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Research Article

Improvement in Institutional Delivery in Gangiri Block, Aligarh

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ABSTRACT

This study was conducted to assess the level of awareness and knowledge attitude and improvement in the practice of institutional delivery and utilisation of RCH services including ANC registration among married people of the age group 18–45 years in community health centre (CHC), Charra, with the help of frontline workers under NRHM supported by S-CCSP-SS under the department of Sociology & Social Work (AMU) with the collaboration of UNICEF in Gangiri block of Aligarh district. Even though the Gangiri block has a population of 297481 (2001 census), the S-CCSP-SS project was launched in 2009 among the block of Aligarh district with the objectives of CCSP SS being to provide supportive supervision to all the CCSP-trained ASHAs and to strengthen the skills of ASHAs through the supervisory cadre (ANMs and LHVs). As a result, they can effectively perform their activities in public health centres under NRHM. The main objectives were to increase institutional delivery in Gangiri block. In this regard, the block supervisor adopted different methods to cope with the problem of home delivery arising due to reluctance of family member, pregnant mother, mother in law, myth & misconception about health services provided by NRHM with the support of frontline workers and MSW students. In the case of behaviour change of rural community, the block supervisor supported village meetings among pregnant/lactating women organised by ASHAs, ANM, AWW and PRI members with the help of MSW students; in addition, they met individually with target groups. As a result, ASHAs were recognised as basic health service providers. In the beginning of the S-CCSP-SS in 2009, the number of institutional delivery was about 1788. However, institutional delivery increased about 3345 from April 2011 to March 2012 (according to CHC).

Keywords: Institutional Delivery, Home Delivery, National Rural Health Mission, Integrated Management of Neonatal and Childhood Illnesses

INTRODUCTION

The MMR in Kerala with 97 per cent institutional deliveries was estimated to be 110 maternal deaths per 100000 births compared with 517 in Uttar Pradesh, with about 10 per cent institutional deliveries in 2001–2003 (Jain, 2010). Almost 600000 women die each year from pregnancy-related causes, of which 99 per cent belong to the developing countries (Radkar 2007). In 2001–2003, the MMR ranged from 517 in Uttar Pradesh to 110 in Kerala. The conclusion one can draw from this is that MMR in India is at unacceptable levels in the modern world and it is very unlikely in the near future that we will be able to reduce it to a respectable figure (Bose 2007: 206). The Government of India launched the National Rural Health Mission in April 2005 with the objectives of meeting the outcomes envisioned in the National Population Policy 2000, the Eleventh Plan, MDGs and Vision 2020 India by improving the reproductive and child health delivery system along with the overall preventive and curative and preventable healthcare system in the country.

Child health is directly linked with the educational and health status of the mother, care during pregnancy, post delivery, care of the newborn and management of early childhood illness. An integrated approach, focusing on the family, community and facility level care of the mother and the newborn, supported by the institutional mechanism for healthcare delivery, is required. For this, a multi- pronged strategy has been envisaged.

The 'Integrated Management of Neonatal and Childhood Illnesses' programme was launched as a pilot in Lalitpur District in 2005. This was further adapted in Uttar Pradesh, and a Comprehensive Child Survival Programme – UP (CCSP-UP) was launched during 2007–08; the programme was launched in 17 selected districts (one district in each division with high IMR and availability of minimum basic infrastructure).

Under the UP-CCSP programme, the frontline functionaries including the ASHAs, ANMs and Health Supervisors are being trained in the management of illnesses of under-fives through an integrated approach using the various training methodologies along with adequate clinical exposure (through hospital and community visits).

Following this training, the trained personnel perform scheduled visits to the house of the newborns to assess, classify and treat for signs of illness. Besides caring and feeding practices, there are other practices including counselling the caretaker on feeding practices, home care, care seeking during illnesses, and when required, and referral along with pre-referral treatment. The trained personnel have been provided with the necessary medicine kits and chart booklet for performing assessment as recommended.

To address this challenge, a project on 'Supportive Supervision of CCSP' was undertaken in twelve blocks of Aligarh district, by the Department of Sociology and Social Work, Aligarh Muslim University – with support from UNICEF – and was implemented in close coordination with the District Administration of Aligarh.

OBJECTIVES

The objective was to describe the present status of institutional delivery in Gangiri block since 2008.

METHODOLOGY

As far as methodology of this research paper is concerned, the block supervisor was used for collecting relevant information for secondary analysis of data from the CHC and district health department. However, the block supervisor had applied random sampling of over twenty ASHAs.

COMPARATIVE ANALYSIS OF INSTITUTIONAL DELIVERY SINCE APRIL 2008 TO MARCH 2012

As the concept and post of ASHA came into existence under NRHM, one of the biggest health programmes of the government in the rural areas with the purpose of improving the poor health condition of children in the villages. ASHAs work in every village having a population of 1000 or more than 1000. An ASHA works as a link between villagers and government health department service providers. They work as key people in the villages who help people receive the health services essential to them.

When the CCSP-supportive supervision project in the collaboration of UNICEF and AMU started in August 2009 in Aligarh district and when the worker/supervisor of the Gangiri block first visited in the last week of July 2009 in the CHC, Charra found lack of infrastructure, less number of staff nurse and other CHC staff such as

- 181 CCSP training ASHAs out of 200
- 16 ANMs in 34 subcentres
- 2 staff nurses
- MS 1 (Medical Superintendent), 1 MO, 1 IO (Immunisation Officer), no HEO
- 2 additional PHCs (Barla, Gangiri), but institutional delivery is not practiced

However, when the supervisor visited the village and attended ASHAs' monthly meeting at CHC to provide supportive supervision in the first week of August 2009, the following challenges and barriers were identified:

- Low social status
- Low economic status
- Being a woman

- Had to follow the practices/customs
- Purdah (*ghunghat* in local language)
- Standing in front of male members
- Keeping voice low
- Unawareness toward Health Care Delivery System
- Illiteracy in the village and resentment towards the system precipitating the rigidity problem
- Hesitation and lack of support in the work of ASHA within the village and her own community
- No single institutional delivery
- Resentment of the community towards vaccination
- Lack of transport facilities

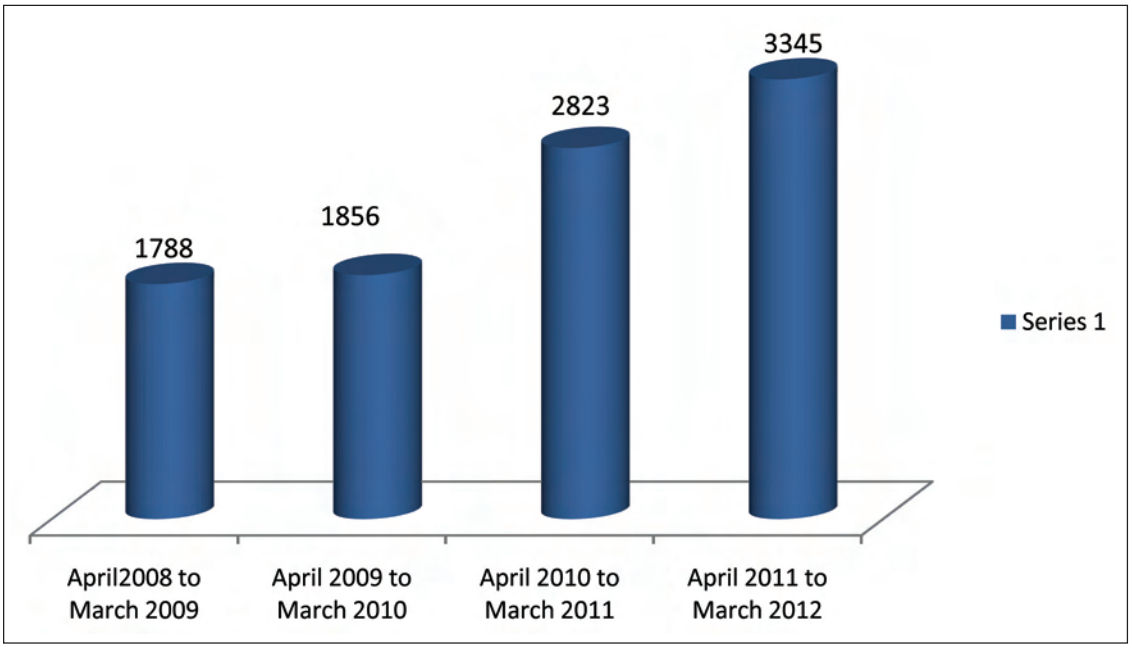
To address the above-mentioned challenge, in the beginning of the S-CCSP-SS in 2009, there were about 1788 institutional deliveries. As a result, the supervisor conducted a community meeting among beneficiaries on priority with the support of MSW students where ASHAs were unable to take the beneficiaries to CHC. Later, ASHAs received recognition as basic health providers by the community member and increases the intuitional delivery at CHC.

SUGGESTION

As far as suggestion is concerned, the supervisor with the support of MSW students developed the skill of frontline workers among the village community through various activities such as conducting target group meeting, door-to-door mobilisation of reluctant families with the support of ANMs, PRI members and stakeholders and disseminate knowledge about basic health services provided by the government. As a result, the ASHAs increased to 3345 from April 2011 to March 2012 in case of lacking infrastructure, staff nurse and inadequate number of ANMs. The supervisor's suggestions is that if the Health Department improves the infrastructure of CHC and fills up the vacant positions of nurse staff, ANMs and other CHC staff such as HEO, it can help in improving institutional delivery.

CONCLUSION

To increase the institutional delivery at CHC, there is need to address the challenges and barriers of the community faced by frontline workers. Furthermore, the government should improve the infrastructure and



Comparatives study of institutional delivery data since April 2008 to March 2012
(Source: Data collected from CHC (Charra), District Program Management Unit (Aligarh) in September–October 2012)

Comparatives Study of 20 ASHAs institutional delivery data since April 2008 to March 2012

S.No.	Name of ASHA	Village	Subcentre	March 2008 to April 2009	March 2009 to April 2010	March 2010 to April 2011	March 2011 to April 2012
1	Sabana Beghum	Satrapur	Shehawli	3	6	18	22
2	Ramshri	Madapur	Madapur	2	5	20	24
3	Inderwati	Ismailpur	Bhudia	2	8	23	25
4	Asha Devi	Salagwa	Bhamorikala	4	9	25	26
5	Kashmiri Devi	Barla 1st	Barla 1st	6	7	23	27
6	Premla Yadav	Paharipur	Dattawli	3	5	15	28
7	Sushila Devi	Majhola	Majhola	2	6	18	30
8	Uma Rani	Bhoghipur	Badharikala	0	7	16	26
9	Somwati	N.Piploi	N. Piploi	7	10	17	32
10	Premwati	Mudhel	Phusawli	3	6	28	34
11	Ajay Kumari	Chabilpur	Bhudia	0	7	25	30
12	Keshar Devi	Dhansinghpur	Majhola	0	5	28	32
13	Sarvesh Devi	Shehawli	Shehawli	3	6	25	33
14	Premlta	Sirauli	Sunpahar	4	7	24	35
15	Urmila Devi	N.baban	Rukhala	2	8	26	30
16	Sukh Devi	Hussainpur	Hussainpur	3	5	27	31
17	Meena Devi	Alampur	Alampur (N. Lale)	0	6	28	34
18	Arti Devi	Beghpur	Nah	0	5	15	24
19	Malti Devi	Wazidpur	Wazidpur	2	7	12	21
20	Rinki	Sikharnakala	Arni	0	5	16	24

fill up the vacant posts of staff nurse and ANMs. In the light of these findings, a focus on increasing demand for existing services seems the most rational action. In particular, financial constraints need to be addressed.

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