Process Evaluation of Health and Nutrition Day (Mamta Day) in Urban Slum Areas of Bhavnagar Municipal Corporation

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Abstracts: Background: Health and Nutrition Day, "Mamta Day", a concept for interdepartmental convergence having desirable health outcomes of children below five years, antenatal and postnatal women and adolescent girls is being introduced in the State of Gujarat by the Department of Health and Family Welfare. This would provide the first point of contact for essential primary health care and would work as the common platform for convergence amongst service providers of Health, ICDS and the community. Objectives: to identifying gaps in planning and organizing Mamta Day to improve quality of services. Methods: 30 from total 261 Anganwadis (AWs) were selected by Systematic Random Sampling. A structured proforma was prepared for data collection. Results and Conclusion: Anganwadi workers had not prepared/shared list of beneficiaries on the Mamta Day and there was no active tracking of drop outs/ left outs. All children were not being weighed on the day of Mamta day and growth chart and community growth chart were not prepared and updated. The professional performance by PHN/ANMs in urban areas in the provision of antenatal care was found to be unsatisfactory. There was miss opportunity in catering health education to beneficiaries. Recommendation: There is need to improve the quality of antenatal/child care through organisational review and implementation of relevant policies and on the job training to improve the skills of frontline workers. The provision of supplies and equipment and its maintenance should be a priority. There is need to strengthen supportive supervision by Health and ICDS supervisors.[Kotecha I et al NJIRM 2012; 3(1): 111-114]

Key Words: Evaluation, Health and Nutrition Day, Mamta Day, Mamta Abhiyan, Urban areas, Anganwadi

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Introduction: Mamta Abhiyan is an approach to strengthening comprehensive outreach RCH Services. It aims at preventive, promotive and curative services through convergence with Integrated Child Development Services (ICDS) and participation of community. There are five components of Mamta abhiyan: Mamta day (Health and Nutrition Day), Mamta mulakat (postnatal care visit), Mamta sandarbh (referral services), Mamta nodh (record and reports) and Mamta taruni (Adolescent health).[1]

Mamta Abhiyan is one of the major approaches towards reaching the goal of reduction of maternal mortality from present 172 to 100. Infant mortality from 50 to 30 and total fertility rate from 2.4 to 2.1 by 2010.[2,3,4] The aim of Govt. Of Gujarat is to be the first state in India to achieve the MDGs.[4]

Mamta day is a fix day, fix site, preventive, promotive health care service center for mother and child population or village per month. All pregnant women, Brest feeding women, under five children are beneficiaries of this session. Services provided through this session including growth health check up, immunization, primary treatment, and referral and counselling services. These services are provided by a team of health worker, ICDS workers, Kishori Shakti Yojana (KSY) girls, Mahila Swasthya Sangh representative and Non Government Organisation representative.[1]

Mamta mulakat is a home visit on 1st, 3rd and 7th day after delivery for preventive promotive health care.[1]

Mamta Sandarbh Service is the development and mapping of fix day, fix site, referral services for Antenatal care (ANC), Postnatal care (PNC), Essential Newborn Care (ENBC), and reproductive tract infection (RTI).[1]

Mamta Nondh, records and reports of RCH services are important to monitor coverage and quality of RCH services. It is done through ICDS Register and Register 4 – 5. All health monitoring and health service record are maintained on Mamta Card given to mother. This card also includes health

education message for mother and child health care facilitating self learning of mother.[1]

Material and Methods: A complete list of the existing Anganwadi of ICDS Project, Bhavnagar was obtained from the ICDS office, Bhavnagar (We shall call these anganwadi as cluster in subsequent discussion) A ward wise alphabetically listing of all the 261 clusters was done. With Systematic Random Sampling 30 clusters were selected and sessions at those Anganwadis (AWs) were observed. A structured proforma was prepared for data collection. Pretesting was done in an Anganwadi. The questionnaire consists of observation on various aspects of implementation of Mamta Day i.e. cold chain and logistics, immunization safety, records and reports, interpersonal communication (IPC), community mobilization and supervision. As the proforma contains qualitative questions also, coding for all the qualitative answers was decided prior to the data entry. Data was then entered in to the computer using MS Excel and analyzed.

Result: Session site for Mamta Day was Anganwadi in 28 sessions, in two sessions it was in premises of community hall and temple. 28 sessions were held as per the address specified in microplan. At 24 sessions (80%) health education materials was displayed at conspicuous place.

At 29 sessions (96%) Anganwadi workers were present in Immunization sessions. Helper and CBHVs were present at 28 and 26 sessions' sites respectively.

Availability of Vaccines and Logistics: Regarding cold chain and logistics, vaccines were collected on same day by ANM/PHN. Only at one sessions 2 ice pack carrier was in used. There were conditioned ice packs at 28 sessions. In 2 sessions ice packs were watery and not conditioned. At all session site vaccine vials and diluents were kept in zipper bag inside vaccine carrier and atleast one vial of each antigen with diluents was available. At one session sites shake test was positive for DPT vaccine. No session had vaccine without label, unreadable label, with expired date, in frozen state or VVM stage III/IV

Table 1: Availability of Vaccines and Logistics at session sites (N=30)

Sr. No.	Vaccines/ Logistics	Availability at session sites (percentage)
1	BCG, Measles, OPV, DPT, Diluents	30 (100%)
2	AD Syringes 0.1/0.5ml and 5 ml Disposable Syringes	30 (100%)
3	Blank Mamta cards	27 (90%)
4	Community Growth Chart	08 (26.7%)
5	Hemoglobinometer	00 (0%)
6	Adult weighing scale	30 (100%)
7	Newborn weight scale	30 (100%)
8	Child weight scale	30 (100%)
9	Hub Cutter (Functional)	28 (93.3%)
10	BP Instrument (Functional)	29 (96.7%)
11	Red disposal bag	22 (73.3%)
12	Black disposal bag	22 (73.3%)

Regarding immunization safety: Adequate AD syringes were available at all session sites. At all session sites there was correct use of diluents and use of separate syringes for reconstitution of BCG and Measles vaccines. At 22 session sites time of reconstitution was written on reconstituted vials. DPT vaccine were being given on antero-lateral aspects of thigh in 96.7% of sessions only at 1 session, ANM were administering DPT on gluteal region. All PHN/ANMs were maintaining at least 28 days gap between two same or different antigens. At two session sites, it was observed that needle was touched with swab or finger before giving injection. There was recapping and bending of used syringes at 4 and 2 session sites respectively. Hub cutter was used at 16 session sites for cutting syringes immediately after use. Whereas at 12 session sites, used syringes were collected in plastic bag to be cut at Urban Health Center after completion of session. Hub cutter was non functional at 2 session sites. Only at 18 sessions broken ampoules/vials were placed in hub cutter. Cut syringes were placed in red bags at 14 session sites. Red and Black bag for disposal of biomedical wastes were not present at 8 session sites. [Table-1]

Table 2: Availability of Drugs and Contraceptive Measures at session sites (N=30)

Sr. No.	Drugs/Contraceptives	Availability at session sites (percentage)
1	Iron Folic Acid (Large)	29 (96.7%)
2	Iron Folic Acid (Small)	06 (20.0%)
3	Calcium tablet	28 (93.0%)
4	Folic Acid tablet	17 (56.7%)
5	Paracetamol tablet	29 (96.7%)
6	Brufen tablet	02 (6.7%)
7	Albendazole tablet	07 (23.3%)
8	Zinc tablet	00 (0%)
9	Oral Rehydration Salts Sachet	06 (20.0%)
10	Vitamin A solution	29 (96.7%)
11	Oral Contraceptives	0 (0%)
12	Condoms	0 (0%)

Maternal Health Service delivery: IFA tablets were provided to the pregnant mothers at 96.7% of sessions. Folic acid tablet was not available at 56.78% of session sites. In 95.6% sessions, pregnant women were weighed and weight was recorded. Blood pressure of pregnant women was measured properly and recorded at 90% sessions. Advice for next antenatal check up was provided along with dietary and relevant counseling in 63.3% sessions. In 36.7% session's relevant history i.e. obstetric, past, menstrual for women coming for the first antenatal check up was elicited. At no session site abdominal palpation for determining fundal height, foetal lie was performed. At no session site privacy i.e. by way of separate cabin/curtains was there. **[Table-2]**

Child Health Service delivery: only at 13.3% session sites, only few infants / children up to the age of five years weighed and the weigh were recorded. (n=42). In 60% Anganwadi, growth charts were not updated. Community growth chart monitoring was not seen in any AWs. It was observed that breastfeeding advices were not being given at any session sites. ORS packets were distributed for diarrhea but there was no demonstration ORS to the beneficiaries.

Family planning service delivery: Family planning counseling was not being provided to eligible women/couples at session sites.

Status of Record Keeping and Mobilization: Regarding tracking left outs / drop outs and missed opportunities, 16 AWWs (53.3 %) added all known pregnancies and births in their area over the past 3 months to AWW register whereas no PHN/ANM added beneficiaries of last three months to register 4-5 even if they have not yet come for vaccination. No AWWs shared list of children due for vaccination on that day with ANM/PHN. There was no active tracking for dropouts using due list of beneficiaries in all AWs. At 21 sessions (70 %), ANM/PHNs were checking immunization status of infants brought to session for other ailments.
Regarding interpersonal communication, at 9 sessions (30%) ANM/Community Based Health Volunteers (CBHVs) were giving 4 key messages to parent/ care taker of beneficiaries.

Regarding records and reports, at 25 sessions (83.3%) information about each vaccination was being correctly and completely filled in cards. Only 14 sessions (46.7%) it was correctly and completely filled in immunization register and 4-5 registers.

Supervision: No supervisory visits by Medical Officer or Mukhya Sevika/ CDPO to the session site in last calendar month.

Discussion: To achieve universal immunization, 100% birth registration and active tracking of the drop outs/left outs are necessary. However, present study shows that only 53.3% Anganwadi workers had registered births in their area over the past 3 months. The primary role of AWW is to survey and identify women and children for the services of Mamta Day but in present study, beneficiaries list was not prepared/shared and there was no active tracking of drop outs/ left outs. It was, therefore, observed that although immunization was taking place to a great extent, but there was still scope for more work that needs to be done to ensure universal immunization of children.

Growth monitoring and nutrition status surveillance are two important activities which are

required to be undertaken on Mamta Day. In the present study it was observed that not all children were weighed on the day of Mamta day and growth chart were not updated.

No emphasise was put on identifying the danger signs, examining the abdomen. The professional performance by PHN/ANMs in urban areas in the provision of antenatal care was found to be unsatisfactory.

Health education during pregnancy should be at individual level. Not all pregnant women were receiving information on exclusive breast feeding, warning signs in pregnancy. This can be taken as a "missed opportunity".

Recommendations: For effective community mobilization, availability of due list of beneficiaries at every session and improvement in counselling skills of front line functionaries were necessary. There is need to improve the quality of antenatal/child care through organisational review and implementation of relevant policies and on the job training to improve the skills of PHN/ANM and AWW. The provision of supplies and equipment i.e. examination table with privacy, Hub cutter, Folic acid, IFA tablet small, Albendazole, Zinc tablets, contraceptives and its maintenance should be a priority and the training of PHN/ANM in its use. There is need to strengthen supportive supervision by Health and ICDS supervisors.

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