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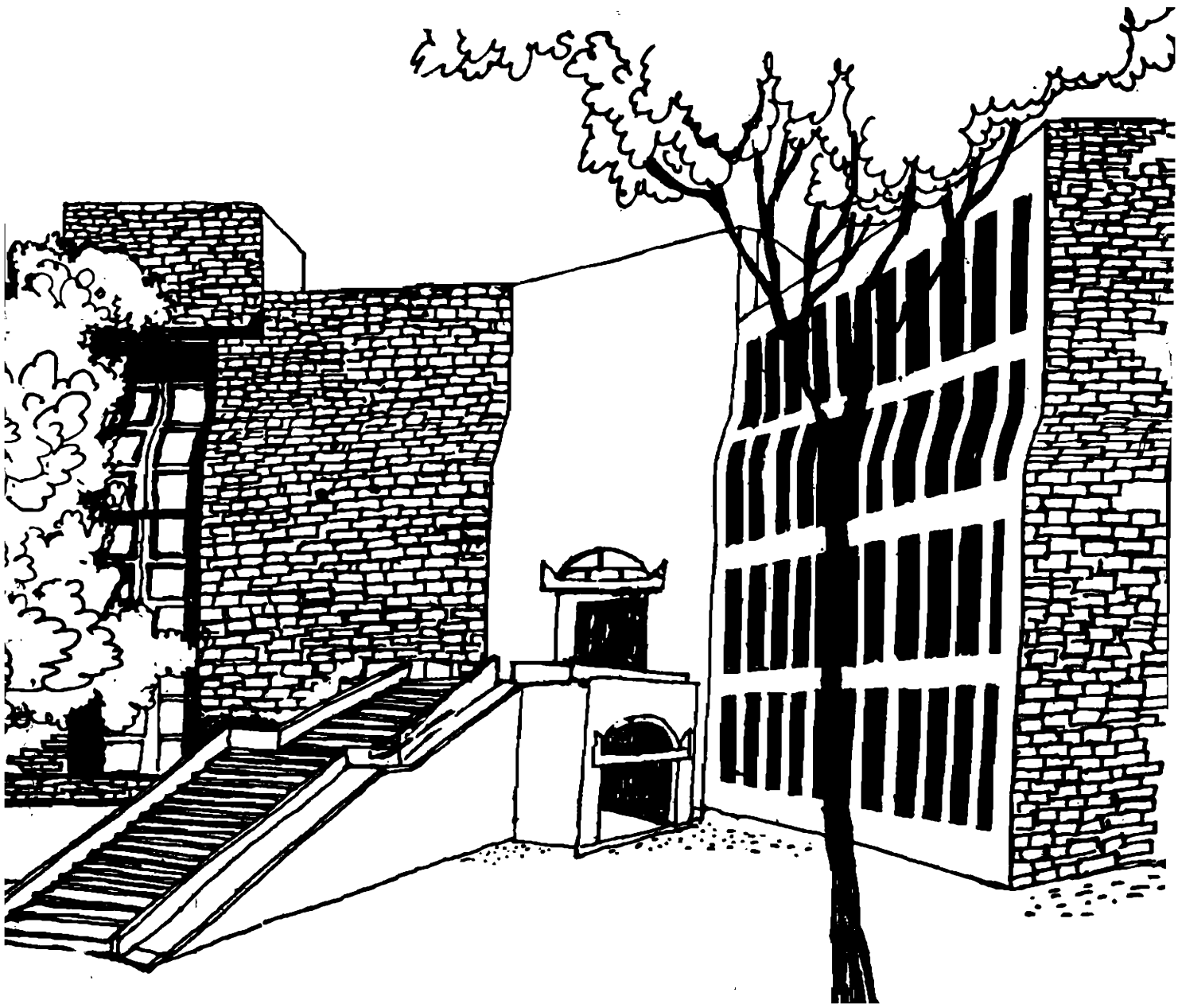

REVIEW OF THE SAFE MOTHERHOOD PROGRAMME IN INDIA IN THE CONTEXT OF REPRODUCTIVE HEALTH: ACHIEVEMENTS, ISSUES AND CHALLENGES

By

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Review of the Safe Motherhood Programme in India in the context of Reproductive Health: Achievements, Issues and Challenges[1]

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Abstract:

Following the Safe Motherhood Conference in Nairobi in 1987, there has been a renewed focus on the problem of maternal mortality and safe motherhood. Global advocacy led to the starting of new initiatives on safe motherhood in many countries. India launched a major programme in 1992 called the Child Survival and Safe Motherhood (CSSM) programme with assistance from World Bank, UNICEF and other donors. The child survival component of the programme was a continuation and expansion of previous child survival activities such as immunisation, ARI and diarrhoea management. While the design of the Safe Motherhood programme based on major new understanding of preventing maternal mortality through Emergency Obstetric Care (EOC) which was a major departure from the old MCH and high risk approach of the 1970s. This paper reviews the developments in the are of maternal health in India that took place in India soon after CSSM programme. It assesses the inputs, processes, outcomes and possible impact of the safe motherhood part of the CSSM. It also discusses the various issues and problems that the programme faces. This paper critically assesses the plans made for safe motherhood under the RCH project and put forth recommendations for improving the activities being planned for Safe Motherhood in future.

[1] This paper is prepared for a volume being published by Population Council for ICPD +5 meeting in The Hague to be held in February 1999

Background

Maternal mortality and maternal health have been one of the foundations of public health development in the western world. In developing countries also, focus on maternal and child health (MCH) along with other disease control activities have played a prominent role in the development of public health. In India, the MCH programme started in early 60s with the establishment of Primary Health Centres (PHCs) and Sub-Centres. In spite of this long history, maternal health was neglected in India and other developing countries untill recently. The Global Safe Motherhood Conference organised by the World Health Organisation (WHO) and other donors in 1987 in Nairobi focused attention on high maternal mortality in developing countries. Following this conference, WHO started the safe motherhood programme and several developing countries, including India, developed specific programmes to address maternal mortality. Recently the International Conference on Population and Development (ICPD) also recognised safe motherhood as a priority in its programme of action (UN 1995).

This paper traces the development of maternal health services in India after the Safe Motherhood Conference. It critically analyses the achievements in safe motherhood so far and some of the problems in operationalizing the safe motherhood programmes. The paper draws lessons from past experience and relates them to the plans made for safe motherhood activities under the new reproductive and child health (RCH) programme.

New Understanding of Preventive Maternal Mortality

In the sixties and seventies, maternal health services under MCH focused on ante-natal care and high risk approach. The basic idea was that good ante-natal care alongwith high risk approach will help in reducing maternal mortality. The second area of focus was to train traditional birth attendants (TBAs) to improve their delivery practices. It was thought that TBA training will also lead to reduction in maternal mortality. After several years of this approach it was discovered in mid-eighties that maternal mortality was still very high in many developing countries including India. A re-look at the causes of maternal death and the socio-medical factors contributing to maternal death brought out a completely new understanding of how to prevent maternal mortality This research showed that cost effective ways of reducing maternal mortality was by way of providing emergency obstetric care (EOC)[1] to mothers who develop complications during delivery. It was also demonstrated that it is not possible to predict which mother will develop complications and hence the high risk approach really does not help much. It was also shown that using the high risk approach many more women will be referred who will eventually have normal delivery thus discrediting the referral process. It was further shown that maternal death generally happened after hours to days of developing complications, and

hence there is time to take a women to a place where complications could be handled. If obstetric complications are handled effectively the mortality could be substantially reduced. It was also shown that once major obstetric complications which can cause death develops, even a trained TBA or a nurse cannot do much at home as many of these complications require surgical interventions, injectable antibiotic and other aggressive treatment. Given all these arguments it was proposed that development of First Referral Units (FRUs) where emergency obstetric care can be provided would be required to reduce maternal mortality. It was also argued that development of FRUs was the most cost effective way of reducing maternal mortality (Main 1991). World Health Organisation also changed its view from promoting high risk approach to providing emergency obstetric care through first referral unit. This approach was also accepted by many international donors and became the main strategy for preventing maternal mortality.

India's Child Survival and Safe Motherhood Programme

In the mid-eighties, following the success of Small Pox eradication and expanded programme of immunisation, UNICEF helped launch Universal Immunisation Programme (UIP) with the objective of reaching 100% children under 5 years of age and pregnant women with basic immunisations. By 1990, the reported service statistics showed near 100% coverage of vaccination in these groups. This was seen as a great success and a major achievement in the country of the size of India. Following this and in view of the uncomfortably high maternal mortality, Government of India decided to expand their focus from immunisation to a wider programme which would include various child survival and safe motherhood interventions. UNICEF, and other donor agencies played a key role in the development of a new programme of Government of India, which was called Child Survival and Safe Motherhood (CSSM) (GOI, 1992).

This programme was supported by the World Bank and UNICEF was requested to become the key technical support agency for it. The total programme budget was about 330 million dollars of which major part was from the World Bank. The programme was for five years and covering the whole country. About half of this amount was for safe motherhood activities (World Bank 1991). UNICEF also contributed financially to the programme.

Programme Design

The CSSM programme had two major objectives. Firstly to reduce infant and childhood mortality, and secondly, to reduce maternal mortality This programme included several interventions for child survival as well as for safe motherhood. These interventions are listed in table 1 (GOI 1994).

Table 1. Key interventions in the CSSM programme.

Child Survival Interventions	Safe Motherhood Interventions
Essential new-born care	Immunisation for pregnant women
Immunisation	Prevention and treatment of anaemia
Management of diarrhoea	Antenatal care and early identification of maternal complications
Management of Acute Respiratory Infections (ARI)	Delivery by trained personnel
Vitamin A prophylaxis	Promotion of institutional delivery
	Management of obstetric emergencies
	Birth Spacing

The goal set for the safe motherhood part of the programme was to reduce maternal mortality from 4 per 1000 births to 2 per 1000 births by year 2000. The strategy for reducing maternal mortality included establishment of First Referral Units for providing emergency obstetric care. These FRUs were to be developed from existing community health centres (CHC) by selecting and upgrading one CHC out of four or five. It was envisaged that each FRU will provide all the emergency obstetric services suggested by the WHO including caesarean section. The project provided funds for equipping the identified FRUs. There was a plan to provide skill training to the staff of FRUs.

The second aspect of the strategy was to improve maternal care including ante-natal care at village level by converting existing village level immunisation sections to mother and child protection sections (MCPs). In these MCPs, the mother would get full ante-natal care as well as identification of high risk cases and referral. Training of TBAs was also going on in this period under other projects. The TBAs were to be given disposable delivery kits to perform hygienic deliveries. The project also provided for equipment kits and drug kits to the sub-centre where the auxiliary nurse mid-wife (ANMs) would provide maternal care Under the CSSM project a monitoring system was to be developed to assess the programme output and the impact.

The project was to be implemented through the existing staff. The District Immunisation Officer was to look after the CSSM programme and the state MCH Officer was in charge at the state level. The support to some staff for maintenance of cold chain equipment, started under universal immunisation programme, was continued.

The strategy also included effort in the area of Information, Education and Communication (IEC) to make people aware of this new programme. This was in continuation of similar efforts made during the universal immunisation programme.

The strategy also had a component of training staff at various levels to orient them to new initiatives and provide some skill up-gradation. (World Bank. 1991, GOI 1994)

Implementation, Issues and Problems

Because of various reasons, only some of the activities planned under CSSM could be implemented. The activities which got implemented were training, equipment supply, and some monitoring. Here we describe these in brief and discuss issues and problems in implementation of components related to safe motherhood.

Within the child survival interventions, immunisation was reasonably well implemented as it was a continuation and consolidation of universal immunisation programme which was implemented as a top priority programme during 1985-90 with very active support of UNICEF. Other components of child survival such as treatment of diarrhoea, Acute Respiratory Infections (ARI) and neo-natal care were neglected because they did not receive as high a priority as immunisation, were not monitored closely and these programmes depended on the regularity of field work by health workers which could not be ensured.

Training

It was envisaged that all the key functionaries would receive orientation training as well as skill development training. As the programme evolved a short orientation-cum-skill development training of five to six days duration was implemented. The training covered all the above mentioned components of CSSM programme and also had modules on planning and monitoring the programme. For this training, it was decided not to rely on the existing training set up in terms of Regional Health and Family Welfare Training Institutions, ANM and Male Worker Training Schools due to their poor capabilities and image. At various levels ad hoc teams of good trainers and medical officers were selected who then trained the lower level staff. The training was based on five modules for medical officers and one module for health workers which covered various aspects of CSSM.

Our analysis of the training showed that it was too brief to be skill training. One of the five modules for medical officers was on safe motherhood. Similarly only a small portion of the health worker's module was devoted to safe motherhood topics (GOI 1992). There were hardly any practical sessions in the training. Many of the newer concepts were presented in a confusing and unclear manner. The new understanding of maternal care focusing on importance of emergency obstetric care was not very clearly and forcefully conveyed It did not cover life saving skills which could be practised by the ANMs or medical officer in case of

obstetric emergencies. The training was delayed and interrupted in some states. (Christensson et al 1997). The quality of training was not very consistent The training was not closely linked to supply of medicines and equipment and monitoring. Supplies and equipment came several months to year after the training. Hence many of the skills which may have been learned during the training were never implemented (Mother Care 1996).

In the original project design, there was a component of skill development training which never got implemented. The skill development on maternal health aspects was completely neglected. The module for skills development for maternal health was not prepared. Skill development was an important part because many of the staff in the system including the doctors did not have the skills for providing normal as well as emergency obstetric care. It was quite clear that one would not get a qualified obstetrician at all the FRUs and hence training general doctor and lower level staff was very crucial.

Equipment

Large amount of equipment were purchased and supplied to FRUs, PHCs and Sub centres. The equipment were of very high quality, imported and potentially very useful. Unfortunately, procurement of quality equipment and supply on such a large scale became a major logistic exercise as India has more than 1700 FRUs, 20,000 PHCs and 130,000 sub centres. There was substantial delay in procurement and supply of equipment because of various reasons and this hindered the implementation of the programme substantially. On the other hand, it was also reported that many of these equipment at various levels were not put to use and at times not even opened from their original boxes because of various reasons and lack of monitoring of work under the programme. Some of the equipment were such that they could not be used given the skill level of the providers or the lack of reliable electricity supply to FRUs. The equipment were supplied without taking into account existing equipment thus leading to duplication. (MotherCare 1996).

Staffing

The most critical problem has been staffing of FRUs. There are no national data available on completeness of key staff at FRUs. It is estimated that not even half of 1748 FRUs identified are fully functional (GOI,1998) But many of them do not have key staff such as obstetrician, paediatrician and anaesthetist. Government of India RCH document also points out that FRUs have not become fully functional due to lack of specialist staff, equipment, drugs and infrastructure (GOI 1997). Data collected from one of the advanced states highlights the staffing problems of FRUs. The state has 88 FRUs of which only 19 have obstetrician, 18 have paediatrician and only 7 have anaesthetist. Data from other advanced states shows that out of 123 FRUs identified only 14 have all the four

specialists viz. obstetrician, paediatrician, surgeon and anaesthetist. In this state the problem is not of lack of availability of specialists, it is more of posting them in FRUs which are located in smaller places.

It was never realised that substantial part of EOC work can be done by a basic doctor with MBBS degree with adequate training. Such skills up-gradation of the basic doctor working in PHC or in FRU has not been done in most states. One of the reasons put forward for not doing such training is the fear of litigation by the patients against the doctor if something goes wrong. This fear has increased after enactment of Consumer Protection Action in India which also covers health services. Similarly, ANM can provide obstetric first aid after some skills training. But such training was also not implemented under CSSM.

EOC functions can be divided in to three levels (EO first aid, Basic EOC and Comprehensive EOC) that can be done by staff of different levels as shown in table 2. But in CSSM project such clarity of EOC functions was not there and hence staffing and training was not planned accordingly.

Table 2: Components of three levels of EOC that can be offered at different levels of facility in PHC system through different level of staff.

EOC Components	Midwifery First Aid & FP	Basic EOC	Comprehensive EOC
Facility level Type of staff	**Sub-Centre ANM**	**PHCs/CHCs MO**	**FRUs Specialists**
Parenteral antibiotics	√	√	√
Parenteral oxytocic for third stage of labour and PPH	√	√	√
Parenteral anticonvulsant	√	√	√
Manual removal of placenta		√	√
Removal of retained products		√	√
Assisted vaginal delivery		√	√
Repair of vaginal and perinatal tears		√	√
Partograph		√	√
New-born Care	√	√	√
Medical treatment for complications or existing condition with special emphasis on anaemia	√	√	√
Caesarean section			√
Anaesthesia			√
Blood Transfusion			√
Family Planning Services	√	√	√

(Source: MotherCare 1996)

IEC and Community Participation:

Some efforts were made in IEC during the CSSM programme But they were limited in scope and actual implementation in field. In the IEC materials produced and efforts made, SM messages received low priority, further limiting its effectiveness for maternal health interventions. Design of the project had limited component of community participation through Mother's meetings. But they were not done on a large scale and when done were more information giving rather than participation generating.

Service delivery:

Many of the interventions envisaged in the SM component of the CSSM programme never got implemented. For example the Mother and Child Protection session to provide ANC at village level was not systematically implemented. Content of ANC remained weak and was limited to TT vaccination and IFA distribution in most places. A study in 24 districts of 13 states by Indian Council of Medical Research (ICMR) clearly showed the limited range of services provided in various components of maternal care (ICMR 1997) . Identification of high risk mothers and complications during delivery were also never systematically implemented. EOC did not become opertational in most places. Thus service delivery did not improve much for maternal care interventions under CSSM.

Access to Blood:

No systematic efforts were made in the CSSM programme to improve access to blood at FRUs On the contrary, during this project period access to blood become more difficult as the supreme court passed an order to ensure blood safety. The order decreed that only those blood banks which comply with the government's guidelines should be allowed to function. Given that government guidelines were very utopian many of the government and private blood banks had to be closed down, thus making blood more difficult to get. Unfortunately the situation has not changed since then and hence it is likely that more mothers may be suffering because of lack of blood now than before the closure of blood banks.

Supervision and Monitoring

The supervision and monitoring aspects of the programme focused much more on some child survival interventions such as immunisation and only a few safe motherhood interventions such as TT immunisation. and distribution of iron folic acid tablets. There was hardly any monitoring of operationalization and functioning of the FRUs. Even now it is very hard to get data on basic parameters such as how many FRUs are fully functional and how many

emergency obstetric care procedures including caesarean have been done at the FRUs. During the project there were detailed guidelines development for monitoring FRU functioning but these were never operationalized. It seems even at national, state and district level most of the monitoring was focused on family planning and immunisation programme.

In the World Bank Staff Appraisal Report it was indicated that national and regional level maternal mortality review committees would be established to monitor, evaluate and assist Ministry of Health and Family Welfare in the development of future strategy and reporting for maternal mortality and morbidity. These committees were to be established by 1st April, 1992. (World Bank 1991). These committees were never established or established only on paper. Thus the monitoring of even the basic data, such as number of maternal deaths and their causes, is not available in most states.

One of the key reasons for lack of supervision and monitoring of this programme seems to be lack of priority given to safe motherhood component within the CSSM programme. Secondly, there was no specific officer at each level designated to look after the safe motherhood component of the programme. UNICEF, the technical agency supporting the CSSM, did not have strong focus on safe motherhood nor it had adequate technical staff to monitor SM activities. Hence the safe motherhood component got neglected in implementation and monitoring.

Impact of CSSM programme

Assessment of impact of such a large national programme takes time and effort as well as good data collection systems. Unfortunately, in India vital registration is fairly incomplete and hence does not give important outcome data to monitor health programmes. In the CSSM programme, no systematic effort was made to develop management information system which will give detailed information on various maternal health interventions. Most information in MIS was focused on immunisation programme and family planning. The little information on maternal health that was collected was also very superficial and unreliable. For example, a review of safe motherhood programme done in 1996 showed that less than 10% of maternal deaths were being reported in the CSSM reporting format. (MotherCare 1996) Recent information from one of the more advanced states showed that only about 20% of maternal mortality is being reported. In this state the number of maternal deaths reported under the special cause of death survey is also not more than 40-50% of the expected deaths. The ante-natal care being reported was mainly of ante-natal registration and ante-natal contact rather than ante-natal examination. Some data collected on number of caesarean sections done in FRUs in three districts in a advanced state indicate that each FRU was doing about 22 caesareans in one year while the estimated need for it was about 600 in one year per FRU. This indicates the low level of performance of FRUs.

There have not been any national survey or systematic study to assess the impact of CSSM programme. Only some quick reviews have been done of the programme which provide some information on the programme implementation and outcomes (MotherCare 1996; Christensson 1997, Mavalankar 1996). The second round of National Family Health Survey will cover some of the indicators of impact of this programme, but the data for this survey will only be available in latter part of 1999. There have been a series of Multi-Indicator Cluster Surveys (MICS) supported by the UNICEF which provides district level data on various maternal and child health indicators. The selection of districts in this survey is such that it does not ensure strict representation of the whole country in any one round, and hence the comparability of data between rounds of survey could be problematic. But it does give some information on the levels of coverage of various MCH services, and hence could be used as one of the data to compare the coverage before and after the CSSM programme. But unfortunately such national compilations of MICS data are not readily available in published form.

There are no systems to measure maternal mortality or morbidity. Hence it is not possible to study change in these indicators. Some surrogate indicators could be used to assess the impact of the CSSM programme on maternal mortality. Proportion of delivery attended by trained staff (doctors and ANMs) and proportion of institutional delivery could give some idea of coverage of maternal health services. Other outcome indicator is infant mortality rate (IMR) which would be affected by the child survival as well as maternal and perinatal care which were part of the CSSM programme. Some of these data compiled from various secondary sources are given in Table 3.

Table 3: Infant Mortality Rate, Coverage TT immunisation and IFA and Type of Attendants at Delivery in India

Programme /Year	1981	1983	1990	1991	1992 (cssm began)	1993	1994	1995	1996	1997
IMR	110	105	80	80	79	74	74	74	72	72
TT (%) Immunisation				55*				67**		
IFA coverage				51*				69**		
% Births in institutions @		19.2	22.9	24.3	24.4	24.5	22.3	25.2		
%of births (at home) attended by trained professionals @		18.1	21.3	21.9	22 9	24.3	27.7	28.2		

@ data from Sample Registration System, * data from NFHS (IIPS 1995),
** data from MICS.

This table indicates there has not been any substantial improvement in these

indicators after the CSSM programme except in TT immunisation and IFA distribution. There is a overall improvement happening over the last several years which has continued in other indicators. There is hardly any impact of the programme seen on infant mortality rate. Thus the available data do not indicate great improvement after CSSM.

One may want to ask the question that given all the problems of implementation in the safe motherhood component of CSSM enumerated above, is it even worth looking at the impact of the SM component of CSSM programme? Because several of the interventions planned did not take place and the monitoring system planned could not be set up, it is hard to imagine that the programme had any substantial impact on maternal mortality and morbidity.

Lessons from CSSM programme:

The planning, design and implementation of safe motherhood programme under CSSM provides several key lessons for future programming in safe motherhood. Here we discuss these lessons in brief.

1. Clarity of strategy and intervention. In the safe motherhood component under the CSSM programme, one finds a mixture of the old ante-natal care and high risk approach as well as the new emergency obstetric care approach. This led to the situation that the safe motherhood interventions became very wide and defused leading to very little achievement in any of the specific components. For example, neither ante-natal care improved much nor EOC became widely available and used. Had the programme focused only on establishing and ensuring utilisation of EOC, then it would have been more successful than the present scenario. The lesson emerges from this experience is that the intervention should be focused on most critical element which will lead to decline in maternal mortality.

2. Co-ordination and consistency between various inputs such as training, equipping and monitoring. In the CSSM programme there were lot of delays between training, supply of drugs and equipment. There was no consistency or correspondence between inputs and monitoring of programme process and output. Secondly, there was also substantial mis-match between these three key elements. Hence the programme outputs did not match the original programme design. For example, one of the programme objectives was to establish FRUs for treating emergency obstetric problems. The equipment for EOC was purchased and supplied but the staffing and training of FRU staff was neglected. The monitoring system also did not systematically monitor performance of FRUs in terms of treating emergency obstetric cases This lead to the situation where there is no clear data on how many FRUs are functional and how many EOC procedures are done. The obvious lesson from this is that all the

inputs should be well co-ordinated and the output should be measured so as to ensure effectiveness of the programme.

3. Necessity of micro-level planning and monitoring. As compared to the immunisation programme, the various interventions of CSSM programme did not receive as much attention and micro level planning effort. Thus many of the safe motherhood interventions were not worked out in detail at various levels along with the indicators to monitor their implementation and effectiveness. For example, for a simple programme such as prevention and treatment of nutritional anaemia there were no micro level guidelines on how to monitor compliance with iron folic acid tablets given to the mothers. There was also no effort to assess whether anaemic women were getting adequate dosage of IFA for adequate duration. There was no monitoring of haemoglobin levels in anaemic mothers. All this lead to the situation where high coverage was reported of iron folic acid distribution but with no data to show that it made any difference to the status of anaemia in pregnant women.

4. Complexity of programme interventions, management capacity and changing priority. In a country of the size and diversity of India, complex programmes with many interventions are very difficult to implement. Such programmes also take a long time to actually get implemented on ground due to various levels of administration involved from the central government to the state and district governments. For example, even technically simple programmes such as immunisation took almost 15 years to reach a level of 70-80% coverage in spite of very high level of priority by the government, international donors including UNICEF which has several field offices. The experience of CSSM which included besides immunisation several other child survival and safe motherhood interventions shows that such a complex programme needs a much higher level of managerial capacity, administrative commitment and resources to have reasonable chance of success. Even if all the three were present in CSSM programme, which they were not, it would take at least 10-15 years to get it reasonably implemented and start showing results. Unfortunately, in rapidly changing international health environment the priorities of programmes changed within a very short time. For example, in 1977-78 Health for All and Primary Health Care was the priority; early and mid eighties, selective PHC and Child Survival became popular; in 1985-90 Universal Immunisation became top priority, 1987 Safe Motherhood became the rediscovered priority and 1994 following ICPD reproductive health became the new priority. Given this fact it is likely that some of the interventions which were started under CSSM programme may get neglected under the new Reproductive and Child health programme. For example, the priority which iron deficiency, anaemia received, at least in programme design, in CSSM programme

does not seem to come through in RCH programme documents. For last several months there is severe shortage of in supply of TFA tablets in the country but no one seem to bother at any level. Proper clarity of priority and consistency with past programming is required if such diversions, and discontinuations of important priorities are to be prevented.

5. Interventions requiring curative care and 24 hour services. Several interventions in CSSM programme, especially in the safe motherhood component require curative and emergency care. For example, EOC and delivery care has to be provided 24 hours and throughout the year. Organising such care requires much more staff, commitment and resources. Just supplying equipment and some medicines does not ensure that curative care will be available as and when required. In most FRUs even today it is not possible to find the required specialists to offer comprehensive emergency obstetric care including caesarean section. Most states are finding it much more difficult to staff FRUs with specialists especially obstetrician and anaesthetists. This is partly because of shortage of these specialists and partly because of unwillingness of specialists to work in sub-district hospitals and CHCs. Given this situation alternatives of training medical officers to do most of the basic EOC function short of caesarean section should have been considered.

6. Programme priorities. It is very clear that within CSSM programme main priority was on child survival and specifically immunisation component. Safe motherhood received substantially less attention in spite of the fact that it was a new approach and perhaps required more attention for it to succeed. The lesson from this is that unless due priority is given to critical and new elements of a strategy, the success of the overall programme may not be achieved. Priority on a single programme will lead to relative neglect of other components of more comprehensive programme. This is a real danger in reproductive and child health programme as the agenda in this programme will be even broader than the CSSM and some programmes such as polio eradication, RTI treatment may get more priority due to various reasons.

Analysis of Plans for Safe Motherhood in Reproductive and Child Health (RCH) Programme

Following ICPD recommendations, government of India is in the process of reorienting the family planning and MCH programme into a new programme called Reproductive and Child Health (RCH) (GOI undated a). This programme is almost four times the size of the CSSM programme in terms of financial allocations. The total budget envisaged for this programme is roughly 1.2 billion $ of which substantial part will come from the World Bank and European Union. The objective of this programme is to improve reproductive health including

maternal health and child health. The key programme elements as indicated in GOI documents called Scheme for Implementation are:

1. Immunisation
2. Essential obstetric care
3. Emergency Obstetric Care
4. 24 hour deliveries at PHC/CHC
5. Referral transport to indigent families
6. Blood supply at FRUs
7. Essential new born care
8. Medical termination of pregnancy
9. RTI/STD clinics
10. Several other components including promotion of Indian systems of medicine, special programmes for urban slums, tribal areas and adolescents, research, development training, IEC, involvement of NGOs, MIS, supplies and logistics and minor civil works. (GOI, 1997)

The RCH programme has officially started from August 1997 but is still being developed. This project follows the review of the family welfare sector done by the World Bank in 1994-95 (World Bank 1995) and other recommendations for changing the family welfare programme in the direction of reproductive health (Pachauri 1994). The design of RCH project as reflected in the staff appraisal document is based on the understanding of the issues and problems faced by the previous programmes and the need to broaden the scope of the services following ICPD to address reproductive health needs which have not been so far addressed in the MCH or CSSM programme (World Bank, 1997). Safe Motherhood forms one of the several interventions in this project which includes child health interventions and interventions to address reproductive tract infections (RTI). The interventions to address maternal mortality focus on strengthening FRUs as well as essential obstetric care at peripheral levels. Conceptually this seems sound but the way schemes for implementation are formulated seem to be quite ad hoc and without adequate review of the experience in the past as well as thinking related to the feasibility of the schemes. For example, the proposal is to provide for additional ANM, staff nurse or PHN at difficult sub-centres and PHCs to improve access to maternal care services. These additional staff will be recruited on contract basis. In most difficult districts it is not possible to get staff on regular salaries which are much better than contract amounts. So firstly, it is not clear if such contract staff will be available in remote areas. Secondly, the staff in such difficult situation don't live in the villages where they have been posted and hence they are not accessible to the community when required. It is not clear how the system is going to ensure that this additional staff, appointed on contract basis, will live at the place of posting and will be available to the community on 24 hour basis for providing delivery services.

The supervision and monitoring aspects which, as discussed earlier, were not well worked out for safe motherhood under CSSM seem to be still neglected in the RCH project documents. Fortunately, the RCH project has commissioned independent district surveys and will be doing concurrent surveys to assess the availability and utilisation of RCH services. The RCH document mentions a list of indicators for monitoring which is taken from the World Bank staff appraisal report. There are only four maternal health indicators listed in this list. They are: (1) percentage of institutional deliveries; (2) number of patients referred to; PHCs, FRUs and Post Partum (PP) centre for management of complications of delivery; (3) number of patients treated for RTI and (4) proportion of women completing 3 ante-natal visits. These indicators are very minimal and do not address various aspects of maternal health and safe motherhood. It is not clear why RCH project has not adopted the indicators suggested by the WHO for maternal health (WHO 1994) and reproductive health. (WHO 1997). The RCH document of GOI does not take in to account or relate to the elaborate monitoring system and indicators suggested for Family Welfare programme under Target Free Approach (GOI undated b).

From the RCH project document, it is not clear at all how several problems faced in the CSSM project which led to substantial under achievement in safe motherhood part of the project will be addressed. For example, it is not clear how FRUs are going to get obstetrician and anaesthetists as this has not been possible under CSSM. The proposal to train more anaesthetist will take 3-5 years to implement. Similarly, the RCH document is silent on how it will encourage or mandate that more and more deliveries would be done by ANMs or doctors at sub-centre and PHC level. One solution offered by the project is to pay additional honorarium to the PHC and CHC staff for doing deliveries after "office hours". This seems sound as a reasonable incentive but can lead to several long term problems and possibilities of misuse. First of all, the PHC and CHC staff are supposed to be on duty for 24 hours, they are not "office" staff to have "office and after office hours". They are even normally supposed to do deliveries at night. This additional incentive may lead to a situation where deliveries during day may be discouraged in favour of deliveries at night or time of the delivery may be misreported.

RCH programme also plans to strengthen medical termination of pregnancy (MTP) services at PHCs. The issues related to availability and use of MTP are quite complex. Only providing equipment and some honorarium to visiting doctors may not solve the problem. The suggestion in the RCH programme document to provide MTP trained doctors once a week to the PHCs will not be legally possible till such PHCs are also recognised as service facility for providing MTP under the MTP Act.

Overall it seems that the way RCH project is being developed may help somewhat in improving some maternal health services. But it will not make

substantial difference as many of the basic barriers in provision of maternal health services and problems in its utilisation have not been addressed systematically and in a detailed manner (Mavalankar 1998). The RCH programme seems to be a collection of some ad hoc schemes put together in a great hurry without substantial detailing of the rationale, the review of experience in the past, and expected outcomes. One senior and reflective health administrator aptly said "the RCH project seems to offer remedies to problems which are even worse than the problems themselves."

Recommendations

To ensure that safe motherhood agenda does not again get neglected in the RCH programme as happened in CSSM, we offer following recommendations based on the analysis of the past project experiences:

1) Need for high priority, clear objectives and well worked out strategy for SM: Given that RCH programme plans to cover a even wider spectrum of serviceds than CSSM, it is very important that high priority be given to safe motherhood otherwise it will again get neglected as happened in CSSM programme. The SM objectives within the RCH programme should be very clearly and measurably stated as reduction in maternal mortality, increase in institutional deliveries and deliveries by ANM and doctors, universal access to EOC. Such clear objectives should be followed by well thought out strategy to achieve them. For example, ensuring that doctors and ANMs are available at the place of work and to communicate to them that conducting deliveries is a high priority, will be required to improve maternal care.

2) Conceptual clarity about maternal care including EOC and detailed implementation guidelines: For any programme to get effectively implemented in the PHC system very clear conceptual framework is needed. This has to be followed by detailed implementation guidelines at various levels so that they can implement the programme properly. The concept of Maternal care should be clarified with specification of what normal maternity care and EOC will be offered at various levels in the health system. The roles of central, state and district level managers has to be clarified. If detailed guidelines are provided then the programme does not remain dependent on a few key managers who originally formulated it but can be carried out by various managers and supervisors down the line. The guidelines should also have detailed plan for supervising the programme so that the supervisors can ensure that the plan is implemented. The plan should also have adequate flexibility so that the programme can be adapted to the local realities. The plan should also provide for contingency arrangements when the key providers or supplies or equipment are not available or working. The local managers should have the power and the resources to do required purchase or repairs or contracting needed staff to

keep the service running without interruption.

3) Co-ordination and consistency between objectives, inputs, process, supervision and monitoring The project development process should ensure that all the critical inputs are provided for addressing the objectives. It whould also ensure that all the inputs such as staff, training, equipment and supplies are made available in a co-ordinated way so that there is no gap between them and they can be immediately used to provide services. The supervision and monitoring should include all the aspects of the objectives and areas where inputs are provided. For example if EOC is to be strengthened the monitoring should include indicators which measure how many FRUs are functional and what proportion of the expected need of EOC is being served by them.

4) Ensuring accountability of the staff and managers: The supervision and monitoring system should ensure accountability of staff at various levels. It should ensure that they are present at place of work, are providing high quality care in a gender sensitive way and are accountable for the outputs of the services they provide. The accountability should include reporting, investigating and monitoring all maternal deaths and major complications in the area and taking required steps to prevent such events. A national maternal mortality study must be carried out every 10 years to ensure that there are reliable data to indicate progress towards ultimate goal of SM.

5) Decentralised management and problem solving: The programme should be managed in a decentralised way so that local managers can adapt it to suit the local conditions. There has to be focus on solving problems so that the services are available in a continuous way. The supervisors and managers should constantly help the subordinates and solve their problems so that they are motivated and can produce results. SM services requires such supporting supervision most as these services are to be provided continuous as they deal with emergency situations.

6) Good quality technical support: As this programme has substantial technical components as compared to other preventive programmes, the government needs high quality technical support at various levels. There should be three kinds of experts to provide technical support to the programme – from public health experts, obstetricians and management experts This support is consistently required throughout the project period High quality experts should be involved in the programme to guide and monitor its progress.

7) Training and Human Resource Development: This is a very important input to the programme but is generally neglected. Past experience shows that training is done in a hurry without proper preparation and resources In this programme long term skills development should not be neglected but should

be taken up with high priority. Skills should also be developed of lower level staff including medical officers and nurses to provide basic EOC services even in the absence of an obstetrician. There should be close link between training, equipping and monitoring to ensure performance.

8) IEC and community participation: IEC to make the community aware of the services and community participation and mobilisation to support the programme is very essential as early recognition of complication and seeking care will be highly dependent on the level of community awareness and mobilisation. IEC has to be on the ground and really implemented, not only reflected in terms of printing of posters and leaflets. TV and radio are very powerful media now and should be used along with local folk media to get best possible results. Inter personal communication should be woven into each act of services delivery.

Conclusion

The review of SM efforts in India showed a very mixed picture with major initiatives taken by the government but not much concrete results seem to have come out. There were several reasons for this which have been discussed above. The challenge is how to make the SM component of RCH project more successful. For this high level priority has to be given to SM with adequate and detailed micro-level programming and follow up to ensure proper implementation will be needed. Many long term problems of the PHC system will have to be solved if the SM component of the RCH is to get implemented smoothly and effectively. Various organisations of the civil society such as the NGOs, donors, professional organisations, media and academic institutions have to support the government to make the SM programme effective. It should be clearly understood that a complex programme such as SM cannot be established in a very large country like India within 5 years. It will take at least 10-15 years of consistent, concerted and sincere efforts for the programme to get established and then to achieve some results in terms of increased coverage of maternal care and reduction in mortality. Frequent changes in priority guided by international opinions, or local priorities may lead to further neglect of safe motherhood.

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[1] EOC - There has been some confusion over terminology of EOC EOC has been used for emergency obstetric care as well as for essential obstetric care. The latter is now preferred and includes the emergency obstetric care as well as non emergency obstetric care such as management of severe anemia. preaclampsia etc Routine care during normal pregnancy and delivery is called routine maternity care Thus in essence EOC is an higher level function.