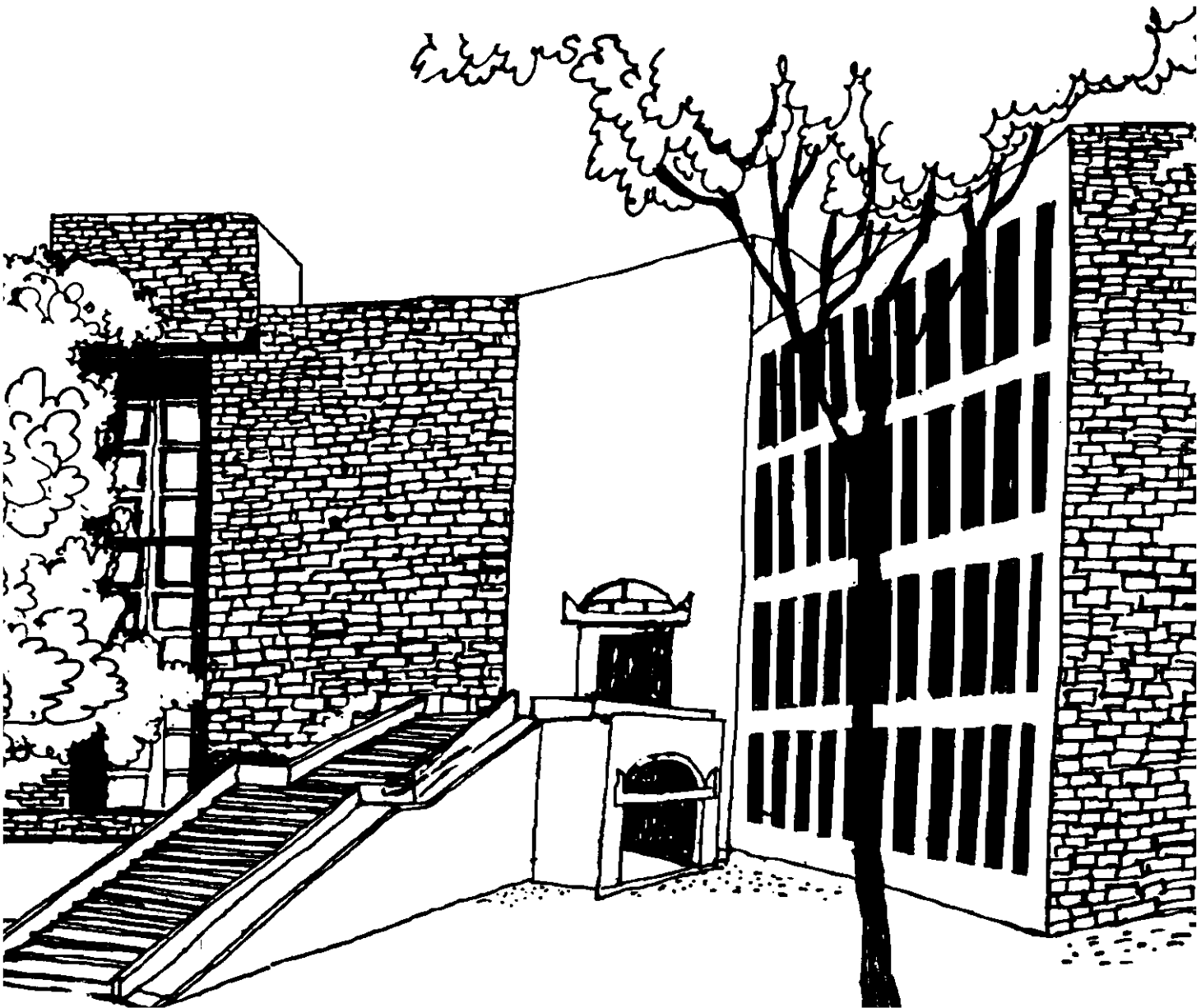




Working Paper



REPRODUCTIVE HEALTH CAMPS: AS INNOVATIVE
APPROACH TO INTEGRATING REPRODUCTIVE
HEALTH INTERVENTION IN PRIMARY HEALTH CARE

By

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**Reproductive Health Camps: As Innovative Approach to Integrating
Reproductive Health Intervention in Primary Health Care**

**Experience of one of the Interventions in Reproductive Health Project in Sanand
Taluka conducted jointly by IIM, Ahmedabad and District Panchayat,
Ahmedabad,
Supported by Ford Foundation**

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Reproductive Health Camps: As Innovative Approach to Integrating Reproductive Health Intervention in Primary Health Care

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ABSTRACT

The International Conference on Population and Development (ICPD) held at Cairo in 1994 recommended a comprehensive Reproductive Health (RH) programme to replace demographically oriented Family Planning (FP) programmes. Owing to several constraints in the PHC system in India it has become challenging to provide RH services through the PHC system. In India Camp approach has been used in various other health programmes including family planning to increase coverage of services within the available limited resources. We have tried out use of camp approach to provide higher quality RH services on periodic basis at the PHCs in one taluka (sub-district). This intervention was carried out in Sanand taluka by the joint efforts of Indian Institute of Management, and District Health Office of Ahmedabad District Panchayat under the RH project which is supported by the Ford Foundation. The camp approach to RH services involved three phases, the first was a experimenting and learning phase when large camps were conducted over one year periodically in each PHC. The second phase was revision of the strategy based on the experience of the first phase to make the camps a routine monthly activity at the PHC and the third was the phase of sustainability testing by handing over the camp organization to the PHCs. The paper presents the details of this intervention, the type of the disease seen and learning from it. Learnings from experience of camp approach points out that such services not only increase the credibility and capacity of PHC system, but provides good and cost-effective strategy for early identification and treatment of chronic RH problems. It also attracts the community as they see more value for their time and effort. The paper also presents cost calculations of this camp based strategy to RH deliver services. This experience shows that this camp based approach has the potential of being replicated on wider scale as an intermediate strategy for providing RCH services in the country like India.

Key words: Reproductive health, Camp approach, cost of care, India.

Reproductive Health Camps: As Innovative Approach to Integrating Reproductive Health Intervention in Primary Health Care

Background:

The Bhore Committee recommended a comprehensive health care system in the country which will include preventive and curative care at all administrative levels. This vision was implemented through the development of Primary Health Care (PHC) System. Unfortunately, during the last several years this PHC system has mainly focused on family planning and immunization services at the expense of other basic health services. The International Conference on Population and Development (ICPD) held at Cairo in 1994 recommended a comprehensive Reproductive Health (RH) programme to replace demographically oriented Family Planning (FP) programmes. In spirit of this recommendation, India is reorienting its Family Welfare programme towards a Reproductive and Child Health (RCH) programme, which will be executed through the PHC system. Though some achievements were made with the introduction of Child Survival and Safe Motherhood (CSSM) programme, but inadequate staff, poor training and supervision, lack of accountability and infrastructural problems hinder the execution of the health services in the PHC system. Given these drawbacks, it will be very challenging to implement the RCH programme through PHC system on a large scale.

It is important to demonstrate the fact that within the constraints of the PHC system, it is possible to introduce new services and new orientation to help move from the FP focus to broader RCH focus. Thus there is an urgent need to implement pilot project to assess the feasibility, effectiveness, and cost of the syndromic approach for the management of symptomatic infections and other reproductive health problems, which are common among women. To do this, Indian Institute of Management, Ahmedabad (IIMA) worked with the Government of Gujarat and the Ahmedabad District Panchayat to develop an operational research for delivering RH services through the PHC system. This project is being supported by the Ford foundation. We describe here in this case study one of the components of the project where RCH services are delivered through a periodic camp held at the PHC. Here we describe the development of this intervention in three phases: 1) Development, 2) Stabilization, and 3) Sustainability testing.

Rationale and Purpose of the Camp Approach to RCH:

What is Camp approach ?

The Camp approach has been used in Family Planning and for Cataract operations for many years. Camp approach for RCH means that the additional

services related to RCH are provided at the PHC or Sub-Center level on a special day with the help of experts coming from higher levels in the health system or outside it. The Camp approach includes IEC activities to generate demand and provision of higher quality of services closer to the community, preferably by a provider that the community would prefer. This approach has been tried for varying objectives in different parts of the country (CHETNA 1993, Bang 1989). However most of these gynecological health camp approaches were for limited time or for specific purpose such as research. Current experience described in this paper is based on systematic camp approach with the objectives to kick-start comprehensive reproductive health package within the government PHC system.

Why Camp Approach?

According to the World Bank, about one-third of the total disease burden in developing country women 15 to 44 years of age is linked to health problems related to pregnancy, childbirth, abortion, human immuno-deficiency virus (HIV), and reproductive tract infection (RTIs). Among diseases for which cost-effective interventions exist, reproductive health problems account for the majority of the diseases for the disease burden in women of this age group (World Bank, 1993). The magnitude of women's reproductive health problems is reflected in the number of deaths related to pregnancy and childbirth, the most direct indicator of reproductive health care. According to the National Family Health Survey, the maternal mortality ratio in 1992-1993 was 420 per 100,000 (IIPS, 1994). There is a clear need to prioritize and to develop a phased approach with an incremental addition of health interventions that require greater skills and resources.

Health facilities at the community level are poorly equipped to deal with gynaecological and obstetric morbidities, since they have neither the diagnostic facilities nor the drug to treat them. Moreover service providers are not trained to detect such morbidities; nor to provide sensitive counseling. The prevention and treatment of common RTIs is not complicated and can be treated at the first level of care. What is needed at the primary health care centre level are facilities for routine diagnosis of gynaecological problems, improved obstetric care, sensitive counseling and sound referral services (Jejeebhoy, 1997). Camp approach is an intermediate solution till regular services are available at the PHC and sub-centers for RCH programme. It also envisages provision of higher level of services closer to the community on periodic basis. This approach was selected with following points in view.

- Health department is used to organise camps for FP and campaigns for other services. It is also observed that it is possible to mobilise special resources for a short time periodically rather than provide high level services continuously in rural areas.

- In a camp or campaign, the workers are willing to put in extra efforts and work as a team. Higher level of services also attracts the community as they see more value in less time and effort.
- Camps can also increase the credibility and capacity of the PHCs for providing good quality RH services.
- Camps can provide good and cost-effective strategy for early identification and treatment of chronic problems especially those such which are not severe enough for warranting visit to higher level health care facility.

Purpose of the RCH Camp:

The RCH camp has several purposes. It is not just a mode of services delivery. They are :

- 1) to provide good quality services close to the clients and thus generate more demand for such services.
- 2) to provide hands-on training opportunity for the PHC staff to learn about diagnosis and management of various RCH problems.
- 3) to help improve the quality of services at the PHC by demonstrating high standards of care being practiced by the specialists.
- 4) to increase the credibility of the PHC system by provision of higher level of care through better linkages within the system.
- 5) to orient the specialists to the realities of PHC and village level care giving thus making them more sensitive to rural patients who are referred to them.
- 6) to build team spirit in the PHC staff.

Setting of the Project:

The field site for the RCH project was selected in consultation with the Gujarat Government after visiting several PHCs and CHCs. Sanand Taluka was selected because it is close to Ahmedabad, it is a small taluka and also has a fair representation of average and backward rural areas seen in Gujarat. Other reasons for selecting it was that 2 out of 4 PHCs, MOs were women and the CHC had a gynecologist.

Sanand Taluka is situated south west of Ahmedabad city in the Ahmedabad district and has 4 PHCs and one CHC. It has a total population of 162,000 persons settled in one town and 64 villages. The PHCs are situated at Sanathal,

Modasar, Uperdal and Zolapur. The taluka is situated about 25-35 Km from Ahmedabad city.

In Gujarat the PHC system is under the direct control of Zilla Panchayat (ZP) and hence the male and female health workers and supervisors are employees of the ZP, while the Medical officers, Lab technicians, BEE and the District level health officers are employees of the state government on deputation to the district. District Development Officer who is from IAS cadre, is the main controlling authority for all the staff of all the developmental departments including health while the Collector controls only the law and order and revenue departments.

Before starting the project interventions, a set of baseline studies were conducted. This included situational analysis of the PHCs, collection of secondary data from the PHCs, sample survey of about 1000 women and 300 men, and 10 focus group discussions on various topics related to the reproductive health problems and services provided by the PHCs. The survey showed that 46% of women had some reproductive health problem at least once in last year.

Organization of the Camps:

The strategy of RCH camps evolved in three district phases, the first was a learning and experimenting phase, second was revision of the strategy based on the experiences of the first phase and the third was the phase of sustainability testing. Here we describe the RCH camp intervention in these three phases.

Phase I : Development of Camp Approach : Experimentation and Learning

In this phase we had planned to organise one RCH camp at each of the four PHCs in Sanand taluka every 3 months. This effort started in May 1996. The IIMA team help to organise these camps at each of the four PHCs of Sanand taluka in Ahmedabad district. The date of the camps were fixed well in advance and the community was informed by the PHC staff and the Anganwadi staff. These peripheral staff were to identify women and children requiring RCH services and refer them to the camp. Workers did this during their regular home visits, they also took help of the Anganwadi workers and helpers to inform the community. Some PHCs have printed handbills with the camp information for distribution in the community. Besides, women with gynecological problems such as RTIs, menstrual problems, the ANMs were told to identify and refer high risk pregnancies in the area who need expert consultation.

The IIM team visited the PHCs in advance a few times to make arrangements for the camp. IIM team arranged specialists from the Medical college and the cancer

hospital for the camp. The process at a typical RCH camp starts with the arrival of the specialists at the PHC at about 10.30 AM with the IIMA project team in the special vehicle. The PHC MO prepared the PHC and equipment for examination ensuring proper privacy and sterilization of the equipment used for examination. The camp is organised in the form of several stations or counters. The counters set up and the work done there are as follows:

1) Registration: Here the health workers fill up a specially designed case sheet for the camp for each of the cases. This form has basic socio-demographic information which is filled up at the registration.

2) History taking: The second counter is for history taking and general examination. Here ANMs or doctors take detailed history of the person and fill it in the form. The history includes obstetric, menstrual history and major complaints. The doctor or the nurse also does general examination including weight, pulse, BP, clinical checking for Anemia or Jaundice, checking for edema, auscultation of the lungs and heart. She explains to the clients about internal examination and also motivates them for undergoing internal examination. If the client refuses, then the treatment is given on the basis of the symptoms only. If the client agrees then she is sent for internal examination by the specialist.

3) Internal examination: Third station is for internal examination . It is located in a separate room with provision made for privacy. The specialist carries out her vaginal and abdominal examination after reviewing the history of the clients. Common problems such as RTI, prolapse etc. if found, are demonstrated to the ANM and the MO as part of their training by the specialist. The specialist prescribes the medicine and briefly explains the management to the clients.

4) Laboratory: If required, the client is referred to the laboratory for simple test such as Hemoglobin and urine tests. After doing the lab test the client returns to the specialist for further consultation and treatment.

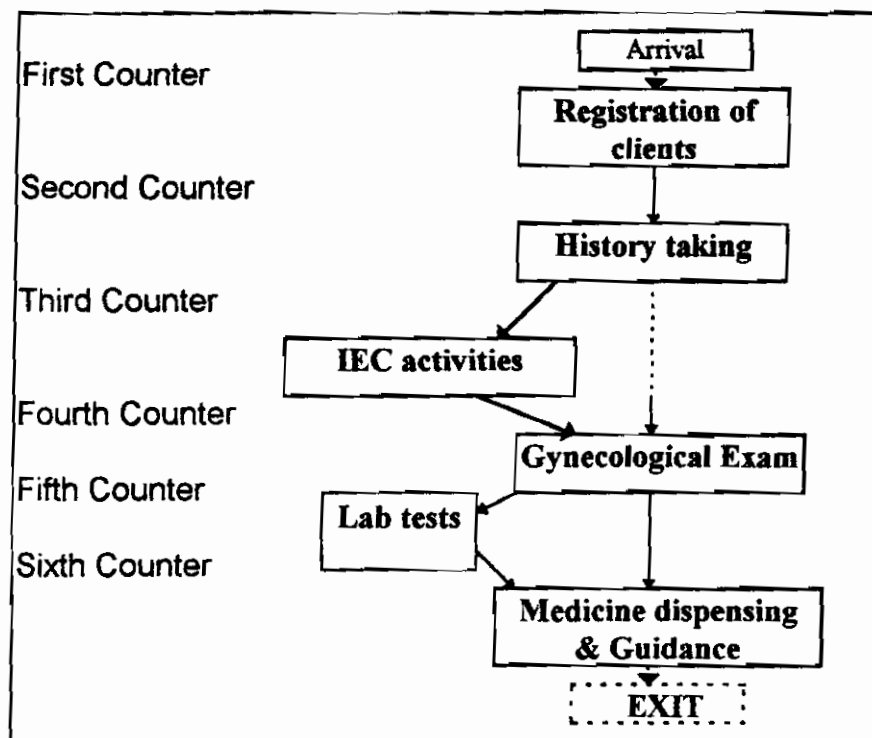
5) Counseling and guidance: Next station is for counseling and guidance to explain to the patient the details of her problems and how to take medicines and preventive measures. This is done by the doctor or nurse. Cases who need further treatment at higher level such as operation for prolapse or cancer are referred to appropriate level of services by giving them a written referral slip.

6) Dispensing of medicines: Finally the clients go to the dispensing counter for collection of medicines prescribed.

7) Health education station: An exhibition is set up for providing health education on various aspects. The clients can see the exhibition while they are waiting to be examined by the specialists. Clients' relatives can also see the exhibition while they are waiting.

Children are also similarly examined by paediatrician if available or by the MO of the PHC following the same routine . Figure 1 gives the service blue print (flow diagram) of the camp.

Figure 1 :



Services offered at the Camp:

The following services are offered at the camp site:

1. Examination by paediatrician of all the children
2. Growth monitoring and immunization, Vitamin A
3. Examination by gynaecologist for women
4. Lab Diagnosis for anaemia, urinary infection etc.
5. Pap smear for early detection of cervical cancer
6. Examination of high risk ante-natal cases
7. Referral for further diagnosis and treatment
8. Treatment for all childhood diseases and women's diseases

Staffing of Camp:

All the PHC staff are given specific duties during the camp. For example, the ANMs and LHVs take the history and help in the internal examination. The male workers do the registration, help in weighing, provide health education, and help in general arrangements. The BIECO provides health education to the women who are waiting for their turn for examination. The MO examines

children if Paediatrician is not there, also manages the regular OPD cases, the task allocation and overall management of the camp.

The camp ends with a review meeting where the problems related to organization of the camp, the type of cases seen and the follow up required, any difficulties faced and lesson learnt are discussed by specialist and PHC staff in the presence of IIM team. The camp ends by 3.00 PM.

The role of IIMA team has been to facilitate the organization of the camp. They provided the initial technical assistance for camp organization and make arrangements for external technical experts. Medicines like antibiotics, vaginal tablets that are not available at the PHC are also provided through the project. Besides, they also provided guidance on how to identify the clients and how to motivate them to come to the camp. They have also provided technical guidelines on management of RTIs to the MO PHC based on WHO guidelines. The data on the camps are also analyzed by the IIMA team and shared with the PHCs.

Results and Observations of the First Phase:

This phase started in May 1996 and lasted upto May 1997. The camp strategy met with great success. In this one year, ten major RCH camps were conducted in which 1407 women and 601 children were examined and treated, thereby making a total of 2008 clients. The details of the cases by PHC is given in Table 1a. This indicates the unmet need for expert services in the villages. The average attendance at each of the ten camps was 141 women (range 34-269) and 60 children (range 24-114). As these camps were very large, we termed them major RCH camps. Unfortunately due to various reasons it was not possible to organise 4 camps per PHC/CHC in an year. We could only get the PHC/CHC to organise 2 camps per center in the first year.

Table 1a : Details of clients attending major RCH camps

Name of PHC/CHC	Women Cases	Child Cases	Total Cases	Total RCH Camps Conducted	Avg. Nos. of cases/Camps
Sanathal	321	119	440	2	220
CHC Sanand	232	101	333	2	167
Modasar	344	115	459	2	225
Uperdal	231	128	359	2	180
Zolapur	279	138	417	2	209
Total	1407	601	2008	10	201

Observation From Major RCH Camps: These camps were a great learning exercise for the project. The key issues and lessons are as follows:

1. Camp strategy seemed to be successful as large number of the clients were found attending the services being provided in the camp. This indicated large unmet need in the community for good quality RCH services.
2. It was also seen that women were ready to be examined by male gynecologist if female doctor was not available which happened in some camps.
3. It is possible to galvanize the PHC team into action for RCH camps. Along with these positive experiences some of the negative aspects also came to light in this first phase.
4. Large number of clients coming to the camp meant long waiting lines and overcrowding. In some camps up to 10 % of the clients left the camp without examination and treatment due to frustration of waiting. Over crowding also affects the management of the camp in the limited space of the PHCs. Substantial time and effort was required just to maintain order in the camp.
5. The IEC activity which was planned during the camp was not possible because of limited space and over crowding.
6. Over crowding also affected the quality of gynecological examination and management of the clients. Given the large numbers, specialists were not able to give due attention to each case. Thus counseling to the clients and hands on training to the para medical staff became very difficult due to pressure of waiting clients.
7. Uniformity in the services provided was not possible as each camp had new sets of specialists. This created problem of variability in diagnosis made in different camps.
8. These camps were planned to be held once in three months but could be only held twice in a year due to various reasons. This was too infrequent to provide consistent services.
9. The cost of organizing major RCH camps seems to be high. (See cost calculations presented later on).

Phase II: Stabilization of the RCH Camp Through Revised Strategy

Learning experience of these major camps was that it was decided to revise the camp strategy in order to provide quality services and make it sustainable in the long term as well as replicable in the RCH program of the government. Thus modifications were done in the methodology for conducting RCH Camp.

The objective of the revised strategy was to make the camps more routine, on regular basis and smaller so that better quality of services could be provided.

Under the revised strategy it was decided, in consultation with the PHC staff and the district health office, that the camp will be held on a fixed day of the month, each month throughout the year. The day for each camp was decided as per the convenience of the PHC staff. For example, currently two PHCs have the camp on the first and second Monday of the month respectively, while in other two PHCs, it is on third and fourth Tuesday of the month. If there is fifth Tuesday in the month then a special camp is organised at the CHC. It was also decided that in each camp about 30 to 50 women and 20 to 30 children should be examined in 3 hours time so that quality of care is not compromised due to heavy rush of clients. These camps were called mini RCH camps.

Under the revised strategy only one gynecologist, preferably a woman is to be invited for the camp. The same specialist is invited for each of the camps in the same PHC. The benefit of this is that there will be better rapport between the specialist and the PHC team as the same specialist comes to the camp each time as far as possible. Paediatric cases were to be seen by the Medical Officer of the PHC.

Over all it was decided that majority of the camp activity should be performed by the staff members of the PHC so that the camp activity become a routine schedule for future services in the PHC. Inputs from the IIM team were also reduced to getting the specialist and bringing few medicines that were not available at the PHC.

Results of the revised strategy:

Out of the total 55 mini RCH camps planned in one year (July 1997-June 1998), 40 mini RCH camps were organized during the year in all four PHCs of Sanand taluka. Remaining 15 camps were not conducted due to various reasons such as rainy season, harvesting season and other priority health programmes. In these camps 1404 women and 1009 children were provided services. On average 35 women and 25 children were served in each of the 40 mini RCH camps. The range of attendance at the 40 camps was 12-65 women and 5-82 children. The number of cases in each PHC and the number of camps held is shown in Table 1b.

Table 1b Details of clients attending mini RH camps for one year.

Name of PHC/CHC	Women Cases	Child Cases	Total Cases	Total RCH Camps Conducted	Avg.Nos. of cases/camp
Sanāthal	370	175	545	9	60.5
Modasar	459	307	766	11	70.0
Uperdal	210	192	402	9	44.6
Zolapur	224	194	418	8	52.2
Sanand	141	141	282	3	94.0
Total	1404	1009	2413	40	60.3

Observation From Mini RCH Camps

The PHC staff became efficient in organizing and conducting the RCH camp at their respective PHC with little support of IIM team. However, for medicine like vaginal tablets and higher antibiotic, they have to rely on IIMA team support as these are not in their rate contract list of the state government. These mini camps were more manageable and became a routine for the PHC, thus requiring much less effort and resources. Community also came to know of the camp as it is now on a fixed day of the month. As the clients were less, the quality of services also became better and there was scope for individual attention to the clients. The costs of the camp also came down as many of the services became routine with little outside in put.

Phase III: Sustainability Testing of the Camp Strategy

After one year of implementing the revised strategy of mini RCH camps, the project decided to test the sustainability of the strategy by handing over the responsibility of the camp to the PHCs. In order to make the RH camp sustainable and an integral part of the PHC system, it was decided that the entire responsibility for organizing and conducting RH camps should be on the shoulder of the PHC staff with minimal involvement of IIM team. The medical office of each PHC was requested to organise the RCH camp. All the tasks including bringing the experts and arrangement for bringing the additional medicine from IIMA office was handed over to the PHC staff. New reporting proforma was designed to record details of each patient from the case sheet. The schedule of fixed days for the camp, RH services provided and the norm for number of clients remained same, as for mini RH camp. Only one member of the IIMA team was to remain present as an external observer and give feed back.

This revised strategy was implemented from July 1998 onwards. The experience of last six months showed that this revised strategy is quite successful and that PHCs are able to organise and conduct the RCH camps without much external

support. The details of these camps held and the number of clients are shown in Table 1c.

Table 1c: Details of clients attending mini RCH camps from August, 1998 to January 1999 organised and conducted by the PHC with little support from IIM team.

Name of PHC/CHC	Women Cases	Child Cases	Total Cases	Total RCH Camps Conducted	Avg.Nos. Of Cases/Camp
Sanathal	192	57	249	4	62.2
Modasar	162	81	243	4	60.7
Uperdal	152	164	316	5	63.2
Zolapur	173	132	305	4	76.2
Total	679	434	1113	17	65.5

Observation From Mini RCH Camps organised by PHCs: These camps seem to be effective, especially when they are well planned. Each worker in the PHC was assigned duties at the respective counters in the camp process. The medical officers showed good leadership and could manage the camps well by them selves. However, on some occasions the government's other priorities such as school health program and pulse polio campaign disturbed the RCH camp routine and hence some of the planned RCH camps were not held.

Since a new gynecologist was recently appointed in the CHC, some PHC medical officer preferred his services for the camp while others used to call private gynecologist. However in both cases, one of the problems observed was that the clients had to wait till the specialist came at about 12 noon to 1 pm, after finishing his work. In a few RCH camps, the hemoglobin and urine tests were not done. Further, it was also noticed that PAP smear was taken in only one PHC. In two PHCs, with the joint efforts of the Female health and Anganwadi workers to find chronic cases of gynecological problems and referring them to the camp site for the treatment was noteworthy.

It was noted that the variability in the attendance of the client at the camp depended on season, agricultural work and publicity and screening done by the workers before the camp day.

In the entire process of conducting the RCH camp by the PHCs, the IEC activities seemed to have weakened and it seemed that it was conducted only if it is pointed out by IIM observers. Since these camps are organised under the supervision of the IIMA team and the PHCs were accountable to the project for the camps, they were organised regularly and efficiently. However, to demonstrate the replicability the camps have to be conducted in one or more districts before they are scaled up to the state and national level.

Type of Medical Problems Seen at the Camps

Here we present the data on type of diseases seen during the camps. In the camps (Phase I), the diagnosis was made based on quick clinical examination by a specialist, without much lab support. During several camps, different experts came which may also have affected the diagnostic pattern. Space was provided on the data form for four possible diagnoses and doctors were encouraged to write down all clinical diagnoses. The analysis of the diagnosis is shown in Table 2a.

It indicates that gynecological problems were predominant with more than 80% women having them as compared to other non-gynecological problems. It came as a pleasant surprise that only a small proportion (2.9%) of the clients refused gynecological examination in spite of the fact that in some camps we had male gynecologists. In the small number of cases who refused internal examination, the main reason for refusal was related to gynec examination being done by male doctor. And some women had symptoms which were not related to reproductive system and thus felt that internal examination was not needed. The most common gynecological problems were RTI (49.1%) followed by menstrual problems (8.7%) and infertility cases (7.8%). A sizable number of pregnant cases (6.7%) were also examined. Besides problems related to prolapse (3.8%) and Urinary Tract Infection (3.3%) were also registered. Among non-gynecological problems, anaemia (20.8%) was the major one followed by hyper- acidity (4.8%) and skin infection (3.8%).

Table 2a: Common Gynecological & Non-Gynecological Problems Among Women in Ten Major RCH Camps

Type of Diagnosis	Percentage of Women having this problem
<u>Gynecological Problems:</u>	
Reproductive Tract Infections	49.1
Problem of Infertility	7.8
Menstrual Problems	8.7
Pregnant Cases	6.7
Prolapse Cases	3.8
Urinary Tract Infections	3.3
Others	6.6
<u>Non Gynecological Problems</u>	
Anaemic	20.3
Acidity	4.8
Skin Infections	3.3
Others	14.3
Refused for Examination	2.9
Total Per Cent (Total number of Women)	100.0 * (N=1271)

Note: * Due to multiple diagnosis in many women total of the percent column is more than 100 %.

Earlier study (Bang, 1989) of rural, tribal women in Maharashtra, reported very high incidence of reproductive tract infections. Physical examinations and lab tests found that some 92% had one or more gynaecological diseases including infections of genital tract, including pelvic inflammatory disease, vaginitis and cervicitis. In Gujarat, recently gynaecological morbidity study have been done by various NGOs, and they have also found high prevalence of gynecological problems. (Baroda Citizen's Council, 1994, SEWA Rural, 1994). Similar Study in rural and urban West Bengal (CINI, 1994) and Bombay slums (Streehitkarini, 1994) also found high levels of reproductive tract infections .

Among the 541 children examined at the major camps, skin infections (25.8%) was a major problem. This was followed by the cases of nutritional deficiencies (21%), upper respiratory tract infection (17.4%), stomach disorders - diarrhoea and dysentery (16.1%) and ear infection - otitis media (10.3%). A sizable proportion of cases related to anaemia (9.1%); breathing trouble (8.4%) pharyngitis (5.3%), worms (4.6%) and malaria (4.2%) were registered. A small number of problems related with eyes (3%) and physical deformity (1.5%) as indicated in Table 2b.

Table 2b: Common Problems Seen Among Children at Ten Major RCH Camps

Type of Diagnosis	Percentage of children with specific problem
Skin Infections	25.8
Nutritional deficiencies	21.0
Stomach disorders	16.1
Otitis Media	10.3
Severe Anaemia	9.1
UTI	17.4
Worms	4.6
Breathing Problems	8.4
Malaria	4.2
Eye Problems	3.0
Physical Deformities	1.5
Phyarngitia	5.3
Others	12.0
Total of Children (no.)	100.0 (N= 541) @

Note: @ Due to multiple diagnosis total of the column of percents will be more than 100.

Similar type of disease pattern was also observed in these mini RCH camps in the second phase. Table 2c shows that, the gynecological problems and table 2d shows common problems seen among children in mini RCH camps.

Table 2c: Common Gynaecological & Non-Gynecological Problems Seen in Mini RCH camps

Type of Diagnosis	% of women ailing in mini RCH camps
<u>Gynecological Problems:</u>	
RTI	36.6
Pregnant Cases	13.8
Menstrual Problems	9.3
Problems of Infertility	4.2
Prolapse Cases	2.7
UTI	2.3
Others	7.1
<u>Non Gynecological Problems:</u>	
Anaemia	31.5
Stomach Disorder: (Gastroenteritis/ Acidity)	7.3
Skin infection	2.3
Others	18.6
Refused for Examination	2.2
Total number of Women	100 (N=588)

(The above analysis was confined to mini camp held between May to Nov. 1997)

Table 2d: Common Problems Among Children Seen in the Mini RCH Camps

Type of Diagnosis	Percentage of Children ailing in RCH camps
Respiratory Tract Infection	26.5
Malaria/Fever	20.0
Stomach Disorder (Gastroenteritis)	13.0
Skin Problems	13.0
Nutritional Deficiency	11.4
Ear infection (otitis Media)	11.0
Severe Anaemia	10.2
Dental Problem	4.5
Eye Problem	4.2
Vaccine preventable diseases	2.5
Others	25.6
Total number of children	100.0 (N=434)

Note: The above analysis was confined to mini camp held in between May to Nov. 1997.

Cost Analysis

Although there is a high burden of reproductive morbidity, cost-effective interventions are also becoming increasingly available. The challenge is to develop cost-effective packages of good quality services to address the needs of specific client group in various setting and to make these available and accessible to all, and especially to the poor and the disadvantaged in the remote areas of our country. In past, because of the complexity of diagnosis and treatment, RTI and STI interventions have appeared to be beyond reach of the poor. However, recently proposed alternatives that simplify case management of STIs such as using a syndromic approach for diagnosis and algorithms for treatment (WHO, 1991) could make selected interventions feasible and affordable at the primary health care level and if it is targeted at high prevalence groups. Thus cost of any intervention is an important factor determining its replicability and chance of scaling up. Here we present a rough cost estimate of the RCH camps in each of the three phases of the intervention.

In the first phase, where major RCH camps were held, the cost per client was high as indicated below:

Table 4a. : Cost Estimates for Major RCH Camps in Phase I (In Rupees)

Cost of various inputs needed for the camp.	Expenditure for one major RCH camp
Honorarium to four specialist from Cancer & Civil Hosp. @ Rs. 600	2400
Honorarium to four Inter doctors from Cancer & Civil Hosp. @ Rs. 300	1200
Honorarium to two sister @ Rs. 200 & Ayah @ Rs. 100	500
Charges for three vehicles @ Rs. 850 per vehicle	2550
Additional Medicine approximate Cost per camp	1800
Snacks and Tea to PHC staff, Cancer & Civil Team and IIM team	1000
IIM's six team members salaries for one day	1800
Cost of Pap Smear Test (10 Rs per slide)	350
Miscellaneous Expenses	500
Total Expenses per major RCH Camp	12,100
Average Expenses per client (About 200 clients)	60.50
Medicine cost per client	9.0
Cost excluding medicinal cost per clients	51.50

In the second phase the strategy was changed from large camps to mini camps with restricted the number of clients. As this was a mini camp many of the overhead costs could be reduced. The total cost of conducting a mini RH camp is summarized in Table 4b.

Table 4b: Cost Analysis for Conducting a Mini RCH Camp

Cost of various inputs needed for the camp.	Expenditure for one camp in Rs.
Honorarium for one specialist @ Rs. 600	600
Approximate Cost of Additional medicine	500
Vehicle charges @ Rs. 850	850
Snacks and tea to the team	350
IIIA team's salary for the day	433
Miscellaneous expenses	150
Total expenses per camp.	2883
Average expenses per clients (assuming 60 clients)	48.05
Medicine cost per client	8.30
Other cost (Excluding Medicinal cost) per clients	39.75

The other expenses in organizing one RH camp seems to be still higher than the cost of medicines for patients. However, for the long term sustainability of such camp strategy requires that these services be conducted on a regular basis in the existing PHC set up with as less additional costs as possible. Thus to make the camp strategy cost effective for replicating it at district level, it was decided to hand over the management of the camp to PHCs thus reducing the costs further. The total cost for conducting such camps managed by the PHC system (Third Phase) is shown in Table 4c

Table 4c: Cost Analysis for Conducting a Mini RCH Camp Manage by PHC

ITEMS on the Camp day	Expenditure for one camp in Rs.
Honorarium for one specialist @ Rs. 500	500
Approximate cost of additional medicine	500
Miscellaneous expenses	150
Total expenses per camp.	1150
Average Expenses per clients (assuming 60 clients)	19.10
Medicine cost per client	8.30
Other cost (excluding medicinal cost) per clients	10.80

Comparative analysis shows that the cost of conducting one RH camp in the PHC set up is very nominal if the PHCs can manage the organization of the camps. Table 4d shows cost comparisons in the three phases of the project.

Table 4d: Comparative Analysis of RH Camp Strategy

Important Camp Variables	Expenses (in Rs) incurred in conducting one camp		
	Major Camp	Mini Camp	Mini Camp managed by PHC
Total Expenses per Camp	12,100	2,883	1,150
Average Expenses per client (200 for Major & 60 for mini RH Camp)	60.5	48.05	19.1
Medicine cost per client	9	8.3	8.3
Other cost (Excluding Medicine cost) per clients	51.5	39.75	10.8

The learning experience during the pilot phase of the RH project suggest that if the minimum requirements are provided in the PHC, the cost of conducting one RH camp will be around Rs. 1,150. However the average expenses per client will come to only around Rs. 19 including medicines, which is very nominal as compared to the charges of private treatment for such RH problems or even just the cost of travel to free government facilities to the city.

An alternate way of providing for specialist services would be to have two gynecologists with DGO qualification, recruited for the camps in one district with 50 PHCs. They provide services for one or two camp per day at PHC level. With these inputs, each PHC can have one camp per month. Each gynecologist should also have a team of one LHV/ANM and one driver-cum-helper and one vehicle. The cost of such a team may be somewhat higher but still affordable as compared to the benefit they provide.

Lessons Learnt

Three years of implementing camp strategy for RH provided several lessons that would be useful for replication of this approach. The key lessons are as follows:

1. It is feasible to provide high quality RCH services and training inputs through camp approach using specialists who visit PHCs on regular basis.
2. Women prefer female doctor, but with adequate preparation and privacy they do not mind being checked by a male gynecologist.
3. Small but periodic camps based on a fixed schedule are better than large, occasional camps. They provide better quality of care at lesser cost.
4. The organization of camp requires good planning, prior publicity and active involvement of the PHC MO and the staff of the PHC. Camps will get very few clients if PHC workers have not made adequate efforts to identify and motivate the clients.

5. Camps provide ample scope for hand-on-training and live demonstration of symptoms of RH problems including RTIs. But this opportunity has to be systematically used for training by the specialist and the PHC staff.
6. The camps can help build better quality of services at PHC by improving the clinical procedure and practice.
7. Once a month RH camp activity does not disrupt the PHC work much so that it is not likely to have any negative impact on the routine services. On the other hand, it increases PHC's credibility as outside specialist's services and special medicines are available at the camp.
8. Smaller camps are easier to manage and reduce waiting time with higher level of satisfaction.
9. Camp approach has provided an opportunity for women to break their "culture of silence" about various reproductive health problems. As many women in the community are going for examination on the camp day, they find support in each other. Such camps where women are properly examined with due privacy and care, help change the norm in the community where unnecessary modesty prevents early diagnosis of many reproductive illnesses and proper management of such problems. Camp also provides opportunity to diagnose many asymptomatic problems such as anaemia, hypertension, diabetes, breast lumps, cervical lesions etc.
10. The RH camp also increases spirit of team work in the PHC staff and creates a sense of pride in providing high quality services that are needed by the clients. This increases the morale of the PHC team.
11. Finally camp also provides a learning experience to the specialists who are located in secondary or tertiary facilities. They learn the ground realities of rural areas and how to manage the patients with limited resources and negligible diagnostic support.
12. Camps also help strengthen the referral linkages as the patients meet the same specialists at the CHC or higher level hospitals when they are referred.

Replication and Future Direction:

This experience of camps has been replicated by the district health office in organizing such camps in difficult to reach area of the districts where backward communities live.

Such camps are being proposed in the new RCH project where provision is being made for inviting consultants from outside for providing specialist care.

The state Government of Gujarat had made provision in the health budget this year for organizing health camps in rural and tribal areas. These camps have been organised this year by the state government in many districts. The National AIDS Control Organization (NACO) has also adopted similar strategy which is called Family Health Awareness Week. Thus this camp based approach has the potential of being replicated on wider scale as a intermediate strategy for providing RCH services in the country like India.

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