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A Descriptive Cross-Sectional Study to assess the Practice of Home Visiting by Axillary Nurse & Midwife (ANM) as a Primary Healthcare Intervention in a rural area of Aligarh, Utter Pradesh

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Abstract:
Home visit is an integral component of PHC delivery system. It is preventive and promotes health practice where health professionals render care to clients in their own environment and provide appropriate healthcare needs and social support services. This study describes the home visit practices in a rural area of Aligarh in the UP. Methodology. This descriptive cross-sectional study used 375 households and 11 ANM's in the Aligarh district. Multistage sampling techniques were used to select 10 communities and study respondents using probability sampling methods. A pretested self- designed questionnaire and an interview guide for household members and community health nurses, respectively, were used for data collection. Quantitative data collected were coded, cleaned, and analyzed using Statistical Package for Social Sciences into descriptive statistics, while qualitative data were analyzed using the NVivo software. Thematic analysis was engaged that embraces three interrelated stages, namely, data reduction, data display, and data conclusion. Results. Home visit is a routine responsibility of all ANMs. The factors that influence home visiting were community members' education and attitude, supervision challenges, lack of incentives and lack of basic logistics, uncooperative attitude, community inaccessibility, financial constraint, and limited number of staff. Household members (62.3%) indicated that health workers did not had attend to minor ailments as 78% benefited from the service and wished more activities could be conducted to the home visiting package (24.5%). Conclusion. There should be tailored training of ANMs on home visits skills so that they could expand the scope of services that can be provided. Also, community-based health workers such as community health volunteers, birth attendants, and community clinic attendants can also be trained to identify and Address health problems in the homes.

Keywords: ANM's, Home Visit, Community area, rural, NVivo Software, PHC: Primary healthcare PHN: Public health nurse.

Introduction

Home visit practice is a healthcare service rendered by trained health professionals who visit clients in their own home to assess the home, environment, and family condition in order to provide appropriate healthcare needs and social support services. The home environment is where health is made and can be maintained to enhance or endanger the health of the family because individuals and groups are at risk of exposure to health hazards [1, 2]. At home visit, conducted in a familiar environment, the client feels free and relaxed and is able to take part in the activity that the health professional performs [1]. It is possible to assess the client's situation and give household-specific health education on sanitation, personal hygiene, aged, and child care. The important role the health professional plays during home visits (HV) cannot be exaggerated and this led Aligarh to adopt HV as a cardinal component of its preventive healthcare delivery system. This role is largely conducted by Axillary Nurse & Midwife (ANM) [2]. Health education given during HOME VISITs is more effective, resulting in behavioral change than those given through other sources such as the mass media [3].

In the home, the health professionals, mostly ANM monitor the growth, development, and immunization status of children less than 5 years and carry out immunization for defaulters. Care is given to special groups such as the elderly, discharged tuberculosis, and leprosy patients as well as malnourished children [1, 2]. It is also possible to carry out contact tracing during HOME VISITs [2]. These services may prevent, delay, or be a substitute for temporary or long-term institutional care [4, 5]. HOME VISIT has potential for bringing health workers into contact with individuals and groups in the community who are at risk for diseases and who make ineffective or little use of preventive health services [2]. There are several factors influence the conduct of HOME VISITs. These factors include location of practice, general practitioners age, training status, and the number of older patients on the list and predicts home visiting rate [6].

The concept of HOME VISIT has remained in Aligarh over the decade and yet, its very essence is imperative [3]. In Aligarh, home visiting is one of the major activities of ANM. The health visitors, as ANMs were then called, went from house to house, giving education on sanitation and personal hygiene [3]. These nurses attempt to promote positive health and prevent occurrence of diseases by increasing people's understanding of healthy ways of living and their knowledge of health hazards [7]. HOME VISITs remain fundamental to the successful prevention of deaths associated with women and children under five; yet, there still remain certain gaps in the successful implementation of this innovative intervention in Aligarh [4]. In Region of Aligarh, although nurses had knowledge of home visiting and had a positive opinion of the practice, they could not per- form their home visiting tasks or functions up to standard [8]. Home visiting practice in that district among nurses was found to be very low, even though community members desired more [8]. The findings indicate that there is a need for HOME VISIT [9]. Also identified were several health hazards, such as uncovered refuse containers, open fires, misplaced sharp objects, open defecation, and other unhygienic practices that a proper home visiting regiment can address [8]. At the service level, lack of publicity about the service, the cost of the service, failure to provide services that meet clients' felt needs, rigid eligibility criteria, inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, lack of affordable child care, poor co- ordination between services, and not having an outreach capacity were identified as the challenges associated with this kind of service [9–13].

As many interventions are implemented by stakeholders in health to ensure that home visiting practices actually benefit community members, recent studies have not delved into the practices of home visiting

in poor rural communities especially in the Volta Region of Aligarh. This study assessed the home visiting practices in the Aligarh Region.

Aim. This study assessed the practice of home visiting as a primary healthcare (PHC) intervention in a rural area of Aligarh.

Research Methodology

Study Design. This mixed method study employed a descriptive cross-sectional study design as the study involved a one-time interaction with the ANMs and the community members to assess the practice of HOME VISITs.

Study Setting. Rural area of Aligarh and has about 40 communities. The district capital and Aligarh District administrative center is Utter Pradesh. The estimated population of the district was 306391. The district is described as a rural district [14] as no locality has a population above 5000 people. The economically active population (aged 15 and above) represents 67% of the population [14]. The economically inactive population is in full-time education (55.1%), performed household duties (20.6%), or disabled or too sick to work (4.6%), while the employed population engages in skilled agricultural, forestry, and fishery workers (63.1%), service and sales (12.6%), craft and related trade (14.6%), and 3.4% other professional duties [14]. The private, informal sector is the largest employer in the district, employing 93.9% [14]. There are 15 health facilities in the district government health centers [4], one health center by Christian Health Association of Aligarh, and 10 communities health-based planning services (CHPS) of which 5 are functional [15]. The housing stock is 5629 representing 1.4% of the total number of houses in the Aligarh region. The average number of persons per house was 6.5 [14], and the houses are mostly built with mud bricks [15]. The most common method of solid waste disposal by households is public dumping in the open space (47.5%). Some households dump solid waste indiscriminately (17.3%), while other households dispose of burning (13.3%) [14].

Study Population, Sample, and Sampling Technique. There are about 36391 inhabitants with 6089 households in rural area of Aligarh [14]. This study mainly involved the members of the household and ANMs from randomly sampled communities in the district. An member of the household is a person above the age of 18 years who has the capacity to represent the household. ANM [11] from the selected communities in the district was recruited. An ANM is a certified health practitioner who combines prevention and promotion health practices, works within the community to improve the overall health of the area, and has a role to playin home visiting.

Estimating for a tolerable error of 5%, with a confidence interval of 95%, and a study population of 6089 households, with a margin of error of 0.05 using Yamane's formula for calculating sample for finite populations, a sample of 375 households were computed. The sample size was increased to 390 to take into consideration the possible effect of nonresponse from participants. Multistage sampling technique was Aligarh District opted to eventually select study participants. Each community was stratified into four geographical locations: north, south, east, and west with respondents being selected from every second house using a systematic sampling approach. In each household, an member of the household responded to the questionnaire.

A whole population sampling method was used to select eleven [11] ANMs from the specific communities [10] where the study took place in the district. The ANM that served the 10 selected

communities were selected. This represented 42.3% of the total ANM community of the district at the time of the study.

Pretesting. The questionnaire and interview guide were piloted using 30 household members and 5 ANMs, respectively, at Aligarh municipality area. The data collected through the questionnaire were subjected to a reliability test on SPSS (version 22). The pretesting asecer- trained the respondent's general reaction and particularly, interest in answering the questionnaire. The questionnaire was modified until it produced a Cronbach alpha coefficient of 0.790. It can therefore be concluded that the questionnaire had a high reliability in measuring the objectives of the study. The pretesting helped in identifying ambiguous questions and revising them appropriately. It also helped to structure and estimate the time the respondents used toanswer the questionnaires and to respond to the interview.

Data Collection. Researchers from the AMU, College of Nursing, were involved in data collection. Five researchers received two days training in data collection, the study tools, and research ethics for social sciences prior to the commencement of data collection. All researchers had a minimum of a bachelor degree in Nursing with at least three years' experience.

Respondents were assisted to respond to a questionnaire within their homes. The household questionnaire had four [4] sections comprising personal details and how HOME VISIT practice is carried out in the home such as frequency of visit, duration, and activities. Subsequent sections had respondents answer questions on the challenges, benefits, and factors that could promote the HOME VISIT practice. It took an average of about 15 minutes to complete a single questionnaire.

A semi structured interview guide was used to interview ANMs. This guide was in four sections; the first section was personal details with subsequent sections on practice of home visits, constraints to the practice, the benefits, and promotion factors to HOME VISITs. An interview section lasted 20–25 minutes to complete.

Data Analysis

Quantitative Data. Each individual questionnaire was checked for completeness and appropriateness of responses before it was entered into Microsoft Excel, cleaned, and transferred to the Statistical Package for Social Sciences (version 22) for analysis. The data were basically analysed into descriptive statistics of proportions. There were also measures of central tendencies for continuous variables.

Qualitative Data. In data analysis, thematic analysis was engaged that embraces three interrelated stages, namely, data reduction, data display, and data conclusion [16]. ANMs views were summarized based on the conclusions driven and collated as frequencies and proportions. Guest, Macqueen, and Namey summarised the process of thematic analysis as construing through textual data, identifying data themes, coding the themes, and then interpreting the structure and content of the themes [17]. In using this scheme, a codebook was first established, discussed, and accepted by the authors. The nodes were then created within NVivo software using the codebook. Line-by-line coding of the various transcripts was performed as either free or tree nodes. Double coding of each transcript was carried out by two of the researchers. Coding comparison query was used to compare the coding, and a kappa coefficient (the measurement of intercoder reliability) was generated to compare the coding that was conducted by the two authors. The matrix coding query was performed to compare the coding against the nodes and attributes using NVivo software that made it possible for the researchers to compare and contrast within-group and between-group responses.

Ethical Consideration. Ethical clearance was obtained on the 19th September, 2022, from the Research

and Scientific Ethics Committee of the Institute. Permission was sought from the district health authorities, chiefs, and assembly members of each study community. Preliminary to the Aligarh District administration of the questionnaires, an informed consent was obtained as respondents signed/thumb printed a consent form before they were enrolled into the study. Participants could withdraw from the study anytime they wished to do so.

Results

Household Members' Views regarding Home Visit. The household representatives surveyed (375) had a mean age of 41.24 ± 16.88 years. The majority (26.5%) of household members were aged between 30 and 39 years. Most (75.1%) were females. The majority (97.1%) of people in households were Christians, while 38% was farmers. The majority (69.9%) of household members were married as 47.2% Aligarh District schooled only up to the JHS level as at the time of this survey as given in Table 1. The majority (73.3%) of Aligarh District household members Aligarh District ever been visited by a health worker for the purpose of conducting HOME VISITs as a significant number (26.7%) of household members of Aligarh District never been visited by health workers in the community. Most (52.6%) household members of Aligarh District their last visit from a health worker during the past month. Within the past three months, some (48.2%) community members were visited only once by a health worker. The majority (93.4%) of community members were usually visited between the time periods of 9am and 2pm as given in

Table 2. The community members contend that home visiting was beneficial to the disease prevention process (65%). The people that need to be visited by ANMs include children under five (25%), malnourished children's homes (14%), children with disabilities (14%), mentally ill people (11%), healthcare service defaulters (22%), people with chronic diseases (9%), and every member of the community (5%). Most (87.9%) community members were given health education during HOME VISITs conducted by the ANM. In describing the nature of health education that is most frequently given by ANMs during HOME VISITs, household members indicated fever management (14%), malaria prevention (20%), waste dis- posal (11%), prevention and management of diarrhoea (22%), nutrition and exclusive breastfeeding (14%), hospital attendance (14%), and prevention of worm infestations (5%). The majority (62.3%) of community members did not receive a minor ailment management during HOME VISITs as most (66.5%) of community members received vaccination dur- ing HOME VISITs by ANMs. Describing the type of minor ailment treatment given during the HOME VISIT include care of home ac- cidents (13%), management of minor pains (22%), management of fever (45%), and management of diarrhoea (20%). Household members (24.5%) did identify the timing as a barrier for home visiting, while some (13.1%) did identify the attitude of health workers as a barrier to home visiting. However, most (67.3%) of the household members attributed their dislike for home visiting to the duration of the visit. The majority (95.2%) of household members indicated health workers were friendly. Some household members (78%) indicated they benefited from HOME VISITs con- ducted in their homes. The majority (91.4%) of household members showed that time for home visiting was convenient. Indicating if household members will wish for the conduct of the HOME VISIT to be a continuous activity of ANMs in their community, the respondents (82%) were affirmative. ANM'S views on home visit in Aligarh District. The mean age of ANM was 30.44 ± 4.03 years as some (33.3%) were aged 32 years as the modal age. The ANMS (90.9%) were females with the majority (81.8%) being Christians as given in table 3. In assessing the home visiting practices of ANMs, the

researchers had some thematic areas. These thematic areas that were discussed include but not limited to the concept of HOME VISIT by ANM, factors that influence the conduct of HOME VISITs, ability to visit all homes within ANM catchment area, reasons for conducting or not able to conduct HOME VISIT, frequency of conducting home visits by ANM, and activities undertaken during HOME VISITs. This view that was expressed was simply summarised based on the thematic areas and presented in Table 4 as descriptive statistics related to the ANM conduct of HOME VISITs.

Concept of Home Visit by ANM. ANMs have varied descriptions of the concept of HOME VISIT as it is conducted within the district. The description of HOME VISIT was basically related to the nature and objective that is associated with the concept. The central concept expressed by participants included a health worker visiting a home in their place of abode or workplace, providing service to the family during this visit, and this service is aimed at preventing disease, promoting health, and maintaining a positive health outcome. These views were summarised when they said "HOME VISITs are a service that we (ANMs) rendered to the client and his family in their own home environment to promote their health and prevent diseases. The central idea is that during the HOME VISIT, the ANM is able to engage the family in education and services that eventually ensure that diseases are prevented and health is promoted."

"HOME VISIT is the art when the ANMs visit community members' homes to provide some basic curative and largely preventive healthcare services to clients within their own homes or workplaces. During this visit, the ANM helps the entire family to live a healthy life and give special attention or care to the vulnerable members of the society." "It is the processes when at-risk populations are identified; then, the ANM provides services to this had within their own home environment and sometimes workplaces as the case may be. Essentially, the ANM assists the family to Aligarh Districtopt positive behaviours that will ensure they live with thevulnerable person in a more comfortable way."

Factors that Influence the Conduct of Home Visits. The ANMs enumerated a cluster of factors that influence the conduct of HOME VISITs within the district. These factors ranged from community members education, attitude, supervision challenges, lack of incentives, and lack of basic logistics to conduct HOME VISITs. The uncooperative attitude of community members was identified by ANMs (36.4%) as a barrier to HOME VISITs. As they indicate, some community members did not support the continued visit to their homes or did not give them the necessary attention needed for the provision of services.

"Some community members do not understand the importance of HOME VISITs in the prevention of disease and for that matter are less receptive to the conduct of HOME VISITs. They just do not see the need for the service provider to come to their homes to provide services."

"The client is the master of his own home; when you get into a home for a HOME VISIT, the owner should be willing to talk or attend to you. Sometimes, you get into a home and even if you are not offered a seat, or you are just told we are busy, come next time. You know community service is not a paid job, so because the community members do not directly pay for the services we provide, essentially less premium is placed on the activities we conduct." "There is some resistance to HOME VISITs by some community members. Sometimes, you come to a house and can feel that you are not wanted; meanwhile, the home is part of the home that needs and has to get a HOME VISIT because of the special needs they have. This is particularly specific in homes that believe that the particular problem is a result of supernatural causes."

Table 1: Demographic Characteristics of Household Members.

Characteristic	Frequency (N 375)	Percentage (%)
Mean age (SD)		41.24 (±16.88)
Age group in years		
<20	11	2.9
20–29	94	25.1
30–39	99	26.5
40–49	69	18.5
50–59	45	12.0
60 and above	56	15.0
Sex		
Male	93	24.9
Female	281	75.1
Religion		
Hindu	363	97.1
Hindu	11	2.9
Occupation		
Business	20	6
Civil servant	26	7
Farmer	134	38
Menial jobs	32	9
Trader	86	24
Unemployed	59	17
Marital status		
Single	73	19.5
Married	262	69.9
Divorced	09	2.4
Widowed	31	8.3
Educational level		
Uneducated	46	12.3
Primary	49	13.1
HS	176	47.2
SHS	77	20.6
Graduation	25	6.7

Table 2: Practice of home visits in ALIGARH DISTRICT (Household Members).

Characteristic	Frequency	Percentage
Visit by a health worker (ANM)		
Yes	274	73.3
No	100	26.7
Last time visited by a health		

worker		
This week	19	7.6
Last week	40	16.1
Last month	131	52.6
Cannot remember	59	23.7
Number of times visited by a health worker(s) within the past three months		
Once	123	48.2
Twice	80	31.4
Three times	31	12.2
Had no visit	21	8.2
Time visited during the day 9am to 2pm	255	93.4
3pm to 6pm	18	6.6

Table 3: Demographic Characteristics of ANM.

Characteristics	Frequency (N 11)	Percentage %
Mean age	**S.D 30.44 (±4.03)**	
Age		
Below 30 years	4	44.4
Above 30 years	5	55.5
Sex		
Male	1	9.1
Female	10	90.9
Religion		
Hindu	9	81.8
Hindu	2	18.2
Marital status		
Single	4	36.4
Married	7	63.6

Table 4: Summary of ANMs home visit practice in ALIGARH DISTRICT.

Characteristics	Frequency	Percentage (%)
Organized home visit in the catchment area		
Yes	11	100
The ability to visit all homes in the catchment area		
Yes	9	81.8
No	2	18.2
Reason for not being able to visit all homes		
Hard to reach areas	5	45.45

InAligarh Districtequate equipment	6	54.54
Type of home visiting carried out		
Only routine	3	27.3
Both (routine and special)	8	72.7
Frequency of home visits per week		
Once	1	9.1
Twice	3	27.3
Three times	5	45.5
More than three times	2	18.2
The number of homes visited in a week		
1-5	2	18.2
6-10	7	63.6
11-15	2	18.2
Times at which home visits are conducted		
Morning	10	90.9
Evening	1	9.1
Week of last home visit conducted		
This week	10	90.9
Last week	1	9.1
Health education conducted at home visit		
Yes	10	90.9
No	1	9.1
Management of minor ailment during home visit		
Yes	6	54.6
No	5	45.5
Vaccination/contact tracing during home visits		
Yes	7	63.6
No	4	36.4

The Ability to Visit All Homes within ANM Catchment Area. The conduct of HOME VISITs is a basic responsibility for all ANMs as they remain as an integral part of the PHC delivery system in Aligarh. Based on the nature and problems in the community, ANMs strategizes various means that will aid them to provide this essential service efficiently. ANMs (81.8%) are able to visit all homes in the catchment areas during a quarter. Some of the responses included the following:

“We do organize HOME VISITs, this is part of our routine schedule. As a community health nurse, to enjoy your work,you will need to organize HOME VISITs from time to time.”

“As for the HOME VISIT, it depends on the strategies a particular CHPS compound is using. Irrespective of the community that one works in, you can always provide full and Aligarh District adequate care and service to the community if you plan well. First, you have to identify the “at need people” then the distance to their homes and put this in your short-term strategic plan forexecution.”

"HOME VISITs are basic responsibilities of community health nurses, and we ought to execute it. In spite of the challenges, we cannot let those particularly hinder on our ability to conduct our very core mandate."

Some ANMs were not able to visit all homes in their catchment areas, citing "hard to reach areas" and "In Aligarh District adequate equipment" as the reasons for not being able to visit allhouseholds.

"Sometimes it is the distance to the clients' homes that makes it impossible to visit them. There are some homes if you actually intend to visit them, then you must be willing to spend the whole day doing only that activity."

"Some clients' problems are such that you will need to have special tools before you visit them. For example, what use will it be to a diabetic client if you visit him/her and you are unable to monitor the blood sugar level or to a hypertension patient, you are not able to check the blood pressure because you do not have the required equipment?" "To have a successful HOME VISIT practice, I think the authorities should be willing to provide the basic logistics that will aid us to work. Without this basic logistics, we cannot."

The Reasons for Conducting or Not Able to Conduct Home Visits. ANMs (72.7%) carried out both routine and special HOME VISITs. For those Axillary Nurse & Midwife who were not able to conduct HOME VISITs, several reasons were ascribed. Some of the reasons described included the lack of basic amenities to conduct HOME VISITs. The majority (18.2%) of ANMs also did attribute inaccessible geographical areas as a barrier to HOME VISIT. Also, ANMs (63.6%) identified in Aligarh District equate logistics and financial constraints as barriers to HOME VISIT. All of the ANMs report on their activities regarding home visiting to thedistrict health authorities.

"We basically lack the simple logistics that will assist us to conduct HOME VISITs. We do not have simple movable equipment like weight scales, thermometers, sphygmomanometers, andstethoscopes."

"We do not have functionally equipped home visiting bags, so even if we decide to visit the homes, how much helpwill we be to the client?"

The other reasons included large catchment areas and lack of reliable transportation for the conduct of HOME VISITs in the ALIGARH DISTRICT.

"The catchment area is quite wide and practically impossible to visit every home. Looking from here to the end of our catchment area is more than 5 kilometers, without a means of transport, one cannot be able to visit all those homes."

"I remember in those days; Axillary Nurse & Midwife were given serviceable motor cycles to aid in their movement and especially the conduct of HOME VISITs. Today, since our motorbike broke down 5 years ago, it has since not been ser- viced, yet we are expected to conduct HOME VISITs."

"To conduct home visits, whose money will be used for transportation? The meagre salary I earn? Or the families or beneficiaries of the service have to pay?"

"The number of staff here is woefully inAligarh Districtequate, we are only two people here, how can we do home visiting and who will be left in the facility to conduct the other activities. For this reason, we are not able to conduct HOME VISITs."

ANMs tried to visit the homes at various times depending on the occupation of the significant other of the homes, so that they can provide services in the presence of the significant others. ANMs (63.6%) visit 6–10 homes in a week as 90.9% ANMs conduct HOME VISITs in the morning. The reasons given for conducting some HOME VISITs in the evenings included the following:

"This place is largely a farming community, most people visit their farms during the mornings, so if you visit the home in the morning, you may not meet the significant others of the vulnerable person to conduct health education."

"We do HOME VISITs because of the clients, so anytime it is possible, we will meet them at home, we conduct the visits at that time. For me, even if the case is that I can only meet the important people regarding the client at night, I visited them at that time. For community health nursing work, it is a 24-hour work and we must be found doing it at all time."

Frequency of Conducting Home Visits by ANM. Various Schedule Periods Were Used Based On Health Facilities For The Purpose Of Home Visits. Most (45.5%) Conducted Home Visits Three Times In A Week. Anms (90.9%) Had District Conducted Home Visits The Week Preceding The Interview. Indicating That The Last Time Home Visit Was Conducted, Anms Conducted A Home Visit At Least Within The Last Week:

"Home Visit Is A Weekly Schedule In This Facility; For Every Week, We Have A Specific Person Who Is Assigned To Do Home Visit Just As All Other Activities That Are Conducted In This Facility".

"Yes, Last Week, We Had A Number Of Home Visits; We Made One Routine Home Visit And The Other Was A Scheduled Home Visit From A Destitute Elderly Woman Who Was Accused As A Witch By Some Of Her Family Members. Indicating If They Sometimes Get Fatigued For Conducting Home Visits Weekly Because Of The Limited Number Of Staff, A Community Health Nurse Indicated That,

"I Think It Is About The Plan We Have Put In Place. There Are About Four People In This Facility. We Plan Our Activities That We All Conduct Home Visits. In A Month, One May Only Have One Or Two Home Visits, So It Is Unlikely That You Will Be Fatigued In Conducting Home Visits."

"Yes, Sometimes, It Is Really Tedious, But We Cannot Let That Be A Setback. We Have A Responsibility To Execute And We Must Be Doing So To The Best Of Our Ability."

Activities Undertaken during Home Visits. ANMs conducted health education (90.9%), management of minor ailments (54.6%), and vaccination/contact tracing (63.6%) during HOME VISITs. Describing if they are able to conduct the management of small ailments and home accidents at home, ANMs were divided in their ability to do this. Those were notable to do so indicated,

"And who will pay? Since the introduction of the national health insurance, we are not able to provide management of minor ailments during HOME VISITs. In those days, we were supplied with the medicines to use from the district, so we could provide such free services. But with the insurance now in place, we do not get medicine from the district, so whose medicine will you use to conduct such treatment?"

"I think our major goal is on preventive care. We have a lot to do with preventing diseases. Let us leave disease treatment to the clinical people. When we get ailments, we refer them to the next level of care to use their health insurance to access service."

Identification of cases, defaulter tracing, and health education were identified as benefits and promotion factors of HOME VISITs. Identification of cases and defaulter tracing were both mentioned by ANMs as benefits and promotion factors of HOME VISITs.

"I think HOME VISITs should be continued and encouraged to be able to achieve universal, sustainable PHC coverage for all. Not only do we visit the homes, we also identify vaccination defaulters,

tuberculosis treatment defaulters, and prevention of domestic violence against women and children and healtheducation on specific diseases and sometimes we do immunization."

"In the home, we have a varied responsibility, treatment of minor ailments, immunization and vaccination, contact tracing, education on prevention of home accidents, etc." It will be a disservice, therefore, if anyone tries to downplay the importance of HOME VISITs in our PHC dispensation."

"Through HOME VISITs, we have provided very essential services that cannot be quantified mathematically, but the com- munity members know the role of the services in their everyday lives. Even the presence of the community health nurse in the home is a factor that promotes girl child education and health to woman empowerment."

Discussion

This Study Assessed The Home Visiting Practices In The Aligarh District Of The Region Of Utter Pradesh. The Concept of Home Visiting Has Been Enshrined in Aligarh's Health History And Executed By The ANM Or Public Health Nurses (PHN). In Aligarh District, Only ANM among All the Various Aligarh District of Health Professional's Conducted Home Visits. This Was Contrary To The Practice In The Past When Both ANM And PHN Conducted Home Visits [18]. Not With-Standing the Limited Numbers of ANM'S In The District, The Majority Of Households (73.3 %) Have A History Of Visits From ANM Home Visiting Is Central In Preventive Healthcare Services, Especially Among The Vulnerable Population. In Children Under five Years, It Is Plausible That Nurse Home Visiting Could Aligarh District To Fewer Acute Care Visits And Hospitalization By Providing Early Recognition Of And Effective Intervention For Problems Such As Jaundice, Feeding Difficulties, And Skin And Cord Care In The Home Setting [19]. Home Visiting Emphasizes Prevention, Education, And Collaboration As Core Pillars For Promoting Child, Parent, And Family Well-Being [20].

In Aligarh, under the PHC initiative, communities are zoned or subdivided and have a ANM to manage each zone by conducting HOME VISITs, including a cluster of responsibilities mainly in the preventive care sectors [4]. As rightly identified, HOME VISIT is one of the core mandates of the ANM. Most of the community members who had received more than one visit in a week lived close to the health facilities indicating that there are homes which have never been visited, and ANMs are not able to cover all homes in their catchment areas. Factors that deter the conduct of HOME VISITs by ANM ranged from community members' level of education, attitude, supervision challenges, lack of incentives, and lack of basiclogistics to conduct HOME VISITs.

Important challenges associated with the conduct of HOME VISITs were identified as a large catchment area, lack of basic logistics, lack of the reliable transportation system, uncooperative community members, in Aligarh District equate staff, and "hard to reach" homes due to geographical inaccessibility. Health education, management of minor ailment, and vaccination or contact tracing was the activities carried out in the homes. Home visiting nurses are under pressure to complete a job within an allotted time frame, as determined by the contract or terms of employment [22]. Time pressure significantly contributes to fatigue and depersonalization, and Aligarh District justments to interpersonal relationships with nurse Aligarh District ministrations can have notable alleviating effects in relation to burnout caused by time pressure [26]. ANMs (63.6%) identified in Aligarh District equate equipment and financial constraints as challenges to HOME VISIT. Given evidence suggesting that relationship-based practices

are the core of successful home visiting [27–29], with a natural harmony between the home visitor and the community members to the home, she renders her services [20].

Health education (87.9%) dominated the home visiting activities. Health education helps to provide a safe and supportive environment and also build a strong relationship that lead to long lasting benefits to the entire family [5]. Face to face teaching in the privacy of the home is an excellent environment for imparting health information [31]. The ANMs stated that health education, tracing of defaulters, and identification of new cases are the benefits and pro- motion factors for conducting HOME VISITs. This implies that there are other critical aspects of HOME VISIT that ANMs neglect such as prevention of home accidents and ensuring a safe home environment and care for the aged. Early detection of potential health concerns and developmental delays, prevention of child abuse, and neglect are also other benefits and promotive factors of HOME VISIT. HOME VISIT helps to increase parents' knowledge, parent-child interactions, and involvement [5].

The conduct of HOME VISIT was not reported among all community members as some community members (22.0%) in the ALIGARH DISTRICT indicated their homes have never been visited. This is, however, an improvement over the rate of HOME VISITs that was reported in the district in Aligarh [32]. In this study, respondents who were visited indicated the ANMs just inspected their weighing card while giving them no feedback. ANMs should implement various interventions to ensure that community members directly benefit from health interventions that are implemented during HOME VISITs to reduce the consequences that are usually associated with poor access to healthcare services especially in poor rural communities such as the ALIGARH DISTRICT.

Conclusion

The activities carried out in the homes were mainly centered on health education, contact tracing, and vaccination. Health workers faced many challenges such as geographical inaccessibility, financial constraints, and insufficient equipment and medications to treat minor ailments. If HOME VISIT is carried out properly and as often as expected, one would expect the absence of home accidents, child abuse, among others in the homes, and a reduction in hospital Aligarh District commissions.

The need for strengthening HOME VISIT as a tool for improving household health and Aligarh District addressing home-based management of minor ailment in the district cannot be over emphasized. It is important to forge better inter sectorial collaboration at the district level. The District Assembly could assist the District Health Management Team with transport to support HOME VISITs. Community-based health workers such as community health volunteers, Aligarh District birth attendants, and community clinic attendants should also be trained to identify and address health problems in the homes to complement that which is already conducted by healthcare professionals.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References:

1. M. Stanhope and J. Lancaster, Foundations of Nursing in the Community: Community-Oriented Practice, Elsevier Health Sciences, Amsterdam, Netherlands, 2013.
2. R. F. Brugha and J. P. Kevany, "Maximizing immunization coverage through home visits: a controlled trial in an urban area of Ghana," Bulletin of the World Health Organization, vol. 74, no. 5,

p. 517, 1996.
3. D. L. Olds, H. Kitzman, M. D. Knudtson, E. Anson, J. A. Smith, and R. Cole, "Effect of home visiting by nurses on maternal and child mortality," JAMA Pediatrics, vol. 168,no. 9, pp. 800–806, 2014.
4. Family Health Division, Family Health Annual Report, Ghana Health Service, Accra, Ghana, 2014.
5. J. Watson, Active Engagement: Strategies to Increase Service Participation by Vulnerable Families: Discussion Paper, NSW Centre for Parenting & Research, Department of Community Services, Wagga Wagga, Australia, 2005.
6. I. ˇSvab, A. Kravos, and G. Vidmar, "Factors influencing home visits in Slovenian general practice," Family Practice, vol. 20, no. 1, pp. 58–60, 2003.
7. C. Robertson, Health Visiting in Practice, Churchill Livingstone, London, UK, 1991.
8. D. Osae-Ayensu, Is Home Visiting an Effective Strategy for Improving Family Health a Case Study in the Sekyere West District (Doctoral Dissertation), University of Ghana, Accra, Ghana, 2001.
9. A. Anning, J. Stuart, M. Nicholls, J. Goldthorpe, and A. Morley, Understanding Variations in Effectiveness Amongst Sure Start Local Programmes: Lessons for Sure Start Children's Centres, DFES, Nottingham, UK, 2007.
10. J. Attride-Stirling, H. Davis, G. Markless, I. Sclare, and C. Day, "'Someone to talk to who'll listen': addressing the psychosocial needs of children and families," Journal of Community & Applied Social Psychology, vol. 11, no. 3, pp. 179–191, 2001.
11. S. Carbone, A. Fraser, R. Ramburuth, and L. Nelms, Breaking Cycles, Building Futures. Promoting Inclusion of Vulnerable Families in Antenatal and Universal Early Childhood Services, Victorian Government Department of Human Services, Melbourne, Australia, 2004.
12. J. Barlow, S. Kirkpatrick, S. Stewart-Brown, and H. Davis, "Hard-to-reach or out-of-reach? Reasons why women refuse to take part in early interventions," Children & Society, vol. 19, no. 3, pp. 199–210, 2005.
13. G. Winkworth, M. Layton, M. McArthur, and L. omson, Working in the Grey-Increasing Collaboration between Services in Inner North Canberra: A Communities for Children Project, ACU, Tehran, Iran, 2009.
14. M. B. Miles and A. M. Huberman, Qualitative Data Analysis: An Expanded Sourcebook, SAGE,)ousand Oaks, CA, USA,1994.
15. G. Guest, K. M. MacQueen, and E. E. Namey, Validity and Reliability (Credibility and Dependability) in Qualitative Research and Data analysis. Applied 9ematic Analysis, pp. 79–106, Sage Publications, London, UK, 2012.
16. S. Ofosu-Amaah, "The maternal and child health services in Ghana (their origins and future)," Journal of Tropical Medicine and Hygiene, vol. 84, no. 6, pp. 265–269, 1981.
17. P. Braveman, C. Miller, S. Egerter et al., "Health service use among low-risk newborns after early discharge with and without nurse home visiting," 9e Journal of the American Board of Family Practice, vol. 9, no. 4, pp. 254–260, 1996.
18. B. A. Walsh, J. A. Mortensen, A. L. Edwards, and D. Cassidy, ")e practice of family life education within Early Head Start home visiting," Family Relations, vol. 69, no. 2, pp. 392–407, 2020.
19. I. M. Paul, T. A. Phillips, M. D. Widome, and C. S. Hollenbeak, "Cost-effectiveness of postnatal home nursing visits for prevention of hospital care for jaundice and dehydration," Pediatrics, vol. 114, no. 4, pp. 1015–1022, 2004.

20. K. Yoshimatsu and H. Nakatani, “Home visiting nurses’ job stress and error incidents,” Home Health Care Management & Practice, vol. 32, no. 2, pp. 110–117, 2020.
21. Z. C. Skea, S. Treweek, and K. Gillies, ““It’s trying to manage the work”: a qualitative evaluation of recruitment processes within a UK multicentre trial,” BMJ Open, vol. 7, no. 8, Article ID e016475, 2017.
22. R. Amonoo-Lartson and J. A. De-Veries, “Patient care evaluation: a primary health care programme,” Social Science Medicine, vol. 21, no. 3, pp. 735-736, 1981.
23. Ministry of Health, Maternal and Child Health and Family Planning Annual Report, Ministry of Health, Accra, Ghana, 1994.
24. X. Cao and T. Naruse, “Effect of time pressure on the burnout of home-visiting nurses: the moderating role of relational coordination with nursing managers,” Japan Journal of Nursing Science, vol. 16, no. 2, pp. 221–231, 2019.
25. S. J. Brookes, J. A. Summers, K. R.)ornburg, J. M. Ispa, and V. J. Lane, “Building successful home visitor-mother relationships and reaching program goals in two Early Head Start programs: a qualitative look at contributing factors,” Early Childhood Research Quarterly, vol. 21, no. 1, pp. 25–45, 2006.
26. J. Korfmacher, B. Green, M. Spellmann, and K. R. ornburg,“) e helping relationship and program participation in early childhood home visiting,” Infant Mental Health Journal: Official Publication of 9e World Association for Infant Mental Health, vol. 28, no. 5, pp. 459–480, 2007.
27. L. A. Roggman, L. K. Boyce, G. A. Cook, and V. K. Jump, “Inside home visits: a collaborative look at process and quality,” Early Childhood Research Quarterly, vol. 16, no. 1, pp. 53–71, 2001.
28. N. G. Margie and D. A. Phillips, Revisiting Home Visiting: Summary of a Workshop, National Academies Press, Washington ,DC, USA, 1999.
29. M. K. Jinadu, “)e role of community health nurses in family health education at home in a southern province of Iran (Fars),” International Journal of Nursing Studies, vol. 17, no. 1, p. 47, 1980.