Status of Quality Care Concerns and Issues of Reproductive Health Services for Rural Women of Uttar Pradesh: A FGD Based Qualitative Analysis

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ABSTRACT

Deficiency in fulfilling the quality care parameter was identified as most detrimental factor for the failure of National Family Welfare Programme (NFWP) of India. Therefore, as an ideological shift with focused on achieving success by providing a range of quality care services with several interventions, nationwide Reproductive and Child Health (RCH) Programme was launched in April, 1996 which further continued as RCH II (National Rural Health Mission). Since several mid- term reports and researches carried out in the area did not show very optimistic results, thus, a study was carried out with the major objective - Analyzing concerns and issues related to quality care in reproductive health services in rural Uttar Pradesh . Findings revealed gaps in the status of general and specific service provisions; interventions made and ground realities (implementation) in terms of all quality care parameters. Complete quality care packages of readily available gender sensitive and responsive services are recommended.

Key words: *RCH; Rural Women Health; Quality Care; Maternal; Child Health;*

In the era of globalization a complete changed scenario can be seen towards awareness and increased demand for the quality care even by the last recipients of the services. Quality care is the crux of any health care programme. However, for country's one of the oldest programmes - National Family Planning Programme (NFPP) that was later known as National Family Welfare Programme (NFWP) and CSSM programme, quality issue was never even been a matter of concern that needed to be addressed. Initially the challenge was to increase the coverage and reach of the services under the Programme and it succeeded to achieve to a large extent. Addressing the quality of services with its multitude aspects remained a distant dream before The International Conference on Population Development (ICPD) that brought the issue of quality care in prominence. Other reasons that forced the policymakers to think in this direction were failure of 'target centered approach', complete absence of a sensitive and responsive quality care and coercive methods used for family planning during emergency, tarnishing the image of the whole programme and its functionaries. (*Singh, Hitaishi, 2004*). Therefore, recommendations of ICPD, Cairo in 1994 and the World Conference on Women, in the following year, generated additional pressure from the global community for changing focus and approach of Indian Family Welfare Programme with wider perspective and coverage of priority groups with special attention on quality concerns. Consequently, nationwide Reproductive and Child Health Programme (RCH) was launched in April, 1996 (*Alcala, Jose M, Oct., 1994*). It was a step forward towards addressing existing challenges associated with socio- cultural contexts, social inequalities and inequities, disparities in health delivery system and capacities of health service providers, etc. with expanded scope of services. Attempt was made to ensure women's access to RCH services by making provision for target free, client centered, and quality care throughout the life cycle. As per the programme document, '*Quality care*

involves a range of services covering varied dimensions and scope put together in form of a package of services. It not only encompass increase in service outreach, strengthening infrastructural and clinical facilities, capacity building and up gradation of medical, paramedical and grass root workers, developing a strong IEC activities base but also addressing more complex socio- cultural and behavioural contexts with a lot of focus on guidance and counseling i.e. building trust and then motivating' (*Anthony R. Measham & Richard A. Heaver, Ministry of Health and Family Welfare, GOI, 1997*).

Further, quality care also focuses on the crucial role IEC (Information Education And Communication) and First Referral Units (FRUs) can play in addressing MTP (Medical Termination of Pregnancy) related issues and some of the very sensitive issues like issues of RTIs (Reproductive Tract Infection, STDs (Sexually Transmitted diseases and HIV/ AIDS.

However, several mid - term evaluation researches and reports on varied aspects of quality care 'RCH revealed that despite new interventions and intensive efforts made under the programme, desired results could not be achieved, quality care remained the most critical detrimental factor. In a study by *Bhandari, M.N., Kannan, S., Sardar, J., (2010),* health care quality, providers attitude, availability of services, distance, etc., were found to be some of the important determinants for accessing Reproductive health care. Weak or no compliance of provisions of number of RCH programme interventions to address quality care aspect resulted into insufficient, scanty, poor and dissatisfactory RCH Programme component coverage. All efforts to improve quality care failed miserably. Therefore, a grave need was felt for a detailed and in - depth enquiry of various dimensions associated with the quality care as conceived and proposed for the various RCH components under the RCH programme and their implementation at ground level. Study attempts to investigate the issue of quality care with the help of the following objectives:

i. Finding status of proposed and existing interventions and services related to quality against identified quality care indicators in Reproductive and Child Health Programme components in rural areas of Uttar Pradesh.

ii. Analyzing proposed and existing status of concerns and issues related to quality care under selected RCH components as perceived by rural women and other service seekers from rural areas of Uttar Pradesh.

METHODODLOGY

The samples were chosen from eight villages of four *Nyaya Panchayats* - two each from two Development Blocks of Lucknow District of Uttar Pradesh using multistage random sampling technique. Final sample constituted 20 per cent of the total eligible couple population of each selected village making a total of 295 eligible women aged 15 to 45 years (both clients and potential clients), their spouse and influential (influencing groups in the immediate settings of respondents) ,Village heads and health service providers. Data was procured with a number of quality care instruments as - Focused group discussions, informal discussions and interviews, observations and secondary data sources on various quality care related key concerns under different RCH components as per the RCH programme document (Ministry of Health & Family Welfare, Oct. 1997). Components analysed for the study included -

I - The Issues considered as Indicator of 'Quality Care Approach' -

A. Service Delivery related Issues - In terms of strengthening infrastructural, clinical facilities, service outreach and access along with social marketing.

B. IEC activities related Issues.

C. Technical factors related Issues.

D. Socio - cultural context related Issues.

II- Response of Rural Women and other Service Seekers (as perceived by them) on the Performance of Proposed vs. Existing Status of Quality Care Provisions made for RCH Services (in terms of Implementation, Credibility, Competency, Commitment Levels, Skills and Behaviour of Service Providers) as Enumerated under RCH Programme Components.

RESULT AND DISCUSSION

Major findings highlighted in the study are as under–

I - The issues as indicators of 'quality care approach':

A. Service delivery related issues - On the basis of observations made & information provided by the

functionaries during informal interviews, FGDs, information obtained from the secondary sources and details provided by the Department on the existing service provisions and interventions considered to have an impact on the quality care, following observations were made against the claimed service provisions and interventions at district level as mentioned in the programme document. These have been divided into three broad sections -

i. *Status of proposed vs. Existing/ functional reproductive and child health related provisions and interventions (service outreach and access)* : Information given in the Table -1 revealed a wide gap between provisions made in the RCH Programme and implementation at the grass root level. Hence, the objective to provide a good quality care to the clients had been marred by negligible or no implementation of provisions at ground level. This, ultimately, had an adverse effect on the realization of programme goals.

ii. *Health facilities available and carried out at the village level*

a. Health facilities available in the selected villages as reported by the village pradhansit was found that RCH services were not very near to all the selected villages. Near most sub centre which is primary unit for providing RCH services was one km. away in case of only one village. For rest, neither health facilities were nearby nor had satisfactory road connectivity and transport facility. Two of the villages had private clinics of quacks. IEC workers & services were nonexistent in all the 6 villages. Again, only two of villages had TBA (Trained Birth Attendant). Though all the selected villages had *Anganwadi* centre but AMN was not reported visiting even once in a month in most of the villages. None of the advanced medical facilities were available within 20 km periphery in the selected villages. Overall poor outreach of services despite more stress being laid on better out reach of services under RCH programme was observed.

b. RCH / health activities carried out by the government health department in the selected villages

Polio camps and door to door polio campaigns were found to be the most religiously and regularly carried out activity by the government Health Department followed by visits by ANM for other immunization activities. Most of Gram Pradhans (village heads) were unaware of referral cases requiring emergency obstetric care & provisions there in. Only three of the village heads in past; referred such cases to FRUs showing negligence or ignorance towards this life threatening situation for women.

None of village has sterilization camps. Outbreak of chicken pox, measles, cholera, and cases of malaria, influenza and diarrhea in last one year in almost all the villages is an eye opener and sufficient enough to prove the insincerity of preventive and curative health service efforts.

iii. Status of quality care indicators – proposed vs. existing general provisions and interventions : The efficient delivery of quality services not only depends on strong network of services but also many other

Table 1. Status of proposed vs. existing/ functional reproductive and child health related provisions and interventions (facilities and activities) at the district level in Uttar Pradesh

Services provisions at district level under RCH programme Component	Service available and functional as per the Information obtained at the time of discussions with the service providers, records and cross checked by the service seekers
Organizing RCH camps for rendering not only services for sterilization but also for providing services for maternal care, children care and care & treatment of RTIs, STIs, and STDs	No such camp was organized. No camps on maternal or child care organized other than polio camps Doctors claimed that they tried organizing camps on prevention and management of RTIs, STDs, HIV/ AIDS but people avoided to attend them due to the fear of revealing their shameful situation in front of the whole community. Only sterilization drive camps were organised
Establishment and Operationalisation of First Referral Units (FRUs)	In principle they were set up but not yet operationalised despite completion of more than three years of programme execution.

factors. For improving the capability, capacity and efficiency of the health system at district level RCH programme proposed to integrate certain General provisions and interventions along with the regular CSSM programme components at district and state level in Uttar Pradesh and more specifically in the district selected for the study. Status of 'Proposed vs. Existing' quality care indicators in terms of General Provisions and Interventions as given in RCH programme document was found as follows -

a. Provision for the construction of at least one labour room and one Operation Theater at PHC and SC level along with water & electricity supply -

Observations : No such facility, so far, was available on any of the SC. Merely two up - graded PHCs from the selected area had all these facilities.

b. Additional staffs support as state level consultants, additional ANMs, staff nurses, lab technicians, anesthetist, and safe motherhood consultants (MBBS and MTP trained doctors) in each PHC and at least one trained Dai in each village was proposed & claimed as ensured for rendering as well as expanding the outreach of services.

Observations : The state of appointment of stipulated number of staff both medical and paramedical or other support staff was not filled up. IEC personnel were found to be completely absent. This state of affaire after almost three years of completion of the programme implementation shows level of seriousness and concern on the part of administrators and policy implementers towards the programme.

c. Day night facility for the delivery at PHC level

Observations : This facility was claimed to be existing by the PHC in - charge of all the PHCs at the time of visits made by the researcher to respective PHCs/ CHCs. But, the respondents reported that they never found a doctor or were able to get medical attendance when ever visited PHC in the night in their dare need so preferred to visit private health service providers.

d. Social marketing in referral services : The demand supply split in its services, has become the accepted part of orthodoxy of health services & has direct responsibility for the RCH services management. Referral services are life line for taking care of rural women in case of complications during pregnancies, emergency obstetric care, severe RTI/ STDs and HIV Infections, etc., thus special provisions were made for such cases and Gram Pradhans (*Panchayats*) were given responsibility to refer such cases of under privileged, if needed from their village.

Complications during pregnancy when not taken care of properly and timely may become fatal for both, the pregnant lady and the foetus. Table -2 reveled that multiple provision were made for referral services, nevertheless, the situation of this particular component was found to be extremely weak at implementation level. Total number of financially supported referral cases of emergency obstetric care by Village *Pradhan* (*Panchayat*)*/ Gram Swasthya Samiti* to PHC/ FRU on the recommendation of ANM was as low as 13 in all eight village in last three years. Many respondents reported their ignorance about the scheme. This issue was also not handled satisfactorily as most of the respondents reported that after having any such complications they had to go to the private practitioner.

Only one out of such 56 cases of RTI, STI/ STD

Table 2. Status of Proposed and Existing Services Provisions under RCH Programme for Referral Services

Services provisions at district level under Each RCH programme Component	Service available and functional as per the Information obtained at the time of discussions with the service providers, records and cross checked by the service seekers
Providing referral services for:	They were found to be least existing in practice so far referring any case of complication is concerned.
Management of emergency obstetric care(provision was made to provide funds for 05 cases in a village per year under the scheme of safe mother-hood)	This facility was still in the process of operationalization Claimed that a good number of such cases were referred, however, record of number of such cases was not available
Care of cases of RTI, STI/ STD and abnormal discharge	Only one out of such 56 cases was referred as reported by the respondents ANM seems no interest in such cases
Treatment of complication after using any of the contraceptive methods	Facility found to be non – existing as only one out of 78 cases with complications was referred

and severe abnormal discharge was referred

Cases and only 01 out of 78 cases with complications after using any of the contraceptive methods were referred to PHCs/ FRUs were known to the respondents. Harsh, rather indifferent behaviour of ANM and Doctors (gynecologist) towards the seriousness of such cases was also reported. (Table 2)

B. IEC activities related issues : In RCH Programme focus was laid on Inter-personal communication and strengthening IEC activities to handle the socio - cultural contexts, behavioural and general attitudinal part of health service providers, clients, potential clients and their immediate social settings.

It was, however, reported during FGDs as well as found that though a large number of IEC martial was produced during the whole programme tenure but was hardly field tested for the understandability and acceptability of content and its effectiveness. ANM, the backbone of the system was found to be completely non - competent in handling such material and hence was not at all making use of them. IEC person was completely absent from the scenario.

C. Technical factors related issues : This Included technical support and lab facilities, efforts for capacity building and competency up gradation of medical, paramedical staff and grass root workers, increase facilities and improve their quality in terms of safety, and hygiene.

It was claimed that provision for training to both medical and paramedical & technical staff on various technical, clinical and IEC aspect was made under RCH Programme. However, health service providers reported that no proper orientation or other technical trainings were provided to them according to the new frame work. Neither any specific printed material or mix media material was provided to them for further use nor provided training in handling them and addressing the technical information needs and socio - cultural contexts. Forget about the content, they were not even able to recall the title of the trainings correctly. Thus, the whole exercise, money and resources failed to change the stereotype mind set, developed through years, of these health service providers about the clients, their attitude, settings, needs, etc.

D. Socio - cultural context related issues : Socio - cultural aspects (norms, values, beliefs, taboos, etc.) and behavioural contexts are expected to be handled essentially and sensitively. However, information procured through secondary sources and in-depth interviews and discussions with the health functionaries revealed that the RCH programme in the State was launched without any adequate preparation and capacity building in terms of training and orientation of health service providers including grass root level workers. Further, no quality care check mechanism on regular basis as per intent of the programme was apparently developed or found being used. Consequently a host of problems pertaining to the competencies and behaviour of medical, paramedical staff and grass root workers in handling clients, aroused.

E. Some other observations: the grass root level reality :

i. Most Sub - centres visited found it most of the time closed. People had not seen the face of ANM since months. They quite often complains about her behaviour and her malpractices during the in -depth discussions.

ii. Clients also found to be dissatisfied with the general behaviour of the ANMs and doctors.

iii. On the contrary on talking to ANMs, they seemed interested only in completing the targets and maintaining the official records. It was found that their mindset remained 'target oriented and judgmental' based on prejudices and preconceived notions toward the clients, their families and settings.

iv. The concept of quality care approach was not even a remotest thought in the dictionary of ANMs and felt that a large chunk of rural population that lives in poorer living conditions needs no such services. Thus, they finish all formalities by just making few visits and distributing IFA and other material to the houses of influential and powerful people of the village and shirk their shoulders from the responsibilities rendered to them. This practice was more or less same in all the selected villages with very few exceptions. In such cases caste factor came as most dominating and influencing factor in service delivery at grass root level. Here the concept of social engineering comes into the scene that unfortunately remained unaddressed though, given important place in the programme.

II- Response of rural women and other service seekers (as perceived by them) on the performance of proposed vs. existing status of quality care

provisions made for RCH service components as enumerated under RCH Programme through Focus Group Discussion (FGDs), in-depth interview and observations - The information was also obtained on performance of proposed vs. existing status of quality care provisions made under each RCH programme component on facilities and services in terms of quality care indicators such as implementation, credibility, competency, commitment levels, skills and behaviour of service providers, etc. as perceived by rural women. Analysis and interpretation made in this regard is given as under –

Following observations were made from the RCH Programme component wise information given in Table 3 :

Table 3. Response of Respondents (as Perceived by them) on the Performance of proposed vs. existing status of quality care provisions made for Service Components as enumerated under RCH Programme

Services provisions at district and grass root level under Each RCH programme Component	Service available and functional as per the Information obtained under Each RCH programme Component at the time of discussions with the service providers, records and cross checked by the Rural Women and other Service Seekers
Quality care for the prevention & management of unwanted pregnancies and fertility control, small family norm and spacing and contraception & contraceptive methods components of RCH programme	
Promoting use of contraception to prevent unwanted pregnancies through informed choice and IEC (information, Education and Communication) activities	Restricted to only achieving targets. Concept of informed choice was not covered. No extra effort or initiative was taken for the concept of informed choice Most materials launched for IEC were not field tested
Supplies of Contraceptive services and material	Service providers seemed disinterested on the issue Most respondents were unaware of any such services or the place from which good quality contraceptive materials can be procured Not a single outlet vicinity of village providing contraceptive material was found in t was in the vicinity of the service seeker
Guidance and counseling in promoting use of contraception to prevent unwanted pregnancies and tackling cases of complications	ANMs had not even heard or thought of concept of guidance and counseling
Use of IEC Material for the purpose	IEC materials developed and produced but not used as a practice by doctors or grass root level workers
Quality Care for Safe Abortion Components of RCH programme	
Safe medical termination of unwanted pregnancies with facility of MTP	This was handled with utmost carelessness. ANMs had not even heard or thought of concept of guidance and counseling MTP facilities were not properly and satisfactorily organised No support by the government grass root health service provider in terms of guidance and counseling
Guidance and counseling in promoting Safe medical termination of unwanted pregnancies with facility of MTP and tackling cases of complications	Any guidance and counseling was found to be non - existing
Use of IEC Material for the purpose	IEC materials developed and produced but not used as a practice by doctors or grass root level workers
Quality Care for Prevention and Management of RTIs, STDs, HIV/ AIDS & Abnormal Discharge Components of RCH programme	
Establishing RTI clinics with at least one lady doctor at CHC level for prevention and management of RTIs, STDs, HIV/ AIDS	Facility non - existing and thus issue remained completely unaddressed. Such clinics, if existed, lack proper staff including doctors ANMs had not even heard or thought of concept of guidance and counseling for such an sensitive health issue
Guidance and counseling in promoting prevention and management of RTIs, STDs, HIV/ AIDS and abnormal discharge	Any guidance and counseling was found to be non - existing

Use of IEC Material for the purpose	IEC materials developed and produced but not used as a practice by doctors or grass root level workers
Quality Care under Maternal Care Components of RCH programme	
General Maternal care	Quite regularly followed up partly and restricted to only achieving targets.
Promoting conducting deliveries either institutional or assisted by skilled birth attendants	This sub - component was taken up by the ANM but her visits were so limited that her advice did not matter on this issue much
Facility of at least one trained dai in each village	Each village visited had a Dai who was often consulted on issues related to RCH especially pre - natal care. Grass root level health workers hardly convinced all clients for institutional deliveries. As a result rural women either had home deliveries or at private hospitals.
Facility for emergency obstetric care	Out of four PHCs covering all eight selected villages, this facility was only available in Two PHCs. in rest the process was going on though at the time of data collection.
Guidance and counseling	ANMs had not even heard or thought of concept of guidance and counseling so far overall maternal care is concern
Quality Care under Child care Components of RCH programme	
Complete child care including ensuring all essential newborn care and vaccination	Only vaccination was the service which was regularly and timely available All those services were advocated by the ANM frequently which is again that had any relation with achieving targeted numbers Children born out of home deliveries carried out by trained birth attendants at hardly received a health checkup by a Doctor/ nurse or even ANM within 24 hours or 2 days of the Birth.
Guidance and counseling	ANMs had not even heard or thought of concept of guidance and counseling so far overall child care is concern

1. Poor status of informed choice and follow-up services for contraception and contraceptive methods was apparent despite the fact that the RCH programme interventions has laid major emphasis on informed choice to the clients and potential clients. As per NFHS- 4, 2015-16 preliminary data the percentage of unmet need in Uttar Pradesh is still 18.1 and with all efforts only 47.5 per cent current users were ever told about side effects of current contraceptive methods. Merely 12.8 per cent health workers ever talked about family planning to the female non – users. Researches also claim unmet need, informed choice, follow - up services, etc. as one of the most important factor for the performance of other RCH components such as maternal health, child health etc. and has multitude of social, economic and health implications to women (*R. Usha, 2000*).

2. The component of safe medical termination of unwanted pregnancies with facility of MTP was handled with utmost carelessness. MTP facilities were not properly and satisfactorily organised. It is shocking to note that in many cases it was suggested as Family Planning method by the grass root health functionary as reported by the respondents.

3. Though RTIs have profound implications for the success of each of the other RCH initiatives (*Germain et all, 1992*), but findings of the present study did not depicted very encouraging result so far providing and availing services related to information, counseling and treatment of these diseases is concern with very low number of the respondents availing services through government service network.

4. The current data of NITI AYOG, Government of India, (2017, based on Sample Registration Survey-2010 - 2012) shows that U. P. still has second highest (292 per thousand live births) MMR in the country

though there is a certain improvement in the performance on Maternal Mortality Ratio. Maternal care, though, in the present study emerged as the only component covered to some satisfactory level; however, was again restricted to the registration of pregnant women and few aspects of prenatal care. Sub - component of institutional delivery and post natal care remained unaddressed to a great extent. NFHS - 4, (2015 - 2016) data supports the same with only 3.8 percent rural women in U.P. who got full antenatal care and 33.2 non - institutional deliveries in Rural U.P. (NFHS- 4 - 2015 - 2016). Quality care issue which can improve the performance drastically, was again found to be absent in terms of treatment and behaviour of the health service providers as reported by the respondents. Cases of complications during pregnancy and emergency obstetric care were handled with least care.

5. Interestingly for child care services, especially for vaccination, government service provider obtained very high status. PHC/ CHC/ sub-centers turn out to the most trusted service provider in terms of quality of vaccination for rural poor. For rest of the services again government sector performed poorly. Probably, this is the reason why Infant Mortality Rate of U.P. with 50 per thousand live births, lags far behind the national average of 40 per thousand live births. (NITI AYOG, Government of India, 2017 based on SRS- 2013). NFHS- 4 – (2015 – 2016) data indicates only 0.8 per cent children born at home were taken to the health facility for health checkups within 24 hours of their birth. With all little variations in statistics, the fact remains that a lot needs to be done so far quality care child health services are concern.

6. Though guidance and counseling can play key role in changing the ways of looking, thinking and perceiving RCH related messages on all the RCH components, guidance and counseling even as a concept, was found to be almost non - existing in all the programme components.

7. In general, behaviour of the doctors and paramedical staff was reported to be very bad, rude and indifferent by the respondents.

8. Respondents associated good quality care with -

a. Availability of doctors at PHC/ CHC as and when needed.

b. Good experience (not only own but also of others) that includes empathetic and kind behaviour of doctors, building trust, motivating attitude during the treatment.

c. Waiting time, levels of responsiveness i.e. time spent, patient hearing by the doctor and thorough examination done by the doctors.

d. Availability of facilities (pathological tests, etc.) and medicines.

e. Cleanliness of the PHCs, CHCs or other government health service centres and following hygienic practices by the staff.

f. Guidance and counseling by the medical and paramedical staff.

g. Taking care of social engineering.

It was revealed that both neither male nor female clients and their family members were satisfied with the quality of services on above parameters.

Suggestions

Following suggestions in this direction may prove to be fruitful for future implementation at policy and action level -

- Immediately focusing on counseling & referral at the peripheral level along with improved diagnostics facilities at primary health centre level as per the advances in technology for addressing the problems.
- There is an urgent need to fill up all the posts lying vacant to provide service support as per the provisions of the programme.
- There is a need to motivate and train for more gender sensitive and client friendly behaviour, raise the moral and make efforts to change the mindset, increase commitment levels of functionaries especially grass root level workers by providing regular hands on training in all aspects to ensure quality care.
- Knowledge and information level of functionaries, particularly ANMs, on RCH related issues and content needs to be upgraded in terms of latest advances to enable them to provide correct and complete information to the audience at right time.
- IEC wing of health system needs to be revived, reactivated and operationalised.
- Public - Private partnership consortiums, inter - sectoral and intra - sectoral planning interlinking health, other line departments and NGO's and

involving *Zila Saksharta Samitis, Panchayati Raj* Institutions, *Jan Shikshan Sansthans* could prove fruitful for making RCH Programme more responsive and accountable.

- Developing a strong IEC activities base with designing appropriate IEC/ BCC strategies and development of field tested material is another area felt necessary to be addressed. Basic training of ANMs in handling such material and using them effectively should be made essential and mandatory part of their services.

CONCLUSION

RCH programme component has broadened the scope of services with emphasis on increasing its outreach. But looking at the evidences related to quality care n service out reach, achieving this objective seems a tuff task. Quality care in all aspects and ensuring availability of complete & correct information and proper clinical & other facilities, behaviour of doctors, technicians is the need of hour. Last but not the least, handling all the interventions separately or addressing only one or couple of aspects will not solve the problem. Since it is a multi dimensional issue with lot of involvement of human element into it, thus a multi pronged approach taken together may solve the problem. All the concern policy makers, programme administrators and implementers will have to look at the programme in totality and take it as a mission keeping human values intact to make it a success story.

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