Reproductive & Child Health Program Implementation in India. Focus Group Discussion with Auxiliary Nurse Midwives in Andhra Pradesh.

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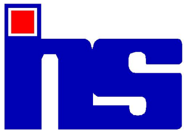

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Reproductive and Child Health Program Implementation in India. Focus Group Discussion with Auxiliary Nurse Midwives in Andhra Pradesh.

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India launched in 1997 the Reproductive and Child Health (RCH) program. The main objective of the program was to meet the total needs of both mother and child, starting from care of the young married girls, ante natal care, child birth and care of new born as well as children under 5 years. It includes components relating to sexually transmitted disease (STD) and reproductive tract infections (RTI). The Andhra Pradesh state in addition drew up a Vision 2020 document setting ambitious health status and population program goals. Female multipurpose health workers popularly referred to as Auxiliary Nurse Midwifes (ANMs) are at the cutting edge of RCH service delivery. To understand various aspects of the program implementation and gain insights for future action, we conducted six Focus Group Discussions (FGD) with 53 ANMs. The specific objectives of the FGD were (a) to seek creative ideas to improve the women and child health status in the state (b) to elicit opinions, perceptions, and understandings about implementation of programs in their respective districts and (c) to discuss about new and potential programs, so as to improve reproductive and child health in the state. We report here results of these ANM focus group discussions[2].

Methods:

The authors discussed among themselves various aspects of the focus group methodology (Stewart and Shamdasani, 1990; Scrimshaw and Hurtado, 1987) to fine tune and align their common understanding. These reviews emphasised the role to be played by the moderator and the recorder, preparation of the discussion guide and how to manage the group dynamics. A discussion guide was prepared to provide direction and set the agenda for the FGD. Briefly, the discussion guide asked the moderators; (a) to exhort the participants to place themselves in the role of the Governor, the Chief Minister, and / or the Health Minister of the state, (b) assume that the participants have full authority but have to operate within the overall socioeconomic environment of the state, (c) collect their life time experience and insights from the field, then (d) ponder how to improve maternal and child health in the state, and (e) how to improve the reproductive and child health services in the state. The moderators and recorders were advised not to suggest potential answers, steer the discussion to start from general issues and then proceed to specific problems, while maintaining a low profile. Pre testing of the discussion guide and a pilot FGD would have been ideal. Due to time constraints these were not carried out, instead a mock FGD was conducted with IHS research personnel as participants. Based on the mock FGD necessary changes were carried out to the final discussion guide.

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[1] All the Authors were at the Institute of Health Systems at the time of the study. The current positions of the Authors, as on December 2003 are as follows. Prasanta Mahapatra: Prl.Secretary, Women and Child Welfare, Government of AP; Panati Samatha Reddy: MCH Candidate, Boston University School of Public Health; N.Mary Nancy, Research Assistant, IHS.

[2] Detailed report of the Focus Group Discussions have been published as Report Series- RP 18/2002. This paper summarises the key discussions and conclusions arising from them.

Six focus groups at the rate of two each in three districts were planned. One district from each of the three regions of the state was selected in consultation with the Commissioner Family Welfare. These are (a) Vizianagaram in the coastal Andhra region, (b) Cuddapah from Rayalaseema, and (c) Adilabad in the Telangana region. In each of these three districts, all the PHC Medical Officers were addressed to nominate two ideal typical ANMs from their respective PHCs. The Medical Officers were requested to identify, as far as possible, sincere, proactive and enthusiastic ANMs who have a comprehensive understanding of (a) the RCH program, (b) women and child health problems, (c) experience in immunisation, (d) good communication and social mobilisation skills, and (e) usually resides at headquarters. In Vizianagaram and Adilabad districts, IHS representative attended the medical officers monthly review meetings to collect the nominations. In Cuddapah, the PHC medical officers were contacted by telephone from the District Medical and Health Officers (DMHO) office to get the nominations. After the collection of nominations, a simple random sample of 20 ANMs from each district was drawn to constitute two groups of ten each. The DMHOs of respective districts issued instructions asking the selected ANMs to participate in the group discussions. An invitation letter was sent to each ANM, informing them the objectives of the group discussion, seeking their presence and active participation.

The six FGDs took place between November - December, 2001. All group discussions took place in a small window of time, without much scope for transcription and sharing of the contents of the discussions in one group with another. Most of this two month period was spent in logistics of conducting the meetings. One person from among the authors acted as a moderator. Another person acted as the recorder. The recorder took notes. In addition proceedings of each group discussion was tape recorded, with prior consent of the participants. None of the groups were briefed about the contents of discussion in other groups. In fact the moderator and recorder would not be aware of the content of discussions moderated by other members of the team.

The Moderator - Recorder team prepared a true transcript of the group discussions using the recorder’s notes and verbatim transcript of the tape recorded conversation. To keep the anonymity of the participants, surrogate names have been used. To keep natural flavour of discussion, the surrogate names were randomly selected from a list of common Telugu names for girls. A map of the real participant name and the research subject name has been placed in a sealed envelope at the Institute. The moderator and recorder’s real name has been retained and appears as such in the true transcripts. Content of the ANM focus group discussions was analysed to identify important issues and policy alternatives emerging from the discussions.

Results:

Many issues and reform ideas appeared in almost all group discussions (Table-1). All ANM groups reported that they find it a lot more difficult to impart health education to illiterate people. The ANMs felt that education of girls helps improve health status in many ways. Firstly educating girls at least up to the high school and some vocational courses there after will increase the age at marriage. Secondly, ANMs recognised that, the educated girls will be more receptive to health education and are more likely to adopt healthy practices. Thirdly, ANMs felt that, education would also give confidence to girls to be more proactive about their reproductive choices. Lastly, some ANMs visualised that, educating today’s girls will help improve tomorrow’s parental attitude towards age at marriage, etc.. The ANMs also recognised the social and economic obstacles towards education of girls. An important social problem recognised by

the ANMs is that educating the girls affects marriage alliances. Parents appear to experience difficulty in finding matches for educated girls and the dowry expectation goes up.

Younger age at marriage of girls and boys was recognised as a problem by four out of six ANM groups. These groups felt that low age at marriage is an important risk factor for maternal mortality. Many of these younger girls are not matured enough to take care of their babies. The predominant opinion among the ANMs was that girls should be married after 21 years and boys should marry after 25 years.

Two ANM groups, one each from Adilabad and Vizianagaram, discussed about the superstitions in Tribal areas and the resultant difficulty in health education. These ANMs recognised that village heads and priests (pujari) in Tribal areas play an important role in sustaining the superstitions. Hence, they suggested that village heads and pujaris from Tribal areas should be specially educated. Although significant changes in attitude to family planning has taken place, many ANMs felt the need for continued awareness building about the usefulness of family planning.

All ANM groups were deeply concerned about the heavy workload and the resultant dilution in quality of their service. All groups found that the population coverage of a sub centre is unrealistically high. The ANMs identified many factors leading to the heavy workload. Firstly, the actual population in many sub centre exceeds the existing norm of 5000 persons per sub centres. Secondly, the change of designation from auxiliary nurse midwife (ANM) to multi purpose health assistant-female (MPHA-F), has expanded their job chart to include all disease control programs and miscellaneous public health activities. Hence, many ANMs felt that they should be given only maternal and child health related work. Thirdly records and statistics work has increased. Some ANMs also mentioned the additional workload on account of household stenciling work to record indoor insecticide spray under the Malaria control program. On the other hand the ANMs ability to deliver services is compromised by lack of any helper, and non availability of any habitation level volunteer to help them in mobilisation of people for health care related work in villages, poor supply of preprinted stationery for periodicals and reports.

All groups were unanimously of the view that the health sub centre population coverage norm should be revised to 3000 instead of 5000 as is the case now. Instead of recruiting male health assistants, more number of ANM posts should be created to staff new sub centres resulting from reduced population coverage norm. Each sub centre should have a helper to assist the ANM. A helper all the more important for remote areas with poorly developed road transport. Even if mopeds are supplied to ANMs by the government, it will be useless since most of the villages and habitations would not be accessible by road. A helper can assist the ANMs to share the burden of carrying her equipment, while walking to these areas. The moped scheme designed to improve ANMs mobility was reported to be not working well. Many needy ANMs do not get the mopeds and some of those who are given are selling them away.

Many other problems affecting the quality of service by sub centres came during the group discussions. One important problem invariably identified by all groups was about availability of sub centre buildings and location of sub centres. Many sub centres do not have a building. There are many disadvantages for the ANMs to operate from rented accommodation. Firstly, rented accommodation is not easily available in villages. If available, the house owners would not like the disturbances due to many people visiting the ANMs place for consultation etc. The rented space would not be enough to see patients, do antenatal

checkups or to conduct a delivery. All ANMs felt that availability of a sub centre building could bring substantial improvement in their services. However, most ANM groups were also concerned the positive aspects of sub centre building may be nullified unless its location is properly chosen. Instances of sub centre buildings being located in outskirts of villages, near burial grounds or wherever government land was available, was mentioned during the discussions. The ANMs were clear that central location within the built up area of a central village is an important factor. Inconvenient location of sub centre buildings severely affects access to its services. Hence, selection of an accessible site and construction of the sub centre buildings on such a site would be the right solution. Yet another problem is lack of minimum facilities and poor maintenance of sub centre buildings. Many sub centre buildings do not have electricity, water supply etc.

All ANM groups appreciated the usefulness of training programs recently organised by the department. The ANMs clearly value the usefulness of continuing education for their work and their self esteem. Many ANMs mentioned that new problems like HIV, hepatitis - B, etc.. are emerging. Some times they encounter certain gynecological problems or for example post immunisation reaction etc.. But they do not have the skills to deal with them. Hence, all groups suggested the need for sustained continuing education programs for ANMs.

Another important problem is the inadequacy of equipment in sub centres. Although sub centres are expected to do antenatal checkups, many of them do not even have a weighing machine or a blood pressure (BP) apparatus. Most ANMs felt, that the sub centres could be equipped to do simple blood and urine tests, to diagnose anemia, and identify high risk pregnancies.

Lack of medicines and supplies was discussed by all groups as yet another major handicap in the sub centres. People in villages expect the ANMs to be able to give simple over the counter type of medicines for common ailments. They should have supplies to dress a wound or give some minor treatment. But the supplies to sub centres consist largely of iron and folic acid tablets. One group commented that drugs are supplied when their expiry dates approaches. The poor quality of syringes and needles supplied for immunisation work was commented during two group discussions. In four out of six groups, many ANMs mentioned that they have to buy out of their pocket, disposable needles and syringes for immunisation program and to meet user expectations. These groups asked that adequate quantity of disposable needles and syringes should be supplied. Some ANM groups mentioned that many women do not tolerate iron and folic acid well and suggested that iron and folic acid syrup should be available. One group of ANMs in Cuddapah felt that they should have supply of sanitary napkins so that they can advise adolescent girls in rural areas about menstrual hygiene. Yet another supply problem is about pre printed stationery mentioned by one group from Adilabad and another group in Cuddapah. The reporting work load has increased over time. Added to that pre printed stationery is not supplied. As result ANMs have to spend a lot of time in first preparing the reporting formats and then filling them up with data.

Let us now turn to matters at the Primary health center (PHC) level. Non availability of medical officers at the PHC and resultant loss in credibility of the PHCs was uppermost in the minds of ANMs. The issue came up in all the six group discussions. In addition, the ANMs recognised many factors contributing to poor support from PHCs. Facilities for emergency obstetric care is not available in most PHCs. At the least, medical termination of pregnancy services should be available in all PHCs. A staff nurse should always be available in the PHC. A lady doctor (obstetrician) should be there.

Table-1: Commonly identified problems and suggestions emerging out of the six focus group discussions by ANMs in Andhra Pradesh.

Problem / Suggestion	ANM Groups[1]					
	1	2	3	4	5	6
It is easier to persuade and convince educated women about health issues, compared to illiterate women. Need education for girls.	Y	Y	Y	Y	Y	N
Younger age at marriage is an important risk factor. Girls should marry after 21 and boys after 25 years.	Y	Y	N	Y	Y	N
Very high work load. Too many villages. Large population. Too many programs. Population may be about 3000. Sub centre area should not cross Gram Panchayat boundary.	Y	Y	Y	Y	Y	Y
Male workers are redundant. Instead, create more ANM posts to reduce the population coverage of sub centres.	Y	Y	Y	Y	Y	Y
Full or part time helper to assist the ANM. Honorary Community Health Volunteer (CHV) / Dayas required.	Y	Y	Y	Y	Y	Y
Sustain and expand recently introduced continuing education for ANMs.	Y	Y	Y	Y	Y	Y
No equipment and inadequate supplies. Except IFA tablets, no other medicine to treat common ailments.	Y	Y	Y	Y	Y	Y
Inadequate supply and poor quality syringes and needles.				Y	Y	
Most sub centres do not have a buildings. Many of those with buildings are inconveniently located in the outskirts and are poorly maintained.	Y	Y	Y	Y	Y	Y
To many records prescribed for ANMs. Duplication of information in different registers.	Y	Y	Y	Y	Y	Y
Non availability of medical officers in headquarters reducing people's confidence in PHCs.	Y	Y	Y	Y	Y	Y
Lack of transport is an obstacle for villagers to access of the PHCs and Sub centers. Need vehicles in PHCs.	Y	Y	Y	Y	Y	Y
Poor referral services at PHCs and Govt. Hospitals	N	Y	Y	Y	Y	Y
Programs not reaching targeted people. Poor management.	Y	Y	Y	Y	Y	Y
Telephone at PHC will help.				Y	Y	Y
Large multi-dose vials leads to wastage of vaccines.				Y	Y	

[1] 1 = Adilabad-1, 2 = Adilabad-2, 3 = Cuddapah-1, 4 = Cuddapah-2, 5 = Vizianagaram-1, 6 = Vizianagaram-2.

Lack of transport facilities was cited during the course of all six group discussions. However, no simple solution appears to be feasible. Some ANMs felt that availability of vehicle in each PHC might help. Yet others mentioned that in some PHCs, available vehicle is monopolised by the Medical Officer. As a result the vehicle would not usually be available for transportation of patients. Some ANMs suggested that availability of telephones in PHCs and sub centres will be of help. They can at least call to find if the PHC Medical Officer is available. That will help them to refer emergency cases to an institution where service is likely to be available. The telephone will be useful in PHCs where a vehicle is available and

the Medical Officer deploys it for patient movement. They can telephone the PHC and request for the vehicle to come to the village instead of losing time.

Poor leadership and supervision by the PHC team was cited by the ANMs as an important cause of their worry. Supervisors from the PHC viewed their role more as bosses over the ANMs rather than resources. Barring few exceptions, most supervisors would not make alternate arrangements to keep up immunisation service schedule, even if the ANM has to go on other official duty. They would not have much interest to listen to the ANMs problems and find appropriate solutions. Instead, the supervisors are usually interested in achievement of targets, reporting of figures, maintenance of records, i.e. more on the procedures and documentation, rather than on service quality. Some ANMs mentioned about the good support by their respective Medical Officers. These ANMs reported that the doctors visit regularly, and make surprise visits as well. In some of these PHCs there are two medical officers. They take turns so that one MO would look after out patients and the other would make field visits. Barring a few such exceptions, appropriate support from the PHC Medical Officers appears to be lacking. Many ANMs recognised that Medical Officers could strengthen the ANMs hand in many ways. Regular visits by the doctor to see patients at the sub centre will increase confidence of villagers on the ANM and the sub centre. Specialist visits to villages at regular intervals will further enhance the confidence of villagers on the sub centre and PHC system. Doctors could endorse ANMs actions to villagers. Doctors could strengthen the ANMs position by giving taking care of patients referred to the PHC by ANMs. A few ANMs reported instances of patently poor management practices adopted by some PHC medical officers. For example, some Medical Officers require ANMs posted in sub centres to come to PHC headquarters daily, sign the attendance register and then only proceed to villages for field work. As a result the ANMs have to waste a lot of time in traveling to and from the PHC headquarters.

Most ANM groups, noted with concern, lack of support by first referral hospitals. Here also Medical termination of pregnancy (MTP) services are not easily available. Patients have to pay for MTP services. A group in Cuddapah mentioned that class-IV employees in government hospitals are demanding money from patients. Specialists and doctors in first referral hospitals do not pay much attention to cases referred by a PHC or a sub centre ANM.

We now turn to ANMs experiences about implementation of specific RCH programs. Five out of six ANM groups complained about faulty implementation of the National Maternity Benefit Scheme (NMBS). This scheme aims to put some purchasing power in the hands of pregnant women from poor households, so that they can have supplement their food intake. But, in practice, NMBS money is paid after delivery. The money is routed through the Mandal Development Officers. During the Medical Officers workshop organised for the same project, it was learnt that the operational aspects of NMBS is significantly controlled by District Collectors. Most of the Collectors view NMBS as an additional source of funds to enhance the incentive package for acceptors of sterilisation operation. Since Mandal Revenue and Development Officers are mobilised by the District Administration, during family planning drives, the NMBS money is routed through the MDOs. ANMs recommended that the NMBS money should be routed through the PHC Medical Officer. The money should be paid in two installments before delivery. The first installment could be immediately after registration and the second installment around six to seven months of pregnancy. This, the ANMs believe, will improve registration for Antenatal checkup and will also make the money available for the mother to supplement her nutrition, i.e. the purpose for which it is meant.

Three out of the six ANM groups discussed about problems of implementation of the Sukhibhava scheme, which aims to encourage institutional deliveries. Women from poor

households, delivering in the PHC or a government hospital are paid Rs300 after the delivery, to defray the additional costs of hospital delivery. The ANMs reported non payment due to problems of certification of income, and suggested that the Medical Officer should have the authority to sanction this amount. Some ANMs pondered, why deliveries conducted at the sub centre are not entitled to this incentive.

One group of ANMs discussed about faulty implementation of the Arogya Raksha scheme. This is an insurance scheme covering medical care for acceptors of sterilisation operation. The ANMs felt that the scheme idea is good. But implementation is poor. The listed private hospitals do not show any interest to take these patients in.

Some ANM groups were concerned about unrealistic sterilisation targets under the family planning program. There is usually a lot of variation between estimated and actual number of eligible couples. Where the actual eligible couples are less, the ANMs have difficulty in achieving family planning targets. ANMs reported that acceptance of oral contraceptives, and intra uterine devices is poor, since these are associated with a lot of side effects. The quality of Nirodh brand of condoms was also reported as poor.

The Balika Samrakshana scheme was mentioned. Here again the ANMs felt that the idea is good. In case of poor families getting a girl child, the government deposits a lump sum money in a bank account. The family would get some money for the girl's education and marriage after a gap of certain years. But there appears to be some lack of confidence. No family appears to have actually received money under the scheme.

Some ANM groups pointed out the large scale wastage of vaccines due to unrealistic vaccine packaging decision. In rural areas, they do not get very large number of children for immunisation on any single day. But the multi dose vials once opened would not stay viable for long. ANMs, felt that, the BCG vaccine vials could be made smaller containing about five doses.

Summary & Conclusions:

Focus Group discussions were conducted with the Auxiliary Nurse Midwifes (ANMs) from three districts. Two groups of ten participants from each district were randomly selected from a panel of ideal typical ANMs nominated by Medical Officers working in PHC of respective districts.

Many of the ANM groups, were concerned about persisting superstitions and difficulty in imparting health education. All ANM groups felt that education of girl child will help improve health status. Younger age at marriage of girls and boys was recognized as a problem by four groups.

The ANMs expressed that it is easier to persuade and convince educated women about health issues. Another argument to educate the girl child, is that it gives confidence to be more proactive about their reproductive choices. Village heads and pujari (priests) play an important role in sustaining the superstitions and hence the need to educate and train them.

All the groups were concerned about the heavy workload and the resultant dilution in quality of their service. An unanimous view that the sub centre population coverage should be revised to 3000 instead of 5000 was strongly expressed. Full or part time helper is required to

assist the ANM. Lack of transport facilities was cited among all the six discussions. The moped scheme designed to improve ANMs mobility to be fully operationalised.

Availability of sub center building can bring substantial improvement in services. But inconvenient location of sub center buildings also severely affects access to its services. Hence accessible location of sub center building would improve the delivery of health care service. Another important problem is the inadequacy of equipment, medicines and supplies in sub centres.

At the PHC level, non availability of medical officer in the headquarters reduces the people's confidence in the PHCs. Regular visits by the medical officer to the sub center will increase confidence of villagers on the ANM and the sub center. Poor leadership and supervision by the PHC team was noticed. Supervisors are usually interested in achievement of targets, reporting of figures, maintenance of records, procedures and documentation rather on quality of service delivery.

The groups flagged many instances of faulty program implementation. There is usually a tendency for certain important program features to be diluted or altogether altered at the stage of implementation. Hence concrete evaluation and qualitative studies of delivery process at the cutting edge would help improve program impact. Some ANM groups were concerned about unrealistic sterilisation operation targets that they have to meet.

There was a felt need for sustained continuing education programs would improve the skill of ANMs in dealing with new health problems like HIV, hepatitis B and post immunisation reaction etc. All ANMs groups appreciated the usefulness of training programs organised by the family welfare department.

Most ANMs noted with concern, lack of support by first referral hospitals. Availability of vehicle in the PHC and telephone facility in the PHC and sub center will help to refer cases to an institution where services is likely to be available.

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