

**A RAPID APPRAISAL OF ORGANISATION AND INFLUENCE OF
RCH CAMPS IN SELECTED DISTRICTS OF UTTAR PRADESH**

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PREFACE

Despite significant improvements made in the past few decades, the public health challenges are not only so huge in our country but are also growing and shifting at an unprecedented rate. The concerns shown by the organisations concerned at the global level indicate that in view of the resurgence of various epidemics, both infectious and non-infectious, the situation can be handled only through a more coordinated public health management approach. This urgency is realised and expressed in the Public Health Conference, as expressed as the “Calcutta Declaration,” which called for the creation of an appropriate structure for public health professionals and for promotion of reforms in public health education and training.

The National Institute of Health & Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and partnership with public health institutions in the country with a view to enhance their research capacity. As the nodal agency for imparting in-service training to health personnel and conducting research under NRHM (National Rural Health Mission), the Institute is an ideal partner to facilitate mainstreaming of the Department of Community Medicine in medical colleges, nursing colleges and other public health education and training institutions in the healthcare delivery system in the country, and for providing a platform to build networks for capacity building of these institutions.

Currently, under the NRHM many innovations have been introduced in the states to deliver healthcare services in an effective manner. The state programme managers wish to know how well these innovations are performing so that in case of gaps corrective measures can be taken to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need has been discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme-relevant information at local and regional levels.

The Rapid Assessment of Health Interventions (RAHI), a collaborative activity with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of the Public Health Education and Research Consortium (PHERC) of the National Institute of Health and Family Welfare (NIHFW) for developing partnerships with different organisations working in the field of health and family welfare. The objective of the project is to

accelerate programme implementation in identified states by organising timely and appropriate research inputs to address priority implementation problems. The specific objectives of this initiative are to develop a network of state/regional institutions for conducting healthcare systems research and to provide technical support for steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of the RAHI project, the UNFPA India supported 12 health system research projects. In this phase, five low-performing states -- Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh, and Orissa-- were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, these 12 projects were finalised in a national workshop conducted at the NIHF. The NIHF faculty provided technical support for finalisation of the tools, training of investigators, and planning and monitoring of the data collection process. A quality assurance mechanism was developed in consultation with the TAG members and experts from the UNFPA. The progress of the projects was reviewed by TAG from time to time. A draft report entitled **“A Rapid Appraisal of the Organisation and Influence of RCH Camps in the Selected Districts of Uttar Pradesh”** by the Department of Social and Preventive Medicine, MLB Medical College, Jhansi, was finalised by the NIHF in consultation with the UNFPA.

It is envisaged that the findings and recommendations of this study will trigger of a series of follow-up measures by programme managers concerned in the state. We also feel strongly about continued need for optimum engagement of available human resources in Community Medicine, Paediatrics and Obstetrics/Gynaecology departments of the medical colleges in such assessments. Such initiatives by the programme managers will not only end current isolation of medical colleges but will also be conducive for incorporating such public health interventions during undergraduate and post graduate training.

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This project would not have been possible without the dedicated efforts of the research team in which every member played a significant role, particularly Dr. A. K. Malhotra, Professor, S.P. M; Dr. Piyush Kariwal, and Dr. Alok Kumar, Department of Social and Preventive Medicine of this institution. Sincere thanks are due to them. Dr. Atul Kumar and Dr. Shalini deserve special thanks for their contribution in data analysis and report writing.

We are also grateful to the Chief Medical Officers of the eight districts and the Block Medical Officers of the 16 Block PHCs and other functionaries for providing us vital inputs. Also, we express our gratitude to all our respondents in this research without whose cooperation the study would not have been completed.

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ABBREVIATIONS

AMBU	Ambulatory bag mask unit
ANC	Antenatal check-up
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
AIDS	Acquired immunodeficiency syndrome
BCC	Behaviour change communication
BCG	Bacillus Calmette Guerin
CHC	Community health centre
CMO	Chief medical officer
Co-PI	Co-principal investigator
DPT	Diphtheria, Pertussis, Tetanus
DT	Diphtheria, Tetanus
Dy. CMO	Deputy chief medical officer
FGD	Focus group discussion
FP	Family planning
FRU	First referral units
Hb	Haemoglobin
HIV	Human immunodeficiency virus
IDI	In-depth interview
IEC	Information, education, communication
IFA	Iron and folic acid
ILR	Ice lined refrigerator
IMR	Infant mortality rate
IPHS	Indian Public Health Standards
IUCD	Intra-uterine contraceptive device
IV	Intravenous
LPS	Low performing states
LT	Lab technician
MDG	Millennium Development Goal
MLBMC	Maharani Laxmi Bai Medical College
MMR	Maternal mortality rate
MO	Medical officer
MOI/c	Medical officer in-charge
NE	North-East
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NSV	Non-scalpel vasectomy
RCH	Reproductive and Child Health
RTI/STI	Reproductive tract infection/sexually transmitted infection
SBA	Skilled birth attendant

TFR	Total fertility rate
TT	Tetanus Toxoid
UPA	United Progressive Alliance
VDRL	Veneral Diseases Research Laboratory
Vit-A	Vitamin-A

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EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM), under implementation since 2005, provides accessible, affordable and quality healthcare services to the rural population. The National Institute of Health and Family Welfare, in collaboration with the UNFPA India Office, undertook a rapid appraisal of various health interventions under the NRHM with the concurrence of Government of India. Twelve institutions across the country conducted appraisals of various schemes in the NRHM under the 'Rapid Appraisal of Health Interventions' (RAHI) Project, funded by the UNFPA. These rapid appraisals have been conducted in five low-performing states, namely Madhya Pradesh, Uttar Pradesh, Orissa, and Jharkhand to critically look into the implementation process of various schemes and innovations under the NRHM.

The Reproductive and Child Health (RCH) camps in Uttar Pradesh are being organised at the block level. Out of the total 854 blocks, each block is proposed with 8 RCH Camps annually, summing it to a total of 5,372. These RCH Camps provide an array of maternal, child health and family planning services for women, children and the general population.

Objectives

- To assess whether the RCH camps are being organised as per the guidelines
- To estimate the number and characteristics of the service providers and beneficiaries
- To assess the referral mechanism and follow-up activities in these camps
- To assess the client satisfaction and usefulness of RCH camps
- To find out organisational challenges and how they are addressed.

Methodology

The study was carried out in 8 districts of Uttar Pradesh, two each from eastern western, central and the Bundelkhand regions (Jhansi, Banda, Allahabad, Jaunpur, Rampur, Moradabad, Kheri and Sitapur.) The study was carried out in the 16 blocks of these 8 districts. The study assessed 16 RCH camps.

Reports and records of RCH camps held in previous years (total attendance, expenditure, and types of services etc.) were collected from respective CMOs and critically reviewed. In-depth interviews of CMOs, Dy. CMOs (RCH/NRHM), MOs. in-charge of CHCs/PHCs, doctors and other staff giving services in the camp were conducted. FGDs were conducted amongst beneficiaries and non-beneficiaries of the previous camp.

Key Findings

- As many as 87.5% of the CMOs/Dy. CMOs received guidelines from the state, but only 37.5% participated in the state-level training and only 25% received organised district level training. Among the paramedical service providers 88.24% received training to organise RCH camps.
- As for as the medicines and consumables are concerned, most of the medicines (including for RTI/STI, gynaecological diseases, sterilisation, antibiotics, pain killers) are available in sufficient quantities in most of the camps except for the iron and folic acid tablets which are available only at 43.75% places, which is an important concern.
- More than half of the CMOs/Dy. CMOs received IEC material (posters and pamphlets) from the state.
- In camp observation, it has been seen that registration table is present in all the camps, but tables for ANCs, immunization and counselling for FP/HIV/AIDS are present only over half of the places and examination table is seen only in 12.5% of the RCH camps.
- Most of the camps are clean (81.25%) and have drinking water facility in 87.5%, and urinals/lavatories in 75.0% camps. Though as per the guidelines, sitting facility for clients should be available in the form of daris/chairs, it has been seen only around 50% of camps. Almost all of the camps (93.75%) have electricity connection/functional generator. Around 50% of the camps have essential equipment such as OT and mini-labs (37.5%), laparotomy (31.25%) and NSV (37.5%).
- At most of the places it has been found that there is deficiency of medical and paramedical personnel in respect to the strength of clients per camp.

About half of the CMOs/Dy. CMOs and MOIs have complained about the absence of lady doctors and paediatricians. Thus the camps are being organised in the absence of these two main service providers.

- Among the major problems faced by paramedical workers, 50% have reported about work overload, while 33.33% have complained of lack of staff. Therefore, 37.5% of CMOs/Dy. CMOs have called for increasing the paramedical manpower, especially surgeons, to improve quality of RCH camps, 25% are of the opinion that the budget has to increase, while another 25% have called for re-orientation training for ANMs, ASHAs and other paramedical staff.

Key Recommendations

- Fund should be increased and vehicles should be provided by the CMO office for transporting beneficiaries.
- Increasing human resources, (medical & paramedical persons), camps can provide better services, and adequate funds should be provided to compensate the doctors.
- Improved OT condition to make RCH camps better followed by the permanent posting of surgeon at the PHC level.
- Improving sitting and transport facilities followed by drinking water and toilet facilities will help ensure better quality of RCH camps.

CHAPTER-I

INTRODUCTION

BACKGROUND

The National Rural Health Mission (NRHM) was launched in April 2005 with a view to bring about dramatic improvement in the healthcare system and the health status of the people, especially those who live in the rural areas. The NRHM seeks to provide universal access to equitable, affordable, and quality healthcare which is accountable at the same time responsive to the needs of the people, reduction in child and maternal deaths as well as population stabilisation, and bringing about gender and demographic balance. In this process, the mission would help achieve goals set under the mission under the National Health Policy and the Millennium Development Goals (MDGs).

Reproductive and Child Health Programme (RCH-II), the flagship programme of the NRHM, is the principal vehicle for reducing IMR, MMR and TFR. The RCH-II encompasses a number of innovations and reforms. Its development objective is to bring about improved and equitable child health, maternal health and population stabilisation through assured, responsive, quality healthcare services, especially in states with low human development indicators.

Up-gradation of Community Health Centres as the first referral units (FRUs) for dealing with emergency obstetric care, 24x7 delivery services at the PHCs, operationalising of sub-centers multi-skilling of doctors, contractual appointments of MOs and AMOs, training medical officers in aesthetic skills, training doctors/ANMs/nurses as skilled birth attendants (SBAs) permitting ANMs to administer certain drugs in emergencies, partnerships with voluntary organisations and RCH camps, offering accreditation to NGOs, IEC activities are the major interventions in reducing MMR.

Operationalisation in the State

RCH camps in U.P are being organised at the block level. For every block, 18 RCH camps are proposed annually. Since UP has 854 blocks, a total of 15,372 camps are planned in the state this year. The services to be provided in these camps are gynaecological check-ups, paediatrics check-ups, immunisation, and

family planning services including counselling and transportation of clients for sterilisation. Though sterilisation camps have been part of the family planning programme for many years, these RCH camps are different in the following manner:

- Provide assured services as per predetermined calendar
- Combine benefits of rural outreach and high quality services
- Provide an array of maternal and child healthcare and family planning services under one roof.

Each RCH camp is scheduled in advance and organisation of these camps needs detailed planning relating to publicity, manpower deployment, camp arrangement, and post-camp services including transport, availability of consumables and medical equipments.

Rationale

The RCH camps provide an opportunity to integrate the efforts of providers and increase access to RCH services for women and children. These camps should also provide assured high quality services within the timeline. Hence, it is essential to assess the quality of organisation and usefulness of these camps.

General Objective

To assess the organisation and influence of RCH camps in selected districts of the state.

Specific Objectives

- To assess whether RCH camps are being organised as per guidelines including financial norms
- To estimate the number and characteristics of the service providers and beneficiaries
- To assess the referral mechanism and follow-up activities
- To assess the client satisfaction and usefulness of RCH camps
- To find out organisational challenges and how they were addressed.

Arranging the Report

The report has four chapters. The first chapter includes introduction and background of the study along with the rationale of the study and the objectives--both general and specific. The second chapter provides a detailed note on the methodology including sampling design, rationale for selection of sample districts and blocks and the various methods and tools that have been adopted in the study. The third chapter reflects on the results of the study along with the narrations and descriptions with important quotes from the field to give a vibrant and authentic picture of the ground realities; and the fourth chapter contains important recommendations emerging from the appraisal, limitations of this study and future directions for research.

CHAPTER - II

METHODOLOGY

Study Area

Jhansi, Banda, Allahabad, Jaunpur, Rampur, Moradabad, Kheri and Sitapur districts of Uttar Pradesh.

Study Design

Type of Study: Observational

Study Subjects

The following stakeholders were the subjects in this study:

- CMOs/Dy. CMOs
- MOIs/c
- Service provider (medical)
- Service provider (paramedical)
- Beneficiaries of the current RCH camps
- Beneficiaries of the previous RCH camps
- Non-beneficiaries

Study was done by two teams each comprising one supervisor and two investigators. Data were collected in two steps by making two visits to the selected districts. In step-1 the district-level information was collected. Details are as follows:

Types of Data collected

Review of Secondary Data

Reports and records of RCH camps held in previous years (total attendance, expenditure, and types of services etc.) were collected from respective CMO and critically reviewed.

Primary Data

In-depth interview of CMOs, Dy. CMOs (RCHs/NRHM), MOs in-charge of CHCs/PHCs, doctors and other staff giving services in the camp

Direct observation at camp site and exit interview of beneficiaries

FGD of beneficiaries and non-beneficiaries of the previous camp

Research Tools

Following research instruments were used for data collection:

- Guidelines for in-depth interview
- Guidelines for FGDs.
- Check-list for direct observation
- Schedule for exit interview
- Check-list for review of secondary data

Study Unit

The study unit was RCH camp being organised at block PHCs/CHCs during study period.

Sample Size

The study was carried out in 10% of total districts of UP. Thus, 7-8 districts were selected by purposive sampling method.

Selection of Districts and Blocks

The study was done in 8 districts of U.P., two each from eastern, western, central and the Bundelkhand regions. Out of the two districts in each region, one was randomly selected from good performing districts and the other from poor-performing districts based on their performance in achieving family planning targets in the previous year. From each district, two blocks were selected purposively, one close to the district headquarters and other remote.

Thus, study was carried out in 16 Blocks in eight districts. And it's assumed that all the camps in one block will be same, so one camp from each block was

selected. Thus, 16 RCH camps in eight districts were assessed. The detailed break-up of activities are given below:

Table: 1: Districts and Blocks Selected for Study

S.No.	Regions	Districts	Blocks
1	Bundelkhand	Jhansi	Chirgaon
2	Bundelkhand	Jhansi	Bangra
3	Bundelkhand	Banda	Bisanda
4	Bundelkhand	Banda	Mahua
5	Eastern UP	Allahabad	Dhanupur
6	Eastern UP	Allahabad	Kaudhiara
7	Eastern UP	Jaunpur	Madiyahu
8	Eastern UP	Jaunpur	Baksa
9	Western UP	Rampur	Bilaspur
10	Western UP	Rampur	Tanda
11	Western UP	Moradabad	Mundapande
12	Western UP	Moradabad	Kanth
13	Central UP	Kheri	Ramiabehad
14	Central UP	Kheri	Nighasan
15	Central UP	Sitapur	Sidhauli
16	Central UP	Sitapur	Hargaon

Observation – 16 RCH camps; In-depth interviews-- CMOs/Dy-CMOs – 8, Block MOIs/c – 16; Medical officers present at camp site–16 (one per site); Paramedical staff present at the camp site- 16 (one per site); Exit interviews–10 beneficiaries of different health problems per site; FGDs Beneficiaries – 16; and Non-beneficiaries – 16.

Data Collection Methods and Organising Field Work

District Level: In-depth interviews with CMOs/Dy. CMOs were done by the study supervisor.

Records and reports of the RCH camps held in 2006 were collected by the field supervisor and one investigator.

Block Level: In-depth interviews with MOIs/c and service provider (doctor and paramedical staff) were done by field investigators. FGDs with beneficiaries and

non-beneficiaries were carried out by field investigators and supervisors. Records and reports of camps held in 2006 were collected by the supervisor.

Safety Considerations

During the preparation and administration of research questionnaire, due care was taken for not hurting anybody's feelings.

Table: 2 Samples Covered, Tools and Techniques Used for Data Collection

S. No.	Stakeholders	Number	Data Collection Method and Tools
1	CMOs/Dy-CMOs	8 (one per district)	In-depth interviews
2	Block MOIs/c	16 (one per block)	In-depth interviews
3	Service providers (medical)	16 (one per block)	In-depth interviews
4	Service providers (paramedical)	16 (one per block)	In-depth interviews
5	Present RCH camp beneficiaries	150 (10 per camp)*	Exit-interviews
6	Previous RCH camp beneficiaries	175 (8-14 per block)	FGDs
7	RCH camp non-beneficiaries	161 (8-15 per block)	FGDs

*RCH camp was not held at one block as only four candidates came to attend it.

Quality Assurance

FGDs in the first district were carried out in the presence of PIs, Co-PIs and/or NIHFW/ their nominees. Around 10% of the schedules were randomly selected and checked by PIs, Co-PIs and/or NIHFW nominees.

Data Analysis Plan

Data processing and analysis was done at the Department of SPM, M.L.B. Medical College, Jhansi, using appropriate tests and techniques. Data processing and analysis started as soon as data collection in the first district was completed. Later on, this continued simultaneously with data collection activity.

Adjectives Used in the Study for Qualitative Data

Proportion of Respondents	Adjectives Used
<10%	Very few
10-24%	Some
25-49%	Approximately half
50-74%	Majority/Over half
75-89%	Most
>90%	Almost all

Ethical Clearance

The project structure was examined and cleared by ethical committee of the institution and the Review Board of the NIHFV for ethical considerations.

CHAPTER- III

FINDINGS AND DISCUSSION

The table below shows that last year among sterilisation operations, tubectomy was the main operation that was done in camp. The data for counselling of beneficiaries and treatment of obstetrical and gynaecological were not available at almost all the places.

Table 3 : Secondary Data of RCH Camps of Eight Sample Districts Between March 2006 and April 2007

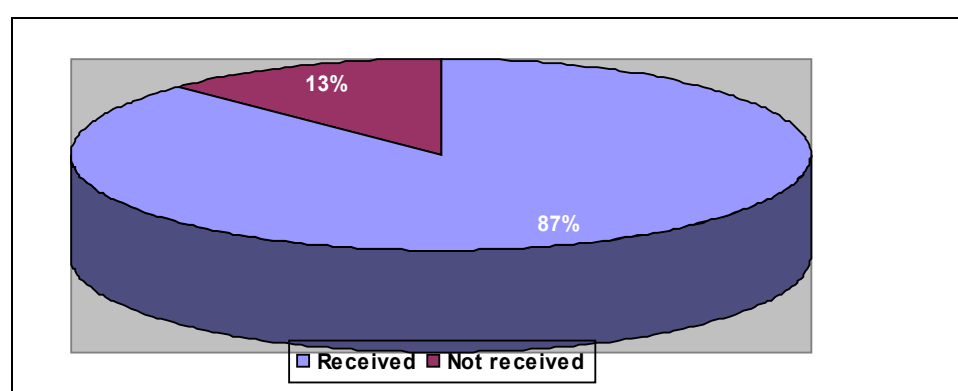
Name of District	V.O	T.O	IUCD	OCP Users	Condoms Users	ANC	Immunization to Children	Counseling Beneficiaries	Obs/Gyne Treated / Referred
Jhansi	19	15,149	25,192	10,355	22,065	50,306	54,961	NA	NA
Banda	06	4,779	19,330	1,35,702	15,36,788	NA	NA	NA	NA
Allahabad	117	21,005	74,794	32,296	65,199	1,51,889	NA	1,62,096	NA
Jaunpur	16	15,882	46,067	3,38,870	2,81,952	1,53,013	92,224	NA	NA
Rampur	03	1,821	16,312	75,820	1,20,252	37,196	53,571	NA	NA
Moradabad	00	2,533	1,726	5,652	7,656	2,368	1,970	5,541	2,470
Kheri	08	8,710	18,598	2,15,673	18,90,411	NA	NA	NA	NA
Sitapur	76	9,994	29,236	2,47,408	2,37,973	1,37,798	1,18,925	NA*	1802

NA*=Not Available

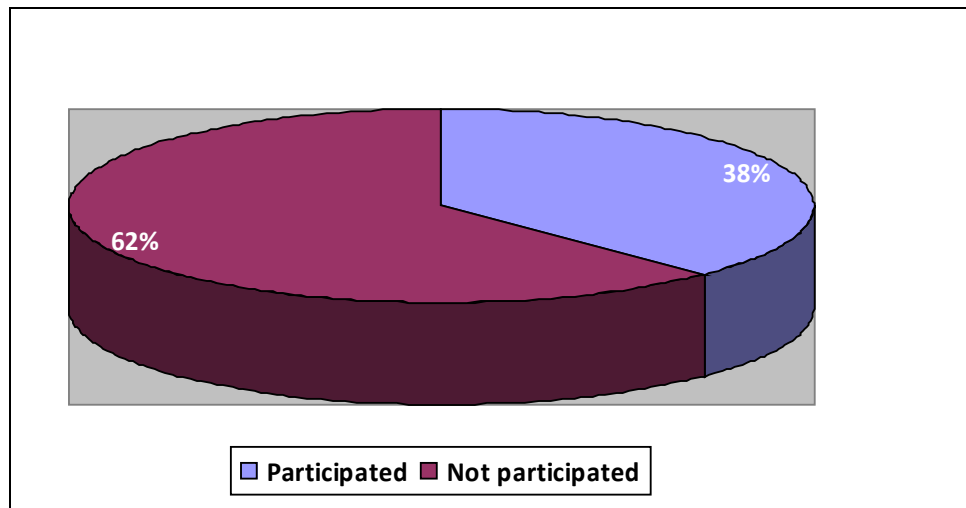
Training to Organise RCH Camp: Training and Guidelines

For organising RCH camps, training and guidelines are provided to the CMO/Dy. CMO from the state. These CMOs/Dy. CMOs in turn provide training and guidelines to block MOIs/c and other staff involved in organising the camp. In rapid appraisal, it was found that most (87.5%) of the CMOs/Dy. CMOs received guidelines from the state but approximately half (37.5%) participated in state-level training and organised district level training (25%).

Graph 1: Percentage of CMOs/Dy. CMOs who Received Guidelines for Organising RCH Camps



Graph 2: Percentage of CMOs/Dy. CMOs who participated in state level training for organising RCH camps



When block MOIs were interviewed, most of them (75%) reported that they received guidelines and training to conduct RCH camps. Among medical service providers (doctors, surgeons) majority (60%), while 88.24% of the paramedics received training to organise RCH camps.

Drugs and Consumables

As for as the medicines and consumables are concerned, most of the medicines (including for RTI/STI, gynaecological diseases, sterilisation, antibiotics, pain-killers) are available in sufficient quantities in most of the camps, whereas the iron and folic acid tablets are available in approximately half (43.75%) of places which is an important concern. Among consumables (gloves, antiseptics,

pregnancy test kits, dressing materials) are available in the sufficient amount at almost all places. Needles and syringes are available in most of the places but where it is not available, same syringe and needle are being used for blood-testing of two or more persons. It increases the risk of infections of contagious diseases like HIV/AIDS, Hepatitis-B. So, this should be immediately addressed.

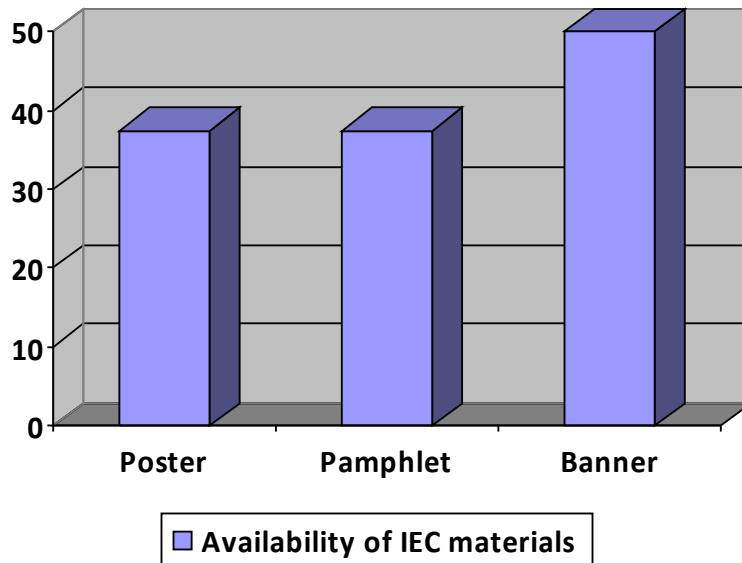
Almost all the emergency drugs are available in sufficient quantities at most of the RCH camps, except for physostigmine, calcium chloride and glucose (25%) which are not present in the sufficient quantities.

IEC

IEC activities are an important part to make people aware of the importance of the camp and services provided in the camps. Majority over half of the CMOs/Dy. CMOs received IEC materials (posters and pamphlets) from state-level but at block-level approximately half of the MOI/c received IEC material and it is displayed in approximately half of the camps. According to the FGDs of beneficiaries, they get information about the camps from the *behanji* (AWW, ASHA). Some other methods used to inform people about the RCH camps are at block level pradhans, lekhpals and the board on healthcare facilities.

'Hamre gaon mein to koi bhi poster nahi lagavat hai, hame to keval behanji nasbandi ke bare me batai rahei' "No posters are displayed in my village, only *behanji* (AWW, ASHA) told me about the camp"

Graph 3: Availability of IEC Materials at PHCs/CHCs according to MOI/c



Local workers have responsibility to inform people about various facilities provided to them in the camps (like treatment for gynaecological problems, ANC, immunization, counselling for FP/HIV/AIDS) but according to most of the people the only information they get is on about sterilization.

‘Hame to behanji keval batai rahein ki bacche na hoye wala operation karae leo, paisa miliye. Aur hame kuch nahi pata ki haspatal ma ka hovat hai (Behanji only told me that after sterilisation operation, you will be given money, she did not tell us about other facilities provided in the camps), according to an FGD.

There is a five-column concept in RCH guidelines, according to which the camps must have tables for registration, facilities for gynaecological problems, ANC, immunization and counselling facilities for FP/ HIV/ AIDS. In camp observation, it has been seen that registration table is present in all camps; tables for ANC, immunization and counselling for FP/HIV/AIDS are present in majority of the camps. But table for gynaecological problems is seen only in 12.5% of the camps. From the above it is clear that the main service being provided is of sterilisation. Almost all (more than 99%) clients who came here are females and tubectomy is done on them.

Table: 4 Five Tables Concept Observed

S. No.	Counter	Bundelkh and (%) n=4	Centra l UP (%) n=4	Eastern UP (%) n=4	Weste rn UP (%) n=4	TOTAL (%) n=16
1	Registration	4 (100)	4 (100)	4 (100)	4 (100)	16 (100)
2	Counselling for FP/HIV/AIDS	2 (50)	3 (75)	2 (50)	2 (50)	9 (56.25)
3	ANC	2 (50)	2 (50)	0 (0)	2 (50)	6 (37.5)
4	Immunisation	2 (50)	2 (50)	0 (0)	2 (50)	6 (37.5)
5	Gynaecological problems	1 (25)	0 (0)	0 (0)	1 (25)	2 (12.5)

Most of the camp sites are clean (81.25%) and facility of drinking water (87.5%), urinals/lavatories are present at 75.0% camps. As the per guidelines, sitting facility for clients should be available in form of dari/chair, but it is available only a little over 50% of the places, and at other places clients and their attendants sit on the ground.

OT Facilities

Tubectomy is the main procedure being done in the camps. For tubectomy, which is an operative procedure, OT should be maintained properly. It should have electricity supply, power back-up, table with trendelenberg facility, working laparoscope for operations, and shadowless lamps for proper lighting at operative site. Almost all of the camps (93.75%) are having electricity/functional generator but at other places it is not available. Shadowless lamp is available only in approximately half of the camps.

Proper handwashing is a must by doctors and other OT staff, in the absence of which the patient may get infected. But we have observed that only around 81% of the doctors and OT staff wash their hand properly. So, it is advisable that persons involved in OT should be educated about precaution to be taken in the OT. At most of the camp sites, almost all the preoperative preparations of the clients are being done. Also, written consent of the person who is undergoing the operation is taken at all of the camps.

Among essential equipments available in the OT, minilap (37.5%), laparotomy (31.25%) and NSV (37.5%) instruments are available in approximately half of the

places. Emergency resuscitation equipments including, suction machine, oxygen cylinder, and IV infusion set are available in almost all of the places, but airways, face mask and AMBU bag are present only in 62.5%, 87.5% and 81.25% of places respectively.

Infection Prevention Practices

Almost all infection prevention practices (autoclave/instrument boiler, sterilized OT gown,) are being used in the camps, but needle destroyers are available at only 68.75% places and at some places it is very disappointing that surgical gloves are being reused after being washed, leading the possibility of transmission of infection. When MOIs/c were asked about this, most of them report that they have to work in limited budget, hence nothing can be done unless the budget is increased, but they have no answer to the question if their actions lead to infections, who will be responsible for that.

Facilities in Laboratory

According to RCH camp guidelines, various tests should be done in the laboratory during the camp. These include urine test for sugar, test for HB, test for RTI/STI (swab test, VDRL, wet mount, pregnancy test, hydrogen peroxide test, smear test, RPR test, amine test) etc.

On observation, we have found urine test for sugar (81.25%) and test for HB (87.5%) being done at most of the places, but test for RTI/STI is being carried out only at a few places. This again shows that various facilities that should be provided in camps are not available or utilised properly.

Immunisation

Immunisation is one of the facilities that should be provided in all the camps. We have observed availability of the vaccines as good. Almost all the vaccines are available in most of the places (93.75%) except DT which is available only at 87.5% places and Vitamine-A at 81.25% camps. But immunisation is not being done on the day of the camp. According to MOIs/c, this is so because immunisation days are fixed on Wednesdays and Saturdays, and camps are not being carried out on those days. So, the component of immunisation is not being fulfilled in the camps.

Human Resources

At the camps there are two types of service providers-- medical and paramedical. Medical personnel should include surgeons, pediatricians, and gynaecologists. Among paramedical personnel the requirements are for nurses and lab technicians. At most of the places it has been found that there is deficiency of both medical and paramedical personnel in respect to the strength of clients per camp.

At some places more than 100 tubectomies are done in a camp and it is done by only one surgeon. If a surgeon is doing so much operation in a day, quality of services can be easily assessed.

Besides this, surgeons have to come from district headquarters for the camp and generally they come late sometime in the afternoon and they perform operations till late night. At a few places, one surgeon is covering two camps. Since tubectomies are the main services being provided in the camps, in the absence of adequate number of surgeons camps which should be started in the morning, starts even in the afternoon when the surgeon comes. But they have to complete all the cases registered.

Lady doctors are present only in 50% of camps and paediatricians at some places only. Thus camps are being organised in the absence of these two main service providers.

About half of the CMOs/Dy. CMOs and MOIs/c complain about the deficiency of surgeons. So it is urgent that the number of surgeons be increased for the proper functioning of the camps. And it is suggested that one surgeon be permanently posted at the block PHC/CHC. There is also a lack of paramedics in comparison to the strength of a camp.

Transport for Clients and Referral Facilities

According to RCH camp guidelines, clients should be provided with transport facility to and fro for the camps. But we have observed that transport facility is present only at 37.5% of camps. People from remote areas come for the

operation on their own. Many camps are held even late into the night and the patient is discharged instantly. In the absence of transport facilities, they suffer a lot. Transport facility is not easily available at night in remote places, and if available it costs much more to the patients.

**“Hamara operation ke bad raat me ghar jane ke liye teen sau rupaiya kharch karna pada”
I have to spent Rs. 300/- to return home at night after the operation, said a beneficiary.**

When asked, the CMO gave the following reasons for this: insufficient number of vehicles (12.50%), insufficient budget (25%) and suggested that budget for transportation be increased.

According to approximately half of the MOIs/c (43.75%), there is no provision of transport to and fro for beneficiaries and all of them are of the opinion that fund should be increased and vehicles should be provided by the CMO office. If any patients with complication arrive, which is unmanageable at block PHC/CHC level, he/she should be urgently referred to a higher centre. And we have observed there are lacunae in the referral mechanism.

Reimbursement of money

After the exit interviews of the beneficiaries, it has been found that money is paid at hardly any camps (1.4%) for any service. Also, only 1.33% of the clients suggested that reimbursement be increased for improving the camps, or reimbursement be provided after the operation (2%).

Follow-up of patients

After tubectomy patients are provided with medicines and follow-up is done by ASHA/ANM/AWW. After 7-10 days stitches are removed. Also, the patients are not asked to come to hospital for follow-up.

Follow-up advices are given to most of the tubectomy/vasectomy patients, but for other cases like condom users, immunisation for children, treated RTI/STI patients, treated gynaecological cases, IUCD acceptors) advices are given only at some places.

Client satisfaction (Total Respondents 150)

Out of the total, 99% respondents are post-tubectomy patients because in almost all camps the only service provided is tubectomy.

Table 5: Client Satisfactions Regarding Various facilities

S. NO.	OBSERVATION	Yes (%)	No (%)
1	Given advice on follow-up services.	144 (96)	6(4)
2	Advice about drugs to be taken	149 (99)	1(1)
3	Satisfied with services	147 (98)	3 (2)
4	Satisfied with staff behaviour	149 (99)	1(1)
5	Services provided in the camp are better than routine services*	74 (49)	34 (22.6)
6	Paid money for any services	2 (1.4)	148 (98.6)
7	Proper sitting arrangements	107 (71)	43 (29)
8	Availability of safe drinking water	130 (86.6)	20 (13.4)
9	Toilet facility	98 (65.3)	51 (34)

* Close to half (49%) of the beneficiaries report that services provided in the camp are better than routine services; another 28% have no idea because they are first-timers. Almost all clients are given advice on follow-up services, drugs to be taken and they are satisfied with services provided.

Table 6: Region-wise Performance of the Camps

S. No.	Performance	Bundelkhan	Central UP	Eastern UP	Western UP
1	No of clients counselled	181	321	129	49

2	No. of ANC check-ups	4	2	2	13
3	No. of tubectomies	127	315	126	48
4	No. of vasectomies	0	0	0	0
5	No. of IUCD acceptors	0	2	2	2
6	No. of RTI/STI cases treated	3	5	2	4
7	No. of gynaecological cases attended	0	0	2	12
8	No. of children received BCG vaccination	0	6	2	0
9	No. of children received polio vaccination	7	0	2	2
10	No. of children received DPT vaccination	0	2	0	2
11	No. of children received DT vaccination	0	0	0	0
12	No. of children received TT vaccination	0	2	2	0
13	No. of children received measles vaccination	0	1	0	0
14	No. of children received Vitamine A vaccination	0	1	0	0

The above table shows the magnitude of different services being provided in the camps, region-wise.

Usefulness of RCH camps

RCH II was started with the aim of bringing about improved and equitable child healthcare, maternal healthcare and population stabilisation through

assured, responsive and quality healthcare services, especially in the states with low human development indicators. The RCH camps were started to provide many facilities under one roof including sterilisation, paediatric care, immunisation, RTI/STI problems and gynaecological disorders.

However, we have observed that at most of the camps the only service being provided is sterilisation, that too tubectomy. Other necessary services are neither being provided in the camp nor many of the hospital staff know about them. Thus, RCH camps are useful only in population control and are not being proved worthy for improvement of child and maternal healthcare.

Challenges in Organising RCH Camps

Table 7: Problems faced by Medical Personnel in Providing Service (No. of respondents 15)

S. No.	Response	No. of respondents (%)
1	Too much work-load in camps, so quality services are difficult to provide	5 (33.33)
2	Inadequate medical/paramedical staff	2 (13.33)
3	OT is not sterilised	1 (6.67)
4	OT capacities/facilities is poor	7 (46.67)
5	Un-cooperative staff	1 (6.67)
6	Some surgeons do not take interest in RCH camps	1 (6.67)
7	Problem of transportation	1 (6.67)

To organise RCH camps, there has to be detailed planning in the areas of publicity, manpower deployment, on-site arrangements, and post-camp services including transportation, availability of consumables and medical equipments.

Our observation has found that, according to 37.5% of the CMOs/Dy. CMOs, the main problem facing the camps is lack of staff especially surgeons, affecting the service quality at the camps. Half of the MOIs/c say that the main problems are the lack of manpower-- medical/paramedical (43.75%), lack of transport facility (25%), high work load (18.75%) and poor OT facilities (18.75%).

For the medical personnel and medical service providers (doctors), the main problems that prevent them from providing quality service are poor facilities in the OT (46.67%) and high work-load (33.33%), while according 50% of the paramedics, too much work overload is their main concern, followed by 33.33% of them citing lack of staff as the main impediment.

Graph 4: Involvement of Paramedical service provider



Suggestions for betterment of RCH camps

Table 8: Suggestions of Clients for Betterment of RCH Camps (Total respondents 150)

S. No.	Response	No. of respondents (%)
1.	Transport facility	25 (16.67)
2.	Toilet facility	16 (10.67)
3.	Sitting facility	26 (17.33)
4.	Higher reimbursement	2 (1.33)
5.	Reimbursement should be provided	3 (2)
6.	Lack of doctors and staff	1 (.67)
7.	Camp must start on time	3 (2)
8.	No comments	11 (7.33)
9.	Drinking water	19 (12.67)
10.	Cleanliness at camp sites	1 (.67)
11.	Stretcher/bed	9 (6)

As many as 37.5% CMO/ Dy. CMO suggest increasing the manpower especially surgeons is must to improve the quality of camps, while 25% favour increase in budget and another 25% of them recommend re-orientation training of ANM, ASHA and other paramedical.

According to 37.5% of the MOIs/c, camps can provide better services if the manpower and the funds is increased besides ensuring that surgeons and their teams reach on time in the camp.

According to 40% of the medical service providers, improved OT condition make the camps better, while one-third of them are of consider that permanent posting of surgeons at PHC-level can improve the services.

Half the number of paramedics suggest that for betterment running of the RCH camps the number of medical/paramedical personnel has to be increased (29.41%) and by ensuring sufficient quantities of medicines and consumables (29.41%).

According to clients, at some of the places the most needed improvement is sitting and transport facilities followed by drinking water and toilet facilities.

CHAPTER IV

RECOMMENDATIONS

Areas of Concern	Actions Recommended
<p>Policy Issues</p> <p>The shortage of medical and paramedical staff is the major hindrance for smooth implementation of the programme, according to health authorities at district and sub-district level</p> <p>Absence of display board with list of camp beneficiaries along with the date of disbursement of incentives is reducing transparency</p>	<ul style="list-style-type: none"> ▪ Staff for providing medical services should be increased at block and peripheral level ▪ All vacancies must be filled up immediately ▪ List of beneficiaries must be displayed at district and block levels
<p>At all levels of camp site logistics support such as operation room is not adequate to meet the increased operation load due to the camp beneficiaries. Among essential equipments available in OT, minilap (37.5%), laparotomy (31.25%) and NSV (37.5%) instruments are available only in half the camps.</p> <p>There is shortage of antibiotics, other medicines and IFA tablets at some camps According to half the CMOs/Dy.CMOs and MOIs/c a major problem is the lack of surgeons. Lady doctors are available at only 50% of camps while paediatricians are even less. Thus camps are being organised in the absence of these two main service providers.</p>	<ul style="list-style-type: none"> ▪ The inadequacy of equipments and infrastructure should be assessed through facility surveys and the deficits are to be filled up urgently to meet increased demand for OT ▪ The IFA tablets should be made available regularly ▪ The inadequacy of specialists like paediatricians, gynaecologists, surgeons hampers the quality of services provided at camp site. So they should be hired on contract basis and proper remuneration should be provided. Proper transport facility should also be made available for them.
<p>Weak monitoring and supervision. No check-list for monitoring and supervision is available at the district and block levels.</p>	<p>There is a need for clear policy on monitoring and supervision. The monitoring and supervision diary at district and block level must be made mandatory.</p>

<p>Programme Issues</p> <p>Little disbursement of money to beneficiaries: after the exit interviews of beneficiaries it has been found that practically none (only 1.4%) of the camps distribute money to the patients...</p> <p>At majority (56.25%) places, patients are referred to higher centres but without any transportation facilities being provided as they have no ambulances, or those camps having one are not functional.</p> <p>IEC</p> <p>More than half the CMOs/Dy.CMOs received IEC materials (posters and pamphlets) from state, while nearly half the MOIs/c got it at block level. But the FGDs of beneficiaries they revealed that they got the information about the camps from the <i>behanji</i> (AWW, ASHA), this is despite the fact that MOIs/c have displayed the material at the display boards of the PHC/SHCs. Some other methods used to inform people about the camps are at block level Pradhan, Lekhpal and Board of Healthcare facilities.</p>	<ul style="list-style-type: none"> ▪ Delay in disbursement of fund at district and block level need to be addressed appropriately ▪ Discrepancies in the amount of compensation received by beneficiaries need to be seriously viewed ▪ Transports facilities must be made available at the camp site and block level ▪ Sensitisation of district and block level programme managers need to be stepped up ▪ Any modification in the programme needs to percolate down the hierarchy in time ▪ Feedback from top to bottom need to be stream lined ▪ Awareness generation activities in the community need to be strengthened
<p>There is a gap in the knowledge level of ASHAs/AWWs & other health functionaries. Also there is a gap in the awareness of other stakeholders and community resulting in large number of non-beneficiaries.</p> <p>As there should be a Five Table Concept in every camp, but tubectomies are the main services being provided in camps. Thus the camps have become virtually tubectomy camps only.</p>	<ul style="list-style-type: none"> ▪ There is a need for repeated training and sensitisation of MOs, service providers (medical and paramedics) and ASHAs/AWWs ▪ Availability of other services should be made wide based. So that beneficiaries could utilise more services under one roof

Limitations of the study

The duration of the study was quite less, therefore a large sample could not be attempted. More number of study districts could have been increased for ensuring more representativeness and generalisation of the findings.

Future Directions of Research

Facility assessment study may be undertaken to map out the areas of deficits and initiate timely corrective measures. With the increasing number of beneficiaries coming to avail of the RCH camp benefits, a study to assess the health system preparedness in meeting the enhanced demand of services is an appropriate area of future research.

REFERENCES

1. Government of India, National Rural Health Mission-Meeting People's Health Need in Rural Areas: Framework for Implementation, Ministry of Health & Family Welfare, 2005
2. Government of India, National Health Policy (2002): Department of Health, Ministry of Health and Family Welfare, New Delhi
3. World Health Organisation (2003), The World Health Report 2003, Geneva
4. Government of India, Reproductive and Child Health Programme: Schemes for Implementation, Oct. 1997, Department of Family Welfare, Ministry of Health and Family Welfare, New Delhi
5. Government of India, Annual Report 2001-2002, Ministry of Health and Family Welfare, New Delhi
6. K.Park Textbook of Preventive and Social Medicine Pages-345-46, 18th edition, January 2005.
7. Government of India, Standards for Female and Male Sterilisation, Ministry of Health and Family Welfare, New Delhi, Oct. 1999.

RESEARCH SITE

(District Map of Uttar Pradesh)

