Knowledge in Tracking Danger Signs in Newborns and their Referrals by Asha 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 danger signs in newborns and their subsequent referrals by the ASHAs in four districts of UP. Through this profile, the knowledge of ASHAs on these danger signs and the action that they take after identification is detailed out.

The relevance of the study assumes significance as data on the details of targeted activities on high risk newborns 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.

Key words: ASHA, JSY, CCSP, Sanginis, NSSK

Introduction:

The current study focused on the role and performance of ASHAs (Accredited Social Health Activist) regarding tracking of danger signs by ASHAs. ASHAs are supposed to track all the deliveries of the pregnant women in their area, visit all the newborns in their area as a prioritized activity. These targets were developed by the Government of UP on the lines of HBNC guidelines provided by GOI. In UP, the delivery tracking and home visits to newborns by ASHAs started with the CCSP in 2008 operated through the National Rural Health Mission (NRHM) that is currently operational in 18 states of India. Uttar Pradesh is one such state. The aspects of danger signs in newborns covered here are the signs like unable to feed, feel cold to touch, convulsions, fever, lethargic or unconsciousness. The study also explores the role of ASHA in referring these high risks newborns to institutions as part of Navjat

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Sushila Surakya Karkoram (NSSK), a component of child health.

**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 into 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 reported that they visited newborns 6 to 7 times. Among the ASHAs, 45.1% reported receiving the 10-day CCSP training. The eighth chapter of the CCSP training module has the details on the danger signs of the newborns and the ways to identify these signs and the expected actions of ASHAs after identification of the danger signs. (GOUP, CCSP evaluation report, Vimars, 2013).

The performance of ASHAs in UP was also done in another study. As per the study, 98% of ASHAs visited newborns within one week of birth. Among the newborns, 73% of newborns were visited by ASHAs (Bajpai N, Dholakia R, 2011).

As per another study in UP, 90% Recently Delivered Women (RDW) reported that their newborns received an initial checkup or first visit at the time of delivery at the facility. Regarding home visits, the second visit increased from 21% to 60% while the third visit increased from 8% to 40% (EOP report, Vistaar project, 2013).

The above two studies do not reflect on the performance of ASHAs with respect to their targets. 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 deliveries in the coverage area of ASHA, total number of newborns visited and the role of ASHAs as an escort for these deliveries to institutions in the reference period of 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 percentage of ASHAs having knowledge about the danger signs in newborns and referring them immediately to an institution. It also deciphered the type of danger signs in 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 and deliveries was seen against the prescribed guidelines for ASHAs by GOI regarding achieving targets for these activities in their coverage areas.

**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, identify danger signs in newborns and referring these high risk newborns to a health facility.
Results and discussions:

In this section, there is one table one for the details on the aspects of referring the newborn in the catchment areas of ASHAs. It also captures the knowledge and performance of ASHAs in knowing the danger signs in newborns that they have visited and referring them immediately to a health facility. All these activities are for the ASHAs in the selected districts.

| Names of districts (n=250) | Banda (n=62) | Barabanki (n=62) | Gonda (n=64) | Saharanpur (n=62) |
|---------------------------|-------------|-----------------|-------------|-----------------|
| Percentage of ASHAs who know about the danger signs of a newborn and refer the newborn immediately in case of these danger signs. |              |                 |             |                 |
| Unable to take feed       | 9.6         | 90.3            | 79.6        | 96.7            |
| Difficulty in breathing   | 29          | 33.8            | 50          | 35.4            |
| Lethargic or unconscious  | 3.2         | 19.3            | 9.3         | 35.4            |
| Fever                     | 100         | 100             | 90.6        | 100             |
| Cold to touch             | 35.4        | 56.4            | 29.6        | 95.1            |
| Convulsions               | 0.0         | 4.8             | 3.1         | 8.06            |
| Refer the newborn immediately | 100        | 98.3            | 54.6        | 95.1            |

The section in the table above is the knowledge of ASHAs on the danger signs that a newborn can have. Most of the ASHAs in the 4 districts identified fever as a danger sign. Except for 10% of ASHAs in Barabanki, more than 80% of ASHAs knew that a newborn being unable to take feed is a danger sign. 30% in Gonda, 35% in Banda, 56% in Barabanki and 95% in Saharanpur knew that if the newborn was touched and the sense of feeling was cold, it was a danger sign. Next sign was difficulty in breathing and here we saw that 30% in Banda, 34% in Barabanki, 50% in Gonda and 35% of ASHAs in Saharanpur knew the sign as a danger sign of the newborn. Similarly, 35% in Saharanpur, 20% in Barabanki, 10% in Gonda and 3% of ASHAs in Banda knew if the newborn was lethargic or unconscious, it was a danger sign. As a danger sign, convulsion was known to 8% of ASHAs in Saharanpur, 5% in Barabanki and 3% in Gonda while no ASHA knew this danger sign in Banda. In referring the newborn with a danger sign, again the ASHAs of Gonda faltered as only 55% of ASHAs replied that they refer the newborn immediately. In rest of the 3 districts, more than 95% of ASHAs replied that they refer the newborn immediately.

Conclusions:

The above results showed that the danger signs like fever and unable to take feed were the danger signs that most of the ASHAs in the four districts knew about. The third most important danger sign that the ASHAs across the four districts knew was that the child feels cold when touched. This is followed by difficulty in breathing. The danger sign of being lethargic and unconscious was the next in line. The all-important danger sign of convulsion was the sign that few ASHAs knew across the four districts. The major problem is that the ASHAs do not compare the performance with their targets. As all the deliveries are not tracked, 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 the deliveries 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 deliveries and newborns should be worked out at the level of ASHAs so that performance is tracked regularly on the referrals of the newborns.
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