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ROLE OF ASHAs THROUGH HOME VISITS TO PREGNANT WOMEN IN UTTAR PRADESH, INDIA

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ABSTRACT

ASHAs were introduced in UP through NRHM in 2005, the first major task of ASHAs was to focus on maternal and child health through roll out of *Janani Surakya Yojana (JSK)* (Maternal Protection Scheme) to reduce Maternal Mortality Ratio and Infant Mortality Rate in the state of UP. Their primary activity was to visit homes of pregnant women. The first program in UP operated through the ASHAs was the Comprehensive Child Survival Program in 2008. Since then, tracking of all pregnancies to decipher messages on ANC and birth planning is an integral part of the work of ASHAs across the state of UP. The current study explores variables like home visits by ASHAs to one of the categories of deliveries. The two categories are the home deliveries and institutional deliveries. The safe delivery messages given by ASHAs to the category of pregnant women opting for safe deliveries are seen through to elicit any deviation, difference or focus by ASHAs in this category in four districts of UP. Further, the study sees the percentage of the ASHAs that give messages on safe delivery like on birth planning related activities that includes like identification of a clean place of delivery at home, identification of a skilled birth attendant, save money for emergency, arranging for transport and arranging for a disposable delivery kit. The pregnant women visited by each of the ASHAs in the 4 districts in their catchment area primarily gave the message for identification of a clean place for delivery. Among other messages, the messages on identification of a skilled birth attendant was the next priority. Next prioritized messages were arranging for the delivery kit followed by arranging money for emergency and transport. Few ASHAs had not given any message at all. This reflected that the focus on safe delivery messages were neither prioritized nor covered by all the ASHAs.

KEYWORDS: JSY, NHP, CCSP, NHSRC, NSSK, Birth Plan, SBR, JSSK.

INTRODUCTION

The current study focused on the role and performance of ASHAs (Accredited Social Health Activist) regarding safe messages to pregnant women opting for home deliveries. It also dealt with the birth planning messages that ASHAs give to pregnant women. These activities were done by the ASHAs in the last 3 months preceding the survey. The visits are critical as they help to prepare the family and pregnant women for the delivery to get a healthy child. The study also analyzed the type of messages received by pregnant women visited by the ASHAs in the reference period.

In UP, the ASHAs came on board on the premise of providing newborn care through the introduction of NRHM where the roll out of JSY was the top most priority (GO UP, 2005-06). At the same time in 2007, GO UP rolled out the CCSP program based on the HBNC guidelines of GOI (GO UP, 2007). Various stakeholders like the *Vistaar* (in detail) project and UNICEF assisted the Government of UP to roll out the CCSP (*Vistaar* project, 2012). The current study focused on the visits to pregnant women opting for home deliveries through the roles and performances of ASHAs.

The National Health Policy (NHP) mentioned about the role of ASHAs in prevention and management of communicable diseases and in maternal and child health. The document mentioned that it will continue to be an important focus in the role of ASHAs (GOI, 2017). Birth planning related activities came under the domain of maternal and child health and it is apt that the current study focuses to analyze the role of ASHAs in this area.

Another study by National Health System Resource Centre (NHSRC) on evaluation of performance of ASHAs suggested optimization of ASHA's functionality and effectiveness. It highlighted low performance in areas of newborn care, postnatal care, antenatal care and nutrition by ASHAs due to lack of skills and support

(NHSRC, 2011). The current study also focuses on these areas to see the performance of ASHAs for the most vulnerable section of pregnant women who opted for home deliveries. In other studies, it is cited that evaluations of CHW performance in 1998, 1999 and 2000 in Siaya, Kenya (Kelly et. al, 2001) found that key reasons for the deficiencies in performance appeared to be guideline complexity and inadequate clinical supervision.

The current and past Still Birth Rate of India tells us that in 2017, 15.8 children and in 2011, 22 children per 1000 live births did not see the world at all (S. Cousens et. al, Lancet, 2011 and Lancet, 2017). Still births are a further critical issue in case of home deliveries. However, it is a matter of maternal care which the current study analyzed through the safe delivery message tracking for home deliveries. The current Maternal Mortality Ratio in UP is 201 where as it is 130 for India (SRS, 2019).

The maternal health is critical for home based newborn care as a healthy mother is essential to provide essential newborn care. Besides JSY, other programs that were in the domain of maternal health but also addressed the newborn care component were the *Janani Shishu Surakya Karyakram (JSSK)* (Mother and Child Protection Program), *Navjat Shishu Surakya Karyakram (NSSK)* (Newborn Child Protection Program) and Maternal Death Review (MDR) (GOUP, PIP, NHM, 2016-17). As per the NHM PIP of GOUP, the *JSSK* program encourages the mother and child to stay in the hospital till 2 days after delivery thereby addressing the warmth component and the breastfeeding component of the new-born. The *NSSK* training helps the ANMs and doctors to train ASHAs in identifying danger signs in new-borns and their immediate referral to a public health facility. The MDR addressed the efforts to know the cause of death of the mother to prevent further maternal deaths. Lesser the number of maternal deaths, lesser will be the number of neonatal deaths.

However, in-spite of all these efforts, home deliveries continue to take place in the state of UP. The relevance of the study assumes significance as data on the details of targeted messages on safe deliveries done by ASHAs through home visits are never discussed in detail and further there is no comparison to their performance visa vis the inputs they received through training on various modules as part of their capacity building initiatives. Further it is significant to note that home deliveries are the high-risk deliveries. The significance is relevant as home deliveries continue to take place in UP in-spite of the enormous focus on the Janani Surakhya Yojana that focuses to increase institutional deliveries.

Background of ASHAs

The ASHAs emerged in India's public health system during the launch of NRHM in 2005 in the state of Uttar Pradesh (GOI, 2005). The ASHAs were in fact inducted to NRHM with the primary aim to roll out the JSY component of NRHM (GOI, 2005).

The study is regarding home deliveries. JSY was launched in 2005 to increase institutional deliveries. After three years, the percentage of home deliveries in UP was 74.5(DLHS 3, 2008). Thereafter, the percentage was 42.1 in 2012-13 (AHS, 2013). However, as per another study, the percentage was 26.5 (HMIS, NHSRC, 2012). As per NFHS 4, the percentage of home deliveries was 32.2. Similarly, home delivery by Skilled Birth Attendant (SBA) in UP was 5.5% in 2008 (DLHS 3, 2008). Further, home delivery by SBA was 28.9% in UP in 2012-13. Home deliveries both by SBA and non-SBA was 26.5% in UP (NHSRC, 2012). In 2019, the database tracking the third goal of the SDG for India shows that 81.4% deliveries are attended by SBAs. This clearly shows that there is progress in making home deliveries safe (WHO, UNICEF, 2019).

A study on evaluation of ASHAs in 2013 in UP reflects that 98.9% of ASHAs provided ANC to pregnant women. As per ASHAs, 96% assisted in birth plan, 99.3% supported for institutional delivery, 98.5% for immunization during pregnancy, 94.8% for clean items for delivery and 98% for selection of health centers for delivery. The study only focused on the number of visits to newborns by ASHAs but not on the newborn care messages provided by ASHAs (GOUP, Vimarsh, 2013). The current study dealt with these messages specifically in the 4 districts of UP.

The performance of ASHAs in UP was also done in another study involving states of Bihar, Chattisgarh, Rajasthan and Uttar Pradesh in 2011. As per the study, each ASHA spent 13 hours per week for ANC activities. Regarding ANC the study reveals that 42% of pregnant women were followed up by ASHAs for ANC. Under awareness creation, the study mentions that all the ASHAs in UP counselled women on birth preparedness and created awareness on newborn care. Only 62% of ASHAs replied that their training on newborn care was optimum. The study does not focus exclusively on messages on ANC and newborn care for home deliveries (Bajpai N, 2011). The current study reflects on the actual primary data collected from the ASHAs related to those pregnant women opting for home deliveries.

The above two studies do not reflect on the performance of ASHAs with respect to their messages on ANC and birth plan for home deliveries. The current study has the percentage for each of the safe delivery message variables used in the study. This study done in 2017 examines the profile of safe delivery messages given to pregnant women visited by ASHAs in their coverage area. The reference period of the study was 3 months preceding the survey.

Research Methodology

Using purposive sampling technique, four districts were chosen from the four different economic regions of UP, namely Central, Eastern, Western and Bundelkhand. Further, the Government of UP in 2009 categorized the districts as per their development status using a composition of 36 indicators. Purposefully, the high developed district chosen for the study is Saharanpur from the western region, the medium developed district chosen for the study is Barabanki from the central region, the low developed district chosen for the study is Gonda from the eastern region and the very low developed district chosen for the study is Banda from the Bundelkhand region (GOUP, 2009).

In the next step, purposefully two blocks were selected from each of the district and all the ASHAs in these blocks were chosen as the universe for the study. In the first stage of sampling, 31 ASHAs were selected from seven of these blocks and 33 ASHAs from one block using power sample method with the total number of ASHAs of each block. The number of ASHAs in each of the 8 selected blocks ranged from 100 to 200. The power sample method suggested that 28 ASHAs from each block constitute an adequate number for sampling. However, in order to have a desired number of 250 ASHAs, 31 ASHAs were selected from seven blocks and 33 were selected from one block.

In the next stage, 'Simple Random Sampling' method was used to select this desired number of 31 ASHAs from seven blocks and 33 ASHAs from one block using the list of all the ASHAs of each of these blocks.

Data Analysis

The data was analyzed using SPSS software to calculate the percentage of ASHA for each type of safe delivery message given to pregnant women. It also deciphered the type of messages given by ASHAs on ANC and birth planning as per the data in the four study districts. The quantitative data related to the details of home visits to pregnant women was seen against the prescribed guidelines for ASHAs by GOI regarding achieving targets for these activities in their coverage areas. The reference period of the study was 3 months preceding the survey. The study also deciphered the percentage of home deliveries in each of the districts as told by the ASHAs during their interview.

Research Tool

The ASHAs were interviewed using an in-depth, open-ended interview schedule which included a section on variables on work done by ASHAs through home visits to pregnant women opting for home deliveries. During these visits, the tool explored about the safe delivery messages that ASHAs gave on ANC and birth planning. All these questions were under the section of home visit of the tool. These activities were also seen against the basic messages that the ASHAs should have given based on the training that they had received on these issues. The safe delivery messages given to pregnant women opting for home deliveries by ASHAs during their home visits to the houses of pregnant women were seen in the last 3 months preceding the survey.

RESULTS AND DISCUSSIONS

This section has two tables where the first table deals with the percentage of deliveries as replied by ASHAS and the second one deals with the safe delivery messages given by ASHAs to the pregnant women who opted for home deliveries in their catchment areas.

Table 1: Percentage of home deliveries as told by the ashas in the last 3 months preceding the survey.

Names of the districts (total number of ASHAs= 250)	Banda (n=62)	Barabanki (n=62)	Gonda (N=64)	Saharanpur (n=62)
Percentage of home deliveries as replied by ASHAs	9	9.5	20.7	8.4

When the ASHAs were interviewed about the home deliveries that were conducted in their catchment area in the last three months preceding the survey, we find that almost one fifth of all deliveries in Gonda district are conducted at home while it is about 10% in Barabanki district. Banda district also comes close to Barabanki district. The only district where the home deliveries were the lowest among the four districts is Saharanpur.

However, it is to be noted that these are figures as told by ASHAs while they recollected the number of deliveries but all of them could not show their record keeping of these deliveries.

Table 2: Percentage of ASHAs delivering safe delivery messages to pregnant women who opted for home delivery.

Names of districts (n=250)	Banda (n=62)	Barabanki (n=62)	Gonda (n=64)	Saharanpur (n=62)
Identify a clean place for delivery at home	58	87	87.5	100
Identify a skilled birth attendant	75.8	35.4	39	90.3
Arrange for disposable delivery kit	66	67.7	46.8	90.6
Arrange transport for emergency	19.3	38.7	17	90.3
Save money for emergency	35.4	67.7	56.2	98.3
None	0.0	0.0	3	1.6

Among all the deliveries, the high-risk ones were the home deliveries. This table dealt with the messages that the ASHA gave to those pregnant women who had opted for home deliveries. Only 58% of ASHAs in Banda district told the pregnant women to identify a clean place for home delivery. This message was given by all the ASHAs in Saharanpur where as 87% of ASHAs gave this message in Barabanki and Gonda districts. The message regarding identification of a skilled birth attendant was given by 35% of ASHAs in Barabanki district and 39% in Gonda district in comparison to 76% and 90% in Banda and Saharanpur districts. Only 47% of ASHAs in Gonda gave the message of arranging for a disposable delivery kit whereas just about 70% of ASHAs gave this information in Banda and Barabanki districts while Saharanpur had 90% of ASHAs giving this message. The message of arranging transport for emergency was given by only 17% and 20% of ASHAs in Gonda and Banda districts respectively. In Barabanki 39% of ASHAs gave this message whereas Saharanpur had more than 90% of ASHAs giving this message. The other aspect of saving money in emergency was only given by 35% of ASHAs in Banda and 56% of ASHAs in Gonda but about 68% gave this message in Barabanki and 98% in Saharanpur. There were 3% of ASHAs in Gonda and about 2% in Saharanpur who replied that they had given no such messages on safe delivery to any pregnant women opting for home delivery.

CONCLUSIONS

The above results showed that the type of safe delivery messages by ASHAs through their home visits to the houses of pregnant women in the catchment area who opted for home deliveries shows a mixed response. This was seen across the districts which are hardly adequate. The major problem is that the ASHAs do not compare their performance regarding the prioritization of type of safe delivery messages for home deliveries. The home visits to those women who opts for home deliveries are not planned in advance. As all the messages are not prioritized by ASHAs as per the trimester of pregnancies of pregnant women, tracking by ASHAs and their supervisors become difficult. The challenge lies in orientating ASHAs on following up all these home visits with the support of Sanginis (supervisors of ASHAs in UP) and that too it should be preferably an onsite orientation i.e. during the home visits while accompanying the ASHAs. Data regarding calculating the targets for visits to houses of pregnant women for both home and institutional deliveries including the type of safe delivery messages to be given should be worked out at the level of ASHAs so that performance is tracked regularly.

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