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COVERAGE EVALUATION OF MATERNAL AND CHILD HEALTH SERVICES IN THREE SUB CENTRES OF PRIMARY HEALTH CENTRE JASOL

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CERTIFICATE

This is to certify that, Dr. Kunal Chandrashekhar Pawar, student of Post Graduate Diploma in Health Management (PGDHM) from Institute of Health Management Research, Jaipur, batch 17th (2012-2014) has undergone summer internship training at UNICEF, Rajasthan. The title of the report is "Coverage evaluation of maternal and child health services in three sub centres of Primary Health Centre Jasol"

The candidate has successfully carried out the work assigned to him during his summer internship training from 8th April to 8th June 2013 and his approach has been sincere, scientific and analytical.

I wish him success in all his future endeavors.

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My thanks and appreciation

ABBRIVATIONS

ANM	Auxiliary nurse mid-wife
ASHA	Accredited Social Health Activist
ANC	Antenatal Care
BCG	Bacillus of Calmette and Guerin
DPT	Diphtheria Pertussis and Tetanus
DDKs	Disposable delivery kits
E-Pill	Emergency contraceptive pill
EPI	Expanded Program of Immunization
IFA	Iron and Folic-acid
IUD	Intra Uterine Contraceptive Device
MCHN	Mother and Child, Health and Nutrition
OPV	Oral Polio vaccine
ORS	Oral rehydration salts
OCP	Oral Contraceptive Pills
PCTS	Pregnant women and child tracking system
PHC	Primary Health Centre
PNC	Post natal care
SC	Sub-centre
SDR	Service delivery register
TT	Tetanus toxoid
UIP	Universal program of immunization

CONTENTS

1. BACKGROUND

In India, the EPI was formally launched in 1978. This gained momentum in 1985 under Universal Immunization Programme (UIP). The main objectives under UIP were universal immunization, reduction in mortality and morbidity due to vaccine-preventable diseases, to obtain self-sufficiency in vaccine production, to establish a well-functioning cold chain system and the introduction of a district level monitoring system. This program was merged into the Child Survival and Safe Motherhood (CSSM) program in 1992-93. Since 1997, immunization activities are an important component of the national Reproductive and Child Health (RCH) program.

Immunization services are provided through a network of sub-centre, Primary Health Centers (PHCs) and Community Health Centers (CHCs). The fixed immunization day is a major achievement of the UIP during 1985-90. This has been subsequently utilized to provide other primary care service packages, which include antenatal care (ANC), Iron and Folic Acid (IFA) and Vitamin A.

Government of India monitor its progress closely through statistics as well as through various sample surveys conducted periodically at different parts of the country and at national level.

2. STUDY OBJECTIVE

As per the national child immunization schedule, a child should receive a BCG vaccination, three doses of Pertussis, Diptheria and Tetanus, three doses of Polio vaccine and Measles vaccine by the infant's first birthday. It is expected that a routine immunization should be held at least once a month in all villages (population >1000) of a sub centre for achieving universal access to immunization.

For the sake of convenience and effective utilization the site, the day and the time for immunization are fixed. As a result the beneficiary would remember that the immunization services would be available at a particular site on a particular day.

2.1 OBJECTIVES:

- To assess the availability and accessibility of immunization and maternal health services.
- To assess coverage of routine immunization by antigens.
- To assess coverage of maternal care services, including antenatal, natal and postnatal services.
- To validate reported coverage.

This report is divided into four chapters, covering various aspects on which data were collected. Besides this introductory chapter, the other chapters are on the following topics:

- Methodology and data collection.
- Child immunization.
- Antenatal healthcare services.
- Post natal healthcare services.
- Family planning services.

3. METHODOLOGY

The study was conducted in the three sub centres of Jasol PHC. Reference period and data collected was from the period of January 2013- march 2013

3.1 STUDY AREA:

- Sub centre Jasol, Sub centre Mungra, Sub centre Ramin selected by simple random sampling

3.2 STUDY DESIGN:

- The study was designed to capture relevant information and data from 3 sub centres of Jasol PHC in retrospective style. The study would have 4 reports eash giving estimate of the 3 sub centres.

3.3 STUDY POPULATION:

- Infants, pregnant women and post delivery women in sub centres of Jasol PHC

3.4 STUDY TOOL:

- Qualitative and quantitative tool was developed to collect data. Quantitative methodologies for estimation of knowledge level of ANM in routine immunization, childhood illnesses and maternal care services while quantitative methodology were used to collect secondary data from form 6, immunization microplan, pcts, sdr.

3.5 DATA COLLECTION:

- Secondary data was collected from form 6, SDR, PCTS for the reference period of January 2013 to march 2013. For knowledge and skill of ANM questionnaire was developed

3.6 SAMPLE SIZE:

- 182 infants, 201 pregnant women and 182 post delivery women

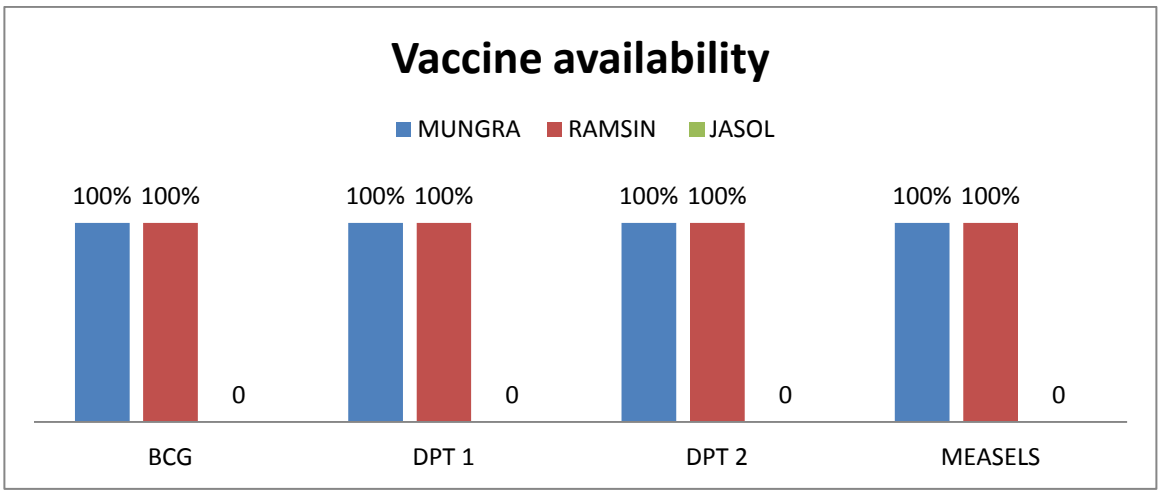
4. CHILD IMMUNIZATION

This topic gives us the details of the coverage of immunization of children along with the availability of vaccine, accessibility of vaccine session by ANM and total immunization of children in the reference period as per form 6 of the respective sub centre.

4.1 AVAILABILITY OF VACCINE:

- Reference period considered here is 3 months, i.e January 2013 to march 2013.
- Total weeks stands out to be 13.
- Here it can be seen that the SC Mungra and SC Ramsin has the 100% availability of all the vaccines required for child immunization, whereas, SC Jasol has absolutely no availability. This is because SC Jasol as well as the PHC doesn't have the account of the vaccine utilized by the SC Jasol and there is no entry either in vaccine stock or vaccine issue register.
- The data of vaccine received provided by the SCs in form 6 were not correlating with the data from PHC stock and issue register.

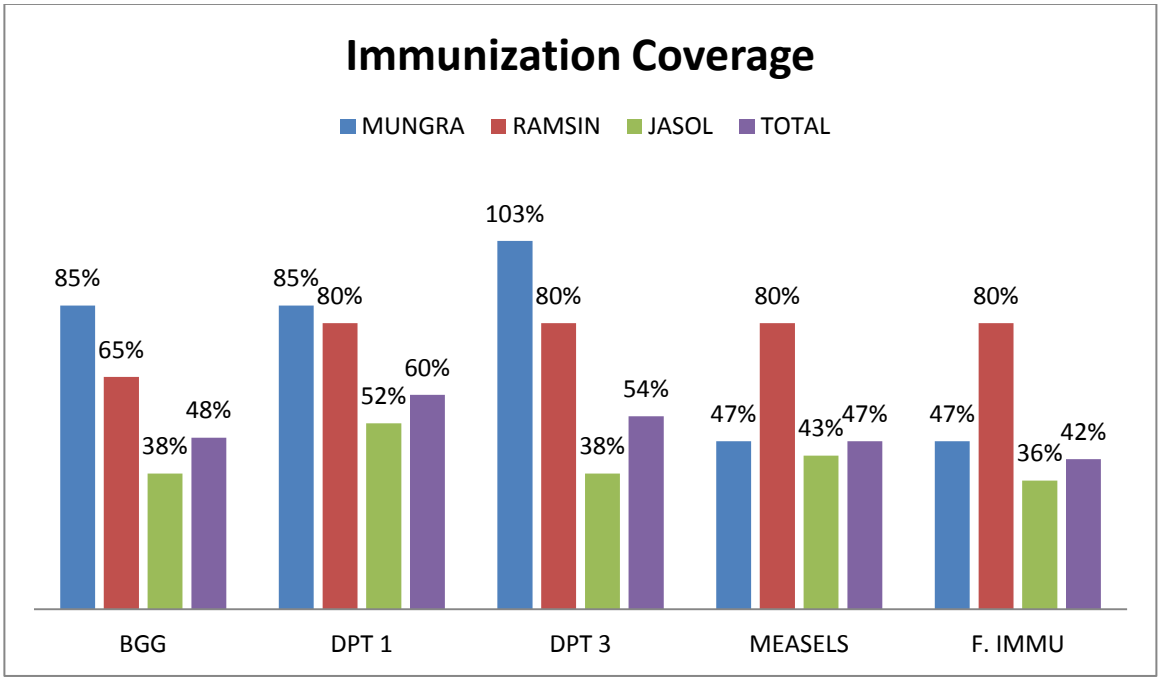
Fig 4.1 Availability of vaccine



4.2 UTILIZATION OF CHILD IMMUNIZATION:

- Drop-out rate in SC Mungra from DPT3 to Measles and Full Immunization is close to 40%. (figure 4.2)
- BCG in SC Ramsin is low apart from that; coverage of rest of vaccines in Ramsin is good.
- SC Jasol has poor coverage of all the vaccination. Low immunization achievement of SC Jasol could be due to high population i.e. 16000 and only one ANM to serve the population.
- Total coverage is low because of the poor performance of Jasol sub centre.
- Accessibility is 100 percent in all the subcentres

Fig 4.2: utilization of immunization of children under 1 year of age

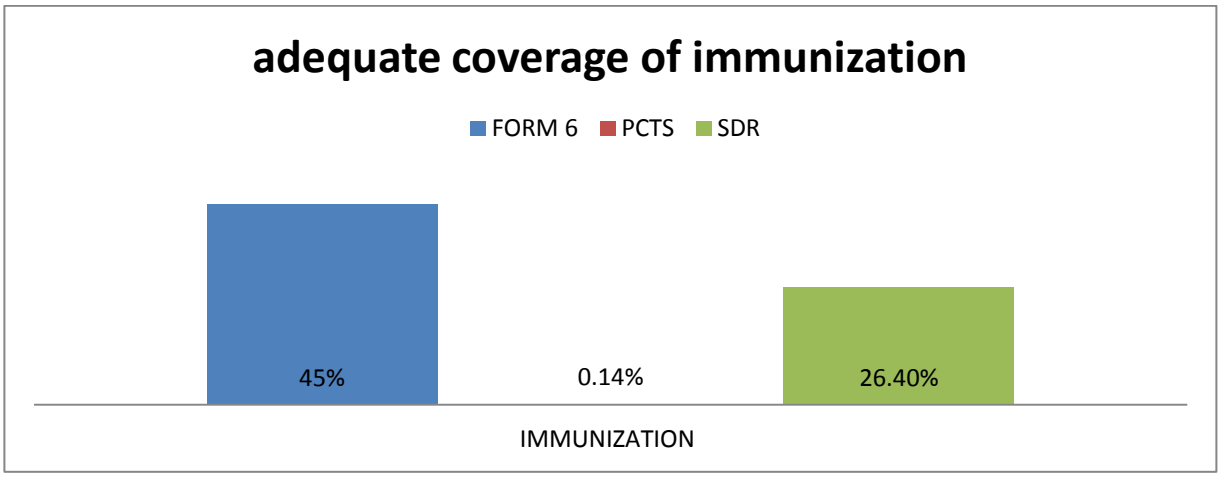


4.3 ADEQUATE COVERAGE OF IMMUNIZATION SERVICES:

- Validation of vaccination services is as per FORM 6, PCTS and SDR.
- Validation has been calculated by field validation of the data taken from the sub centers'.
- From figure 4.3, it can be seen that utilization of PCTS is very low at 0.14%. It is because there is no data entered in the PCTS about the immunization status of the child.

- SDR is not updated on day to day basis. ANM notes down the immunization of a child on a piece of paper rather than entering it in SDR and later forgets or does not enter that data into the SDR.
- SC Jasol was the poorest of all, with very less data about the immunization of child.

Fig 4.3 adequate coverage of immunization services



4.5 FACTORS AFFECTING COVERAGE OF ROUTINE IMMUNIZATION

- The services are provided by the ANM during the session and ACCESSIBILITY is 100% for all the sub centres.
- Effective coverage of immunization service, based on the availability of AD syringe, was 100 percent in all the sub centres
- Poor record keeping and entry in SDR is major factor affecting the coverage of immunization.
- PCTS is updated very rarely, despite the fact that task of entering data into PCTS has been assigned to ASHA supervisor. Reason could be traced to the poor records keeping in SDR.
- Due lists are not provided to the ASHAs prior to the immunization resulting in the child being left/ drop out from the immunization schedule.
- In case of Jasol SC, human resources needs to be enhanced. Guidelines of 1 ANM per 5000 population is clearly not observed here. It serves to the population of 16000.
- No full time ANM in SC Jasol. Assistant ANM is in-charge of the sub centre. Ironically assistant ANM has not been given any training in immunization or maternal and child health. There are high chances of AEFI if the training is not conducted on time.

- Immunization cards of the beneficiaries are not updated or sometimes not provided by the sub centres.
- Poor register and records were observed in all the SCs

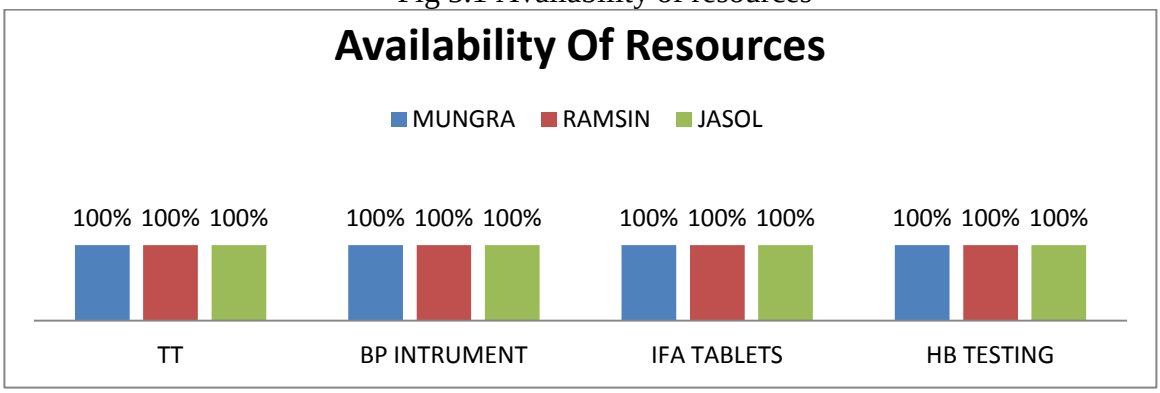
5. ANTENATAL HEALTHCARE SERVICES

Healthcare services helps in lowering maternal morbidity and mortality and also helps in lowering the complications during pregnancy and delivery. It also helps the mother in identifying the danger signs and promptly act accordingly. This chapter discuses about the coverage of maternal care services provided at the sub centre level. The reference period considered here is from January 2013 to march 2013.

5.1 AVAILABILITY OF RESOURCES

- Availability of Basic resources necessary for maternal health such as injection of tetanus toxoid for pregnant women, BP instrument, iron folic acid tablets and hemoglobin testing kit were available in the reference sub centres. (Fig 5.1)

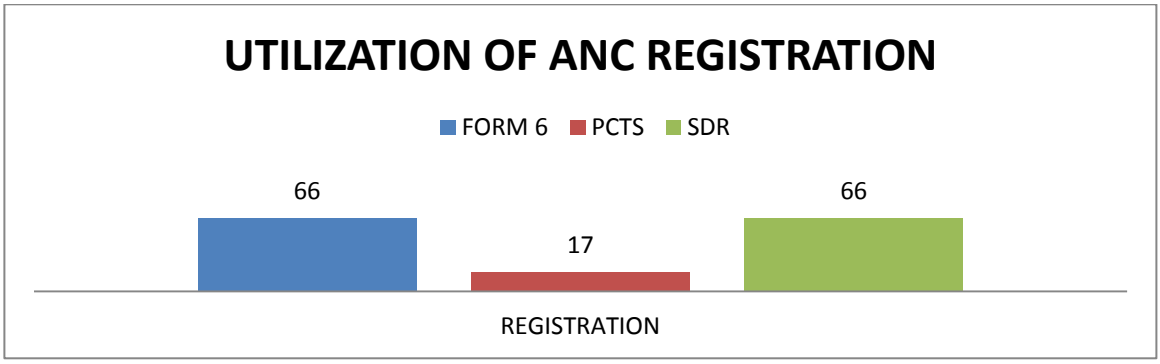
Fig 5.1 Availability of resources



5.2 UTILIZATION OF ANC REGISTRATION

- Registration of ANC in form 6 and SDR are at the satisfactory level (fig 5.3)
- PCTS remains unutilized

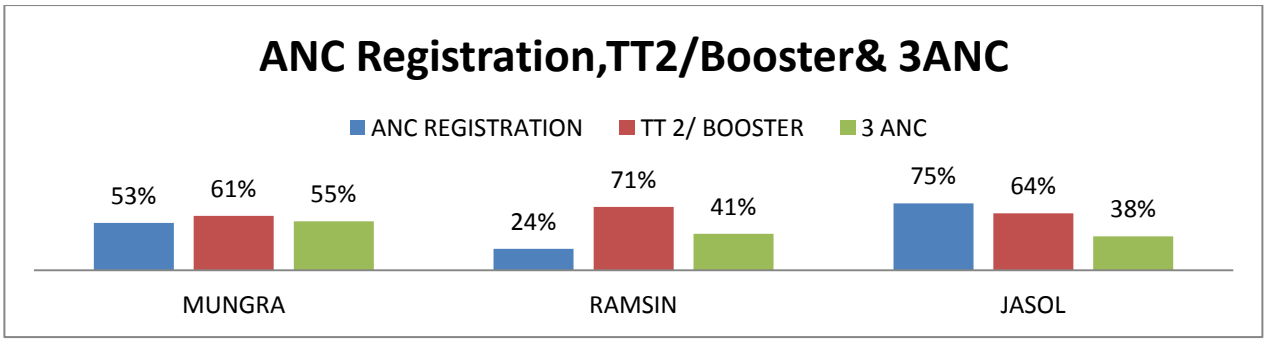
Fig 5.2, utilization of ANC registration



5.3 ADEQUATE COVERAGE OF ANC REGISTRATION, TT2/BOOSTER & 3 ANC CHECK UP

- Accessibility is 100 percent in all subcentre.
- Very low ANC registration can be observed in Ramsin SC, reason being the achievement of target that was set during micro planning. But on the contrary, the TT2/ booster doses are high in the same time period, it could be because of error in reporting or due to poor record keeping of sub centre.(Fig 5.2)
- Poor registration also points at the fact that the LMP data of the eligible couple is not maintained. LMP register could help in early detection on pregnancy in women.
- Poor knowledge among beneficiaries was also the reason of poor registration. Women were ignorant about their menstrual cycle ultimately leading to pregnancy.

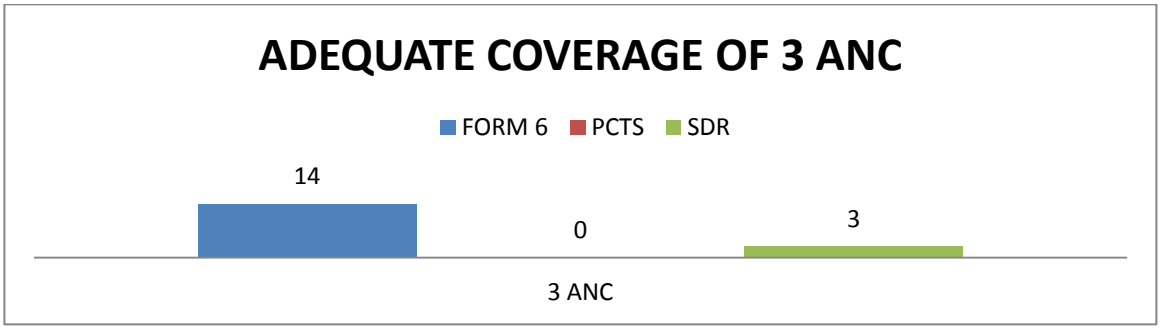
fig 5.3 Adequate Coverage of ANC Registration, TT2/Booster & 3ANC check up



5.4 ADEQUATE COVERAGE OF 3 ANC SERVICES.

- Unsatisfactory coverage of ante natal three checkups. (Fig 5.4)
- Poor knowledge among pregnant women about the importance of health check up.
- Poor follow up by the ANM.
- Poor record keeping leading to this unsatisfactory coverage.

Fig 5.4 adequate coverage of 3 ANC



5.5 FACTORS AFFECTING COVERAGE OF ANC SERVICES:

- Availability and accessibility of all the sub centres is 100 percent
- Effective coverage of ANC services, which includes skill of ANM to take weight and BP of ANC, is 100 percent. This data was collected for the qualitative questionnaire that was prepared for the ANM
- Unutilized PCTS is the major bottle neck in this analysis, but this untilization is also because the SDR is not completed.
- If details of the beneficiary are entered on regular basis in SDR and PCTS, monitoring and tracking of pregnant women would be easier. Also, PCTS sends text message on the registered mobile number of the beneficiary which would in turn help beneficiary to know the service for which she has to follow up.
- Only upto 2 ANC checks are given to the ANC mother. In this area the tradition of pregnant women going to her paternal home is very common. And this usually takes place by the 7th running month of amenorrhea. It is because of this, the 3rd ANC check is left out in most of the cases. This problem can be avoided if the ANC mother, after

going to her paternal home, registers herself to the nearest health facility and avail the benefits of the health service.

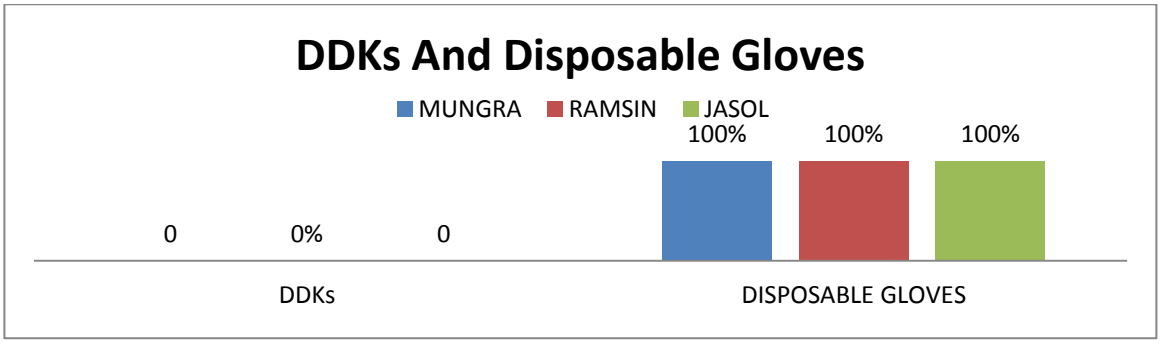
6. POST NATAL HEALTHCARE SERVICES

The health of the mother and her newborn child depends not only on the health services she receives during pregnancy and delivery, but also on the care she and her child receive during the first few weeks after delivery. Post-partum checkups within two months after delivery are particularly important for births that take place in non institutional settings.

6.1 AVAILABILITY OF DDKs AND DISPOSABLE GLOVES FOR DELIVERY

- Unavailability of disposable delivery kits in all SCs.
- Reason could also be traced to the fact that most of the deliveries are institutional where all the facilities are available.

Fig 6.1 Availability of DDKs and disposable gloves for delivery

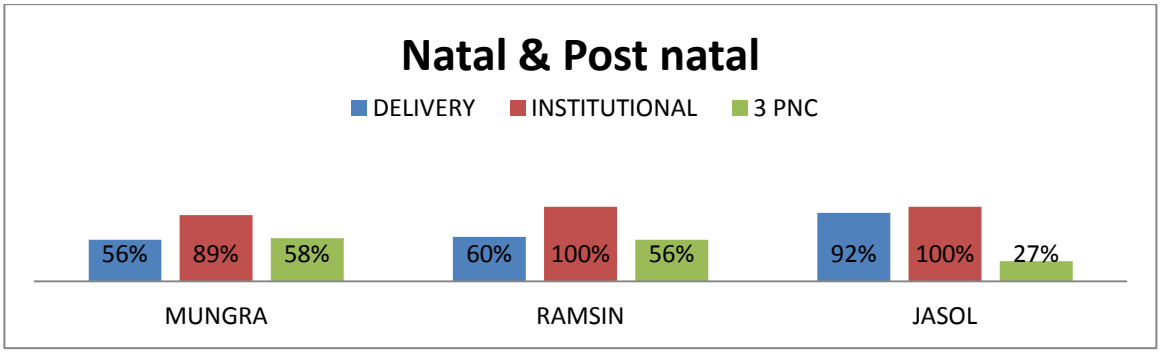


6.2 UTILIZATION OF NATAL AND POST NATAL SERVICES

- (Fig 6.2) Mungra and Ramsin showed unsatisfactory results in total number of deliveries for the reference period.
- 2 home delivery in Mungra SC leading to poor institutional delivery performance. These two home deliveries were due to delay in decision making.

- 3 PNC services, which includes going to the beneficiary by the healthcare provider to check for post delivery complications and health of baby, is low in sub centre. This is mostly because the mothers pass the sub centre and directly go to the nearby government institution because of which the ANMs are not aware of the delivery in their area. Also, the expected date of delivery of pregnant women is not recorded by the ANM leading to this problem.

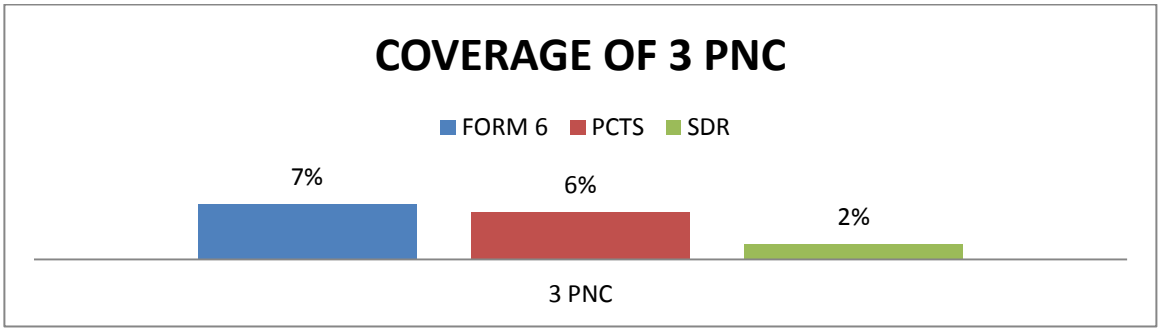
fig 6.2 utilization of natal and post natal services



6.3 ADEQUATE COVERAGE OF 3 PNC SERVICES

- Adequate coverage of 3 PNC services remains very low. As low as 2%. This could be due to the fact that the PNC mothers stay in their paternal homes for more than 1 months. So giving 3 PNC service is a problem. Also because most of the time ANM are not aware of the expected date of delivery of the mother, due to poor record keeping, leading to poor follow up after delivery. (fig 6.3)

Fig 6.3: adequate coverage of 3 PNC services



6.4 FACTORS AFFECTING COVERAGE OF POST NATAL HEALTHCARE SERVICE:

- Unavailability of Disposable delivery kits, leading to delivery under unhygienic condition by SBA.
- Adequate coverage is very poor, which shows that people are coming to the health facility initially but are not following up because of the poor conditions
- Effective coverage, on the basis of skill of ANM to draw partograph, was poor. None of the three ANM knew about the partograph.

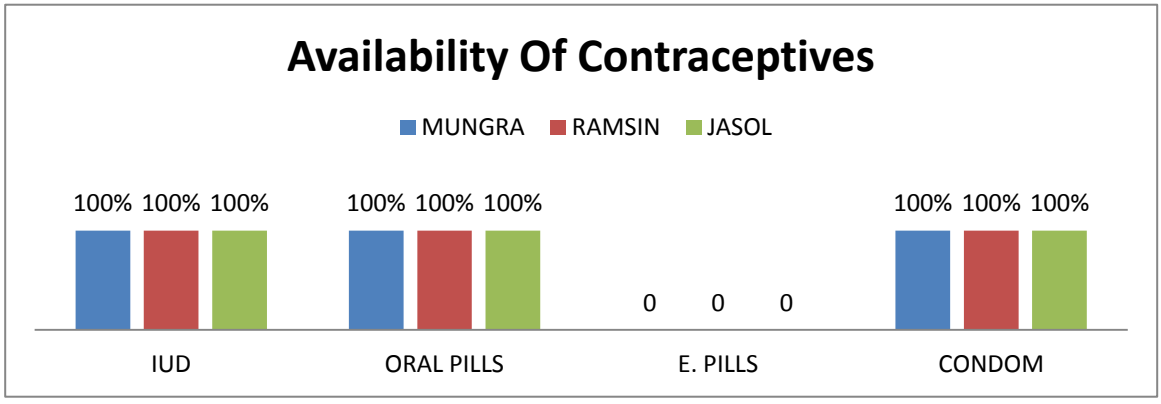
7. FAMILY PLANNING

India aims to achieve replacement level fertility of 2.1 by 2017 (12th FYP). Permanent method of sterilization, laparoscopic tubal ligation, is the main service focused on eligible couples with 2 or more kids. Newly married couples are encouraged to take oral pills or copper t. and couples with 1 child who desire for second are advised to use copper t. Currently target free approach is used by the government of India. It is upto the couple to select the their choice of contraception from the basket of options available to them

7.1 AVAILABILLITY OF CONTRACEPTIVE

- Because of the absence of Emergency contraceptive pills, weekly availability of all the contraceptives is zero, even in the 100% presence of others. Emergency contraceptive pills were not in stock at the PHC.

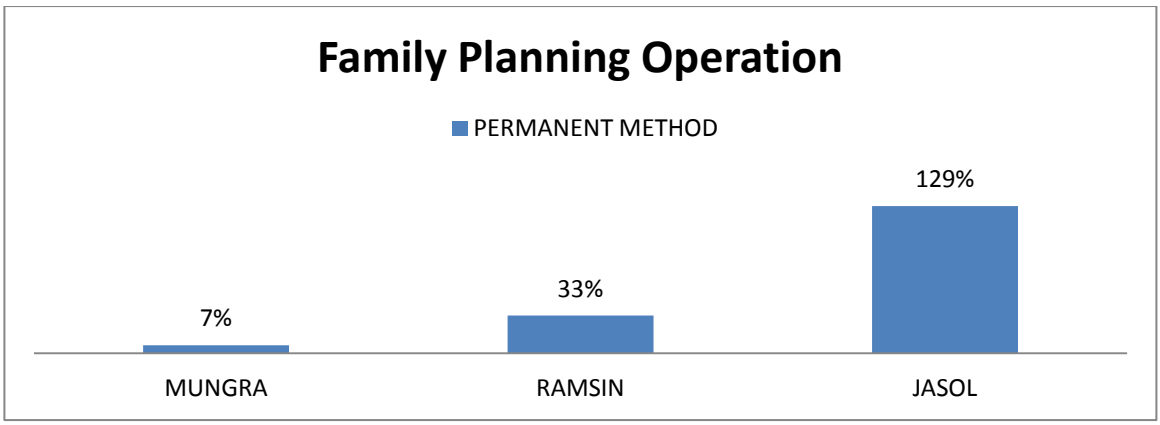
Fig 6.1 availability of contraceptive



7.2 UTILIZATION OF FAMILY PLANNING OPERATION:

- From the figure below(fig 6.2), it can be seen that the performance of Mungra and Ramsin are poor, but actually during the reference period Ramsin and Mungra had already complete the coverage of eligible couples. SC jasol was a slow starter and hence it is working hard to reach the unmet need to family planning.

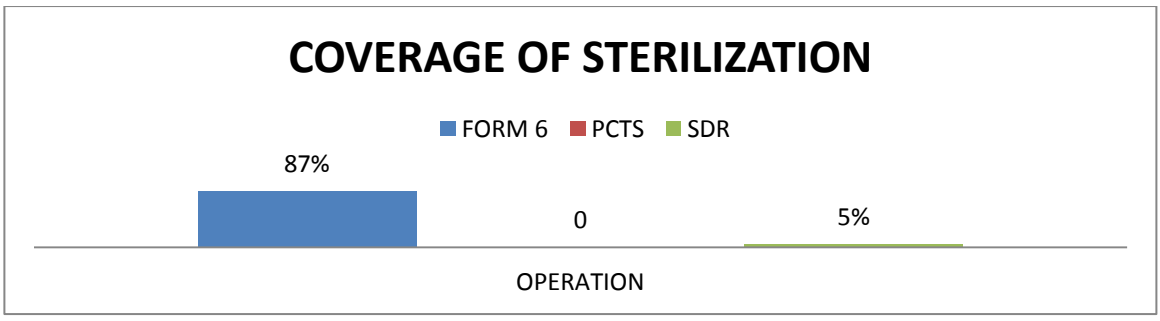
Fig 6.2 utilization of family planning operations.



7.3 ADEQUATE COVERAGE OF STERILIZATION METHOD:

- The trend of unutilized service of pcts and sdr seems to be present in this also.
- As can be seen, the reported coverage of fp, in form 6, is 87 percent. While pcts remains at zero and sdr at 5 perent respectively.

Fig 6.3 adequate coverage of sterilization method



7.4 FACTORS AFFECTIVE COVERAGE OF FAMILY PLANNING:

- Unavailability of resources, emergency contraceptive pills.
- Effective coverage of family planning, based on skill of ANM to insert IUD, is good. 2 out of 3 ANM knew how to insert IUD.
- BCC and IEC of the family planning services are required.

8. OBSERVATIONS FROM ANALYSIS.

- Limited availability of skilled human resources, especially nurses.
- Low coverage of services and of skilled staff posting among marginalized communities.
- Inadequate supportive supervision of front-line service providers.
- Low quality of training and skill building.
- Lack of focus on improving quality of services.
- Insufficient information, education and communication on key family practices.

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