Quality of Reproductive Health Service at PHC level with reference to skill and competency of the Health Service Providers in Nepal

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Pramila Thapa (Master in Nursing)
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Abbreviations

AHW:	Auxiliary Health Worker
ANC:	Antenatal care
ANM:	Auxiliary Midwifery Nurse
DoHS :	Department of Health Service
DPHO:	District Public Health Office
HA:	Health Assistant
HP:	Health Post
INGO:	International non governmental Organization
MCHW:	Maternal and Child Health Worker
NGO:	Non governmental Organization
ORC:	Outreach Clinic
PHCC:	Primary Health Care Center
SHP:	Sub Health Post
VDC:	Village Development Committee
VHW:	Village Health Worker
WHO:	World Health Organization

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CHAPTER – I

INTRODUCTION

Landlocked between India and China, the tiny kingdom of Nepal is a country of geographic and cultural wonders, including the Himalayan peaks, ancient temples, and colorful marketplaces. Yet the dramatic landscape that attracts tourists also creates significant obstacles to health care for Nepali women and their families. Those who live in remote mountain villages are often a day's walk from health care services, including family planning.

'Health for all by 2000 AD' through primary health care was declared in 1978 in the Alma Ata Declaration. Among its signatories, which included India, this Declaration accelerated development of and strengthened family welfare and Maternal and Child health (MCH) programs, encouraged new strategies and provided more health facilities in order to achieve the goal. Included in the Declaration's aims was that by the year 2000 all people of the world would have obtained a sufficient level of health to permit socially and economically productive lives. On World Health Day in 2002, WHO launched the slogan 'Move for Health'.

Reproductive health is a crucial part of overall health which is central to human development and affects everyone. Reproductive health has been taken as a fundamental human right and its importance has been mainly focused from 1994, International Conference on Population and Development (ICPD) held in Cairo. Reproductive health implies that peoples are able to have satisfying and safe sex life and they have capability to reproduce and have the freedom to decide if when and how often to do so. So it is very important to ensure quality Reproductive Health service at community level.

According to the World Bank, about one-third of the total disease burden on women of 15 to 44 years of age, in developing countries, is linked to health problems related to pregnancy, childbirth, abortion, human immuno-deficiency

virus (HIV), and reproductive tract infections (RTIs). Among [redacted] for which cost-effective interventions exist, reproductive health problems account for the majority of the disease burden in women of this age group. The 1994 International conference on Population and Development (ICPD) set forth the challenge of ensuring, not just that reproductive health services are universally available, but also that they are of adequate quality.

Quality of care encompasses,

- Access to services
- Adequate supplies and equipment
- Standards of technical, managerial and interpersonal skills of health staff

Quality of care is about rights as well as services. When individuals and communities understand their rights, they can demand appropriate care. This demand can, in turn, influence service providers and health systems by improving their understanding of how to supply better services.

A concern with quality of care is part of health reform processes that are under way in many countries including Nepal. But often insufficient attention is given to the specific ways in which quality of care applies to reproductive and sexual health services.

The components of quality reproductive health care are well established. Clients need a choice of contraceptive methods, accurate and complete information, technically competent care and good interaction with providers, continuity of care, and a constellation of related services.

Similarly the importance of reproductive health rights has increasingly been recognized by the international community. In the September 2005 World Summit the goal of universal access to reproductive health was endorsed at the highest level. Reproductive rights are recognized as valuable ends in themselves, and essential to the enjoyment of other fundamental rights. Special emphasis has been

given to the reproductive rights of women and adolescent girls, and to the importance of sex education and reproductive health programs.

The heavy load of reproductive morbidity among Nepalese women is an outcome of their poverty, powerlessness, low social status, malnutrition, infection, high fertility and lack of access to health care. Thus, socio-economic and biological determinants operate synergistically throughout the lives of poor women to undermine their health, resulting in high levels of morbidity and mortality. The magnitude of women's reproductive health problems is reflected in the number of deaths related to pregnancy and childbirth, the most direct indicator of reproductive health care.

Over 80 percent of Nepal's population lives in rural areas, where basic health care services remain limited. For a majority of people living in rural areas, access to health care and facilities is hampered by geographical, economic and cultural barriers. In addition, the decade-long armed conflict has jeopardized the provision of basic health care services, exacerbating the lack of health workers, health facilities and medical supplies.

The maternal mortality rate is 539 per 100,000 live births, the highest rate in South Asia. Similarly more than half of all births occur at home without the benefit of qualified birth attendants or doctors. So providing appropriate, quality reproductive health services under such conditions is a major challenge. Although the contraceptive prevalence rate is close to 40%, sterilization still accounts for more than 60% of family planning methods. The unmet need for family planning is close to 30% and growing since more than one-fifth of the country's population is comprised of adolescents under the age of 21.

Reproductive health programs are designed to address clients' needs and, therefore, an important implication for their implementation is to ensure that the quality of services is improved, particularly from the perspective of the user. Several studies have highlighted the wide social and cultural gap that exists

between the providers and users of services. In order to bridge this gap, more attention should be focused on the users' perspective within the overall framework of the service delivery system. There is a need to specially focus on women since they constitute the major client group or users of these programs and also have the greatest problem of access, both physical and social to health services.

The provision of high quality maternity care will make the difference between life and death or lifelong maiming for millions of pregnant women. Barriers preventing access to affordable, appropriate, acceptable and effective services, and lack of facilities providing high quality obstetric care result in about 1600 maternal deaths every day

The presence of a skilled birth attendant at delivery is important in averting maternal and neonatal mortality and morbidity. It has now shown that even trained traditional birth attendants (TBAs) cannot, in most cases, save women's lives effectively because they are unable to treat complications, and are often unable to refer. Qualified midwives and doctors are often not available in the rural areas and community settings where most women in developing countries deliver. Defining the minimum competency level necessary to meet the definition of skilled birth attendant is important, particularly in countries such as Nepal with limited availability of facility-based emergency obstetric care.

Alma-Ata (1978), the Maternal Health component of Primary Health Care has greatly evolved. The traditional maternal health services, which comprised primarily antenatal care, safe delivery and post natal care, include a much wider spectrum of services today. This evolution, among other factors, has been greatly influenced by many factors.

No issue is more central to global well-being than maternal and perinatal health. Every individual, every family and every community is at some point intimately involved in pregnancy and the success of childbirth. Yet every day, 1600 women and over 10000 newborns die due to complications that could have been prevented.Since its inception in January 2005, the Department of Making Pregnancy Safer (MPS) at the World Health Organization, sets out a way forward

for making pregnancy and childbirth safer for women and their newborns, and thus accelerating the reduction of maternal and perinatal mortality and morbidity - especially in the developing world, where 98% of these deaths occur.(WHO, 2007)

Over 80 percent of Nepali people reside in rural areas, where only basic healthcare services are available. Besides, resource crunch, geographical barriers, ignorance and such hindrances pose a threat to reproductive healthcare system. With this in mind, being an international development agency UNFPA is trying its best to promote the right of every women and child to enjoy health and equal opportunity. Moreover, it is ironical that the decade-long armed conflict has jeopardized the healthcare delivery system exacerbating the lack of healthcare providers and other accessories. (Kantipur News, 2007)

Mwaniki PK, *et. al.* (2002), conducted a Utilization of antenatal and maternity services by mothers seeking child welfare services in Mbeere District, Eastern Province, Kenya result showed that the proportion of mothers who utilized health facilities for antenatal and maternity services was 97.5% and 52%, respectively. Utilisation of health facilities for maternity services was significantly influenced by number of children and distance to health facility.

Rational of the study:

Reproductive health is given prime concern in the national and international communities. Since it is a sensitive health issue, so it has been given more attention in health sector. In our context over 80% of the population lives in rural areas, where basic health care services including Reproductive health remain limited. For majority of the peoples living in rural areas, access to reproductive health service is mainly hampered by geographical, economic and cultural barriers which can be reflected by high maternal mortality of 539 per 100,000 and having only about 20% deliveries conducted by health worker of total expected pregnancy and by various other indicators. Similarly increasing the proportion of births that take place with a skilled attendant is an internationally agreed goal but still it is a great challenge for us.

At grass root level health workers are not able to provide appropriate care due to the lack of quality education, appropriate training, lack of appropriate infrastructure and equipments and timely monitoring and supervision. Similarly qualified midwives and Doctors are often not available in the rural areas and community settings where most of the Reproductive health problems occur and home delivery takes place. So conducting study in this subject matter is very essential and important.

Objective:

To assess competency of health care provider with Reproductive health at PHC level.

CHAPTER

METHODOLOGY

STUDY DESIGN

- Study will be descriptive/ Cross-sectional study and include both qualitative as well as quantitative data.

STUDY AREA AND STUDY POPULATION

- Study will be conducted in PHCCs of six districts, where the district includes Kathmandu, Bhaktapur, Lalitpur, Kavre, Chitwan and Kanchanpur which were selected purposively. In these six districts PHCCs were selected as convenient of the researcher. So altogether fifteen PHCCs were included in the study.
- Health service providers mainly PHC Nursing staffs were taken as a study population.

SAMPLING

- Six districts (Kathmandu, Bhaktapur, Lalitpur, Kavre, Chitwan and Kanchanpur) were selected purposively, from where total thirty Primary Health Care providers was taken as convenient to the researcher/ randomly.
- Structured questionnaire were used to describe the quality and status of the reproductive health at PHCC level.

METHOD OF DATA COLLECTION

The data was collected by using questionnaire method. The investigator introduced herself and obtained an oral consent from the health care providers to participate in the study. The purpose of the study and the importance was explained before collecting the data. Then the questionnaire was administered to the health care providers to assess the knowledge

CHAPTER- III

DATA ANALYSIS AND INTERPRETATION

Table- 1

Distribution of Demographic variables of the Nurses

Demographic Characteristics	Number	Percentage
Categories of Nursing Staff		
Staff Nurse	11	36.67
ANM	19	63.33
Total	30	100.00
Course Completion		
TU	18	60.00
CTEVT	12	40.00
Total	30	100.00
Age of Nursing Staffs		
20-30	8	26.67
31-40	14	46.67
>40	8	26.67
Total	30	100.00
Job experience(Years)		
1-5	3	10.00
6-10	6	20.00
>10	21	70.00
Total	30	100.00

From table number 1 it was known that majority of nursing staffs were ANM (63.33%) followed by 36.67% staff nurses. Most of the Nursing staffs had completed their Nursing course from Tribhuwan University (60.00%). Higher percentage of nursing staffs belongs to age group 31-40 years (46.67%) followed by under 30 and under 40 years(26.67% each). Majority of nursing staffs (70%) had more than 10 years of working experience and few numbers of nursing staffs (10%) had less than 5 years of experiences.

Table: 2

Distribution of Anti-Natal Care knowledge with Nursing staff

Anti-Natal Care	Number	Percent	Remarks
Safest Method to postpone Pregnancy			
Condom/Pills/Depo	18	60.00	
Surgeries/IUCD	8	26.66	
Safeperiod	7	23.33	
Others	1	3.33	Let mother decide
How will you know that the baby is growing normally?			
Losing weight	0	100	
Experiences nausea and vomiting	8	26.66	
Increase in size of abdomen and weight	25	83.33	
Others	5	16.66	Ammerrhoea,Fundal height,Increase the weight of mother,Medical Examination
Conditions mother requires immediate medical care			
Epigastric pain	4	13.33	
Sudden Gush of fluids and blood per vagina	25	83.33	
Muscle cramps	9	30.00	
Others	6	20.00	Abdomen Pain,Aclempsia,Odema, High BP,High risk Mothers, High risks group
How will you conform that mother is pregnant			
When your partner miss her period	5	16.67	
Pregnancy Test	29	96.67	
complaint about nausea and vomiting	6	20.00	
Others	3	10	Abdomen size increase, Personal history
When you have to take mother for first antinatal visit?			
As soon as she knows she is pregnant	22	73.33	
After 3 months	5	16.67	
After 5 months	3	10.00	
Total	30	100.00	

From table number 2 it was known that higher proportion nursing staffs(60%) said that Condom/Pills/ Depo were safest method to postpone pregnancy (95% CI=42.5<p<77.5) followed by Surgeries/IUCD (26.66%) , safe period (23.33%) and others (3.33.00%). Under the study we found no evidence of proportion difference among staff nurse and ANM in knowledge about safest method to postpone pregnancy (Fisher exact test (p) = 0.266).

Out of 30 respondents, 83% answered that increase in size of abdomen and weight is the sign for growth of baby. Likewise 27% and 16% staff nurses & ANM had stated both Nausea & vomiting and increase in size of abdomen and weight respectively.

It was also reported that 83.33% respondents believed that when mother had sudden gush of fluxes and blood in vagina (95% CI=70<p<97) requires pregnant women immediately medical care. It was also found 30% respondents had reported two or more conditions under which mother requires immediate medical care (see table 2). Similarly 8 and 1 ANM and Staff nurse respectively reported muscle cramps was also the condition for pregnant women immediately medical care.

Under the study, it was known 97% respondents confirmed pregnancy through pregnancy test (95% CI=90.24<p<100.00). Nearly 37% and 26% staff nurses and ANM understood pregnancy can be confirmed by two or more characteristics respectively.

It was also identified that 73.33% respondents answered mother should visit first antenatal care as soon as she is pregnant (95% CI=57.5<p<89.15). Similarly 17% respondents answered first antenatal care should be after three months of pregnancy (95% CI = 3.30<p<30.00). There is no evidence of significance among ANM and Staff nurses in knowledge about conformity test of pregnancy (Fisher exact test (p) =0.9).

Table: 3

Distribution of Intra-Natal Care knowledge with nursing staff

Intra-Natal Care	Number	Percent	Remarks
How will you know mother is labour			
Low back pain and sudden gush of fluid	22	73.33	
Abdominal pain	14	46.67	
Orbital edema	4	13.33	
Others	5	16.66	Personal History,PV Show
Normal weight of New Born Baby (kg)			
2	0	0.00	
2.5-3	30	100.00	
>3	0	100.00	
When should mother give first breast feed to the baby?			
After one day	1	3.33	
Within half an hour	29	96.67	
After three	0	0.00	
When mother can start taking normal food and fluids after delivery?			
After one day	1	3.33	
After 6 hours	4	13.33	
Conditions of mother and baby stabilizes	21	70.00	
Others	4	13.33	
Total	**30**	**100.00**	
What type of minor discomforts mother may experience after delivery ?			
Nausea and Vomiting	4	13.33	
Episiotomy pain and backache	28	93.33	
Oral Ulcer	2	6.67	
Others	10	33.33	Abdominal Pain, Bleeding, Tear,hammorrhaes, Body ache,Weakness
In what conditions mother require Immediate medical attention after delivery ?			
Episiotomy pain	4	13.33	
Severe bleeding	29	96.67	
Constipation	2	6.67	
Others	6	20.00	Hematoma,Infection,Moth er Shock,Retain Placenta,Sepsis

In table 3 it was found that 73% respondents answered low back pain and sudden gush of fluid is the sign for labor. Similarly out of 30, 47% respondents answered about abdominal pain (95% CI = 29.00<p<65.00).and 13.3 % had reported about orbital edema. (95% CI = 1.20<p<25.50).

From the study it was known that knowledge about normal weight of baby (2.5 – 3 kg) and about breast feeding (within half an hour) are universal.

About 70% respondents answered that mother should take normal food and fluids when the conditions of mother and baby stabilizes (95% CI = 53.60<p<86.39). One ANM had reported the same after one day.

In the study we found 93.3 % respondents said episiotomy pain and backache is the minor discomfort mother experience after delivery (95% CI = 84.40<p<100.0). Out of 3o, 33.33% have reported various types of discomfort seen in mother (see table 3).

Majority of respondents (97%) answered that under severe bleeding mother immediately require medical attention. Very few had reporting about constipation, hematoma , shock , retain and sepsis etc.

Table: 4

Distribution of General Care knowledge with nursing staff

General Categories	Number	Percentage	Remarks
Have you receive any safe motherhood training?			
Yes	15	50.00	
No	15	50.00	
Total	30	100.00	
Have you conduct more than 20 normal deliveries during In your student's period ?			
Yes	28	93.33	
No	2	6.67	
The supervisor during in your student's period			
Teacher	22	78.56	
Doctors	3	10.72	
Hospital Staffs	3	10.72	
Total	28	100.00	
Which are the institute you have practice in your student periods about maternal and child health care?			
Hospital	15	53.57	
Maternal Hospitals	10	35.71	
PHC	3	10.71	
Total	28	100.00	
Have you ever taken history to the ANC Mothers according to protocals and guidelines?			
Yes	21	70.00	
No	9	30.00	No idea & Practice about Protocal
Total	30	100.00	
Have you ever taken Physical Examination to the ANC Mothers according to protocals and guidelines?			
Yes	22	73.33	
No	8	26.67	No idea & Practice about Protocal
Total	30	100.00	
Have you ever taken History to the PNC Mothers according to protocals and guidelines?			
Yes	20	66.67	
No	10	33.33	No idea & Practice about Protocal

Total	30	100.00	
Have you ever taken Physical Examination to the PNC Mothers according to protocals and guidelines?			
Yes	22	73.33	
No	8	26.67	No idea & Practice about Protocal
Total	30	100.00	

From table 4, it was known that 50% respondents had participants in safe motherhood training (95% CI = 32.10<p<67.89).Among respondents, 93.33% had conducted more than 20 deliveries in their student life. More than 75% of these respondents were supervised by teacher. Very few respondents were supervised by medical doctors and hospital staffs. Among these respondents nearly 54 % had practice in hospital followed by maternal hospitals (35.71%) and PHC (10.71%) respectively.

Only 70% respondents had taken history to the ANC mothers according to national protocol and guidelines (95% CI = 53.60<p<86.39). Remaining 30% did not have an idea about national protocol and guidelines. Similarly 73.33% women did physical examination to the ANC and PNC mothers according to national protocol and guidelines. It was also known that 66.67% women taken the history according to national protocols and guidelines.

Table: 5

Distribution of General Care knowledge with nursing staff

General Categories	Number	Percentage	Remarks
Do you provide breast feeding education to mother?			
Yes	30	100.00	
No	0	0.00	
Total		100.00	
Do you provide new born education to the mothers?			
Yes	30	100.00	
No	0	0.00	
Total	30	100.00	
Do you provide health education to the mother about weaning ?			
Yes	28	93.33	
No	2	6.67	Reason for No-Believe in own culture by mothers
Total	30	100.00	
Have you make routine observations according to the postnatal care protocal ?			
Yes	20	66.67	
No	10	33.33	Reason for No-No idea about protocal and unavaibility
Total	30	100.00	
Have you provide home visits services to PNC Mothers?			
Yes	11	36.67	
No	19	63.33	Client didnot seek care, No Delivery cases, Patient themselves come to PHC
Total	30	100.00	
Person Responsible for home visits to PNC Mothers			
Staff Nurse	4	36.36	
ANM	6	54.55	
Health Workers	1	9.09	
Total	11	100.00	
Types of service include in Home Visit			
Health Education	10	33.33	
New born care	7	23.33	

Family Planning	9	30.00	
Others	3	10.00	Breast feeding and Nutrition

From table number 5, it was known that cent percent respondents had provided breast feeding and new born education to the mothers. More than 90% respondents had provided education to the mother about weaning. Remaining respondents did not provide health education about weaning because people believed in own culture by mothers.

It was found that only 67% respondents had made routine observations according to the postnatal care protocol (95% CI = 49.79<p<83.53) and rest of respondents did not have an idea about protocol and unavailability.

Nearly 37% respondents had provided home visits services to PNC Mothers (95% CI = 19.42<p<53.90). Out of these 54.55% are responsible ANM followed by 36.36 % Staff Nurses and 9.09% health workers. During the home visits they provided health education (33.33%), Family planning (30%), new born care (23.33%) and Breast Feeding & nutrition (10%) to the PNC mothers. About 24% respondents had provided education more than three subjects to the PNC mothers.

Table: 6

General Categories	Number	Percentage	Remarks
Have you provide appropriate adolescent/youth services?			
Yes	17	56.67	
No	11	36.67	Reason for No-Community People not interested,No specific Service
N/A	2	6.67	
Total	30	100.00	
Have you manage third stage labour ?			
Yes	22	73.33	
No	8	26.67	
Total	30	100.00	
Have u manage severe bleeding case during delivery?			
Yes	12	40.00	
No	18	60.00	
Total	30	100.00	
Do you know emergency contraceptive ?			
Yes	27	90.00	
No	3	10.00	
Total	30	100.00	
If yes, which method you will preferred			
Pills	17	62.96	
Pills and IUCD	8	29.63	
N/A	2	7.41	
Total	27	100.00	
Do you know Major Side effect of IUCD?			
Yes	27	90.00	
No	3	10.00	
Total	30	100.00	
Major Side effects			
Bleeding	16	53.33	
Pain	10	33.33	
Infections	6	20.00	
Others	5	16.66	Nausea, odema, vaginal pain, white discharge
Have you given immunization to the children according to national protocal?			
Yes	28	93.33	

No	1	3.33	
N/A	1	3.33	
Total	30	96.67	
Have you given nutrition education during ANC visit to the mothers ?			
Yes	30	100.00	
No	0	0.00	
Total	30	100.00	
Have you used IEC materials during MCH visits?			
Yes	25	83.33	
No	5	16.67	
Total	30	100.00	

From table 6, It was known that 56.67% respondents had provided appropriate adolescent /youth services (95% CI = 38.93<p<74.39). Similarly only 73.33% respondents had managed severe bleeding cases during delivery. Only 40 % and 20% severe bleeding were managed by ANM and Staff nurses respectively. There is no proportion of difference in severe bleeding managed by ANM and Staff Nurses (Fisher exact test (P) = 0.712).

Similarly more than 90% respondents had knowledge of contraceptive methods. Out of these 63 %(95% CI = 44.74<p<81.17) had said Pills followed by both IUCD and Pills (30%, 95% CI=12.40<p<46.85) and remaining 7% did not answer the questions. More than 90% respondents knew about the side effect of IUCD.

When the question was asked about immunization to children according to National protocol more than 90% respondent answered positive. Cent percent respondents had given nutrition education during ANC visit to the mothers. Similarly 83.33% respondents used IEC materials during MCH visits (95% CI = 69.99<p<96.69).

RESULTS AND DISCUSSION

Government of Nepal has endorsed the concept of Cairo conference, which was held on 1994. Ensuring the quality of reproductive health at various levels of service centers including PHCC is necessary since it is a crucial part of overall health which is central to human development and affects everyone. Reproductive health implies that peoples are able to have satisfying and safe sex life and they have capability to reproduce and have the freedom to decide if when and how often to do so. So it is very important to ensure quality of Reproductive Health service at various health care providing centers including PHCCs.

This study has focused to find out the situation and quality of reproductive health service at PHCC level. For conducting the study total 6 districts (Kavre, Lalitpur, Bhaktapur, Kathmandu, Chitwan and Kanchanpur) were taken purposively from where total 15 PHCC were included for the study.

The results and discussion of the study is based on the findings obtained from the statistical analysis. The data is collected with the help of the questionnaire method.

DEMOGRAPHIC CHARACTERISTICS

Majority of nursing staffs were ANM (63.33%). Most of the Nursing staffs had completed their Nursing course from Tribhuwan University (60.00%). Higher percentage of nursing staffs belongs to age group 31-40 years Majority of nursing staffs (70%) had more than 10 years of working

Nurses are key health workers needed to reach Nepali goals of women's reproductive health and widespread use of contraception to increase the amount.The first school of nursing opened in Nepal in 1956, and now there are seven nursing schools. Currently, three programs for nursing preparation are available in Nepal. The first is the initial Program for Certificated Licensed Nurses (PCLN), which takes three years and is the practice level of most nurses in Nepal. The PCLN program focuses on basic nursing skills development. Subsequently, a Bachelor of Nursing (BN) program is available to PCLN graduates who have practiced for three years or more. The BN program builds on basic skills to focus on management and teaching skills. There is one Master's of Nursing

program in Nepal at Tribhuvan University in Kathmandu. In addition, several master's prepared Nepali nurses have obtained their advanced degrees from programs outside the country or in affiliation with universities outside Nepal

Recent efforts to improve maternal health have focused on skilled attendants and emergency care at health facilities. Skilled birth attendants and access to emergency obstetric care are essential to saving mothers lives. In developing countries, 60 million women give birth at home without skilled care and with high maternal and neonatal mortality. Nearly all essential newborn care can be provided safely, effectively, and at a low cost at the household level. The same is true for care of the mother, and many effective interventions can be implemented at the household and community level that will save mothers' lives.

Anti-Natal Care

It was known that higher proportion nursing staff said that safest method to postpone pregnancy. Under the study we found no evidence of proportion difference among staff nurse and ANM in knowledge about safest method to postpone pregnancy.

Majority on nurses answered that increase in size of abdomen and weight is the sign for growth of baby. It was also reported that 83.33% respondents believed that when mother had sudden gush of fluxes and blood in vagina requires pregnant women immediately medical care. It was also identified that 73.33% respondents answered mother should visit first antenatal care as soon as she is pregnant.

Expansion of the Role of Nurse Auxiliaries in the Provision of Family Planning Services. In this study FRONTIERS and the Ministry of Health (MOH) examined the feasibility of training nurse auxiliaries, who staff rural health centers, to provide IUDs, injectable contraceptives (DMPA), and Pap tests. The project documented the acceptability and feasibility of training nurse auxiliaries to give DMPA injections. Recommendations included including training for the delivery of services in auxiliary nursing school curricula, exam requirements and MOH/nongovernmental organization job descriptions.

In-service training ensures that health professional's already providing services have the opportunity to update their knowledge and skills according to the latest scientific information and standardized practices. Often, in-service training updates knowledge rather than skills because clinical training sites are lacking. JHPIEGO's interactive training

approach calls for strengthening the inservice system so that it can provide competency-based training, which transfers skills as well as knowledge and attitudes (Sullivan 1995). JHPIEGO's approach also involves linking inservice training to preservice training, especially for clinical skill development, whenever possible. This linkage results in a systematic, coordinated training effort in which resources are focused most effectively and development becomes more sustainable.

Pakistan is one of the countries with a high maternal and infant mortality rates. Women, especially pregnant women suffer even at primary care level due to a lack of properly trained and skill health care worker in the community

Intra-Natal Care

It was found that 73% respondents answered low back pain and sudden gush of fluid is the sign for labor. From the study it was known that knowledge about normal weight of baby (2.5 – 3 kg) and about breast feeding (within half an hour) are universal.

About 70% respondents answered that mother should take normal food and fluids when the conditions of mother and baby stabilizes In the study we found 93.3 % respondents said episiotomy pain and backache is the minor discomfort mother experience after delivery Majority of respondents (97%) answered that under severe bleeding mother immediately require medical attention.

General Care knowledge

It was known that 50% respondents had participants in safe motherhood training. Among respondents, 93.33% had conducted more than 20 deliveries in their student life. More than 75% of these respondents were supervised by teacher. Among these respondents nearly 54 % had practice in hospital followed by maternal hospitals. Only 70% respondents had taken history to the ANC mothers according to national protocol and guidelines. Similarly 73.33% women did physical examination to the ANC and PNC mothers according to national protocol and guidelines. It was known that cent percent respondents had provided breast feeding and new born education to the mothers. More than 90% respondents had provided education to the mother about weaning. It was found that only 67% respondents had made routine observations according to the postnatal care protocol Nearly 37% respondents had provided home visits services to PNC

Mothers. Out of these 54.55% are responsible ANM followed by 36.36 % Staff Nurses and 9.09% health workers. During the home visits they provided health Family planning (30%), new born care (23.33%) and Breast Feeding & nutrition (10%) to the PNC mothers. It was known that 56.67% respondents had provided appropriate adolescent /youth services only 73.33% respondents had managed severe bleeding cases during delivery. Similarly more than 90% respondents had knowledge of contraceptive methods. More than 90% respondents knew about the side effect of IUCD. About immunization to children according to National protocol more than 90% respondent answered positive. Cent percent respondents had given nutrition education during ANC visit to the mothers. Similarly 83.33% respondents used IEC materials during MCH visits.

The road to safe motherhood is blocked by several barriers, such as poor socio-economic development, low literacy, excessive fertility, high-risk pregnancy, life-threatening complications leading to the death of the woman. Likewise, raising the status of women, developing poverty reduction strategies, providing quality reproductive health services including family planning, improving community-based maternity services, and upgrading accessible first-level referral services, will contribute greatly to the reduction of maternal mortality.

The World Health Organization believes that improvements are possible, through efficient application of existing knowledge, appropriate technology and better resource management. However, strong political will is the prerequisite for successful introduction of the relevant reforms in health and education, in maintaining a better spread of income generated, and in tackling the problems of social malaise and disruption.

Summary

Reproductive health is a crucial part of overall health so it has been taken as a fundamental human right and its importance has been mainly focused from 1994, International Conference on Population and Development (ICPD) held in Cairo.

This study has mainly focused to explore the quality and status of reproductive health service at PHC level. A concern with quality of care is the part of health reform processes that are under way in many countries including Nepal. It is a Cross-sectional/descriptive study which includes both qualitative as well as quantitative data.

For conducting the study, six districts were chosen purposively which includes Kathmandu, Bhaktapur, Lalitpur, Kavre, Chitwan and Kanchanpur. From these six districts total fifteen PHCCs were selected as convenient to the researcher. Altogether fifteen PHCCs were included in the study. Structured questionnaire and observation checklist were used to describe the quality and status of the reproductive health at PHCC level.

Finding of the study shows the mixed scenario on the quality and status of reproductive health service provided by the PHCCs. Most of the PHCCs have fulfilled the sanctioned post of health personnel except few, where the staff were in study leave or deputed temporarily to other place, but regarding medical officers only 20% of them were present in the PHCCs, which need to be fulfilled as soon as possible.

For providing the reproductive health service mainly Staff nurse and ANMs were involved. Most of the services were found to be conducted regularly except abortion service which was only conducted by 13% of the PHCCs, likewise Norplant and IUCD services were still not available in 33% of the PHCCs, so these services need to be strengthened.

Service providers had taken various trainings that were required to provide the service, but BEOC training still need to be provided since only few staffs had taken this training.

Likewise they had told that they need additional training on Reproductive Health Service Protocol and CoFP.

Necessary infrastructures were available in most of the visited PHCCs, but operation theater and post operation room were only found in 27% of the PHCCs. Similarly lab service did not seem to be well established in the visited PHCCs.

Reproductive health protocol was not used in most of the PHCCs by the service providers. With regard to the various information sources present in the PHCC for providing information to the community most of them had these various sources of information.

Although outreach clinic were regularly conducted by the PHCC, but only 67% were providing the family planning service and 40% were providing the ANC service, which reflect that the coverage of the service is not satisfactory. Regarding the support provided by the PHCC for conducting the home deliveries, it was found that only 53% of the visited PHCCs have provided such support. Complicated pregnancy cases were not found to be handled in the visited PHCCs, likewise only 60% of the PHCCs had initiated cost sharing scheme.

For providing RTI/STI service, only 33% of the PHCCs were found to be providing lab based diagnosed service and in the rest of the PHCCs they were providing symptomatic treatment or providing treatment just to the minor cases and refer other cases. Likewise only 13% of the PHCCs had conducted abortion service, so it is very urgent to strengthen these services.

Most of the PHCCs had conducted awareness program on the reproductive health issues and also on the matters related to adolescence reproductive health issues by conducting school health education as well as through VHW, FCHVs, mother groups and by conducting various program during feast and festivals.

Reproductive health programs conducted by the PHCCs were regularly monitored and supervised by the DPHO and other responsible concerned bodies. Similarly it was found that PHCCs were also being supported by the communities for conducting the service effectively.

- From the overall scenario of the study, we can conclude that reproductive health services provided from the PHCCs still need to be strengthened in various aspects as it exist in present situation, so that it will be able to cover the unmet demand of the population and can provide quality service at the community level.

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APPENDIX

Questionnaire for assessing the Quality of Reproductive Health Service at PHC level Conducted by: Nepal Health Research Council, Ram Shah Path Katmandu

1. Sample No.
2. Name of PHC
3. categories
   - Staff Nurse
   - ANM
4. Course completion
   - TU
   - CTEVT
   - KU
   - BPKIHS
   - NMMS
5. Age
   - 20- 30 years
   - 31-40 years
   - >40 years
6. Job Experience
   - 1-5 years
   - 6- 10 years
   - 10 years
7. What is the safest method to postpone pregnancy?
   - Condoms / pills/ Depo
   - Surgeries/ IUCD
   - Safe Period (Natural Method)
   - Others
8. .How will you know that the baby is growing normally in the womb?
   - losing weight
   - experiences nausea and vomiting
   - Increase in size of abdomen and weigh
   - Others

9. What among the following conditions, mother requires immediate medical attention?
   - Epigastric pain
   - Sudden gush of fluids and blood per vagina
   - Muscle cramps
   - Others

10. How will you confirm that mother is pregnant?
    - When your partner miss her periods
    - Pregnancy test
    - complaint about nausea and vomiting
    - others , specify

11. When you have to take mother for first antenatal visit?
    - As soon as she knows she is pregnant
    - After 3 months
    - After 5 months
    - Others

12. How will you know that mother is in labour?
    - Low back pain and sudden gush of fluid
    - Abdominal pain
    - Orbital edema
    - Others

13. What is the normal birth weight of the new born baby?
    - 2 Kg
    - 2.5 Kg- 3 Kg
    - > Kg

14. When mother should give first breast feed to the baby?
    - After one day
    - Within half an hour
    - After 3 days

15. When mother can start taking normal food and fluids after delivery?
    - After one day
    - After 6 hours
    - When conditions of mother and baby stabilizes
    - Others, specify

16. What type of minor discomforts mother may experience after delivery?
    - Nausea and vomiting

- Episiotomy pain and backache
- Oral ulcer
- Others, Specify

17. Have you receive any safe motherhood training
    - Yes
    - No

18. Have you conduct more than 20 normal deliveries during in your student's period
    - Yes
    - No

19. If yes, who were your supervisors?
    - Teachers
    - Doctor
    - Hospital Staffs
    - Senior Students
    - Others, mention

20. Which are the institute you have practice in your students periods about maternal and child health care?
    - Materiality Hospitals
    - Children Hospital
    - PHC
    - Family Planning center
    - Others.

21. Have you taken history to the ANC mothers according to national protocol and guidelines
    - Yes
    - No

    If no, specify region

22. Have you perform Physical examination to the PNC mothers according to national protocol and guidelines
    - Yes
    - No

    If no, specify region

23. Do you provide Breast Feeding education to the mothers

- Yes
- No

If no, specify region

24. Do you provide Newborn care education to the mothers

- Yes
- No

If no, specify region

25. Do you provide health education to the mother about weaning

- Yes
- No

If no, specify region

26. Have you make routine observation according to the postnatal care protocol

- Yes
- No

If no, specify region

27. Have you provide hone visit services to PNC mothers

- Yes
- No

If no, specify region

28. If yes, who is responsible person

- Staff nurse
- ANM
- health workers
- TBA
- Others

29. What type of service include

- Health education
- New born care
- Family planning
- Others.

30. . Have you provide appropriate adolescent / youth services

- Yes
- No

- If no , specify region
- How will manage third stage labour
- Yes
- No

If no, specify region

31. . Have you manager sever bleeding during delivery period
- Yes
- No

If no, specify region

32. Do you know emergency contraceptive?

Yes

No

If, yes, which method you will preferred

33. Do you know major side effect IUCD
- Yes
- No

If, yes, specify the tree major point

34. have you given immunization to the children according to national protocol
- Yes
- No

35. Have you given Nutrition Education during ANC visit to the Mothers?
- Yes
- NO

36. Have you used IEC material during MCH visits
- Yes
- No

If, No specify