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Original Research Article

Postnatal Consultation According to Who Recommendations Has the Motherhood of Thereference Health Center of Kalaban Coro in Bamako (Mali)

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Abstract: The aim was to evaluate the postnatal consultation (CPON) according to WHO recommendations at the maternity ward of the Kalaban Coro reference health centre in Bamako (Mali). ***Material and Method*:** This was a cross-sectional study with prospective collection from May 21 to July 21, 2018, i.e. a period of 2 months. ***Results:*** In our study, we recorded a total of 440 deliveries who were seen in postnatal consultations. When this number is compared to the total number of deliveries, this gives a postnatal consultation completion rate of 56.4% (782). Of the 440 women, 390 performed all three recommended CPON (88.4%). Fifty (50) women gave birth performed only the first CPON while only 2 completed the first and second CPON. There were no significant differences between women receiving CPON based on medical and obstetric history The factors influencing the occurrence of neonatal death in this work were: adolescence (<20 years); the emergency reference, the existence of high blood pressure in the mother and premature delivery. Less than 5% of neonatal deaths were recorded during our study the number of women seen at the first, second and third postnatal visits were 440, 392 and 388 respectively. There was no association between antenatal consultation rank and the woman's age, education and occupation. Primigestity, the existence of high blood pressure during pregnancy and reference during labour were the three main factors associated with the occurrence of maternal complications after multivariate analysis.

Keywords: Postnatal consultation, WHO recommendations 2018, CSRéf Kalaban Coro.

INTRODUCTION

Each year, an estimated 289,000 women die worldwide due to complications related to pregnancy, childbirth or the postnatal period [1] and up to two-thirds of these maternal deaths occur after childbirth [2, 3]. Poor maternal and newborn care outcomes also include 2.9 million neonatal deaths per year [4]. Of the maternal and neonatal deaths that occur worldwide, 99% occur in low/middle-income countries [1, 5]. According to the World Health Organization (WHO), the postnatal period begins immediately after delivery and lasts six weeks [6]. In low-income countries, nearly 40% of women experience complications after childbirth and an estimated 15% develop life-threatening problems [7]. Postnatal care services are a fundamental component of the continuum of essential obstetric care, which also includes antenatal care and skilled delivery. Properly delivered, this care reduces maternal and neonatal morbidity and mortality in low/middle-income countries [8.9]. Compared to other maternal and child health services [10], postnatal care coverage tends to be relatively low. Increasing this coverage was identified as a priority [11]. In the Democratic Republic of the Congo,

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for example, at least 93% of pregnant women receive antenatal care and skilled attendance at delivery, but only 35% of women who give birth receive postnatal care [12]. In Kenya, less than 20% of women use postnatal care services [13]. In 2014, WHO recommended that a mother and her newborn receive postnatal care within 24 hours of birth, and then at least three more times, i.e. at least on the third day after birth, the second week after birth and six weeks after birth [14]. Postnatal care services can be defined as preventive care practices and assessments to identify and manage or refer complications for both mother and newborn. In general, these services include an integrated package of routine maternal and neonatal care as well as additional care for newborns who are considered particularly vulnerable because they are, for example, premature, have low birth weight, are small for their gestational age, or have mothers infected with the human immunodeficiency virus (HIV) [15].

Possible postnatal interventions for the mother include: (i) folic acid supplementation for at least three months; (ii) screening for and treatment of infections, hemorrhage, thromboembolism, postnatal depression and other abnormalities; (iii) prophylactic antibiotics given to women with third- or fourth-degree perineal tears; and (iv) counselling on early and exclusive breastfeeding, nutrition, birth spacing, and family planning options, including any available contraception [14, 16, 17]. Possible postnatal interventions for the newborn include: (i) umbilical cord care; (ii) special care for preterm, low birth weight and HIV-infected newborns [14, 15, 18]; (iii) screening and treatment of infections and postnatal growth restriction; (iv) assessment of predisposing factors for childhood anaemia [19]; (v) teach the mother to seek additional care for her newborn if she notices danger signs such as seizures or feeding problems [14]. Low utilization of postnatal care services is associated with lack of information, poverty and limited access to health care facilities [2]. However, these associations have not been systematically evaluated. In Mali, according to reports by the Directorate General of Health and Public Hygiene, the use of postnatal care services is still low. The same observation has been made by WHO in several developing countries, leading it to formulate recommendations for not only improving access to this care but also its quality [14, 20]. After the restitution / training of trainers workshop co-organized by WHO and the African Society of Gynecology – Obstetrics in 2018 in Abidjan, Mali quickly appropriated these recommendations during a workshop organized by the DGSHP. All regions of the country participated. The purpose of this work is to appreciate the added value of the implementation of these recommendations in our country on the one hand and on the other hand to contribute to improving the scarcity of work on postnatal care in our country despite their importance.

OBJECTIVES

The aim was to evaluate postnatal consultations according to WHO recommendations at the Kalaban Coro reference health centre. Determine maternal morbidity and mortality. To determine neonatal morbidity and mortality.

MATERIALS AND METHODS

The study took place in the maternity ward of the reference health center (CSRéf) of Kalaban coro which is a^{2nd} reference structure within the country's health pyramid. This center receives patients from the circle of Kati, the district of Bamako and those coming from the interior of the country.

Type of study: This was a cross-sectional study with prospective data collection at the Kalaban Coro Reference Health Centre.

Study Period: It took place over 2 months from May 21 to July 21, 2018 at the Kalaban coro CSRéf.

Study Population: The study involved all women who gave birth at the Kalaban Coro Reference Health Centre during the study period.

Sampling

Inclusion Criteria: Included: All patients who completed their postnatal follow-up in our department during our study period and who agreed to participate in the study.

Non-inclusion Criteria: Not included: All women who had delivered from the centre who refused to participate in the study. All deliveries at the centre who have not been actively searched.

Sampling Technique: This is a systematic recruitment of all patients who received postnatal surveillance in the gynecology and obstetrics department of the Kalaban Coro CSRèf during our study period and who agreed to participate in the survey.

The Process: After choosing the theme, we proceeded to the bibliographic search and then we developed a protocol that was validated by the thesis director. The observations were made with the greatest possible discretion and remaining totally passive. The survey sheets used made it possible to answer the questions quickly. Counselling and questions related to CPON were conducted prior to discharge from the maternity ward, after obtaining their consent.

The shadow of postnatal visits and timing: At least three additional postnatal visits are recommended for all mothers and newborns, on the third day (48-72 hours), between the 7th and 14th day and the sixth week after birth.

Data Collection: Data were collected using individual questionnaires.

Variables: BP, Postpartum complication, Period of maternal death, Cause of maternal death, Period of neonatal death, Cause of neonatal death.

Data Analysis and Processing: Data was entered into Excel spreadsheet software and analyzed with SPSS Version 20.0. For differences between qualitative variables, we used Pearson's khi^2 test. When the conditions for using the Khi² test were not met, we used the Yates continuity correction or the Fisher exact test wisely. For analyses of variance, we used the Kruskal – Wallis test. The odds ratio (OR) and its confidence interval were used to estimate the level of associated risk. The statistical significance threshold was set at 5%.

Ethical aspects: Data confidentiality has been guaranteed. The names of the patients do not appear on any document relating to the results of this study. Voluntary participation was a pious part of our study with the informed consent of all participants. The participation of women in the survey we conducted did not bring them any advantage or disadvantage. This work is purely scientific and concerns the evaluation of the quality of maternal follow-up in the postnatal period.

RESULTS

Epidemiological aspects

A total of 440 women were seen in postnatal consultations. When this number is compared to the total number of deliveries, this gives a postnatal consultation completion rate of 56.4% (782). Of the 440 women, 390 performed all three recommended CPON (88.4%). Fifty (50) women gave birth performed only the first CP O N while only 2 performed the first and second CPON. The number of women seen at the first, second and third postnatal consultations was 440, 392 and 388 respectively. There was no association between the rank of antenatal care and the woman's age, education and occupation (Table 8, p>0, 05). Moreover, for the vast majority of ethnic groups, the number of women seen at the first consultation was higher than the number received for the 2nd and 3rd consultations. These epidemiological aspects are summarized in Table 1 and Figure 1.

Clinical aspects

We observed a CPON utilization rate of 56.4%. Indeed, more than 8 women out of 10 seen at the second CPON completed the 4 CPON. Tables 2 and 3 summarize these clinical aspects.

Elements of maternal Growth

The frequency of complications was higher when deliveries were seen at all 3 CPONS, 30.6% (119/389) vs. 25% (13/52) when they had only one or two postnatal consultations. It appears that each of the CPON was the opportunity to diagnose a complication in 3 out of 10 women. Primigestity, the existence of high blood pressure during pregnancy and reference during labour were the three main factors associated with the occurrence of maternal complications after multivariate analysis. Adeath was recorded during our study. The rate of complications occurring ex utero for the newborn was less than 1% except for conjunctival pallor. Less than 5% of neonatal deaths were recorded. Factors influencing the occurrence of neonatal death in this work were: adolescence (<20 years); emergency referral, maternal hypertension, and preterm delivery. Elements of maternal prognosis are presented in Figures 2 & 3, Tables 4, 5, 6, 7.

Table 1: Epidemiological aspects

Variables	Postnatal consultation			
	1st consultation n (%)	2nd consultation n (%)	3rd consultation n (%)	p-value
Age				0,999
< 20	96 (21,8)	84 (21,4)	84 (21,7)	
20 – 29	292 (66,4)	260 (66,3)	257 (66,2)	
>= 35	52 (11,8)	48 (12,2)	47 (12,1)	
Educational attainment				0,997
Illiterate	293 (66,6)	255 (65,1)	253 (65,2)	
Primary	36 (8,2)	32 (8,2)	32 (8,3)	
Secondary	75 (17,1)	74 (18,9)	71 (18,3)	
Upper	36 (8,2)	31 (7,9)	32 (8,2)	
Occupation				1,000
Housewife	36 (8,2)	33 (8,4)	31 (8,0)	
Student	11 (2,5)	9 (2,3)	9 (2,3)	
Pupil	21 (4,8)	20 (5,1)	20 (5,2)	
Official	63 (14,3)	53 (13,5)	53 (13,7)	
Liberal	309 (70,2)	277 (70,7)	275 (70,9)	

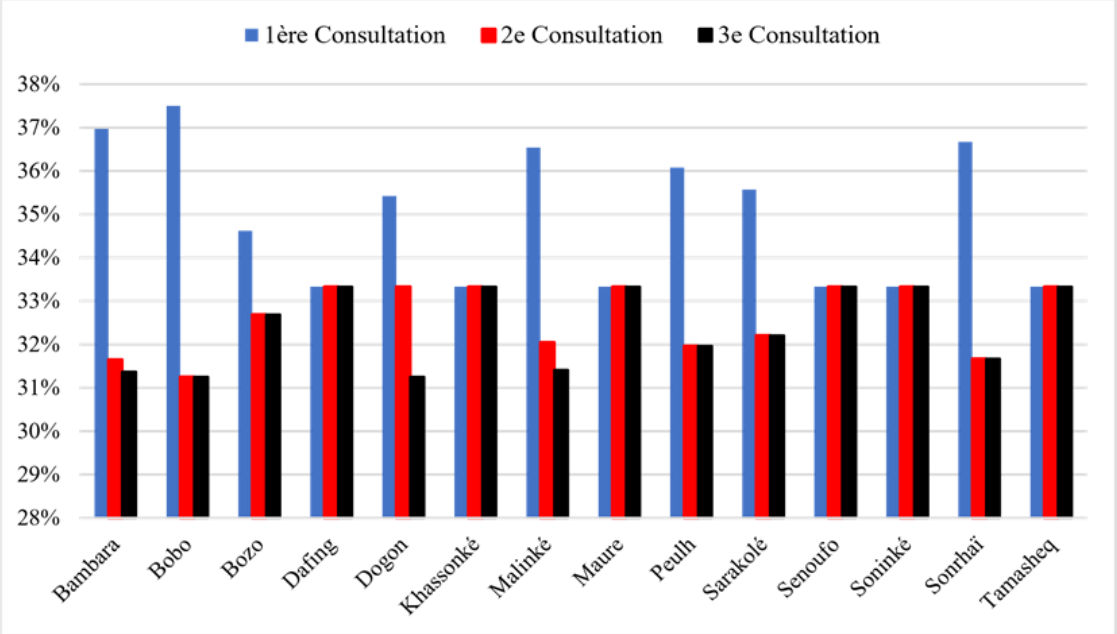

Figure 1: Distribution of women by ethnicity and rank of postnatal consultation

Table 2: Clinical aspects

Variables	Postnatal consultation			
	1st consultation n (%)	2nd consultation n (%)	3rd consultation n (%)	p-value
Medical history HIV positive				0,995
Yes	1 (0,2)	1 (0,3)	1 (0,3)	
No	439 (99,8)	391 (99,7)	387 (99,7)	
Positive HBS AG				0,968
Yes	4 (0,9)	3 (0,8)	3 (0,8)	
No	436 (99,1)	389 (99,2)	385 (99,2)	
Gestational diabetes				0,990
Yes	2 (0,5)	2 (0,5)	2 (0,5)	
No	438 (99,5)	390 (99,5)	386 (99,5)	
HTA				0,946
Yes	27 (6,1)	25 (6,4)	26 (6,7)	
No	413 (93,9)	367 (93,6)	362 (93,3)	
Gestrity				0,941
Primigeste	122 (27,7)	100 (25,5)	96 (24,7)	
Paucigeste	151 (34,3)	144 (36,7)	147 (37,9)	
Multi-gesture	125 (28,4)	109 (27,8)	110 (28,4)	
Great gesture	42 (9,6)	39 (10,0)	35 (9,0)	
Parity				0,968
Primiparous	170 (38,6)	142 (36,2)	140 (36,1)	
Paucipare	145 (32,9)	138 (35,2)	138 (35,6)	
Multiparous	101 (22,0)	88 (22,5)	90 (23,2)	
Large multiparous	24 (5,5)	24 (6,1)	20 (5,2)	
Multiple pregnancy				0.065
Yes	4 (0,9)	4 (1,0)	14 (1,0)	
No	436 (99,1)	388 (99,0)	384 (99,0)	
Cicatricial uterus				0,979
Yes	41 (9,3)	37 (9,4)	35 (9,2)	
No	399 (90,7)	355 (90,6)	353 (91,0)	
Method of admission				0,991
Referred	355 (80,7)	320 (81,6)	313 (80,7)	
Came by herself	85 (19,3)	72 (18,4)	75 (19,3)	
Mode of delivery				0,924
Instrumental	28 (6,4)	23 (5,9)	23 (5,9)	
Low track	370 (84,1)	333 (84,9)	326 (84,0)	
High track	42 (9,6)	36 (9,2)	39 (10,0)	

Table 3: The clinical aspects following the scene

	Postnatal consultation			
	1st consultation n (%)	**2nd consultation n (%)**	**3rd consultation n (%)**	**p-value**
Prenatal follow-up				0,997
Yes	419 (95,2)	373 (95,2)	369 (95,1)	
No	21 (4,7)	19 (4,8)	19 (4,9)	
Iron + Folic acid				0,811
Receipt	376 (85,5)	341 (87,0)	335 (86,3)	
Not received	64 (14,5)	51 (13,0)	53 (13,7)	
VAT				<.0001
Receipt	364 (82,7)	270 (68,9)	235 (60,6)	
Not received	76 (17,3)	122 (31,1)	153 (39,4)	
TPI				<.0001
1st dose	75 (17,1)	45 (11,5)	44 (26,8)	
2nd dose	114 (25,9)	77 (19,7)	73 (18,9)	
3rd dose	169 (38,4)	119 (30,4)	111 (28,7)	
No	82 (18,6)	150 (38,4)	159 (41,1)	

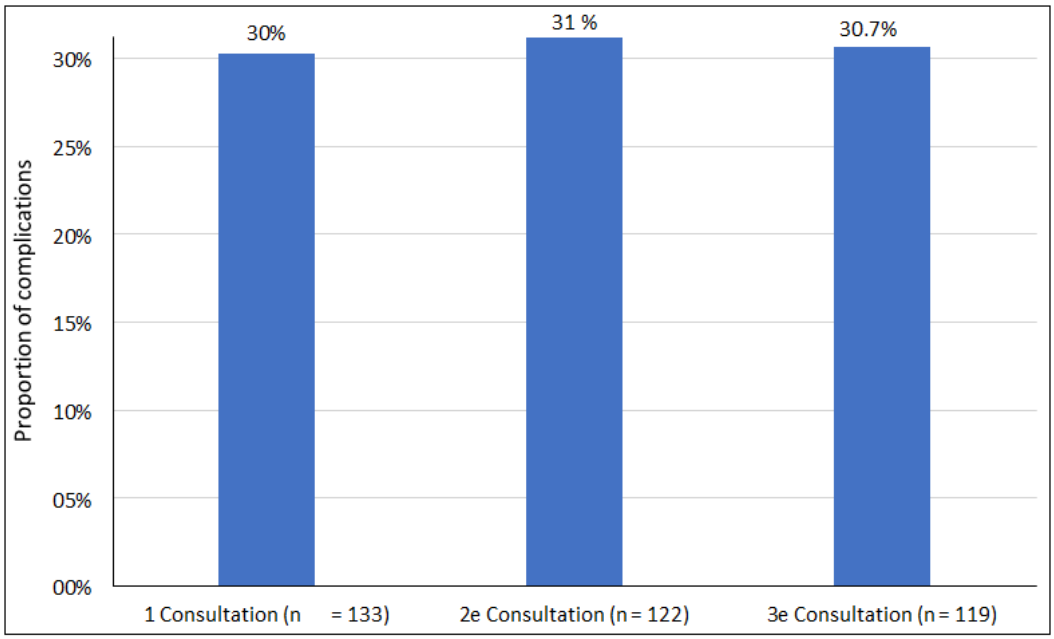

Figure 2: Frequency of maternal complications by postnatal consultation rank

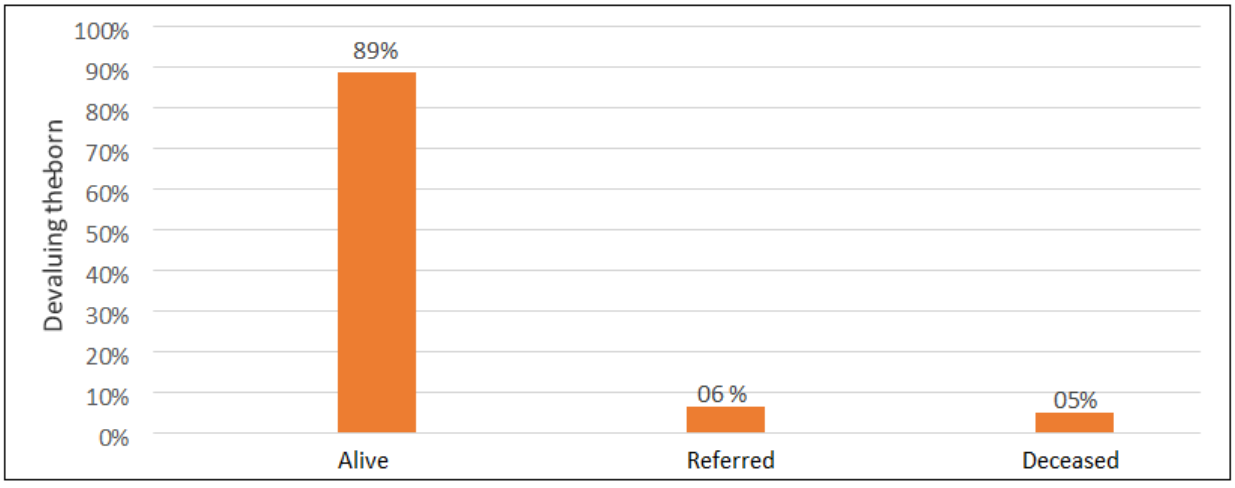

Figure 3: Newborn outcomes

Table 4: Major abnormalities in women with postnatal complications

Variables	Number of staff (n)	Percentage (%)
Anaemia		
Dizziness	85	22,7
Palpitation	3	0,8
Dyspnoea	3	0,8
Dizziness+Palpitation	271	72,5
Dizziness+palpitation+dyspnea	12	3,2
Perineal pain		
Yes	74	19,8
No	300	80,2
Postpartum hemorrhage		
Yes	6	1,6
No	368	98,4
urinary incontinence		
Yes	0	0
No	374	100
Thromboembolic disease		
Yes	0	0
No	374	100
Psychological problems		
Absence	286	76,5
Anxiety	54	14,4
Extreme fatigue	24	6,4
Anxiety and fatigue	10	2,7

Table 5: Univariate and multivariate analysis of factors influencing the occurrence of maternal complications in postnatal

	RAW GOLD [95% CI]	p-value	Ora [95% CI]	p-value
NPC		0,157		0,465
Yes	1,00		1,00	
No	1,47 [0,86 - 2,53]		1,24 [0,70 - 2,22	
Age		<.0001		0,049
< 20	**1,98 [1,48 - 2,65]**		1,42 [0,97 - 2,09]	
20 – 29	1,00		1,00	
>= 35	**1,59 [1,10 – 2,30]**		1,48 [0,97 - 1,20]	
Education		0,552		0,417
Illiterate	0,93 [0,72 - 1,19]		1,05 [0,93 - 1,20]	
At least primary	1,00		1,00	
Gestrity		<.0001		0,015
Primigeste	**2,17 [1,59 - 2,96]**		**1,75 [1,20 - 2,57]**	
Paucigeste	1,00		1,00	
Multi-gesture	1,08 [0,78 – 1,50]		1,01 [0,72 - 1,41]	
Great gesture	**1,80 [1,17 – 2,78]**		1,43 [0,87 - 2,36]	
Method of admission		0,002		0,010
Coming of herself	1,00		1,00	
Referred	**1,61 [1,19 – 2,17]**		**1,51 [1,11 - 2,07]**	
HTA		0,003		0,023
Yes	2,04 [1,28 – 3,24]		**1,79 [1,08 - 2,94]**	
No	1,00		1,00	

Table 6: Frequency of maternal deaths

	Postnatal consultation			
	1st consultation n (%)	**2nd consultation n (%)**	**3rd consultation n (%)**	
Living	433 (35,49)	389 (31,89)	387 (31,72)	
Deceased	1 (0,08)	1 (0,08)	0	
Referred	6 (0,49)	2 (0,16)	1 (0,08)	
Variables	**Postnatal consultation**			
	1st consultation n (%)	**2nd consultation n (%)**	**3rd consultation n (%)**	**p-value**
Birth defect				1,000
Yes	5 (1,1)	5 (1,3)	5 (1,3)	
No	435 (98,9)	387 (98,7)	383 (98,3)	
Prematurity				1,000
Yes	33 (7,5)	29 (7,4)	29 (7,5)	
No	407 (92,5)	363 (92,6)	359 (92,5)	
Conjunctiva				<.0001
blade	6 (1,4)	1 (0,3)	1 (0,3)	
average	37 (8,4)	3 (0,8)	2 (0,5)	
Colorful	397 (90,2)	388 (98,1)	385 (99,2)	
Dyspnoea				1,000
Yes	1 (0,2)	1 (0,3)	1 (0,3)	
No	439 (99,8)	391 (99,7)	387 (99,7)	
Neonatal herpes				0,639
Yes	0 (0)	1 (0,3)	0 (0)	
No	440 (100)	391 (99,7)	388 (100)	
Hypothermia				0,778
Yes	2 (0,5)	1 (0,3)	0 (0)	
No	438 (99,5)	391 (99,7)	388 (100)	
Neonatal jaundice				1,000
Yes	1 (0,2)	1 (0,3)	1 (0,3)	
No	439 (99,8)	391 (99,7)	387 (99,7)	
Birth trauma				1,000
Yes	2 (0,5)	1 (0,3)	1 (0,3)	
No	438 (99,5)	391 (99,7)	387 (99,7)	

Table 7: Factors influencing neonatal mortality

	RAW GOLD [95% CI]	**p-value**	**Ora [95% CI]**	**p-value**
NPC		0,951		0,416
Yes	1,00		1,00	
No	1,04 [0,32 - 3,42]		0,58 [0,16 - 2,15]	
Age		0,023		0,039
< 20	1,90 [1,04 - 3,47]		2.67 [1.14 - 6.25]	
20 – 29	1,00		1,00	
>= 35	2,31 [1,15 - 4,62]		1,77 [0,78 - 4,05]	
Education		0,866		0,724
Illiterate	1,05 [0,61 - 1,82]		0.90 [0.48 - 1.66]	
At least primary	1,00		1,00	
Gestrity		0,053		0,218
Primigeste	1,10 [0,55 - 2,20]		0,58 [0,25 - 1,37]	
Paucigeste	1,00		1,00	
Multi-gesture	0,94 [0,47 - 1,91]		0,87 [0,40 - 1,87]	
Great gesture	2,57 [1,21 - 5,46]		1,82 [0,70 - 4,69]	
Method of admission		0,000		0,002
Coming of herself	1,00		1,00	
Referred	2,83 [1,65 - 4,86]		2,50 [1,38 - 4,51]	
HTA		< 0.001		0,009
Yes	4,14 [2,10 - 8,18]		2,86 [1,30 - 6,31]	
No	1,00		1,00	
Prematurity		0,000		0,001
Yes	3,42 [1,75 - 6,70]		3,20 [1,57 - 6,51]	
No	1,00		1,00	

DISCUSSION

This study found that: (i) the rate of use of CPON was not optimal on the other hand the vast majority of women seen in CPON performed the three recommended CPON; (ii) adherence to the three postnatal consultations is an opportunity to diagnose more complications; (iii) primiestity, the existence of arterial hypertension during pregnancy and reference during labour were the three main factors associated with the occurrence of maternal complications after multivariate analysis; (iv) high blood pressure during pregnancy, reference during delivery and preterm birth are the three main contributors to neonatal complications. Finally, (v) the prenatal consultation was an opportunity to correct certain needs not covered during pregnancy, including tetanus vaccination and iron/folic acid intake as well as access to a contraceptive method. We observed a CPON utilization rate of 56.4%. This rate corroborates the results of the latest demographic and health survey. Indeed, according to the latest demographic and health survey, only 56% of women who had given birth in the previous two years had received postnatal care in the first 2 days after delivery, while 40% had received no antenatal care. These indicators were 54% and 42% for the newborn respectively [22]. Similar rates have been reported in Ethiopia where, according to a systematic review, the rate of CPON use varied between 6.3% and 66.8% depending on the place of residence [23]. It was the same in Tanzania [24]. Similarly, comparable rates of CPON were reported in a meta-analysis conducted in sub-Saharan Africa which reported a CPON attendance rate of 52.48% (52.33% – 52.63%) [25]. The rate of adherence to NPCs is very high. Indeed, more than 8 women out of 10 seen at the second CPON completed the 4 CPON. Lower completeness rates of all postnatal visits have been reported elsewhere with determinants including caesarean delivery, primiparity and high education [26]. The 4 recommended visits are planned as follows: the first day, the 3rd day, between the 7th and 14th and 6 weeks after delivery [21, 26]. This indicates the importance of communication in favour of the CPON and the availability of human resources. Indeed, a student was specifically involved in this activity as part of her thesis. In the periphery, in rural areas, insufficient human resources and geographical barriers are major obstacles to access to and provision of postnatal care. In Ethiopia, in a meta-analysis, the determinants of CPON use were: women's autonomy in decision-making, history of use of NPC services, a CPN number >2, and the realization of NPC by a trained officer [23]. In addition, strategies to include the provision of postnatal care on day 3 and day 7 to day 14 in the package of activities of community health workers have been introduced in other settings and have been successful [27]. These strategies can significantly improve access to antenatal care in Mali, where indicators are not optimal. The realization of the CPON was the opportunity to diagnose a complication in about one in three women. Rates of maternal or neonatal complications comparable to those found in this work have been observed elsewhere in Africa [28]. Since deaths occur in the postnatal period constitute a very important part of infant mortality, the promotion of postnatal consultation is undoubtedly a strategy for improving this indicator. Primigestity is significantly associated with the occurrence of postnatal maternal complications in our work. In the study by Elkhoudri N et al, on the other hand, a number of pregnancies greater than 3 is associated with the occurrence of postnatal complications [29]. If the exhaustion of the uterine muscle with the occurrence of postpartum hemorrhage has been supported by some authors to explain the link between the occurrence of maternal complications and multigestity [30], in the case of primigestity, the high frequency of preeclampsia and its severe complications including eclampsia and even postpartum hemorrhage can be evoked. Also, most of these primigestes are young adolescent girls in our context not prepared either physically or economically for pregnancy and childbirth. The association of high blood pressure and the often induced prematurity associated with it is widely documented in the literature as a source of neonatal complications. These complications are numerous and include respiratory distress, transient tachypnea of the newborn, and even neonatal death [31]. The not yet optimal frequency of NPC performance, irregular follow-up and poor quality of antenatal care are among the factors that darken the prognosis of pre-eclampsia in our context. The CPON is an opportunity to intervene to improve the health of the mother by often addressing certain unmet needs as is reflected in this work. Indeed, according to WHO, possible interventions include: (i) iron and folic acid supplementation for at least three months, (ii) screening and treatment of infection, hemorrhage, thromboembolism, postnatal depression and other diseases; (iii) prophylactic antibiotic therapy for women with^{3rd} or 4th degree tear; and (iv) and counseling on exclusive breastfeeding, nutrition, birth spacing, and family planning options, including the availability of contraception [16, 17]. Thus, the positive influence of postnatal consultation, in particular, communication messages for social change and behaviour change immediately after birth, and possibly reinforced at 3 months, have a positive influence on the contraceptive rate as well as the administration of vaccines to the mother [32]. In another trial in Burkina Faso and DRC Congo, favorable effects of postnatal intervention packages were observed on contraceptive use [33]. In addition, immunization programmes can protect the health of babies, not only by vaccinating newborns in the postnatal period but also by administering vaccines to the mother, since this also benefits the baby. Most vaccinations that target neonatal health, such as tetanus vaccination and rubella vaccination, are given to the mother. It is the tetanus vaccine that has the greatest impact, although other vaccinations given before pregnancy, such as rubella vaccination, also save lives and reduce rates of serious disease and disability [34]. However, to be able to discover all these needs, the practitioner must be very

tactful to help mothers during their journey during gravido-puerperium in general, and in the postnatal period in particular. It is this tact that will allow the mother's problems and worries to be openly explored and resolved. Tact "brings a spirit of care that is felt" which increases confidence and self-esteem. It allows the mother to emerge as herself, independently of professional care but with a promptness to seek help if necessary and at the appropriate time. Moreover, it is a fact that sustains the satisfaction of the work of the midwife and the nurse, who receive the gratitude of these brave women because of what they have done. Tact is the component that makes the difference and should not be overlooked. More than a word, it is a whole content, a concept that is felt in the confident and calm woman as well as in the smile of midwives and nurses [35].

CONCLUSION

Postnatal consultation is feasible in our context. Well organized, it is an opportunity to diagnose a large proportion of potentially dangerous complications for both the mother and the newborn whose management must be codified. It is also an opportunity not to be missed to meet the unmet needs for immunization of both the mother and the newborn, as well as the unmet need for contraception.

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