American Journal of Humanities And Social Sciences Research (AJHSSR)
e-ISSN : 2378-703X
Volume-03, Issue-11, pp-14-17
www.ajhssr.com
Research Paper Open Access

Decision and Activities Done by ASHAs in Newborn Care in Uttar Pradesh, India

Dr. Tridibesh Tripathy
Homoeopathic and Public Health Expert, 2/338, Vishwas Khand, Gomti Nagar, Lucknow-10,

ABSTRACT :Introduction
The engagement of women community health workers has been recognized as one key strategy to tackle the emergent shortage of health workers in developing countries. The ASHAs are instituted by the state as part of National Rural Health Mission of the Government of India for the grassroots health care delivery. The home-based newborn care initiatives and empowerment of the local women are crucial for effective health care delivery for the section from where life begins. The current study explores some of the crucial variables of the decisions taken by ASHAs in case of an emergency in the newborn and the activities she does at the household level on newborn care in the state of UP.

Research methodology
A total of four districts of Uttar Pradesh were selected purposively for the study and the data collection was conducted in the villages of the respective districts with the help of a pre-tested structured interview schedule with both close-ended and open-ended questions. In addition, in-depth interviews were also conducted amongst the ASHAs and a total 250 respondents had participated in the study.

Results
All the ASHAs in the four districts replied that they did not treat the newborn. Among them, 88% of ASHAs in Saharanpur and more than 95% of ASHAs in the rest 3 districts replied that they referred the newborn to a Government health facility. Regarding the activities done by ASHAs, it was seen that 90% of ASHAs in all the four districts assessed the health of the newborn but the most crucial activity of taking care of the low birth weight baby was not done by any ASHA in Banda and Barabanki districts. Even in the most developed district of Saharanpur, only about 3% of ASHAs did this activity.

Conclusions
The process of decision making and activities to be done by the ASHAs on newborn care is a significant strategy in developing the community health workforce. In fact, the home-based newborn care model was the platform on which the ASHAs were launched in the country. The capacity building initiatives for ASHAs need to reinforce the issue of newborn care. These would lead to improve the level of motivation, confidence, work skills, quality and quantity of their home visits. The home visits would be more effective if the areas such as regular guidance, work related problem solving, record keeping and documentation of newborn care related activities were discussed frequently among the ASHAs and their supervisors.

KEY WORDS : *ASHA, HBNC, newborn, danger signs*

I. INTRODUCTION

Globally it is seen that there is a paucity of evidence with respect to CHWs' role in community participation and empowerment. Recurring efforts are done to improve the performance of the work force for the last six decades. In India, the Accredited Social Health Activists (ASHAs) are the community health workers instituted by the Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM) (Bajpai and Dholakia, 2011). The challenge in the health sector in India is unique as there is continuous improvement in vital health indicators but the development is not in line with India's impressive economic growth (Das, 2017). To cater to a large population, involvement and engagement of adequate number of significant primary field staffs is essential. Provision of outreach services at the point of care i.e. often in the patient's home would be possible then. As is the case, usually the patients are transported to the Primary Health Centers for the evaluation and treatment of a Medical Officer. The study deals with the issue of newborn care on these lines.

Background of ASHAs

The ASHAs emerged in India's public health system during the launch of NRHM in 2005 in 18 states where the state of Uttar Pradesh was one such state. Their induction training included the GOI-prescribed introductory module which includes a total of 8 training modules over a 23 day training schedule. In 2007-08, with the efforts of the Vistaar project (2006-2012), the program implementation plan utilized the existing platform of monthly meetings at the PHC and CHC level for continued capacity building of the ASHAs (COP report, Vistaar, 2013). Initially, the content of these meeting platforms was on the issue of newborn care so that the ASHAs can identify danger signs in newborn and do the need-based activities at home during their home visits. These efforts were expected to lead to improved performance, alongside the priorities of the community and the structure of the health care delivery system (GOI, 2015).

The report of Vistaar project also mentions about second and third visits to the houses of newborns by ASHAs. During the period of 2006-2012 in eight states of UP where the project was implemented, there was an increase from 21% to 60% for a second visit and 8% to 40% for a third visit. The respondents were the mothers of newborns. The first visit is a visit done by the doctor or ANM. The report does not mention the first visit by an ASHA (COP, Vistaar project, 2013).

In the initial phase, the emphasis was given on home-based newborn care, as the government of UP was rolling out the Comprehensive Child Survival Program (GOUP, 2013). Although they are appointed by Panchayati Raj Institutions (PRI), the ASHAs perceive themselves as incentive-based workers of the public health system; they do not link themselves with the PRI (Joshi, Mathew, 2012). The community behavior tracking survey conducted in UP in 2015 also studied the newborn care component. It recommends qualitative improvement in the use of these issues so that it leads to effective interaction between the community and frontline workers like ASHAs (UP-TSU, 2015). Another study in 2012 states that educational qualification of ASHAs did not make a difference to health outcomes such as for newborns but duration and content of training did make a difference (Sundarraman et. al, 2012). This establishes the importance of the focus on newborn care. The evaluation study of the Comprehensive Child Survival Program mentioned above also emphasizes on the effective use of these newborn care issues to build the capacity of ASHAs in the state of Uttar Pradesh (GOUP, 2013). The current study done in 2017 examines the status of the decision- making process of ASHAs in case of an emergency in newborn and how the ASHAs have acted during their home visits.

II. 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. 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. The data was analyzed using SPSS software to calculate the percentage of ASHAs taking the type of decisions and activities on newborn care in the four study districts.

Research tools

The ASHAs were interviewed using an in-depth, open-ended interview schedule which included a section on variables on home visits. The home visit section had questions on visits by ASHAs to the houses of newborns where one question was on the type of decisions that they take on identification of danger signs in newborns. The other question was regarding the type of activities that the ASHAs do during their home visits. The activities ranged from counseling, assessment and to taking care of mother and newborn.

III. RESULTS AND DISCUSSIONS

Table 1

Percentage of ASHAs taking type of decisions if she finds danger signs in newborn				
Names of districts	Banda	Barabanki	Gonda	Saharanpur
Refer to a government	95	96.7	95.3	88.7

facility				
Refer to Auxilliary Nurse Midwife	0.0	1.6	3	9.6
Refer to private doctor	4.8	1.6	6.2	1.6
Treat the newborn before referral	0.0	0.0	0.0	0.0

Treating and referring the newborn were the two actions that the ASHAs took if they found danger signs in the newborn. While all the ASHAs in the four districts replied that they did not treat the newborn, 88% of ASHAs in Saharanpur and more than 95% of ASHAs in the rest 3 districts replied that they referred the newborn to a Government health facility.

While none of the ASHAs referred the newborn to ANM in Banda district, about 2%, 3% and 10% of ASHAs referred to ANM in Barabanki, Gonda and Saharanpur districts respectively. 6% of ASHAs referred to private doctor in Gonda where 5% of ASHAs in Banda and about 2% of ASHAs in Barabanki and Saharanpur referred the newborn to a private doctor.

Following this activity, the table below gives the details of the type of activities done by the ASHAs while visiting the house of a newborn.

Table 2

Percentage of ASHAs doing type of activities during the home visit of a newborn				
Names of districts	Banda	Barabanki	Gonda	Saharanpur
Counsel mothers/family members on newborn care	35.4	3.2	1.5	33.8
Assess the newborn's health	93.5	96.7	93.7	100
Take care of the mother	27.4	51.6	40.6	66.1
Take extra care of low birth weight baby	0.0	0.0	39	3.22
Any other	0.0	0.0	17	0.0

The next actions of ASHAs were the activities that they did when they visited the houses of newborns. The type of activities discussed here were the counseling of mothers/family members on newborn care, assessment of the newborn's health, take care of the mother and take extra care of the low birth weight baby. Here the study found that counseling was done by very few ASHAs in Barabanki and Gonda districts where as only about 35% of ASHAs did this activity in the other two districts. The activity done by more than 90% of ASHAs in all the four districts was the assessment of the health of the newborn but the related activity of taking care of the low birth weight baby was not done by any ASHA in Banda and Barabanki districts.

Even in the most developed district of Saharanpur, only about 3% of ASHAs did this activity. In the low developed Gonda district, 39% of ASHAs did this activity. In comparison the activity regarding taking care of mother was done better by all the ASHAs in the four districts. 66% of ASHAs did this activity in Saharanpur followed by 52% of ASHAs who did it in Barabanki district. Gonda with 41% of ASHAs and Banda with 27% of ASHAs followed these two districts. Surprisingly about 17% of ASHAs in Gonda did non-specific activities regarding newborn care during their home visits the details of which did not match at all with that of newborn care.

Hence, the study found that except Saharanpur, the ASHAs in other three districts lagged behind in giving messages on ANC, birth planning and safe delivery to pregnant women. Further, the most sensitive lot of pregnant women who opted for home delivery did not receive the messages from all the ASHAs. The critical messages on newborn care which the current study dealt with were also not given by majority of ASHAs. Except for the message on exclusive breast feeding, all other messages were not given during home visits by most of the ASHAs in 3 districts except Saharanpur.

Similarly, when these messages should have been given by most of the ASHAs to the mothers of newborns, again in 3 districts few ASHAs gave this message during home visits except for Saharanpur district. For referral of the newborns, public health facility was the preferred choice for most of the ASHAs in the four districts which was the ideal action. In terms of activities done by ASHAs during home visits to the newborns, except for the assessment of health of the newborn, all other activities were not done by ASHAs across all the four districts.

IV. CONCLUSIONS

The above results showed that the newborns are visited by the ASHAs. While the decision-making process by ASHAs is done fairly, the activities done by the ASHAs while visiting the houses of newborns needs improvement. The ASHAs also agreed that their home visits would improve if onsite handholding is done by the supervisors while they do the home visits. This would be possible if recurring capacity building initiatives are held on the issue of newborn care at the block level. All these efforts would lead to decrease in neonatal mortality in UP which currently stands at 35 per thousand live births as against 22 for India (SRS, 2019). Hence, the focus should be to have improved home visits both quantitatively and qualitatively.

REFERENCES

[1]. Bajpai N, Dholakia R. (2011). Improving the performance of ASHAs in India, working paper No.1, working paper series, globalcentres.columbia.edu/southasia, 2011.
[2]. Das Shankar (2017). Health Care System in India. In Christian Aspalter, Kenny T. Pribadi, Robin Gauld (Eds.). Health Care Systems in Developing Countries in Asia, Routledge, Taylor and Francis Group. New York.
[3]. GOI (2015). Ministry of Health and Family Welfare; Update on the ASHA Programme, January 2015.
[4]. Government of Uttar Pradesh (2009). Planning Atlas of Uttar Pradesh; Area Planning Division, State Planning Institute, Planning Department.
[5]. Government of Uttar Pradesh (2013). Report on evaluation of Comprehensive Child Survival Program, NRHM, September, 2013.
[6]. Joshi S. R., and G. Mathew (2012). Healthcare through community participation, role of ASHAs, Economic and Political Weekly; vol XLVII no.10, March 10, 2012
[7]. Sundararaman T., Rajani Ved, Garima Gupta, M. Samatha1 (2012). Determinants of functionality and effectiveness of community health workers: results from evaluation of ASHA program in eight Indian states, BMC proc, 2012, 6 (suppl. 5) 030, published online Sept. 2012.
[8]. UP-TSU (2015). Community Behaviour Tracking Survey: Results of the first round, September 2015.
[9]. Vistaar project (2013). Project close out report, Intra Health international, April, 2013, www.intrahealth.org
[10]. Sample Registration System, Registrar General of India, Census office, New Delhi, 2019.