, child care and family planning services was poor(1). However, several Non-Governmental Organizations (NGOs) experiments in the country have shown effective coverage and reduction in neonatal and infant mortality.

The paper, based on the experiences of the Institute of Health Management, Pachod (IHMP), describes some of the alternative approaches used by the programme.

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Background

The IHMP has been implementing a health programme in 52 villages of the Paithan taluka since 1978, covering a population of 60,000.

Maternal and Child Health (MCH) services have been a major component of the health programme initiated by the institute. After conducting a detailed baseline survey in 1978, the IHMP started providing MCH services in its project villages through trained Traditional Birth Attendants and Female Multipurpose Workers.

Alternative Approaches Used by the IHMP

A. *Health Post Strategy*

In the present infrastructure, one Primary Health Centre (PHC) covers 30,000 population with 24 or 25 villages. Each PHC has 6 subcentres with one male and one female multipurpose worker (MPW). In the sixties one multipurpose worker used to cover a population of 15,000. This has been reduced to 5,000 in the eighties. Despite this reduction the coverage of pregnant women and care at the time of delivery has increased only marginally. This is reflected in the high neonatal and infant mortality rates.

A large number of deliveries in rural areas are taking place at home and are conducted by untrained dais and relatives(2). Therefore, a decentralized health delivery system is required with a major emphasis on community based traditional birth attendants(3).

The IHMP decided to provide MCH services using 'Health Posts' in 1978. Health Posts are fixed facilities provided by

the community. The FMPW visits a village on a fortnightly basis and the Traditional Birth Attendants (TBAs) and Community Health Volunteers (CHVs) detect pregnant women during their house visits and inform them to come to the Health Post for examination. The FMPW registers the antenatals, confirms TBA's findings after physical examination and does all those tasks which the TBA cannot perform, such as immunization, checking blood pressure, urine examination and treatment of minor ailments. The FMPW makes planned house visits after the MCH clinic along with the TBA and CHV to register antenatals, postnatals, high risk cases and severely malnourished children.

The FMPWs, who reside at the base hospital are taken to a different village everyday by a vehicle. Thus one FMPW covers six villages in a week and only two FMPWs are required to cover all the villages in the PHC area on a fortnightly basis. Their visits ensure effective coverage of antenatals and provide supportive supervision of grass root level workers. The strategy requires reallocation of resources from salaries and expenditure on maintenance of subcentres to an effective transportation system and incentives for TBAs(4).

B. *Payment Linked to the Quality of Services Provided and Outcome*

The IHMP has introduced a system of payment of incentives to grass-root level workers which is linked to outcome rather than activities. The TBA gets Rs. 20/- as an incentive for every neonatal survival. This has resulted in early detection of pregnancies by the third or fourth month and the proportion of women receiving minimum antenatal care has increased form 57% in 1978 to 74% in 1988(5).

The percentage of children receiving immunization has also increased from 57% in 1977 to 90% in 1989(6).

C. *Decentralized Micro Planning and Monitoring*

A community based surveillance system was introduced in 1987 by the IHMP in all the villages. The objective of this system was to ensure the minimum required antenatal care to the majority of pregnant women and also provide the basis for the advanced planning of the village-wise work-load. FMPWs prepare their planners from the monitors for each village giving details of services to be provided to each woman.

The planner also provides estimation of the work-load and the worker is able to assess her performance against the work-load. This also helps her to manage her time efficiently in the village and also provides the basis of planning for materials.

During the monthly group meetings each worker presents to the team the actual work done as against the estimated work-load. This information is verified by the male MPW during his house visit. Thus there is a built-in system for cross verification and checking. The dynamics resulting at the group meetings give rise to the standard of productivity, which every member of the team tries to achieve.

D. *IEC Strategy for Demand Generation*

The Information, Education and Communication (IEC) strategy used by the IHMP is based on the principle of change from within the community and the theory of substitution. Health education given on 'one to one' basis, only changes individual norms, whereas to increase the utilization

of services and for generating demand, new group norms need to be created.

In the IHMP programme area, women and children are used as change agents to disseminate the information. In Awareness camps they are given the opportunity for self expression and every camp ends with a decision making process. These women take up the responsibility of implementing the decision taken and informing the other community members to do the same.

Pregnant women who come to the Health Post for receiving services are usually accompanied by mothers, mothers-in-law and neighbors. So, there is always a group of women who have gathered at the Health Post, which also serves as a venue for the group interaction and dissemination of information.

The introduction of a comprehensive package including the above four approaches has resulted in the reduction of neonatal mortality rate from 94.8 in 1987 to 39.1 per 1000 live births in 1988. The maternal mortality rate even though not statistically significant has shown a consistent downward trend from 12.0 to 2.1 per 1000 LB in 1988(5).

Conclusions

The existing primary health care infrastructure of the country has not been able to achieve its targets laid down by the Seventh Five Year Plan. This might be due to the higher priority and budget being given to the family planning services and several vertical programmes providing MCH services rather than one comprehensive package. A recent survey by the Indian Council of Medical Research has shown that even basic facilities like weighing machine, BP apparatus and instruments for hemoglobin and urine analysis, *etc.*, are not available to the worker, which also might be responsible for the under utilization of the available services.

The alternative approaches like the Health Post strategy for the delivery of services, payment linked to outcome rather than to the activities, decentralised village based planning and alternative IEC strategy, when introduced as a comprehensive package have proven to be successful in providing effective MCH services. This does indicate that it is possible to achieve national goals if innovative approaches are introduced in the present delivery system with the backing of adequate logistic supplies and with equal emphasis on all three components of the MCH services.

REFERENCES

1. Evaluation of Quality of Maternal and Child Health and Family Planning Services in Primary Health Centres. Indian Council of Medical Research, New Delhi, 1989.
2. Ledam E. Traditional Birth Attendants. Int J Gyne Obstet 1985, 23: 249-274.
3. Bhargava SK. Perinatal and neonatal care: The need for reappraisal and action. Indian Pediatr 1989, 26: 1073-1078.
4. Dyal Chand A, Khale M. Neonatal Services at the Primary Level: Desired Minimum Standards and Relevant Strategies (Unpublished).
5. Dyal Chand A, Khale M. A community based surveillance system for perinatal and neonatal care. Indian Pediatr 1989, 26: 1115-1121.
6. Dyal Chand. Community Financing for Primary Health Care—Report of a Study, Econ Pol Wkly 1987, 22: 951-956.