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CHILD SURVIVAL THROUGH INTERVENTION OF ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA) IN ALIGARH DISTRICT

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Abstract

Accredited Social Health Activist (ASHA) was introduced by the government of India, under National Rural Health Mission (NRHM) in 2005 to render health care services to rural population with major focus on vulnerable groups i.e. women and children. In India, poor accessibility health care services for children resulted with high child mortality, and Uttar Pradesh, stands below than national average. The ASHAs endeavour for the survival of every child through rendering care services in every village. The efforts of the ASHAs for child survival in Aligarh are reflected in the several studies by DLHS, NFHS, and AHS. District Level Household Survey-3 (DLHS, 2007-08) reported that Infant Mortality Rate (IMR) and Child Deaths Under- 5 years were 85 and 73 respectively. Subsequently, DLHS- 4 (2013-14), reported some improvement in which IMR came down 72 and Child Mortality Under- 5 were reduced by 65. Immunization indicators also improved as full immunization of children in Aligarh District was of 30.4 percent in 2011 which improved to 56.62 in 2015 (Annual Health Survey, 2013). National Family Health Survey (NFHS- 4, 2015- 16) also supports some improvement in child health indicators in Aligarh. This study is based on data by secondary sources from studies, surveys, reports, and modules etc. The current study attempts to highlight intervention of the ASHAs at grass root level for ensuring child survival.

Key Words: *ASHA, NRHM, Child Survival, IMR, Child Mortality, Immunization*

INTRODUCTION

The Government of India has been adopting measures concerning health care services for masses at grass root level, and children and women are paid special care and attention due their vulnerable health condition. High child mortality is a grave issue since many decades. In India, an estimated 26 millions of children are born every year. As per Census 2011, the share of children (0-6 years) accounts 13% of the total population in the country. An estimated 12.7 lakh children die every year before completing 5 years of age. However, 81% of under-five child morality takes place within one year of the birth which accounts nearly 10.5 lakh infant deaths whereas 57% of under-five deaths take place within first one month of life which accounts for 7.3 lakh neo-natal deaths every year in the country (MoHFW, 2013).

Historically, The First and the Second Five-Year Plans witness some programs for people's health care, and Child health services were integrated with family planning services as part of the Minimum Needs Programme during the Fifth Five-Year Plan, aimed at providing at least a minimum level of public health services to pregnant women, lactating mothers, and preschool children. In 1992–93, the Child Survival and Safe Motherhood Programme continued the process of integration by bringing together several key child survival interventions with safe motherhood and family planning. In 1996, safe motherhood and child health services were incorporated into the Reproductive and Child Health Programme which integrates maternal health, child health, and fertility regulation interventions with reproductive health programmes for both women and men. Besides other elements of maternal and reproductive health, the important elements of the programme include encouragement of institutional deliveries or home deliveries assisted by trained health personnel (prcs-mohfw.nic.in/writereaddata/research/470.doc). National Rural Health Mission (NRHM) launched in 2005, as a mega health care program following the second health policy of India in 2002, and Millennium Development Goals (MDGs) to achieve health goals by 2015, in which reducing child mortality by two third was goal 4 by ensuring child survival (MDGs, 2019). Health for All through primary health care involving Community Health Workers at grass root level was declared in Alma- Ata Conference, Kazakhstan, USSR in 1978 (WHO, 1978), and subsequently Accredited Social Health Activist (ASHA) as CHW in India is understood as a key strategy under NRHM program in 2005 in order to link people with public health system and to create awareness about health facilities and services especially for children in rural settings.

Selection and Trainings of ASHA

The Government of India introduced ASHA with certain conditions, and roles and responsibilities for their selection and routine functioning, as they should be selected by her community, based in her community and serve as resource to their community (NRHM, 2013 page 7). An ASHA must be a woman with primary resident of a village with formal education up to the eighth class, and preferably married/ widowed/ divorced/ separated in the age group of 25-45 years with communication and leadership skills. She would be selected by the Gram Sabha through an intense community mobilization process under supervision of District/Block nodal officer designated by District Health Society (DHS) (NRHM, 2013). ASHA is provided with some trainings includes induction training for 23 days or

consolidated 08 days, program specific trainings, periodic training, refresher training and on job training etc. She is also be equipped with a drugs kit, and works as key frontline workers in close coordination with Auxiliary Nurse Midwife (ANM) and Aaganwadi Worker (AWW), Gram Pradhan and PRIs. Thus, proper selection, training and coordination of ASHAs are quiet necessary for desired outcomes sought by NRHM goals.

Roles and Functions of ASHA

ASHA as a pillar of NRHM for health care services at grass root level functions in the roles as a facilitator of health services links people to health care facilities, as a provider of community level health care, and as an activist who builds people's understanding of health rights and enables them to access their entitlements (NRHM, 2013). An ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. They carry out routine activities as home visits, attending the village health and nutrition day (VHND), visits to health facility, holding village level meetings and maintaining records, with focus interventions for ensuring child survival which are universal immunization, safe delivery, newborn care, and prevention of water-borne and other communicable diseases, nutrition and sanitation. She will be accountable to the Panchayat, and will be entitled to receive performance-based compensation for providing health services (WHO, 2006). Guidelines for Community Processes (2013) has illustrated functions of ASHAs involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries, educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services, participation in health campaigns and enabling people to claim health entitlements. Thus, the ASHAs in different roles and functions address the health requirements of people including children in particular.

MATERIALS AND METHODS

Objective

The objective of this paper is to discuss the roles and functions of the ASHAs in ensuring child survival.

Data and Sources

The present study is based on secondary sources. The data and information has been collected from government reports, training modules, studies conducted by national & international agencies, independent organisations, state departments etc. The contribution of ASHAs for child survival has been studied in Aligarh District.

In India the major causes of child mortality has been given by the World Health Organization (WHO) which is making efforts across the world in making good policy and planning by the countries to control it.

Child Health Indicators in Aligarh District

High child mortality in Aligarh District indicates a serious health issue in Uttar Pradesh. Infant Mortality Rate is 70, followed by Neo natal Mortality 51 and Under five Mortality 90 respectively.

Table 1 Status of Child Health Indicators of Aligarh

Indicators	Aligarh District
Infant Mortality Rate (IMR)	70
Neo-Natal Mortality Rate (NNMR)	51
Under-five Mortality Rate (U5MR)	90

(Source: NHM & DoHFW- UP, 2017)

Thus, for ensuring the survival of every child in Aligarh District, ASHAs are working day and night since 2005- 06 and putting their best efforts to control mortality.

Health Infrastructure, ASHA and other Frontline Workers in Aligarh District

As per Census 2011, total population of Aligarh district is 3673849. There are 05 *Tehsils* and 12 rural blocks in the Aligarh District. The health facilities in Aligarh district comprise of 03 District Level Hospitals, 13 Community Health Centres, 35 Primary Health Centres and 333 Sub Centres. In urban area there are 18 Urban Primary Health Centres. There are 2146 village and 2850 ASHAs, 103 ASHA Facilitators, 3039 Aaganwadi Wadi Workers, and 348 ANMs working in Aligarh District.

Table 2 Health Infrastructure in Aligarh District

Total Number of Sub-Centres	Total Number of Aaganwadi Centres	Total Number of Primary Health Centres	Total Number of Community Health Centres	Total Number of District Hospitals	Total Number of Medical College
333	3039	35	13	03	01

(Source: NHM & DoHFW- UP, 2017)

Table 3 Front line Workers in Aligarh District

Total Number of Accredited Social Health Activists (ASHAs)	Total Number of ASHA Facilitators (AFs)	Total Number of Aaganwadi Workers (AWWs)	Total Number of Auxiliary Nurse Midwives (ANMs)
2850	**103**	**3039**	**348**

(Source: NHM & DoHFW- UP, 2017)

Intervention of ASHAs for Child Survival in Aligarh District

The intervention of ASHAs for ensuring child survival involve they conduct household visits and prepare the list of all pregnant women, particularly the poorest families, and in the sections which tend to get left out, e.g. women from SC/ST communities, women living in hamlets far from the main village, or in hamlets that fall between villages, newly migrant women and women headed households (NRHM, 2013). She helps pregnant women getting registered as early as possible but within 12 weeks of pregnancy and receive four Antenatal care services as two Tetanus Toxoid (TT) injections, several tests, Haemoglobin, Blood Pressure, Blood, Urine, HIV, Sugar etc. They educate women about the importance of the four ANC visits and to maintain balanced diets (milk, pulses, beans, nuts, vegetables, fruits, eggs) and adequate rest. They ensure that all pregnant women should receive supplement rations from their nearest Aaganwadi Centres. They motivate and support the pregnant women for institutional delivery. They escort pregnant women to the primary or community health centre at the time of delivery for safe delivery. They necessarily involve in the few important care and services to the newly delivered babies as maintain cleanliness, drying of newborn, ensuring warmth, early initiation of breast feeding, weighing, no traditional feedings, no immediate bath before one weak, immediate immunization, avoid pre lacteal feeding and get rid of harmful traditional practices. ASHAs undertake post natal home visits six or seven times. When the child is delivered at hospital, ASHA has to visit six times, and if delivery held at home, she needs to conduct seven home visits in the series 1, 3, 7, 14, 21, 28 and 42 for home delivery, and 3, 7, 14, 21, 28 and 42 for institutional delivery. During home visits she assesses the children completely for various symptoms and practices whether being followed by the family or not. She carries out the activities such as weighs the child, assess fever, exclusive breast feeding practice by mother, birth registration, free supplementary food from Aaganwadi, diarrhoea, pneumonia, yellowness in the child. She counsels the mother to follow adequate diets and full immunization be given to the child along with supplementary

foods from Aaganwadi centre. She educates the mothers about danger signs of the children as fever, diarrhoea, no breast feeding, crying, convulsion, chest in drawing, and lethargic and unconscious, and the child is caught by any such signs, it is immediately call to ASHA and visit to the higher centre for specialist treatment. ASHA ensures complete immunization of the children along with nutritious foods and diets as essential to avoid them from diseases and timely growth. She further enquires the malnourished children and refers them to nutrition rehabilitation centre at district level through proper channel. She endeavours in her area with other frontline worker for the better health care of every children.

Table 4 Status of Child Immunizations in Aligarh

Indicators	Rural	Urban	Total
		(%)	
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT)	79.2	63.6	67.9
Children age 12-23 months who have received BCG	95.3	94.3	94.6
Children age 12-23 months who have received 3 doses of polio vaccine	92.9	77.5	81.7
Children age 12-23 months who have received 3 doses of DPT vaccine	82.4	78.8	79.8
Children age 12-23 months who have received measles vaccine	87.0	83.4	84.4
Children age 12-23 months who have received 3 doses of Hepatitis B vaccine	79.3	63.0	67.4
Children age 12-23 months who received most of the vaccinations in public health facility	85.7	93.0	91.0

(Source: International Institute of Population Sciences, 2015)

Table 5 Child Feeding Practices and Nutritional Status of Children in Aligarh

Indicators	Rural	Urban	Total
		(%)	
Children under age 3 years breastfed within one hour of birth	23.6	26.2	25.4
Children under age 6 months exclusively breastfed	22.6	27.9	26.2
Children age 6-8 months receiving solid or semi-solid food and breast milk	56.4	32.9	43.1
Breastfeeding children age 6-23 months receiving an adequate diet	7.7	3.9	5.0
Non-breastfeeding children age 6-23 months receiving an adequate diet	6.6	0.0	3.0
Total children age 6-23 months receiving an adequate diet	7.4	3.2	4.6
Children under 5 years who are stunted	42.1	52.2	49.1
Children under 5 years who are wasted	20.8	11.9	14.6
Children under 5 years who are severely wasted	6.3	1.9	3.2

Children under 5 years who are underweight	37.5	38.4	38.2
Children age 6-59 months who are anaemic (<11.0 g/dl)	66.2	67.0	66.8

(Source: International Institute of Population Sciences, 2015)

Data reveals some improvements in child immunization as full immunization, BCG vaccination, polio vaccination, DPT, measles and immunization in public health facility among various child health indicators leading to child survival by the consistent efforts of ASHAs in their respective villages of Aligarh District. Similarly ASHAs are needed to put more efforts on child feeding practices and nutrition of children so as to improve nutritional necessities of children as these data are not well improved in the data shown in last table 5. Therefore, the intervention of ASHAs should be more focused on services as well as familial practices, diets and feeding practices by the families.

Results and Discussion

The results of data reveals, ASHAs have been endeavouring to control child mortality in Aligarh District. They are providing child health care services to the children at door step but the parents and families are needed to abide by the instructions and advices in order to maintain nutritional requirement of children. They conduct post natal home visits and check-ups the child thoroughly, counsels the family for care and sometimes if any child in severe problem, refer to higher centre. System Registration Survey (SRS) presents, neonatal mortality rate has fallen from 53 in 1990 to 31 in 2011 and deaths among 0-28 day's neonates decreased from 13.2 lakh to 8.2 lakh. And total number of under five mortality rate is 55 per thousand live births which translates into 14.5 lakh deaths of children below 5 years of age, at the same time, about 43 percent of under five years child deaths take place within first 7 days, and 56 percent under five deaths occur in a very first month, and 80 percent of under five deaths happen within one year (SRS, 2013). Thus, it is very apparent that improvement in child survival cannot be ensured as long as the life of children (0-365 days) is safe and secured. The ASHAs could be the instrumental in ensuring the survival of children. Thus, the efforts are ASHAs are also reflected by Common Review Mission (CRM in Annual Report 2016-17 MoHFW, New Delhi) shows that ASHA has been a key figure in contributing to the positive outcomes of increases in institutional delivery, immunization, active role in the disease control program (malaria, kala-azar, lymphatic filarisis etc.) and improved breast feeding and nutrition practices.

Conclusion

The introduction of ASHAs is instrumental for improving child survival in Aligarh District, but it is needed some more efforts to get better results in other child health indicators. There has been an improvement in child immunization with a significant percentage as compared to feeding and nutritional status. Proper support system in field by PRIs and families and system support could help ASHAs in bringing desired outcomes set in NRHM, MDGs and SDGs for child survival.

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