

CHAPTER: 14

ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH SERVICE AT 24X7 PHCS IN FOUR DISTRICT OF RAJASTHAN

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INTRODUCTION

In developing nations, especially in India, there is a prevalent and expanding need for primary healthcare. This need highlights the growing concern among policymakers and program administrators about comprehending how health systems can attain increased equity, inclusiveness, and impartiality [1]. The Alma-Ata declaration on primary healthcare in 1978 offered guidance for the establishment of efficient primary healthcare, particularly in member countries such as India [2]. Furthermore, the Bhore Committee in 1946 fervently recommended the adoption of the primary healthcare approach to guarantee effective and fair healthcare services in India [3]. Addressing various reproductive health concerns in India is crucial to improving the reproductive health status of the population. Reproductive health programs should prioritize enhancing access to quality reproductive health services provided by gender-sensitive healthcare providers. In India, there are 2-3 million people living with HIV, and up to 90% of these individuals are unaware of their HIV status [4].

RESEARCH QUESTIONS

According to IPHS guidelines, what was the provision of sexual and reproductive health services at 24x7 Primary Health Centers (PHCs) in HPDs and NHPDs of Rajasthan?

RESEARCH OBJECTIVES

1. To evaluate the accessibility of sexual and reproductive health services in 24x7 PHCs.
2. To pinpoint deficiencies in sexual and reproductive health services within 24x7 PHCs.
3. To compare the sexual and reproductive health services offered in 24x7 PHCs between High-Performing Districts (HPDs) and Non-High-Performing Districts (NHPDs).

RESEARCH METHODOLOGY

The study was characterized as a descriptive cross-sectional investigation with a duration of two months, focusing on 24x7 Primary Health Centers (PHCs) in specified districts. The high-priority districts, Rajsamand and Banswara, were distinguished from the non-high-priority districts, Baran and Pratapgarh. The selection criteria for these districts were based on the majority of the population residing in rural areas. The study respondents included medical officers, ANMs (Auxiliary Nurse Midwives), LHVs (Lady Health Visitors), pharmacists, and lab technicians. The sample size determination employed the Probability Proportion to Size (PPS) sampling technique, with a sample size set at 20% of the 24x7 PHCs in each selected district. The study involved 17 individuals from each category of medical officers, ANMs, LHVs, pharmacists, and lab technicians.

Data collection methods encompassed observation using a facility checklist developed according to IPHS guidelines, focusing on sexual and reproductive health services, infrastructure, personnel, equipment, and the availability of drugs and supplies at the health centers. Additionally, an interview schedule based on the same facility checklist was employed to gather information on human resources, infrastructure, equipment, drugs, supplies, and services related to sexual and reproductive health at 24x7 PHCs. The collected data was entered into SPSS to perform analysis, and accordingly, required tables and graphs were generated and interpreted.

RESULTS & DISCUSSION

Out of the seven selected 24x7 PHCs in non-high priority districts, four PHCs had a minimum of two medical officers, whereas three PHCs had only one medical officer. In the two high-priority districts, out of ten 24x7 PHCs, only one PHC had a minimum of two medical officers, whereas nine PHCs had only one medical officer. In non-high priority districts, only one PHC had a trained medical officer in both BemOC and RTI/STI, two PHCs had a trained MO in only one service, and four PHCs had no medical officer trained in both BemOC and RTI/STI. Out

of the ten 24x7 PHCs in high-priority districts, three PHCs had a trained medical officer in BemOC and RTI/STI, only one PHC had a trained MO in only one service, and six PHCs had no medical officer trained in both BemOC and RTI/STI.

Analysis regarding the manual removal of the placenta at 24x7 PHCs in non-high priority districts showed that out of the seven PHCs, at six PHCs, doctors or other nurse staff manually removed the placenta, whereas at one PHC, doctors or other nurse staff did not remove the placenta manually. In high-priority districts, eight PHCs out of ten PHCs manually removed the placenta, while at two PHCs, doctors or other nurse staff did not remove the placenta manually. After comparing high-priority districts with non-high-priority districts, gaps were found more in high-priority districts as compared to non-high-priority districts for the management of RTI/STI, tubectomy/vasectomy, internal examination for RTI/STI, and manual removal of the placenta.

CONCLUSION

The study findings indicated that for 24x7 Primary Health Centers (PHCs) to function effectively and deliver sexual and reproductive health services in rural areas, they needed to be adequately equipped according to the Indian Public Health Standards (IPHS). A significant contributing factor to the subpar quality of services provided to new mothers and infants, particularly in PHCs operating 24/7, was the shortage of dedicated human resources for sexual and reproductive health care. While the National Rural Health Mission (NRHM) made strides in enhancing critical infrastructure, more efforts were required. Essential infrastructure necessary for the efficient delivery of sexual and reproductive health services in rural areas needed further development. Moreover, challenges such as the limited availability of medications related to sexual and reproductive health and contraception had to be addressed by 24x7 PHCs. It was imperative to enhance the investigative services offered by PHCs around-the-clock. Furthermore, there was a lack of qualified staff for 24x7 PHCs' BEmOC, RTI/STI services, and MTP programs. These shortages necessitated both infrastructure improvement and adequate human resource support.

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