National Journal of Multidisciplinary Research and Development
ISSN: 2455-9040; Impact Factor: RJIF 5.22
Received: 05-02-2020; Accepted: 06-03-2020; Published: 10-06-2020
www.nationaljournals.com
Volume 5; Issue 2; 2020; Page No 03-07

State and district level stakeholder's perspective on home based newborn care program in Uttar Pradesh, India

Tridibesh Tripathy[1], Umakant Prusty[2], Chintamani Nayak[3], Rakesh Dwivedi[4], Mohini Gautam[5]

[1] BHMS (Utkal University, Bhubaneswar), MD (BFUHS, Faridkot), MHA (TISS, Mumbai), Ph.D. in Health Systems Studies (TISS), Mumbai, Maharashtra, India

[2] Research officer (Homoeopathy), Regional Research Institute (Homoeopathy), Puri, Odisha under Central Council for Research in Homoeopathy, Ministry of AYUSH, Government of India, Odisha, India

[3] Assistant Professor, National Institute of Homoeopathy, Kolkata, West Bengal, Government of India, Kolkata, West Bengal, India

[4] Associate Professor, Centre for Advanced Studies in Social Work, Department of Social Work, Lucknow University, Lucknow, Uttar Pradesh, India

[5]Assistant Professor, Centre for Advanced Studies in Social Work, Department of Social Work, Lucknow University, Lucknow, Uttar Pradesh, India

Abstract

When ASHAs were introduced in NRHM in 2005, their primary aim was to visit homes of newborns as the first program in UP operated through the ASHAs was the Comprehensive Child Survival Program in 2008. Since then, tracking of all deliveries and all the newborns are an integral part of the work of ASHAs in all the primary health care programs operated by the NHM in UP (GOI, 2005, GOUP, 2013). The current article examines the role, work & approach of ASHAs through the feedback of the program managers at district & state level. Evaluation studies on the performance of ASHAs was done since 2011 as by then ASHAs had actually worked in the field for a minimum period of 5 years. It is to be noted that National Rural Health Mission was rolled out in April 2005 but it took about one to two years for the states to hire ASHAs and put things in place right from the state to the village level (GOUP, 2013). In this article, a comprehensive feedback is elicited from the program managers of newborn care program at the district & state level.

The current study explores some of the crucial variables on the performance of ASHAs through the feedback of program mangers on the role of ASHAs in newborn & child health programs followed by their role in Home Based Newborn Care program. The article also includes the feedback of the program mangers on the work & approach of ASHAs. That's how the perception of the program managers in the state of UP is included in this article. The program managers responded about the performance of ASHAs based upon their experience in the work by ASHAs on Janani Surakhya Yojana (JSY), New Born Care (NBC) & Routine Immunization (RI) as these are the frontline programs for the states. They were selected as respondents as they were the nodal persons for rolling out newborn care related programs.

The relevance of the study assumes significance as data on the details of the program awareness of managers on child health & newborn are not included in many surveys. Further, feedback details on the health personnel's performance is usually not collected from the nodal officers looking after the programs at district & state level. Such responses that collect feedback on the work & approach of ASHAs including the awareness of the program managers are not the focus in very large-scale health surveys. Such feedback on work & approach of ASHAs including the opinion & knowledge of program managers about the current implemented programs come under the ambit of social audits. The audits gain more teeth when the feedback is solicited from the people who manage the programs.

It is important to note that social audit is an integral part of the National Health Mission document but it is not a priority activity of NHM. Usually, the responses, knowledge of trained health personnel are assessed in many studies while neglecting the response & perception of the program managers of the public health system. Here in this article, the managers talk about their own knowledge about the current programs, give feedback on the work & approach of ASHAs including the performance of ASHAs in the child health & newborn care programs. Here also it is seen that usually in social audits, the trained health personnel become the respondents as part of evaluation of their timely actions in many other studies. The uniqueness of the current study is that those who manage the programs are the respondents. These managers become the pivot around which the contents of the current article revolve.

A total of four districts of Uttar Pradesh were selected purposively for the study and the data collection was conducted among the program managers in the respective districts & the state with the help of a pre-tested structured interview guide with only open-ended questions. These in-depth interview guide collected descriptive details as responded by managers. The qualitative data were conducted amongst the managers and a total of 5 respondents participated in the study.

The results reflected that among the operational programs, it was surprising to note that none of the policy makers in the four districts mentioned about the Facility Based Newborn Care programs. The state level manager gave the details about the child health & newborn care programs but hinted that Home-Based Newborn Care (HBNC) was recently at the forefront because of the emphasis on setting up Kangaroo Mother Care (KMC) centers at selected public health facilities.

The knowledge of policy makers about the role of ASHAs in the roll out of newborn related program was poor across all the districts except the state level. Further, it was imperative that the management of program related information was not at all the priority of the program managers. The results also showed that regular monitoring was not at all a priority area for the program managers. However, the state level program manager could note the opportunity and challenges. Except Banda district, none of the program managers thought that assigning specific responsibility was an important area to develop the program. The state level program manager did not think geographic issues as a forefront issue.
Regarding the work & approach of ASHAs, the program managers agreed that the ASHAs lacked the intrinsic qualities. The state level program manager opined that application, self-confidence and referral were done poorly by ASHAs.

Keywords: ASHA, JSY, JSSK, FBNC, HBNC

Introduction

The current study focused on the responses of program managers of four selected districts & state level. Feedback of the mangers were on their current knowledge about the operational programs on child health, newborn care program, work & approach of ASHAs. The responses included the challenges & opportunities that they face and their future plans to strengthen the HBNC program in future. The responses included two discussions on the role of ASHAs in the new-born care programs. Hence, it is prudent to mention about studies that mention about performance of ASHAs in newborn care in UP.
The research tool or the interview guide included feedback from the managers of the programs at district & state level community on the role, work & approach of ASHAs. It also included their knowledge on the current programs, challenges & opportunities they face in roll out of the program and the plans in future to strengthen the programs.

ASHA & HBNC program in UP

The ASHAs emerged in India's public health system during the launch of NRHM in 2005 in the state of Uttar Pradesh (GOI, 2005) [1]. The ASHAs were in fact inducted to NRHM with the primary aim to roll out the JSY component of NRHM to increase the institutional deliveries (GOI, 2005) [1]. The selection of 500 RDWs was dependent on the catchment area of 250 ASHAs as two RDWs were selected from each of the selected ASHA's area. Besides these, 5 mothers of SC community were selected as respondents for the study to give a qualitative perspective to the study. There were 20 mothers of SC community for the study and their responses were also elicited. Further, from each of the selected districts, one program manager looking after the newborn care program and the state level program manager were selected as respondents. The responses of these 5 program managers is the content of this article in the results & discussion section.
The current article dealt on ASHAs & newborn care program. A study done in 2014 in UP demonstrated that ASHAs did not follow Home Based New Born Care formats & skipped critical signs (Das E, 2014) [5]. Another study in UP mentions that need of training to ASHAs was expressed by almost all the District Nodal Officers (DNO) & Block Nodal Officer (BNO) (Deoki N, *et al*. 2008) [6]. The study had a sample of 4 DNOs & 12 BNOs.
The evaluation report of ASHAs in 2013 informs that as responded by ASHAs that they visited 38.3% of newborns 6 to 7 times (GOUP, 2013) [4]. Further, the Comprehensive Child Survival Program evaluation report mentions that as per the Eligible Women (EW), 43.8% of them were visited by ASHA once in a month for their neonates. The report adds that 26.7% of EW reported that ASHAs visited mothers & newborn more than 5 times. To add to that, 58.4% of EW told that ASHA provided Kangaroo Mother Care (KMC) to them & their neonates (CCSP report, 2013).
Here, it is noted that among the above-mentioned studies, only the feedback & performance of ASHAs were focused primarily except one where the BNOs & DNOs were involved. This shows that feedback from the program managers are scarce to find in many studies. The current article focuses upon the feedback from the program managers on ASHAs. The reasoning further substantiates the importance of the current article.

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) [2].
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. From the list of all the ASHAs in each of the two blocks, 31 ASHAs were chosen randomly from each block for the study. In this way, 62 ASHAs were chosen for the study from each of the districts. In Gonda district, 64 ASHAs were selected to make the total number of ASHAs for the study to 250. From the catchment area of each ASHA, two Recently Delivered Women (RDW) were chosen who had a child in the age group of 3-6 months during the time of the data collection for the study. In this way, 124 RDWs from three districts and 128 RDWs from Gonda district were chosen thus a total of 500 RDWs were selected for the study. In order to include the category of caste & inclusion issue in to the domain of the study, 5 Scheduled Caste (SC) mothers from each district were selected from the existing list of ASHAs. As each district has two selected blocks, three mothers were selected randomly from one block & the other two from the other block. The existing list of Recently Delivered Women (RDW) available with the ASHAs at the time of the survey was the universe for selecting the respondents. In this way, a total of 20 SC mothers were selected from the study. The criteria for choosing these mothers were that they had a 3 to 6 months old baby at the time of survey to fulfill the inclusion criteria of being an RDW for the current study or article.
The current article deals with the last stage of the sampling. In the last stage, the four program managers looking after the program at the four selected districts and the state level manager were selected as respondents to include the perspective of the personnel of the public health system. In this way, 5 managers were selected in the study & the current

article deals with the responses of these 5 program managers. The following figure shows the four districts of UP in the map of the state of UP.

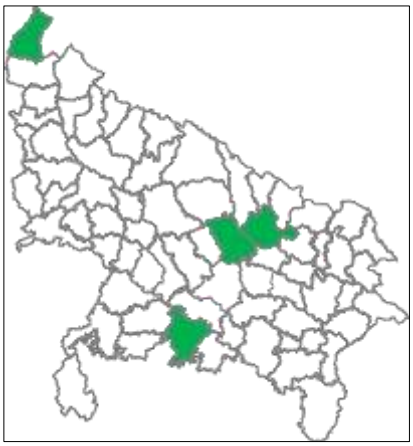

Fig 1

Data analysis

The data was analyzed using SPSS software to calculate the number of responses for each of the responses. The qualitative data related to the details of all these type of responses forms the basis of the results & discussions section of this article. The reference period of these responses was their entire programmatic experience & contacts with the ASHAs since the ASHAs were put in place with the introduction of National Rural Health Mission (NRHM). These managers were selected as respondents of the current study or article. Five program managers were selected where four were from the 4 selected districts of UP & one from the state.

Research tool

The program managers were interviewed using an open-ended interview guide which included six open ended questions. The article deals with these six questions of the guide. The response of the managers was the detailed description of their experiences with ASHA since their inception in UP. These descriptions included the programs currently operational at the district or state level on child health & new-born. The second question was the role of ASHAs in newborn care programs. The third question was on the role of ASHAs in Home Based Newborn Care (HBNC) programs. Following that the interview guide dealt on the opportunities & challenges the managers see or face in the program roll out. The last discussion point was on the approach & work of ASHAs as a community worker. All these aspects were seen in the context of the entire experience & contacts of the ASHAs through the feedback from the blocks for the district level managers & feedback from the district for the state level managers. Five interview guides were used for the study to interview 4 managers at the four districts and one at the state level. The following section details out the results and discussions related to the study.

Results and discussions

There are six tables in this section with multiple indicators and the tables are in sequence. It starts with the response of the program managers about the programs that are operational regarding child health & newborns. Thereafter the discussion revolves around newborn care programs & the various roles of ASHAs in the newborn care program followed by the role of ASHAs in Home Based Newborn Care programs.

The next table is on the responses regarding the opportunities & challenges in the roll out of the programs followed by the responses on the future plans to strengthen the program. The last table is on the responses related to the work & approach of ASHA as a community worker.

Table 1: Responses of program managers at district and state level

Number of policy makers (n=5)	Banda (n=1)	Barabanki (n=1)	Gonda (n=1)	Saharanpur (n=1)	State level (n=1)
Operational programs on child health and newborns					
HBNC	1	1	1	1	1
FBNC	0	0	0	0	1
CDMP, pneumonia, RI	0	Only CDMP	1	Only RI	1
RBSK	1	1	0	1	1

The first question was on the current operational programs on child health and the newborn programs in detail. Among the operational programs, it was surprising to note that none of the managers in the four districts mentioned about the FBNC programs. However, besides the above list given in the table, the policy maker at Saharanpur mentioned about the Mission Indradhanush campaign, deworming campaign. He also mentioned that HBNC was a package of IMNCI program. He also linked JSSK to child health although primarily it comes under maternal health. The policy maker at Banda mentioned about IAPPD and the BSPM campaign in UP which aims at Vitamin A supplementation every 6 months. He also linked the SBA training to the child health intervention. He also emphasized to activate the quality control cell and need for a separate cell for training.

The manager at Barabanki mentioned about the modular training to ASHAs and supply of drug kits to ASHAs. The manager at Gonda mentioned about the critical role of DCPM in monitoring the program and that both monitoring and reporting were the issues to be addressed.

The state level program manager gave the details about the program but hinted that HBNC was recently at the forefront because of the emphasis on setting up KMC centers at selected public health facilities.

Table 2: Role of ASHAs in newborn programs

Home visits & names of districts	Banda (N=1)	Barabanki (N=1)	Gonda (N=1)	Saharanpur (N=1)	State (N=1)
Register newborn, mother and do home visits	0	1	1	1	1
Avail JSY and JSSK benefits	0	1	1	0	1
Prepare for birth preparedness for institutional delivery	1	1	1	1	1

Prepare for birth preparedness for home deliveries	0	0	1	0	1
Treat and refer the newborn in case of danger sign	0	1	0	0	1

The manager at Banda could not mention the basic activities of ASHA. Except for Gonda and the state level, the manager did not mention the role of ASHAs in home deliveries as they perceived that all deliveries were now institutional deliveries. This showed that the knowledge of managers about the role of ASHAs in the roll out of newborn related program was poor.

Table 3: Role of ASHAs in HBNC programs

Register newborn & names of districts	Banda (N=1)	Barabanki (N=1)	Gonda (N=1)	Saharanpur (N=1)	State level (N=1)
Home visits (BF, wrapping, delay bathing, cord care)	1	0	1	1	1
Fill HBNC checklist and VHIR	0	0	1	0	1
Follow up at household level	0	0	1	1	1
Treat and refer the newborn in case of danger sign	0	1	0	0	1
Maternal nutrition	0	0	0	0	0

None of the managers talked about the component of maternal nutrition as a role of ASHA in HBNC program. Except the policy maker at Gonda district, none of them talked about the HBNC checklist and the VHIR to be filled by ASHA. Only one of them in Barabanki district mentioned about treatment and referral in spite of the fact that provision of drug kit was an integral component of ASHA. Only Gonda and Saharanpur mentioned about follow up at household level. None of them mentioned about the critical components of HBNC. It was imperative that the management of program related information was not at all the priority of the managers.

Table 4: Opportunities and challenges in program roll out

Total number of stakeholders (N=5) & names of districts	Banda (N=1)	Barabanki (N=1)	Gonda (N=1)	Saharanpur (N=1)	State level (N=1)
Meetings at PHC level	1	1	1	1	1
Cluster meetings	1	1	1	0	1
Handholding of ASHAs	0	1	1	1	1
Reinforcement of training	0	1	1	0	1
Incentives	0	1	1	1	1
Monitoring	0	0	0	0	1

The poorest response was from Banda district followed by Saharanpur district. None of them saw monitoring as a challenge. The common opportunity was the monthly meeting. Surprisingly, the manager at Banda district did not mention incentives under opportunity or challenges. This showed that regular monitoring was not at all a priority area for the managers. However, the state level manager could note the opportunity and challenges.

Table 5: Future plans to strengthen HBNC programs

Total Number of stakeholders (N=5) & Names of districts	Banda (N=1)	Barabanki (N=1)	Gonda (N=1)	Saharanpur (N=1)	State level (N=1)
Roll out issues	0	0	0	0	1
Reporting issues	1	0	0	1	1
Feedback issues	0	0	1	0	1
Area specific issues (Geographic)	1	0	1	0	0
Training curriculum	0	1	1	1	1
Monitoring and supportive supervision	1	1	0	1	1
IEC	0	1	1	0	1
Specific responsibility	1	0	0	0	1

Regarding future plans, the poorest response was from Barabanki district. None of the managers thought that rollout was an issue to be dealt in future. In future plans reporting issues were not the priority for Barabanki and Gonda districts although reporting issues were the backbone of the HBNC program. Except Gonda district, the other three districts did not include feedback issues to be dealt in future towards strengthening of the program. Geographic considerations were only thought over as priority issues by Banda and Gonda districts. Surprisingly, Banda district did not prioritize training as an issue to be strengthened towards improvement of program. Similarly, Gonda district did not have plans to deal with the monitoring and supervision issues of the program. This helped us to conclude that none of the districts could address all the basic issues of the program that they can address in future to work on the program. Development of relevant IEC materials were only mentioned by Barabanki and Gonda districts. Except Banda district, none of the program managers thought that assigning specific responsibility was an important area to develop the program. The state level manager did not think geographic issues as forefront issue.

Table 6: Approach and work of ASHAs as a community worker

Total Number of stakeholders (N=5) & Names of districts	Banda (N=1)	Barabanki (N=1)	Gonda (N=1)	Saharanpur (N=1)	State level (N=1)
Knowledge	0	1	0	1	1
Skills	1	0	0	1	1
Attitude	0	0	0	0	1
Application	1	0	1	0	0
Self confidence	0	1	1	0	0
Timely visits	1	0	0	0	1
Referral	1	1	1	1	0

The interviews with the program managers showed a mixed picture for the response towards approach and work of ASHAs. The Banda manager thought that the ASHAs had skills, application, did timely visits and referred cases without having knowledge, attitude and self-confidence. The Barabanki manager agreed that the ASHAs had knowledge, self-confidence and refer cases but they did not have skills, attitude and no application and thus did not do timely visits.
In Gonda, ASHAs had application, self-confidence and referred cases. He said that they did not have adequate knowledge, skills and attitude leading to poor quality and un-timely visits. As per the Saharanpur program manager, ASHAs only had knowledge and skills which helped them to refer cases. This meant he agreed that they lacked the intrinsic qualities. The state level manager opined that application, self-confidence and referral were done poorly by ASHAs.

Conclusions

The above results showed that the feedback of the program managers on the work of ASHAs through their feedback on the work & approach of ASHAs is unsatisfactory across the four districts. The major problem is that large scale studies do not focus on the response of the program managers at district & state level. The opportunities, challenges & the future plans that they spoke about shows that they are only rolling out the training activities primarily without touching upon other modalities.
The feedback of managers of the programs like newborn & child health would only improve if they make field visits & follow up on the progress of the Management Information System reports on the program progress. Monthly meetings should discuss on these program aspects. This strategy would help in more buying in both at the level of mothers & the managers. The process would make the referrals of the ASHAs effective & timely there by improving the program progress through the eyes of the community & the public health system.

Limitation of the study

As shown in the section on the research methodology, the current article has just 5 program managers. The current study was basically a quantitative study at large where this mere sample size was to address the qualitative part of the study & the perspective of the personnel of the health system. Hence, the responses of this small sample size can not be attributed to the entire health personnel of any unit like block, district & the state of UP. This is just a tangent to the entire periphery of the health system of UP.

References

1. GOI. Ministry of Health and Family Welfare; Update on the ASHA Programme, 2005, 2015.
2. Government of Uttar Pradesh. Planning Atlas of Uttar Pradesh; Area Planning Division, State Planning Institute, Planning Department, 2009.
3. GOUP. Report on evaluation of ASHAs in UP, SIFPSA, Vimarsh, 2013.
4. GOUP. Report on evaluation of Comprehensive Child Survival Program, VIMARSH, SIFPSA, 2013.
5. Das E *et al*. Performance of ASHA to provide HBNC, a situational analysis, India Paediatrics. 2014; 51(2):142-4.
6. Deoki N *et al*. Assessment of functioning of ASHA under NRHM in UP, 2008. www.researchgate.net/profile/deoki_nandan.