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## ROLE OF ASHAs IN NEONATAL VISITS IN UTTAR PRADESH, INDIA

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### 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. The current study explores some of the crucial variables of the targeted activities of the ASHAs in absolute numbers in four districts of UP. Through this profile, the average number of deliveries in the coverage area of ASHAs, tracking of both institutional and home deliveries by ASHAs, number of deliveries escorted by ASHAs in the last 3 months prior to the survey and the number of newborns that they covered through home visits. The relevance of the study assumes significance as data on the details of targeted activities done by ASHAs in comparison to their performance are usually not available in various studies. 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. The number of neonates visited by each of the ASHAs in the 4 districts in their catchment area per month was in the range of 2-3. Among these neonates who had normal birth weight (at least 2.5 kilograms), the number of visits per ASHA per month was 2-3. Those with low weight (less than 2.5 kilograms) received 1-2 visits per month per ASHA. This reflected that the focus of visits were just adequate for each of the ASHAs.

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### INTRODUCTION

The current study focused on the role and performance of ASHAs (Accredited Social Health Activist) regarding visits to newborns with normal and low birth weights in the last 3 months preceding the survey. The visits are critical as they help to maintain warmth, food (colostrum and breast feeding) and security to the newborns. These three comprise the Home Based Newborn Care (HBNC) package. The study also analyzed the number of neonates visited separately for both normal birth weight and low birth weight newborns. Among the HBNC, warmth component is very critical. A newborn baby is homoeothermic.

A low birth weight baby has decreased thermal insulation because of reduced amount of brown fat. Newborn loses heat by evaporation (amniotic fluid by surface), conduction (touch with cold object), convection (fan, window) where cold air replaces warm air. The warm and pink feet of the baby indicate thermal comfort. The behaviors like delayed bathing, delayed weighing and kangarooing in case of low birth weight babies contribute to warmth of the baby (NNFI, 2015). It further summarizes to address three components which were clean airway, breathing and temperature. The warmth component is extremely critical for low weight babies because if they are not kept warmth, they would not feed and will not gain weight in early neonatal period. Timely visit by ASHAs are critical to ensure proper care leading to weight gain in these babies. Low weight neonates are more prone to communicable diseases like diabetes, hypertension and heart disease in later life (Blencowe *et al*, 2010).

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Studies on home based newborn care reflected its importance through various studies in India and abroad as well. It had been demonstrated that a developed package of home based neonatal care including management of sepsis like septicemia, meningitis and pneumonia was tested in the field for 3 years and it reduced neonatal, infant and perinatal mortality by 62.2%, 45.7% and 71% respectively. Case fatality in neonatal sepsis also reduced. It was also seen that home based neonatal care costs only 5.3 US\$ per neonate. Such care averted one death per 18 neonates (Bang, A. Bang, R. *et al*, 1999). They interpreted that Home Based Neonatal Care including management of sepsis is acceptable, feasible and reduced neonatal and infant mortality by nearly 50% among the malnourished, illiterate rural population. The decrease was most marked in preterm and low birth weight infants. The current study focuses on the visits of ASHAs to low birth weight babies i.e. neonates with birth weight less than 2.5 kilograms.

On focusing upon the preterm babies as mentioned above, it is seen that 30% of the India's total annual live births being born with a birth weight less than 2500 grams. These are the babies who were addition to being at a higher risk of neonatal mortality, were at an increased risk of post-neonatal mortality, stunting, and long-term neurodevelopmental impairment during childhood. The prevalence of birth defects in the country is 6-7% which translated to around 1.7 million birth defects annually. The common birth defects includes congenital heart disease (8-10 per 1000 live births), congenital deafness (5.6-10 per 1000 live births), and neural tube defects (4-11.4 per 1000 live births) (March of Dimes, Lancet 2006). If these babies are visited in time by ASHAs, they will gain weight and be less vulnerable to mortality.

**Background of ASHAs:** The ASHAs emerged in India's public health system during the launch of NRHM in 2005 in the state of Uttar Pradesh (GOI, 2005). The ASHAs were in fact inducted to NRHM with the primary aim to roll out the JSY component of NRHM (GOI, 2005). A study on evaluation of ASHAs in 2013 in UP reflects that 38.3% of ASHAs visited the houses of newborns 6-7 times and only 4.6% of ASHAs visited the houses of newborns more than 7 times. The study does not categorize the visits separately for normal and low birth weight newborns (GOUP, CCSP evaluation report, Vimarsh, 2013). The current study dealt with these categories specifically in the 4 districts of UP.

The performance of ASHAs in UP was also done in another study involving states of Bihar, Chattisgarh, Rajasthan and Uttar Pradesh in 2011. As per the study, three activities of ASHAs were mentioned for new-borns. It reflected that 99% of ASHAs register births, 98% of ASHAs visit new-borns within one week of birth and 73% of new-borns were visited by ASHAs. The percentage of new-borns visited was a weighted average calculated in the study. The current study reflects on the actual primary data collected from the ASHAs (Bajpai N, Dholakia R, 2011). The above two studies do not reflect on the performance of ASHAs with respect to their targets of visits to new-borns. The current study has the numbers for each of the variables used in the study. This study done in 2017 examines the profile of total number of new-borns visited by ASHAs in their coverage area, total number of new-borns visited for both normal and low birth weight categories. The reference period of the study was 3 months preceding the survey.

## RESEARCH METHODOLOGY

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

### Data analysis

The data was analyzed using SPSS software to calculate the total and average number of visits, total number of visits to new-borns that included both normal and low birth weight neonates. It also deciphered the number of newborns visited by ASHAs using the detail profiles of deliveries as per the data in the four study districts. The quantitative data related to the details of home visits to newborns was seen against the prescribed guidelines for ASHAs by GOI regarding achieving targets for these activities in their coverage areas. The reference period of the study was 3 months preceding the survey.

### Research tool

The ASHAs were interviewed using an in-depth, open-ended interview schedule which included a section on variables on work done by ASHAs through home visits to newborns under the section of home visit of the tool. These activities were also seen against the targets that should be achieved by the ASHAs to track the number of visits to the houses of number of newborns in the last 3 months preceding the survey.

## RESULTS AND DISCUSSION

The visits to the newborns in the last 3 months showed that in all districts the ASHAs did not visit all the newborns. The number of newborns who were not visited by the ASHAs is 16 in Banda, 17 in Barabanki, 26 in Gonda and 7 in Saharanpur. This showed that in Gonda district, the visit coverage of newborns was lowest among the four districts. Further, when we saw the average visits in terms of weight of newborns, 5 visits were done to newborns with normal weight in Banda, Barabanki and Gonda districts where as only 4 visits in Saharanpur, the most developed district among the four districts. Similarly, for newborns with low weight, 7 visits each were done in Banda and Gonda, 6 visits each in Barabanki and Saharanpur. This showed that the poorly developed districts did better than the developed districts among the four.

**Table 1. Number of newborns visited by ASHAs during home visits in the last 3 months preceding the survey**

Names of districts	Banda (n=62 ASHAs)	Barabanki (n=62 ASHAs)	Gonda (n=64 ASHAs)	Saharanpur (n=62 ASHAs)
Number of newborns visited by ASHAs during home visits in the last 3 months preceding the survey				
Number of newborns visited by ASHAs	496	414	412	384
Average number of visits to a newborn with low weight	7	6	7	6
Average number of visits to a newborn with normal weight	5	5	5	4

**Table 1.1.0**

Districts		Number of times newborn with normal weight visited in a month	Number of times newborn with low weight visited in a month
Banda	Mean	4.60	6.63
	N	62	62
	SD	1.207	1.550
Barabanki	Mean	4.58	6.44
	N	62	62
	SD	1.337	2.244
Gonda	Mean	5.09	6.97
	N	64	64
	SD	1.294	1.543
Saharanpur	Mean	3.98	6.26
	N	62	62
	SD	0.735	0.991
Total	Mean	4.57	6.58
	N	250	250
	SD	1.228	1.654

Further, in all the districts, the number of visits was less than one visit as per the number of scheduled home visits prescribed in HBNC package of GOI. The table below gave the descriptive statistics like mean and standard deviation for the indicators related to the visits of newborns as mentioned in the above table.

### Conclusions

The above results showed that the average number of visits of ASHAs to the houses of new-borns in the catchment area of each ASHA per month was in the region of 2-3 in the last 3 months of preceding the survey. This was seen across the districts which are adequate. The major problem is that the ASHAs do not compare the performance regarding the visits with their targets as the home visits are not planned in advance. Similarly, the average visit to the normal weight category new-borns was 2-3 per month and those with low weight were in the region of 1-2 per month. As all the deliveries are not tracked by ASHAs, the newborns are also not tracked and that's why all the newborns are not visited by the ASHAs in all the districts. The challenge lies in orientating ASHAs on following up all these home visits with the support of Sanginis (supervisors of ASHAs in UP) and that too it should be preferably an onsite orientation i.e. during the home visits while accompanying the ASHAs. Data regarding calculating the targets for visits to houses of newborns should be worked out at the level of ASHAs so that performance is tracked regularly.

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