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The Quality of Family Planning Services in Uttar Pradesh from the Perspective of Service Providers

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There is a growing realization in India that unless the quality of services in the public sector is improved, acceptance and continuation of contraception to the desired levels may not be achieved.

It is important to understand the social, physical, and administrative environment in which the grassroots components of a health program function and provide services. Bruce (1990) created a framework that conceptualizes this environment as program effort consisting of policy and political support to the family planning program, resource allocation; and family planning program management and structure. Given the shortage of essential resources and the problems with facilities in many areas of India, providing a high quality of services is a challenging task. In a complex and bureaucratic system like the Indian Family Welfare Programme, workers at the grassroots level have limited Opportunities to discuss and resolve their problems. They often neglect their duties by not visiting field areas, not attending clinics, providing only a limited range of services, or meeting only some of the goals set by higher officials. Foremost among these goals has been the achievement of method-specific targets, particularly for sterilization. To improve the program's services, program managers must take into account not only the perspectives of users, but also the perspectives of providers.

In this chapter we present health workers' perspectives on the quality of program services, specifically the readiness of health facilities to provide high-quality services and the obstacles that workers face in performing their jobs. We discuss providers' views on the need to offer a range of services, to inform clients about available contraceptives, and to follow up acceptors. We also examine, from the providers' perspective, the consequences of over-emphasizing family planning targets, particularly sterilization targets, for the quality of services.

Data and Methodology

In 1995, using a brief guideline, we conducted a series of focus-group discussions, in-depth interviews, and informal discussions with 70 health providers in Sitapur District, Uttar Pradesh. The research team also visited a number of primary health centers (PHCs) and sub-centers to assess their facilities, logistics, equipment, and staffing levels. During those visits we observed interactions between clients and providers, and, wherever possible, tape-recorded the observations. Each member of the research team-an anthropologist, a gynecologist, and a sociologist-conducted about two months (January to March) of intensive fieldwork collecting data for the study. Table 12.1 lists the groups who provided our quality-of-care data.

Table 12.1: Study coverage: Sitapur District, Uttar Pradesh, 1995

Qualitative approaches used to collect information from different levels of staff	**Number**
Focus-group discussions	2
Medical officers (doctors)	1
LHV	2
ANMs	
In-depth interviews (ANMs)	54
Informal discussions	1
Chief medical officer	2
Deputy chief medical officers	8
Medical officers (doctors)	
Observations	1
PPC	2
CHCs	10
PHCs	16
Sub-centers	3
Camps	

ANM = auxiliary nurse-midwife; CHC = community health center; LHV = lady health visitor; PHC = primary health center; PPC = postpartum center.

Sitapur District is located in central Uttar Pradesh, at a distance of 66 kilometers from Lucknow, the state capital. The total population of the district, as enumerated by the latest census, was 2.6 million in 1991, comprising 2 percent of the state's population. Only 12 percent of the district was urban, compared with 20 percent for the state as a whole. One-third of the district's population is scheduled castes. Only 17 percent of adult women were literate, compared with

25 percent for all of Uttar Pradesh. Sitapur District is characterized by very high fertility (a total fertility rate of 5.6 children per woman) and low contraceptive use (15 percent of married couples). Unmet need for contraception is estimated to be as high as 42 percent of all couples (SIFPSA and the Population Council 1994).

The public health facilities in rural areas of the district consist of 19 block-level PHCs and community health centers (CHCs), 41 additional PHCs, and 396 sub-centers. Included in the present study are five block-level PHCs, five new PHCs, and 54 sub-centers that fall under the administrative jurisdiction of a deputy chief medical officer.

Findings

In the sections that follow, we quote extensively from our informants. In translating their comments into English, we have attempted to preserve the flavor of their speech, editing their statements only for clarification or brevity.

Problems of Covering Assigned Work Areas

Of the 54 auxiliary nurse-midwives (ANMs) interviewed, only 24 (44 percent) were residing in sub-center villages. The rest were staying either in larger villages outside their work areas or in nearby towns or cities. Many were living in the town of Sitapur, the district headquarters. The distance between nonresident ANMs homes and their sub-center clinics ranged from 5 to 26 kilometers. Most of them commuted from home to their sub-centers by bus, motor scooter, bicycle, horse cart, or truck. Most traveled by foot from the sub-center to other villages in their work areas, but in cases where the villages were located in remote areas, the ANMs used a bicycle, motor scooter, or cart to reach them. Several ANMs reported hiring local boys to take them by bicycle to the remote villages.

During the focus-group discussions and individual interviews, the ANMs said they preferred to reside in nearby towns or large villages because of the lack of educational facilities for their children in the smaller villages, and also for security reasons. The lack of adequate transportation and their meager travel allowance made it difficult for them to cover all the villages in their work areas. Covering each village on foot was difficult and time-consuming, and spending their own limited resources for official work was also problematic. Although many ANMs maintained that they tried to visit all the villages in their work areas, our observations and discussions with villagers indicated that most of the ANMs covered only a few of the more accessible villages. More distant villages were either completely neglected or visited only during the months of December

through March, when the search for sterilization cases was in high gear. As one of the ANMs admitted:

> *Only during camp I visited my entire work area once, along with my husband, on motorcycle.*

Two other ANMs commented:

> *Out of 24 villages in my work area, I am hardly able to visit eight to 10 villages every month, 10 to 12 villages once in two months, and the remaining three to four villages are visited less often (once in three or four months).*

> *Two to three villages are very far (five or six kilometers) [away] and also not safe enough to go [there] alone. During family planning camps I told the doctor that I was not able to visit those areas. He put two more ANMs on duty to help me so I could cover those areas with them.*

A lady health visitor (LHV), who supervised some of the ANMs, stressed the problems of distance, mobility, and safety faced by the ANMs in covering their work areas:

> *Villages are scattered at a distance of four to five kilometers. All the burden is on her [the ANM] alone. There is absolutely no security for a female health worker. Even the gram pradhan [elected village leader] cannot be trusted. There has been a case of rape by him. Under such circumstances even if an ANM fails to do her duty at times or loses interest in her work, I personally do not blame her.*

Nearly one-fifth of the ANMs we interviewed had responsibility for 6,000 or more inhabitants (Table 12.2), as compared with the prescribed norm of 5,000 per sub-center. A majority (61 percent) were responsible for six to 15 villages, but nearly one-fourth had to cover 16 or more villages spread over a radius of at least five to six kilometers. Given the inadequate transportation and other field problems facing the workers, covering all the villages in their assigned areas appears to have been a difficult task. Most of the ANMs confessed during their interviews that they did not visit remote villages.

Table 12.2: Number of villages and combined populations in areas assigned to ANMs: Sitapur District, Uttar Pradesh, 1995

Coverage	Percentage
Number of villages assigned per ANM	17

1-5 6-10 11-15 16-20 21+	24 37 9 13
Total population size of assigned work areas < 5,000 5,001 - 6,000 6,001 + Don't know	54 26 18 2
(No. of ANMs interviewed)	(54)

ANM = auxiliary nurse-midwife

The health workers also hesitated to work in certain areas because of the difficulty of working with some caste or religious groups. Such groups, they explained, did not approve of family planning and therefore did not want to listen to or cooperate with the workers. According to the ANMs, however, the situation is changing and the ANMs have started gaining acceptance in those areas. As one of the medical officers put it:

> *We will have to touch these pockets through our workers. We are also trying our best. [The] situation is changing now. Earlier, water was also not offered to workers in these pockets, so they were not willing to go [there] in summer. But now TV, radio, and media communication are changing their [the villagers'] views. We are also trying to reach them. Besides, we have started a link person's scheme for every 20 households. These link workers help ANMs in their various activities.*

Both the ANMs themselves and the doctors we interviewed mentioned the fear of theft, robbery, and sexual violence as a reason for the ANMs' unwillingness to live in their work areas and for not covering all the villages assigned to them. According to the respondents, each ANM had one or two hamlets where she would not dare to go without a male escort, even during daylight hours. As one medical officer-in-charge told us:

> *[The] feeling of insecurity among ANMs is tremendous. So she [an ANM] always wants [a] companion. This further hinders the work, as she is dependent on the other person and has to work at his convenience. During [the] sterilization drive, often they take their husbands or someone else to escort them and cover all the areas.*

Talking about the widespread insecurity in the area where he worked, one medical officer described his own situation:

> *I came here from a district hospital about one and a half years back. I wanted to do things in a better way, [to] understand problems, and [to] solve them. So when I was posted here, I came along with all my luggage and [my] family. Once, when I went to Lucknow for training, my wife was alone at home. Our house was looted in the night. Now my wife is not willing to stay here. But if I do not stay here, how can I expect my junior staff to stay here? So I am staying here with my family despite their opposition.*

He added:

> *I met the district magistrate, police superintendent, etc., and appealed to them for a license for a rifle. I said, "If you get me a license for a rifle, then I will stay here." They have agreed to give me a license. But who [else] will take all these risks? My children are all terrorized in the evening. Even though the staff is local, they themselves are afraid.*

Conditions of the Public Health Facilities

Proper logistic support is crucial if providers are to offer good-quality services. Our visits and discussions with doctors revealed that only a few sub-centers were situated in government-owned buildings. Most of the clinics were housed in rented or donated buildings, many of which were inadequate for that purpose. A medical officer-in-charge of a sub-center commented on the government's policy of acquiring land for clinics:

> *The government spends [money] on buildings but not on land. Land in villages would be available for a couple of thousand rupees. Instead of spending a few thousands, the government wants free land. [In some areas] free land is available [only] near the graveyard. Neither is the ANM willing to stay there, nor is the client willing to visit the center or deliver her child in the graveyard. If the government would spend a few thousand [rupees] extra and purchase land in the center of a village, then ANMs would stay there.*

The absence of a proper space for holding clinics provides a good excuse for many ANMs not to open the clinics or to provide proper care, such as conducting physical examinations of patients. Our field visits revealed that most of the sub-centers were functioning in a single small room with no electricity or toilet facilities. Drinking water, however, was available in all the villages.

Referring to the lack of proper space for holding clinics, an ANM remarked:

> *I do not have any proper place to sit or to keep instruments. Where do I ask them [patients] to sit or where do I examine them? [How] can I conduct a regular clinic in such a situation?*

Another complained:

> *We get only 50 rupees per month for renting a house [to use as a clinic]. Nowadays how do we get a two-room house for 50 rupees? Why cannot government provide us a clinic with living quarters?*

Still another ANM said:

> *We do not even get this amount of 50 rupees regularly. It is paid after three or four months. During this period either we have to pay the rent from our pocket or face trouble from the landlord, who of- ten threatens to throw away the goods of the sub-center.*

Many sub-centers had inadequate supplies of medicine. Most of the ANMs told us they lacked medicines for treating patients suffering from even common ailments, such as malaria, infection, sepsis, dysentery, colds, cough, or fever. Even if medicines were provided, the quantities were insufficient to meet the sub-centers' needs. Except for iron, folic acid, and calcium tablets, other medicines were largely unavailable at the 54 sub-centers we visited (Table 12.3).

Table 12.3: Supplies of medicines at selected subcenters: Sitapur District, Uttar Pradesh, 1995

Conditions requiring treatment	**Percentage of ANMs reporting medicines as**		
	Available on date of interview	**Out of stock in past 6 months**	
		Once	**More than once**
Cold or cough	31	13	7
General fever	24	11	6
Malaria	11	6	2
Infection or sepsis	18	6	7
Diarrhea	37	9	4

Dysentery	18	7	4
(No. of ANMs interviewed) (54)			

ANM = auxiliary nurse-midwife

In a focus-group discussion, ANMs made the following observations:

> *When people ask for medicine and we do not have it to offer them, they lose confidence in me and think that we are only there to provide family planning services and not other types of health care.*

We are provided with only iron and calcium tablets and sometimes paracetamol and antibiotics. Many times we have to prescribe or even purchase medicines from the market, spending money from our own pocket just to keep patients happy, especially if she [a patient] is a potential case for sterilization.

The biggest problem is that we have been provided with no other medicine except iron and calcium. People complain and almost throw it back in our face, demanding to know why is it that only red tablets and white tablets are given for all the problems. They have almost lost faith in me and my treatment.

One in three ANMs complained of short supplies of vaccines (e.g., to prevent measles; tuberculosis; diphtheria, pertussis, and tetanus; and polio). At the time of our interviews, one-third of the ANMs reported that those vaccines were not in stock at their clinics. Such shortages pose a serious problem for the ANMs, who are compelled to give incomplete series of vaccinations to children. We observed ANMs inviting women clients to return with their children the following week for immunizations, but we do not know how many of those mothers actually returned, or whether all the vaccines were available if they did return.

Having basic equipment in working condition and basic supplies is also a prerequisite for providing good-quality services. Although 70 percent of the ANMs had an operable blood pressure (BP) instrument, which the United Nations Children's Fund (UNICEF) had recently provided under the Child Survival and Safe Motherhood (CSSM) Programme, only 13 percent had a working stethoscope (Table 12.4). Without a stethoscope, how useful a BP instrument can be is an open question. Similarly, most of the sub-centers lacked an examination table, weighing scale for adults, or reagents for urine and blood tests. Weighing scales for infants were available and in working condition in 34 sub-centers (63 percent). Those too had been provided recently under the CSSM

Programme of UNICEF. Nondisposable gloves and thermometers in working condition were available in 74 and 80 percent of the sub-centers, respectively.

Table 12.4: Available of equipment and medical supplies at selected sub-centers: Sitapur District, Uttar Pradesh, 1995

Equipment and supplies	**Percentage of ANMs reporting equipment or supplies as**	
	Available	**In working condition**
Needles and syringes	66	64
Blood-pressure instrument	76	70
Stethoscope	24	13
Thermometer	82	80
Weighing scale for infants	74	63
Weighing scale for adults	20	19
Examination table	33	24
Non-disposable gloves	74	NA
Chemicals used for testing Urine Blood	6 2	NA NA
Test tube	19	13
(No. of ANMs interviewed) (54)		

ANM = auxiliary nurse-midwife; NA = not applicable

Typical of the comments we heard from ANMs were the following:

> *For antenatal cases, I would like to record her [the woman's] weight, but there is no weighing machine. I know that [a] urine test to examine albumin is necessary for antenatal cases, but there are no test tubes or reagents. How do we do [a] urine test?*

> *I have nothing in my sub-center. No table, [no] stool, no bed. There is one table, which is useless. Further, no medicines, no equipments, no cologne [antiseptic], no pressure cooker or utensils or stove are available. What can I suggest for improving the quality of services?*

> *Madam, you are asking about quality of services. Here we have problems in providing even the basic services.*

Contraceptive supplies were inadequate or lacking altogether at most of the sub-centers and even at the PHCs in Sitapur District. For example, according to the ANMs we interviewed, a third of the 54 sub-centers we canvassed did not have either intrauterine devices (IUDs) or IUD insertion kits. Of the 10 PHCs we visited, five did not have IUDs in stock. In at least three PHCs, condoms or oral contraceptives were not available. The medical officer-in-charge had no explanation for the shortages, merely asserting that contraceptives were always available to workers except during the end of the fiscal year (March).

Eighteen of the 54 sub-centers (33 percent) had both equipment for sterilizing instruments and kerosene, which is needed to boil water to sterilize equipment. Thirty had equipment but no kerosene, and six had neither the required equipment nor kerosene. Thus only a third of the sub-centers were able to sterilize their instruments. Disinfectants (Cidex, Savlon, and alcohol) were available in only five sub-centers. The following complaints were typical of those we heard from both ANMs and LHVs:

> *We have to do vaccinations without using spirit. Even if we want to purchase it from [the] market, we cannot because it is sold only under license.*

> Kerosene oil is not available at sub-centers. We never get a supply. Although there is an allocation of 30 rupees per sub-center each month for the purchase of kerosene oil, it never reaches the sub-center. God knows what happens to it!

Neither disposable (sterile) nor non-disposable gloves were available to a third of the ANMs. Lacking gloves, some ANMs inserted IUDs without first doing a pelvic checkup. Some did pelvic examinations without gloves, but two resourceful ANMs told us they used condoms for doing pelvic examinations.

ANMs, particularly those who were staying at their sub-centers or in nearby villages, provided assistance in deliveries. Only a few of the 54 ANMs we interviewed had delivery kits, however. They did not have even a pair of gloves. Cotton and gauze, needed for immunizations, were not available in adequate quantities at any of the sub-centers. Many ANMs spent their own money to buy those supplies.

The following comments suggest that, with adequate support for their work, the health workers we interviewed could improve their services:

> LHV*: In the absence of adequate facilities and medicine, the services provided by the ANMs are optimum. If facilities are improved, we can think of improving quality of services also.*

Medical officer-in-charge*: I feel that the ANMs are doing as much as they can do. It is unfortunate that no facilities or quarters are provided to them. There are never enough medicines, instruments, or other essential logistic support for them at the sub-centers-not even for IUD insertion and vaccination.*

ANM: *The condition of the sub-center should be improved. We should have equipments like weighing scale, reagents for urine test, blood-pressure measuring instruments, stethoscope, etc. Some medicines, like calcium, B complex, Methergine, and Ciplin, should also be available to us. Some furniture, such as [an] examination table, table and chair for myself, should also be provided. I want the people to look at me as their ANM. I do not want them to think that I am one of the old dais [traditional birth attendants].*

A lack of appropriate information, education, and communication (IEC) materials was another problem. Out of 54 sub-centers, only 36 (66 percent) had books, 19 (35 percent) had pictures or posters, and 3 had a model of the female reproductive organs that could be used to explain family planning methods to clients. Such IEC materials as pamphlets and booklets on family planning and maternal and child health were available at only one-half of the sub-centers for distribution to clients. Seventeen of the sub-centers had no IEC materials whatsoever. Moreover, during our two months of field work we did not observe clinic staff using any of the available IEC materials. We were told that this was because most of their clients, being illiterate, could not read the pamphlets. The ANMs regarded the materials as useless, and a medical officer-in-charge agreed:

A lot of printed materials are wasted. Provide something which is useful.

Another medical officer-in-charge noted a problem with the program's IEC efforts:

IEC activities planned so far have not given any results or significant impact. The truth is that the BEE [block extension educator, now called a health education officer] has no role to play. The BEE could have done lot of things but has not done anything so far. They do not do any motivational work, while they are assigned a key post to carry out this activity. This is a frustrated cadre; and as there is no avenue for any promotion, it does not stimulate them to work.

When a health education officer at one of the PHCs was asked about this, he had the following response:

We try our best to promote IEC activities, as this is going to be our only activity. But we have to depend on district or CHC authorities for getting vehicles and also VCR [video cassette recorders] and projectors for organizing a video or slide show. They hardly cooperate or take initiative. What can we do alone, with no support?

Time Management

To assess how the ANMs managed their time and to what extent they had enough time to do outreach work, we carefully examined their work schedules. In discussions with the ANMs and LHVs we learned that their schedules varied with the season. April was a somewhat relaxed month, from May to August they were preoccupied with epidemic control, and from October to March they concentrated on family planning. When time permitted, they did immunization work. Maternal care and primary health services were mostly neglected.

An analysis of their schedules revealed that the ANMs wasted a lot of time in unproductive work. For instance, every Tuesday they went to the Sitapur District Hospital to collect vaccines, arriving at about 11:00 a.m. and returning to their clinics with vaccines between 2:00 and 2:30 p.m.; on this day no other work was done. Similarly, on Thursdays most of them went to *Kisan Seva Kendra* (a farmers' cooperative). The purpose was to inform the farmers about family planning and other services available from the PHC or sub-centers and thus motivate them to have small families. In reality, however, the ANMs had no role in the meetings. Instead, they just sat there for the whole day and then returned to their clinics. Most did not know why they were supposed to attend the meetings. As one of the ANMs said to us:

Thursday is the camp day, and if there is no camp I have to attend Kisan Seva Kendra for three hours. I do not do anything there. People come from different departments and talk with farmers. But I do not have any role. I never understand why they call me there.

Even those who did know the purpose of attending the meetings thought they were wasting their time there:

During the meeting my duty is to explain about immunization and family planning to the women. But hardly any women come there, and if no woman comes then what do I do? Also no one comes from my department. Only [male] farmers come to the meeting. But because it is my duty, I sit there from 10:00 a.m. to 5:00 p.m. If any officer comes to cheek [on my attendance], at that time I should be present there.

We noted a similar misuse of ANMs' time during camp days. At least one day per week, all the ANMs had to attend sterilization camps to assist in various activities, whether they had a case or not. On several occasions during our field visits we observed far more PHC and sub-center staff at the camps than the number of women and men who had turned up for sterilizations. On one occasion only one case was there for a vasectomy, but all 24 ANMs were present. They had nothing to do with the camp. Instead, all were sitting in a room, talking among themselves. When we asked the doctor why it was necessary to call all the ANMs for just one case, he replied:

> *When camps start, we divide all the ANMs into four or five groups to attend different [kinds of] work-one group for OT [operation theater], one for ward duty, one for clothing, etc. So they have to come for every camp. We never know in advance how many cases will be coming on a particular day.*

During the summer, outbreaks of malaria, cholera, and gastroenteritis are common. In that season, epidemic work occupies every- one and all other activities are stopped. As a medical officer put it:

> *Epidemic disturbs the whole work. Every one of us is busy with the epidemic work. Last year [1994] the condition was quite bad; I have not seen such a [serious] condition in the last 17 years of my service. [This situation] demands day and night service, and everyone is busy with epidemic work.*

Family planning activities come to a halt at such times. The following comment by an ANM was typical:

> *During an epidemic, when there is the question of life and death, how do we talk of family planning and sterilization?*

How much time do ANMs actually have for outreach work? According to the work plan mentioned by the ANMs we interviewed, they had only two days a week for field visits. As one of them told us:

> *Frequent field visits are not possible. [Each] month I have to come to the PHC to collect vaccine for four days, [attend] camp for four days, and [attend] monthly meeting for two days. In this way [I spend] 10 days [at the] PHC. Four days I do vaccinations, four to six days I spend at the clinic and Kisan Seva Kendra, and four Sundays and other holidays are [spent] there. In the remaining four to five days I have to cover all 11 villages.*

The schedule of two field days per week is not fixed for the ANMS. Occasionally a monthly meeting is called on the day normally reserved for field visits. Sometimes the ANMs go to collect their salaries on that day. If they have any personal work to do on that day, they also postpone their field visits. As one ANM stated:

> *Tuesday, Wednesday, Thursday, and Friday we have [a] fixed schedule; hence a field visit is not possible. On Monday and Saturday I go to [the] field according to my convenience and depending on whether or not I have some ad hoc work.*

Support from Male Workers

From our observations in the field and discussions with medical officers, it became clear that ANMs were the key workers at the grassroots level. Most of the sub-centers were managed by the ANMs alone, as the number of male workers was very limited. Even when male workers were posted at a sub-center, the ANMs did not get adequate support from them. Both the ANMs and the LHVs complained that they received negligible support from their male counterparts. According to three LHVs:

> *Male workers were very helpful earlier. They used to accompany us to the field. We [female workers] used to get lifts, and in turn the [sterilization] cases motivated by us were shared by both of us. We used to cater to antenatal, postnatal, and other cases, and males Used to do their malaria and survey work. But now we have to do our work all alone.*

They [male workers] only go around and order like bosses in meetings. Otherwise they do no work, though we have the same portfolios [work responsibilities].

The male supervisors project themselves as experts and are always ready to guide us-or order us. They go on buttering the officials and escape from all work.
Taking the side of male workers, however, another ANM argued:

[A] female worker covers 5,000 to 6,000 populations, and [a] male worker has to cover 25,000 population. How can he help five or six ANMs at a time? They [the male workers] have their own duty too.
A medical officer-in-charge agreed with most of the LHVs and ANMs that male worker generally did not help the ANMs.

Besides transport problems, there are no pukka [reliable] roads, no vehicles and the distances to be covered are long. They [the ANMs] have to carry heavy vaccine containers to the field. Male health workers seldom accompany them to the field. Most of the ANMs have complained that they do not get much support from their male counterparts.

Provider's Perspective on the Quality of Services

During the interviews we asked health providers to give us their views on the quality of services being provided at public-sector clinics. In general, the ANMs appeared satisfied with the services they were providing, although most of them could not define quality of care. Few could identify gaps in their activities or give suggestions for improving services.

The medical officers-in-charge of the PHCs blamed the lack of infrastructural facilities and the inadequate equipment, medical supplies, and other logistical problems for the clinics' failure to provide a high quality of services. They also mentioned the poor location of the sub-center buildings, including safety considerations; the lack of traveling and living allowances; and the late payment of salaries as obstacles to improving the quality of services. All three of the medical officers-in-charge felt that discussing the quality of services without defining minimal physical, technical, and logistic standards did not make sense. According to one deputy chief medical officer:

We have to think of the given situation before talking of quality of services. We cannot turn Sitapur into Miami. People here are poor, illiterate, and have very low expectations. They have very few basic needs and do not have high expectations of counseling or informed choice. They are happy and satisfied as long as they get the [contraceptive] method, which they desire. We certainly have to improve our services, but we have to keep in mind the local situation and socio-cultural milieu.

A female worker stated:

We have so much work that we cannot satisfy the clients fully. We have large populations to cover and [must] move around 20 villages. During epidemics all of us busy controlling the epidemic. PHCs and sub-centers are full of people, and we have to work day and night. In such situation how can we satisfy everybody?

Technical Competence and On-the-Job Training

When asked whether they needed additional training, most ANMs indicated their willingness to attend training sessions to strengthen their skills or improve their performance; but they could not identify any specific topic or skill area in which they needed training. The following comment, by an ANM, was typical:

> *At our center, I am doing immunization, distributing medicines, doing dressings, etc. I provide pills and condoms if they [the clients] ask for contraception and attend sterilization camps. I am inserting IUDs alone [without assistance]. During my training I inserted three or four IUDs. So, if you design my training program for further improvement of our work, I am ready to attend it. Otherwise I myself am unable to pinpoint any specific area for training.*

Another ANM, however, wanted training to improve her "counseling skills for better motivation.' An LHV mentioned the need for training in supervision:

> *If we are given training on how to improve our supervision work, it will help s in improving our work and help the ANMs in providing better-quality services.*

Some staff told us that the training sessions were often not useful or taught the same subjects every time. A general view was that trainers were far removed from the realities of the villages and that much of the training could not be put into practice. Those perceptions were reflected in the following comments made by LHVs during a focus-group discussion, as well as in comments made during individual interviews:

> *All trainings are the same. What we had learned in 1985 is being repeated in every other training. It is in fact a waste of 8 to 10 days and money. If we are given some practical training instead, we will be more interested.*

During the training, they [the trainers] present ideas, which are not at all practical at the field level. For instance, in CSSM training it was suggested that for each delivery a woman should use new cloth of about two meters to spread on the floor for avoiding infection. The poor women are not even ready to spare their used saris for this purpose. Where will they find 10 to 15 rupees for purchasing new cloth?

The medical officers-in-charge told us that reorientation training should be critically examined and designed to meet workers' needs. They felt that in rural Uttar Pradesh, not all procedures prescribed in textbooks and training manuals could be practiced. The trainers who designed the reorientation courses needed

to understand better the realities in the field and teach what could actually be done, not simply proper procedures in ideal circumstances. These comments indicate a need for serious thinking on how orientation and training programs should be restructured to make them more practical, realistic, and of immediate use to the workers. Unless these issues are given due attention, health workers will consider training to be "punishment" rather than something useful to them.

Providers' Knowledge of Family Planning Methods

Interviews with individual health workers, as well as informal group discussions and the focus groups, revealed that the providers were generally well aware of various family planning methods. They also knew which questions they should ask and which examinations they should perform before prescribing a method. For example, in the case of oral contraceptives, an ANM said:

> *[I should ask about] age of the woman and her youngest child, lactation status, and menstrual history [date of last menstrual cycle], and [should] examine her nails, eyes, and tongue to check for anemia. If a blood-pressure instrument is available I will check her blood pressure also; otherwise [I will] ask whether she had any symptoms or previous history of high blood pressure.*

On the administration of oral pills they also demonstrated knowledge:

> *We tell them to take one pill daily in the evening. We also tell them that if she forgets to take [a pill] one day, she should take two pills the next day. Some women do not wish to take pills on the day of fasting. In such cases I advise [them] to take two pills on the next day.*

The ANMs were able to describe with confidence what they should ask or tell their clients when instructing them in the use of other methods. However, during our field visits we observed that they did not provide detailed information to their clients about how specific methods worked, what the possible side effects were, and in some cases, such as condoms, how a method was used. According to one ANM:

> *What is there to tell about condom? We give condom to only those women who ask for it and know how to use it.*

Another said:

> *This knowledge is natural. We do not have to tell them how to use condom. Usually one out of every four women asking for condom is coming for re-supply.*

Similarly, most of the ANMs interviewed had theoretical and practical knowledge about IUDs. For example, 42 of the 54 ANMs said that they inserted IUDs and were trained in IUD insertion. Most of them had received IUD-insertion training, mainly by the LHV, at their PHCS. In a few cases they had been trained at the CHC by doctors. Because most of them had actually inserted only three ok four IUDs during their training, few were confident about their skill in this procedure. As one ANM said:

> *Didi [the LHV] taught us how to insert an IUD. During training I inserted IUDs in two women. I am not confident to do it independently. Even today I wait and insert an IUD only in the presence of the LHV.*

Thirty of the 54 ANMs interviewed had the required equipment for IUD insertions at their sub-centers. Those who did not have the equipment either shared IUD insertion sets with other ANMs or depended on the LHV for IUD insertions.

As mentioned earlier, most of the ANMs did not do pelvic examinations. Among those who did, only a few had gloves and used them while doing the examinations. If in the course of doing an examination the health workers identified a reproductive health problem, instead of treating the patient or referring her to the PHC or CHC for treatment, some simply told her that an IUD would not suit her. Even worse, some ANMs would insert an IUD despite noticing some indication of a reproductive tract infection (RTI), especially if the woman was already motivated to accept the method. As one LHV said:

> *If we do a pelvic cheek, we find that 75 percent of the women are suffering from at least one major or minor reproductive health problem, whether [or not] there is any wound or swelling. I still insert an IUD; otherwise we may lose the case. Who knows whether she will come back again for an IUD [after she recovers]?*

It was therefore encouraging to hear one ANM say:

> *I refer some of the cases with n-did or severe reproductive health problems to the postpartum center, the community health center, or the district hospital before*

inserting an IUD. To women with minor reproductive health problems, I give iron, folic acid, and calcium tablets.

A majority (33) of the ANMs reported that it was important to ask women for their medical histories and to do a pelvic examination. Nevertheless, only one-third of them mentioned that it was necessary to do a blood test, RTI screening, and urine test before inserting an IUD. In most cases, the ANMs did not inform clients about the side effects of contraceptives. A typical reply was, "We ask women to come back if they have any problem."

Contraceptive Choice

All the health workers in the group discussions and even during individual interviews agreed with the statement that all contraceptive methods should be promoted. However, by tailoring their advice to the presumed need of each client, they missed the opportunity to promote a broader choice of methods. For example, an ANM in a group discussion was applauded by all the other coworkers when she said:

For newly married couples, we recommend condoms only. After first child, when she is lactating, we give condoms or motivate for IUD. If she is not breast-feeding, then we suggest oral pills. After two children, we motivate them mainly for sterilization.

The worker perceived that she was offering the client method choice and not emphasizing any particular method. In actuality, however, she was trying to motivate the client to accept a particular method, depending upon the woman's parity or reproductive status, rather than helping her to choose a method from the available contraceptive basket. During our observation period of several weeks, we seldom observed an ANM discussing all appropriate family planning methods with clients or giving them detailed information about the methods. The following comment was characteristic of the ANMs' attitude:

After three or four pregnancies a woman's skin [uterus] becomes loose and often IUD comes out on its own. What is the point in pre- scribing such women the IUD? To all of them I advise sterilization.

Cultural biases-especially a preference for sons-also prevented some ANMs from telling clients about all the methods. For example, in counseling a woman who was pregnant and had come to the clinic for an abortion and sterilization, the ANM suggested:

Why don't you continue with this pregnancy? You have only three daughters. See if your next child is a son, and then you can go for the operation.

Others told us:

We would never ask a woman with only daughters to go for sterilization. A son is required by the family and the society. Who will look after [the parents] in their old age? Even for couples with one son I would recommend sterilization only after the son has completed his first year. If by God's wish something [bad] happened [to the child], I would be in trouble. I myself would feel sorry for the couple.

I mostly recommend the IUD to women with one or two children. After two children [one of them a son], I motivate them only for sterilization.

When the issue of promoting a broader method mix was discussed with the medical officer-in-charge, he had the following comment:

Our ANMs are attuned to understand that they have to do only sterilization work. They are not bothered about any other problem. They talk and discuss only sterilization. Even with me, they think they have to talk only of sterilization. I feel if they start promoting spacing methods also, they can do better work. But, unfortunately, they are never asked questions about spacing [births].

When we asked him whether, as the medical officer-in-charge of the PHCS, he asked ANMs at monthly meetings whether they promoted spacing methods, he replied:

I ask, but so what? If I talk of the IUD, they would say that they do not have apparatus and applicators. It is also true. More than half of the ANMs do not have kits for IUD insertion. Many times I have reminded higher officials, but I do not know why these are not supplied! I can only remind the seniors. Sterilization facilities are also not adequate. Kerosene is not available many times. How to sterilize equipments? Theories for improving quality of care and promoting method mix are many, but one has to look into practical problems as well.

Family planning targets, particularly sterilization targets, were also mentioned by the ANMs as an important reason for not giving attention to method mix:

If one provides all services-antenatal care, postnatal care, and all family planning methods-but has not achieved this [sterilization] target, then it means that she has not done anything. So we are compelled to put more emphasis on sterilization.

We do not get any credit for achieving spacing targets, but we get a scolding for not achieving [our] sterilization target. Sterilization is also easy for the rural women. They take rest for a week and it is [done] once and for all. On the other hand, non-terminal methods are cumbersome, difficult to use in the given social setting, and have one or the other side effects.

Thus the ANMs offered IUDs and oral pills only to those clients whom they could not motivate to accept female sterilization. They did not talk of male sterilization, for several reasons:

Vasectomy is not at all popular in this region.

Females themselves oppose [vasectomy] because of fear of failure. Even in the case of genuine failure of vasectomy, females would be blamed. The women would be accused of conceiving by another man. About three years back, this happened in this village to an educated inspector's wife. When she conceived after the inspector was vasectomized, there were a lot of problems and finally the husband underwent medical checkup to find out the truth.

We do not force them [couples] or tell them about vasectomy be- cause women believe that the man is the bread earner; and if some- thing happens to him or he becomes weak, then what will happen to the family?

We cannot do much in removing these fears regarding vasectomy be- cause everybody believes it, and these fears are now very deep-rooted.

A similar discussion with the medical officers revealed that they had almost written off vasectomy as a family planning method. The following comments, made during an informal group discussion with about 12 medical officers of PHCs and deputy chief medical officers, reflect their thinking:

I do not think much could be done to revive vasectomy.

If you really want vasectomy to revive, train the doctors in nonscalpel vasectomy. This new technique may attract males for vasectomy. In this area all believe that

vasectomy is not suitable for males. Women themselves oppose vasectomy for their husbands. What can the worker do?

When we asked what the medical officers were doing to encourage vasectomy, they could not give a firm answer. One said:

Why spend so much time and energy to remove misconceptions about vasectomy, when they are so strongly believed by all? With the same effort, workers can motivate many women for sterilization.

Despite the fact that vasectomy is much simpler than tubectomy, with a shorter recovery period and fewer side effects, often the community members believed otherwise. In a recent study covering about five hundred males, probing revealed that a majority of them believed that tubectomy was simpler (61 percent) and needed less time for rest and recovery (52 percent) than vasectomy (Khan and Patel 1997). Our interviews with many doctors posted at the PHCs revealed that they were not technically prepared to conduct vasectomy operations. Some who had been trained earlier to perform vasectomies told us they were out of practice and could no longer do the procedure. Thus, for all practical purposes, vasectomy is not offered, nor are the doctors posted at the PHCs trained to do vasectomy or skilled in conducting vasectomy operations.

Family Planning Targets

The Indian Family Welfare Programme has adopted a method-specific target approach to reduce the birth rate. The emphasis has been on numbers of acceptors rather than on the quality of service. The method-specific annual targets for each state are planned at the central level in consultation with the respective state governments. The state governments distribute targets to their districts, which in turn allocate targets to the PHCs and finally to the workers. In Sitapur District, each ANM has been assigned an annual target of 36 male and female sterilization cases, 70 IUD cases, 200 pill users, and 500 condom users. Each LHV has a target of 24 sterilization cases. In reality, the ANMs and LHVs place major emphasis on achieving the sterilization targets. Few of the ANMs we talked with appeared even to remember their targets or achievements for IUD and pill acceptors. To find out, they had to refer to their registers or discuss this question with other ANMs.

Table 12.5, which presents the percentages of sterilization and IUD targets met by the 54 ANMs during the year between April 1994 and March 1995, shows that despite the program's emphasis on targets, few ANMs could achieve their assigned target of 36 sterilizations and 70 IUDs. In the case of sterilization, nine

out of 10 ANMs had motivated 10 or fewer cases. Only 25 percent of the total sterilization targets were achieved.

Table 12.5: Percentage of sterilization and IUD targets met by 54 ANMs: Sitapur District, Uttar Pradesh, 1994-95

Method and number of cases	Percentage achieved
Sterilization (target = 36 per ANM)	38
1-5	50
6-10	4
11-15	8
16+	
IUD insertion (target = 70 per ANM)	5
1-20	8
21-40	24
41-60	36
61-80	27
81+	

ANM = auxiliary nurse-midwife; IUD = intrauterine device

The ANMs and LHVs were aware that higher officials would not reprimand them if the workers achieved only one-fourth of their sterilization targets. Because of this general understanding the ANMs were not motivated to put extra effort into persuading more clients to accept the procedure. The following exchange, which took place during one of our observation sessions, illustrates this attitude. A mother with three daughters who thought she was pregnant came to an ANM in mid-March for an abortion, to be followed by sterilization.

ANM: Why don't you continue with the pregnancy and have a son? If you still do not want this pregnancy, come after 20 days. We will go to Sidhauli [where there is a CHC] or Sitapur [where the district hospital is located] for the operation.

Researcher (to ANM): Why did you not motivate her to undergo sterilization now?

ANM: It is possible that she will change her mind and continue with the pregnancy to have a son and then undergo sterilization. And if still she does not want the pregnancy and wants to get operated, I will get it done after 20 days when the new year starts. I have to have some sterilization cases for the next year

also. This year I already have completed eight cases of sterilization out of a target of 36. I do not need any more.

Nearly all the workers complained that they faced major problems in achieving their assigned sterilization targets. Most believed that competition from workers in the Revenue Department exacerbate d the difficulty:

I am facing problems because of the Revenue Department workers. Using provisions under various developmental schemes, they are able to give much more attractive incentives, like 4 bighas [1 bigha is roughly one-fifth of an acre] of land or 5,000 rupees for building, and thereby take away their motivated cases. We cannot provide these types of incentives. If someone is very poor, then I may give her one sari, but not more than that.

When asked why she must spend money from her own pocket to in- duce clients to; accept sterilization, the worker replied:

What to do? We have to get sterilization cases. Otherwise we would be transferred or would not be paid for months. Nowadays all women who want to have an operation [tubectomy] are getting it done through the Revenue Department workers because they offer good incentives. But they do not take MTP [medical termination of pregnancy] cases. So for an MTP, women have to come to us. Thus instead of sterilization cases, we are getting mostly MTP cases. Three out of my five cases are MTP cum sterilization cases.

Another ANM explained:

We serve women right from their second or third pregnancy, take care of them in their antenatal period, [care for] their newborn, and go on counseling them for family planning. But they do not listen to us even after the second or third child. After the fifth, sixth, or seventh pregnancy, when they [have] become very weak and again be- come pregnant, then they come to us and say, "Oh, my didi, oh mother, now save me from this pregnancy!" Then they are ready to get sterilized after MTP. This time they have to come to US [for MTP]. Otherwise they would go to revenue workers for help and incentives.

Our impression is that the ANM's search for sterilization cases was becoming increasingly selective. Many of those we observed seemed to seek out women with unwanted pregnancies who wanted to terminate them. A majority of the sterilization cases recruited by the ANMs were also abortion cases. Many of their clients regarded induced abortion simply as another family planning method,

and the ANMs appeared to promote that view because it helped them to achieve their sterilization targets and prevented those women from going to the revenue workers for sterilization:

> *It is very difficult to motivate rural people. After great difficulties I motivate one or two cases to accept sterilization. However, often on camp days, instead of coming with me they go through revenue workers. They [the revenue workers] are giving them land, a house, buffaloes, and cows under various development schemes. From where will I [find the wherewithal to] offer them these incentives?*

> *As they [the revenue workers] are giving more incentives, poor people would obviously like to get operated through them. At times their husbands tell us that the revenue people are giving incentives worth 5,000 rupees, and the husbands ask, "What are you giving?" This year I have only five cases, and I had to spend an average of 1,000 rupees after each case.*

At least one-half of the ANMs with whom we interacted agreed that sterilization targets affected their suggestions to clients regarding appropriate family planning methods. Because of their supervisors' emphasis on meeting sterilization targets, the ANMs encouraged all women with two or more children to be sterilized. In a focus-group discussion some ANMs admitted that because of the targets they did not tell the women about the disadvantages of each family planning method, and they overemphasized the advantages of tubectomy:

> *I discourage the women with higher parity from accepting IUD so that they accept sterilization. After the second child or one son, I only motivate them for sterilization.*

Nevertheless, a majority of the ANMs also told us they did not at- tempt to persuade women with contraindications to be sterilized.

> *If the woman has any serious problem, then we think about her also. In such cases we never force her [to accept] any particular method. We have to live and work in the same community. If anything [bad] happens to her [as a consequence of being sterilized], then we will only be in trouble.*

The targets not only affected client counseling and reduced the range of methods the providers offered to their clients, but also had a negative effect on the quality of their work. For example, during sterilization camps, we observed at least three cases in which health workers operated on women whose hemoglobin levels were less than 10 g/dL, the borderline level for performing the procedure safely.

The workers recorded the levels as 10 g/dL in their records. Workers also told us they arranged for women with advanced pregnancies to receive abortions followed by sterilization, as well as for women with pelvic infections to accept IUDs:

LHV: Because of our target, if I get a patient who is anemic and wants to have an operation, I will not leave her. I will definitely try to bring her in for an operation, and as much as possible I will try [to make sure] that her operation is done.

ANM: Many times in case of MTP, even if the pregnancy is more than three months, we never leave the case because along with MTP they easily and readily accept the sterilization. Even if the doctors ask the clients for some money to do MTP at an advanced stage of pregnancy, we do not bother about that. We pay that money from our own pocket on behalf of the clients and get the MTP and sterilization done.

LHV: Out of 50 IUD cases only 20 women will be found normal after pelvic examination. But because of my target I insert an IUD even if some discharge or infection is noticed.

It is easy for workers to inflate the number of acceptors of non-terminal methods in their records, and many of the ANMs we interviewed told us they did so. The following comment was typical:

We do not have any problem in achieving the target for spacing methods. Whatever number of pills and condoms we were given to distribute, we distributed that easily.

When asked how many clients were currently using pills and condoms, however, they did not know the answer.

In a focus-group discussion, the ANMs reported that women them- selves demanded spacing methods and came to them for fresh supplies:

Women come for contraceptive resupply, especially on the vaccination day.

During our field visits, however, we saw no evidence of such demand. Health workers may have exaggerated IUD acceptance as well:

It is somewhat difficult to convince the women [to accept an IUD], but once they understand [its advantages] then they accept it easily and use it for a long period. There is not much problem in achieving the target for IUDs. Even Muslim women accept this method.

When we asked the LHVs about the reliability of more than 500 reported cases of IUD insertions in the previous fiscal year, at first they insisted that those were the figures reported to them by their ANMS. Upon further probing, one LHV admitted that the actual number of cases may have been only 50. Another LHV added:

We know that the majority of the cases shown in the records by ANMs are wrong, but what could they do? They are under pressure to produce 100 percent result.

A similar picture emerged from our discussion with ANMs at the CHC. During the formal focus-group discussion, which we tape-recorded, all the participants said that they had nearly achieved their IUD targets. At the end of the discussion we switched off the tape recorder and started talking with them informally. The women be- came more relaxed and spoke more candidly. When we asked how, after so much motivational work, the ANMs were recruiting only six to eight sterilization cases, whereas they could easily recruit 70 to 80 IUD cases, an ANM sitting close to the researcher said:

Actually I have inserted only four IUDs. But the adhikari [officers] wants updated register and 100 percent achievement of target. That is why we show 70 to 80 cases in the register.

Then we asked the remaining ANMs about their actual achievement of IUD targets. They admitted recruiting only 30-35 IUD acceptors. At this point the first ANM intervened, addressing her coworkers:

Nothing is being [tape] recorded. Now you people can tell the truth.

All then revised their numbers of IUD acceptors to 10 or 15. The first ANM hinted that we were still not getting the correct figure. All the ANMs were smiling, but no one mentioned fewer than 10 cases:

Researcher: Tell me what happens to the IUDs you have not inserted. Do you sell them?

ANM: Who will purchase them? What will they do with IUDs? Researcher: Then what do you do with extra IUDs, condoms, or pills? ANM: We can't throw them away anywhere, so we bury them.

Another ANM (in a lowered voice): There are many places where we can still throw them away.

Another ANM: IUD targets are as much emphasized, but the IUD does not suit everybody and we do not get much time to motivate cases for IUD. When we go to the village, women are not found at home. They are on their farms.

The implication was that the ANMs falsely reported IUD acceptance in those cases and dumped the IUDs to destroy the evidence.

Later, when we told a higher official about this conversation, his response was:

To some extent we all know about it. This is all because of targets.

Continuity of Care

During the fieldwork, we attempted to assess how much value the providers attached to following up their family planning acceptors. In both focus-group discussions and individual informal interviews, the ANMs and LHVs acknowledged that although they attached great importance to following up sterilization cases, few of them visited IUD acceptors, and none of them followed up pill acceptors.

Follow-up of sterilization cases is required not only because sutures must be removed, but also because community members expect the ANM to follow up surgery cases. The following comments were characteristic:

Follow-up of all the sterilization cases is essential. We follow up even those cases, which are motivated by other workers of the Block Office [Revenue Department].

I try to follow up all sterilized cases who are located in close vicinity twice, once within three days and the second time after seven or eight days to Cut Stitches. If the acceptor is in a remote village, I visit her only once, on the seventh or eighth day.

We make sure to follow up all sterilization cases. Any complication after [the] operation could spoil my field. Who will believe me if I do not try to help a woman in case of complications?

If we leave the clients without follow-up, next time we will not get a single case.

In contrast, providers followed up very few IUD acceptors, even those acceptors who lived in the village where the sub-center was located or in nearby villages. The workers felt no necessity to visit clients at home. In general they advised the acceptors to contact them in case of complications:

In case of very mild bleeding [spotting], I ask women to come to me. In case of pain and heavy bleeding, I refer them to the doctor at the PHC.

I tell IUD acceptors in my work area that as long as one can feel the thread, it is all right. When you don't feel it, then come and see me. For follow-up, I call on them after eight days and then after one month.

This last statement represented the exception to the usual practice. We asked the ANMs how many women were still using IUDS, but they could not give an estimate:

Many women take out the IUD on their own or get it taken out, so how do we know how many are actually using it?

Similarly, none of the providers could tell us how long, on average, women used IUDs. The ANMs knew, however, that not many women continued to use IUDs for extended periods:

Because of the complications, most of the women [seven or eight out of every 10 IUD acceptors] discontinue it within three to four months.

Some ANMs suggested that some women spontaneously expelled their IUDs. While discussing IUD follow-up with a medical officer, we asked him whether spontaneous expulsions were common:

Impossible! Even for high-parity women, IUDs cannot be expelled that way. This is only their [the ANMs] excuse to save themselves from being caught for falsifying IUD acceptor cases. It is also possible in some cases that IUDs are not inserted properly by the ANMS, as they lack training.

Despite probing, we could not elicit precise information about the reasons for the discontinuation of IUD use. Among the frequent causes mentioned by providers were excessive bleeding, backache, white discharge, excessive discharge, and swelling. Most of these symptoms are indicative of improper insertion or infection. It is difficult to assess whether the infections were caused by the IUD insertion itself; or whether they had existed before the insertion and were merely aggravated by the insertion.

We learned that acceptors of oral contraceptives were not followed up. The following comment was characteristic:

> *Oral pills have no disadvantage, and in case of any complication the woman will either come to me or will herself discontinue the method. So what is the need of follow-up?*

Most ANMs gave acceptors a month's supply of pills at a time and expected the women to come back when they needed more:

> *Why should we bother if she does not come for resupply? If she has gone to her parents' house or wants [an] additional child or is suffering from side effects, she will discontinue the use of the pill. If she comes to me, I will also advise the same.*

> *I do not follow up oral pill users. It is not required. Also, if she faces any problem, she will stop taking it. But there is no major problem with pills which needs our attention.*

> *I visit them [acceptors] once in a month for giving them [a] resupply. Sometimes for that I do not go. I instruct them that before finishing it, they should come and get a resupply.*

Conclusion

Our study has highlighted several factors that bear directly on the performance of the health workers and the quality of the services they provide. It indicates that the public health system lacks a readiness to deliver quality services. The system's most crucial deficiencies are the lack of appropriate space for clinics and inadequate equipment and supplies, such as medicines, serum for immunizations, and even contraceptives at times. Unless these needs of the PHCs and sub-centers can be addressed, the clinics will have no recourse but to

compromise quality. This does not mean, however, that a major allocation of funds is required to improve the quality of services. Nevertheless, our findings argue for an increased allocation of resources to bring the clinics tip to a minimal level of readiness so that they will be used by the people. Lack of transport for workers appears to be the next most serious obstacle to providing outreach services. It demands experimentation with various interventions to enhance workers' mobility, such as providing interest-free loans to enable them to purchase mopeds, motor scooters, or bicycles. New approaches to workers' assignments could also improve the situation: Perhaps 25-30 percent of the ANMs' time could be saved or more effectively utilized by changing their work routine. Similarly, better logistics would improve the availability of contraceptives at a number of PHCs and sub-centers.

Although we cannot comment on the technical competence of the workers, our discussions with the doctors suggest that ANMs need a comprehensive technical reorientation, particularly in IUD insertion and counseling skills. As many ANMs pointed out, the training should be practical rather than theoretical, should simulate actual working conditions in a rural setting, and should be based on workers' needs. The workers do riot believe they learn much from the training sessions that are available. According to them, the orientations either present information they already know or are impractical.

Finally, our findings highlight the adverse consequences of method-specific family planning targets in the Family Welfare Programme. The target approach has not only undermined women's right to make an informed choice of contraceptive method, but also contributed to an erosion of ethical considerations in providing health services and, on occasion, serious health injuries to women. Sterilization of anemic women and IUD insertions in women suffering from RTIs by poorly trained ANMs are just two examples.

The recent initiative by the Indian government to withdraw method targets nationwide is highly encouraging and, if effectively implemented, has the potential to contribute to expanded contraceptive choice and improved quality of care. In contrast, the involvement of Revenue Department workers in the Family Welfare Programme is causing major problems for health workers at the PHCs and sub-centers. By offering large incentives to sterilization acceptors under various developmental programs, the revenue workers have the advantage in competing, for those cases. One consequence is that health workers have frequently been forced to recruit their sterilization cases from among pregnant women seeking abortions, with sterilization often made a precondition for the abortion. Many states- for example, Karnataka, Maharashtra, and Tamil Nadu- have recently withdrawn the involvement of other agencies in family planning works. It is time that the remaining states do so as well.

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