Role of ASHA in Providing Home Based Newborn Care (HBNC) Services in District Kheda, Gujarat

Internship Training
at
District Program Management Unit, District Kheda, Gujarat at
National Rural Health Mission, Government of Gujarat
(February-April, 2014)

By
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Under the guidance of
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Post Graduate Diploma in Hospital & Health Management
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Institute of Health Management Research
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TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Kajal Chauhan student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at District Program Management Unit, dist. Kheda, Gujarat under NRHM, Govt. of Gujarat from 4 February to 30th April,2014 .

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.
I wish her all success in all her future endeavors.

Dr Ashok Kaushik
Dean, Academics and Student Affairs
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Dr. S.D Gupta
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District Health Society

District Program Management Unit, Kheda; Nadiad

CERTIFICATE

The certificate is awarded to…Dr. Kajal Chauhan…. In recognition of having successfully completed her internship in the department of …RCH , District Health Society, Kheda)..

During this period she has successfully completed her project on *Role of ASHA in providing HBNC services in District Kheda.*

She comes across to be sincere, committed and deligent person with a pleasant nature.

We wish her all the Best for future endeavors.

Place: District Health Society, Kheda

23/5/14

Chief District Health Officer,
DHS, Kheda

Chief District Health Officer
Kaira Dist. Panchayat Nadiad.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "Role of ASHA in providing Home Based Newborn Care services in district Kheda, Gujarat ", submitted by Dr Kajal Chauhan Enrollment No 1320 under the supervision of Dr S.D. Gupta for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 4 Feb,2014 to 30th April 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

(Dr. Kajal Chauhan)

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I would like to express my sincere gratitude to the Mission Director, NRHM, Government of Gujarat for providing me an opportunity to work with a wonderful organization and for making all the facilities/support available in all possible ways for completion of internship & Dissertation.

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Dr. Kajal Chauhan

(PGDHM,17)

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ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
CDHO	Chief District Health Officer
CHC	Community Health Centre
DDO	District Development Officer
DH	District Hospital
DPMU	District Program management Unit
DPO	District Program Officer
HBNC	Home Based Newborn Care
IEC	Information Education and Communication
IMR	Infant Mortality Rate
LBW	Low Birth weight
LHV	Lady health Visitor
MMR	Maternal Mortality Ratio
NABH	National Accreditation Board for Hospital/ Healthcare.
NRHM	National Rural Health Mission
PCM	Paracetamol
PHC	Primary Health Centre
RCH	Reproductive and Child Health
SC	Sub Centre
SPSS	Statistical Package for Social Science
UNICEF	United Nation Children Fund
WHO	World Health Organisation

DISSERTATION REPORT

Executive Summary:

Neonatal mortality in India is about 36/1000 live births and neonatal mortality accounts for 50% of deaths of all children under five, it suggests that the current level of neonatal deaths needs to be atleast halved in order to achieve Millennium development goal.

HBNC programme is a process sensitive approach towards reducing maternal and neonatal deaths in India, especially at homes. The core principle underlying this programme is the "continuum of care" aimed at improving new born survival by providing Care for both the mother and newborn from conception till the first 42 days after delivery at the home/community levels, institutions where delivery takes place and again at home after discharge from the facility by means of ASHA workers who act as connecting link between the health services and the community

A study in this relation was conducted in district Kheda amongst 102 ASHA‟s to assess the role of ASHA in providing HBNC services by means of understanding the knowledge possessed and the services provided as per the need of HBNC protocol. For this, three talukas were selected based on performance criteria and data was collected based on semi structured questionnaire.

The results revealed that majority of the ASHA (95%) had completed training sessions for both module 6 and 7 and felt no further need for training, although the duration of last training session held ranged from 3 months to more than 1 year. Despite adequate training ,three fourth of them (75%) could not identify/ enlist general danger signs in fever amongst newborns.

Although, the ASHA‟s were clear about providing 6 home visits(69.2%) in institutional deliveries , the ASHA‟s were not very clear about the number of visits to be given in case of home delivery .The knowledge of ASHA regarding conditions of high risk pregnancy was found adequate as almost all of them could enlist major conditions found in high risk mothers. The criteria for providing tab PCM during fever in ante natal mothers could be enlisted correctly only by 28 percent of respondents whereas , the treatment protocol for fever in new born was correctly matched by half of the ASHA.

The knowledge of ASHA with regard to criteria for low birth baby was not adequate as Only 41 % of them considered babies less than 2.5 kg as LBW .The examination of new born at home by ASHA did not cover all essential signs/ symptoms as Only 26.5 percent of the ASHA were examining the eyes in newborns . Level of alertness (20%) and redness in umbilicus (20.6%) were the least examined features in new born.

Majority of ASHA had correct knowledge about minimum number of breast feeds (69%) to be given to new born and minimum number of meals to to be taken by pregnant women.It was found that ASHA had no specific hurdles in providing HBNC through home visits . Although they felt the job was underpaid , job satisfaction was the major motivational factor for the ASHA.

Thus, the HBNC strategy‟s success in reducing neonatal mortality ultimately depends on ASHAs making timely home visits and properly identifying, treating, reporting and referring sick infants. Improving ASHAs‟ ability to correctly assess and classify illness requires strengthening their skills, improving the clarity and usability of HBNC formats as decision support tools, and ensuring ongoing supportive supervision.

5. Introduction

Each year, of the almost 27 million infants born in the country, 0.88 million die before they complete one month of their life .With IMR 41 (SRS 2012) and Annually,1.1 million neonatal deaths occurring in India the largest number in any single country, there was an thus an urgent need to find new solutions to address this issue along with maternal deaths both being millennium development goals

Various studies on distribution of Neonatal deaths reveal that the most vulnerable time in the newborns life is during birth and the first week of life. For this, effective interventions for the care of the mother and the baby during and immediately after delivery and in first few weeks of life is essential.

Although significant proportion of mothers prefer to return home within a few hours after delivery, which means that home based newborn care needs to be available even for such babies born in institutions to tide them over the first day and thereafter. Though this is not desirable and all efforts should be made to convince mothers to stay in the institutions for 48 hours after delivery, existing evidence shows that while at an all India level nearly 45% of mothers return home before 48 hours post delivery.(***Coverage evaluation Survey, 2009, UNICEF) .***

Thus, the provision of maternal and newborn care by means of community worker or ASHA, through a continuum of care approach, ensuring care during critical periods of delivery and postnatal period, addresses the needs of the mother and the newborn through a seamless transition from home and village to the facility and back again.

Therefore, The SEARCH, Gadchiroli model of Home-based Newborn Care (HBNC) was started as an intervention research in 1988 which was a major breakthrough towards finding a way to reduce the IMR. HBNC is a process sensitive approach where newborn care was a home-spun solution which had emerged from the grassroots and showed that there was a way of giving home based care to the new born child which would enable the newborn child to survive neonatal deaths.

Home based new born Care is one such provision where Care for the mother and newborn is provided from conception till the first 42 days after delivery at the home/community levels, institutions where delivery takes place and again at home after discharge from the facility. Although, infant mortality has fallen in many developing countries but, the rate is very slow (***UNICEF 1999***) the reason being the slow decline in neonatal mortality due to unavailability of essential newborn care. According to ***WHO 1996 guidelines*** essential newborn care emphasises on cleanliness, thermal protection, initiation of breast feeding, early and exclusive breast feeding, eye care, immunisation, management of illness and care of low birth weight infants.

Home Based Newborn Care is included in the Government Policy which aims to improve the newborn survival. The XI Plan Document (2007-2012) and the Minutes of Meeting of the Mission Steering Group Committee (June 2011) clearly state that the ASHA s will be trained on identified aspects of newborn care during their training. Further, it was also decided that the ASHA will receive an incentive of Rs. 250/- for completing a series of HBNC visits. It was also agreed upon that if no maternal and infant deaths are reported in a year, the ASHA of the particular village community will also receive an award.

5.a) Objectives of HBNC

The major objective of HBNC is to decrease neonatal mortality and morbidity through

- The provision of essential newborn care to all newborns and the prevention of complications
- Early detection and special care of preterm and low birth weight babies.
- Early identification of illness in the newborn and provision of appropriate care and referral.
- Support the family for adoption of health practices and build confidence and skills of the mother to safeguard her health and that of the newborn.

5.b) Key activities in HBNC

- Care of newborn by a series of home visits by a trained health worker in the first six weeks of life. In most state contexts this health worker is ASHA.

- Information and skills to the mother and family of every newborn to ensure better health outcomes.
- An examination of every newborn for prematurity and low birth weight.
- Extra home visits for preterm and low birth weight babies by ASHA or ANM, and referred for appropriate care as defined in protocols.
- Early identification of illness in newborn and provision of appropriate care at home or referral as defined in the protocols.
- Follow up of sick newborns after they are discharged from facilities.
- Counselling the mother on post partum care, recognition of post partum complications and enabling referral.
- Counselling the mother for adoption of an appropriate family planning method.

5.c) Skills needed by ASHA in the provision of HBNC

- Mobilize all pregnant mothers and ensure that they receive the full package of antenatal care
- Undertake birth planning and birth preparedness with the mother and family to ensure access to safe delivery
- Provide newborn care through a series of home visits which includes:
    - Weighing the newborn
    - Measuring newborn temperature
    - Ensuring warmth
    - Supporting exclusive breastfeeding through teaching the mother proper positioning and attachment for initiation and maintaining breastfeeding
    - Diagnosing and counselling in case of problems with breastfeeding
    - Promoting hand washing
    - Providing skin, cord and eye care,
    - Health promotion and counselling mothers and families on key messages on newborn care which includes discouraging unhealthy practices such as early bathing and bottle feeding,
    - Ensuring prompt identification of sepsis or other illnesses.
- Assessing if the baby is high risk through the use of protocols and managing such LBW or preterm babies through

- Increasing the number of home visits,
- Monitoring weight gain,
- Supporting and counselling the mother and family to keep the baby warm and enabling frequent and exclusive breastfeeding,
- Teaching the mother to express breast milk and feed baby using spoon if required

- Detect signs and symptoms of sepsis, provide first level care ad refer the baby to an appropriate center.
- Recognize post partum complications in the mother and refer appropriately.
- Counsel the couple to choose an appropriate family planning method.
- Use the checklist for first visit to newborn and home visit form to remind her to ask the key questions and ensure that she follows the steps of examination and counselling the mother.
- Provide immediate newborn care, in case of those deliveries that do not occur in institutions.

6. Review of Literature :

- A study was conducted in the community involving mothers who had given birth in two hospitals in the Puttalam district in Sri Lanka. The intervention was a 4-day training programme and primarily aimed at increasing knowledge and skills of essential newborn care (ENC) among health care providers in the maternity units of these hospitals. Three months after the intervention, 150 mother–newborn pairs were interviewed at home. Results revealed that there was a significant improvement in umbilical cord care practices at home following the intervention. Application of „surgical spirit" on umbilical cord has declined from 71.5% in the pre-intervention to 45.3% in the post-intervention samples. Pre-intervention breastfeeding rates were high, and there wasn't any further improvement in the post-intervention. There was a 35% reduction in the proportion of newborns who developed any undesirable health events at home.[12]
- Singh et al (2010) suggests that young recently delivered women (RDW) have the highest likelihood of utilizing ASHA"s services by undergoing early registration, adequate ANC and postnatal check up. On the other hand, likelihood of receiving antenatal care declined sharply with rise of birth order,

which is partly attributed to greater home responsibilities of women with higher parity and non-availability of help at home during their absence.

Singh et al (2010) also stress on sensitized ASHA in post natal care (PNC) because a large majority of women lack this information. There is need to enhance the knowledge and awareness of ASHA on the importance of PNC where she is provided with training in PNC component by specialists. Individual and community level factors were found to motivate ASHAs more than the health system factors in Odisha (Gopalan, Mohanty & Das, 2012).

- Shrivastava and Shrivastava (2012) in their study among trained ASHAs in Thane found that ASHAs lacked in knowledge of various aspects of child health morbidity Both studies have recommended better training being imparted to ASHAs in order to enhance their knowledge levels. Refuting this view Shukla and Bhatnagar (2012) revealed that ASHAs have optimal knowledge of expected work and are the major source of information and support for pregnancy related service.
- A study by Mishra (2012) suggests greater involvement of community in recruitment of ASHAs, so that ASHA can efficiently act as a bridge between community and health system. Strengthening the sub-center and public health centre for safe childbirth service can enhance ASHA‟s contribution because the commute from primary health service to long distance hospital acts as a major constraint for institutional delivery. Cash incentives certainly increased the number of institutional deliveries as the ASHAs make all possible efforts to take pregnant women to Government health care facilities for delivery.
- Studies conducted in Bangladesh, India and Pakistan have shown that home Home visits for can reduce deaths of newborns in high mortality, developing country settings by 30 to 61% (3–7). The visits have improved coverage of key newborn care practices such as early initiation of breastfeeding, exclusive breastfeeding, skin-to-skin contact, delayed bathing and attention to hygiene, such as hand washing with soap and water, and clean umbilical cord care

7. Problem Statement

Every year, in India, 28 million pregnancies take place with 67,000 maternal deaths, 1 million women left with chronic ill health, and 1 million neonatal deaths.

Neonatal mortality in India is about 36/1000 live births and neonatal mortality accounts for 50% of deaths of all children under five. Three quarters of all neonatal deaths occur during the first week of life, and about 20% take place in the first 24 hours. This is also the period when most maternal deaths take place.

Up to two-thirds of these deaths can be prevented if mothers and newborns receive known, effective interventions . A strategy that promotes universal access to antenatal care, skilled birth attendance and early postnatal care by means of ASHA as service provider will contribute to sustained reduction in maternal and neonatal mortality . Studies at various levels have shown that home-based newborn care interventions can prevent 30–60% of newborn deaths in high mortality settings under controlled conditions.

8. Research Question

- What is the role of ASHA in providing HBNC services ?
- Is ASHA able to render their responsibilities effectively

9. Objectives of Study

9.a) **General objective :**

- To review the role/ responsibilities of ASHA for providing HBNC services .

9.b) **Specific objective**

1) To access the knowledge of ASHA in relation to role/ responsibility for the HBNC services .
2) To study ASHA"s performance in terms of services provided under HBNC.
3) To identify areas of improvement in effective implementation of the HBNC services provided by ASHA

10. Methodology

10.a) Study design : Descriptive cross sectional study.

10.b) Study Area: The study was conducted in District Kheda of Gujarat. Three Blocks were selected based on the criteria of high performing, medium performing and low performing in HBNC services on the basis of physical reporting/ secondary data available at the District level.

The Criteria for performance was as follows :

a) Number of Home visits given against total number of deliveries.
b) Total number of Low birth babies referred against total number of low birth babies reported.
c) Proportion of Babies breastfed within 1st hour .

On the basis of the above criteria 3 blocks of Nadiad, Thasra and Matar were chosen to represent the district.

10.c) Study respondents : ASHA at sub centres, and PHC levels.

10.d) Sample size : A sample of 102 was included for the study as follows:

Table # 5 : Taluka wise number of ASHA

Name of Taluka	Total No. Of ASHA
Nadiad	195
Thasra	134
Matar	171

10.e). **Sampling method:**

A sample of 102 ASHA was drawn from amongst 500 ASHA in the three talukas chosen by Simple Random sampling of Sub centres under each PHC. ASHA was then interviewed from these blocks. The data was collected by visiting sub centres and homes of ASHA.

10.f) Data Collection tool/ technique

Primary data was collected from the field through interview with ASHA on pre dssigned Semi structured questionnaire. This included questions regarding the services included in HBNC along with knowledge asssement questions. The questionnaire also focussed on understanding the challenges in providing HBNC services.

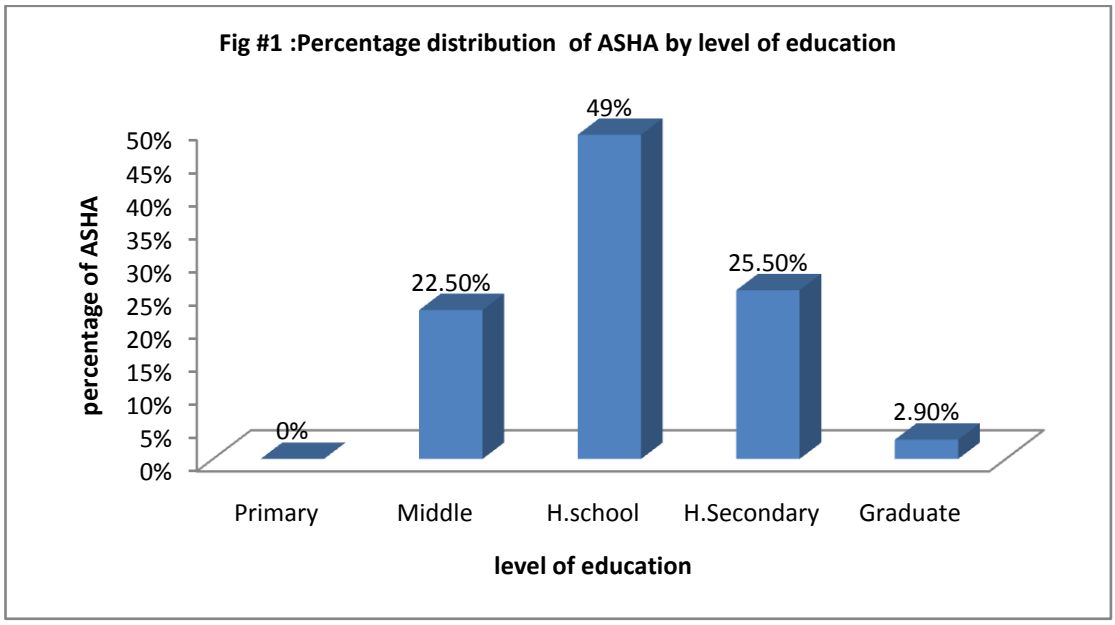
10.g) Data Analysis:

- Data was entered and analysis done with help of SPSS software .

11. Results

The national rural health mission (NRHM) introduced the Accredited Social Health Activist (ASHA) for improving maternal and child health (MCH) of rural India and is the considered to be a healthcare facilitator and provider for HBNC at grass root level. According to the guidelines the ASHA should be a resident women of the village in age group 20-40 years.The average age of ASHA"s under study comes out to be 34 years .

11.1 Education level amongst ASHA.



Basic education is an essential requirement for effective services as the ASHA should be able to carry out services like weighing, measuring and reporting accurately . It was found that nearly half of the ASHA (49 %) had received high school education and nearly one quarter (25.5%) of them had higher secondary education. ASHA with minimum qualification were 22.5% in distribution . However, A very few (3 ASHA"s) were graduates in basic education. It was observed that the ASHA had difficulty in doing basic calculations and counting number of visits as well as maintaining records.

11.2 Training Sessions attended by ASHA :

Table # 5 Training status of ASHA

Serial No.	Training Sessions	Number of Respondents		
		Yes	No	N/A
1	Induction training	93	9	0
2	Training for both module 6 &7	97	5	0
3	Further need for training felt	92	5	5

11.2a) Induction training

Induction training forms an integral part in helping understand the role and responsibilities for the desired job description.

The study revealed that Majority 91.2% of the ASHA‟s had received induction training at the time of joining. However , the rest 8.8% of them were either new ASHA who had recently joined or were old ASHA who had not received any induction training.

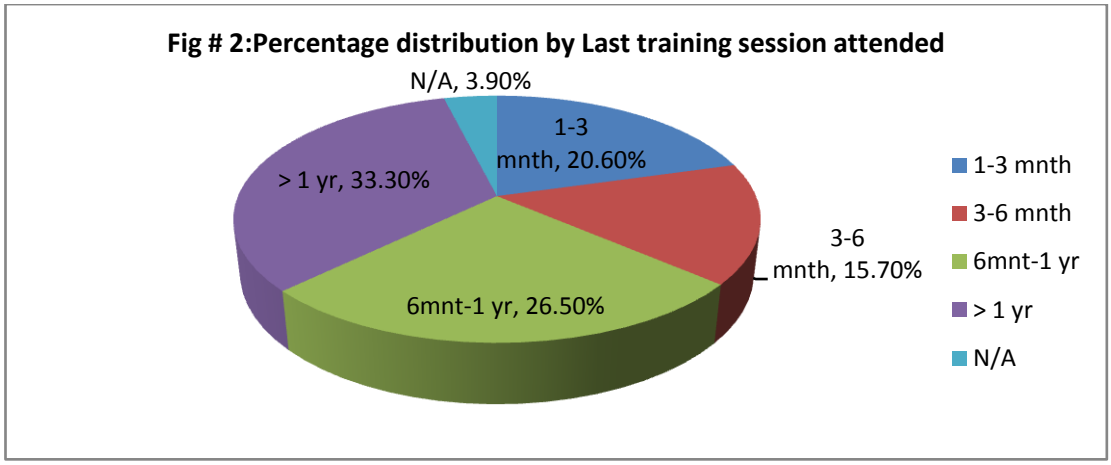
11.2 b) Complete training for modules 6 and 7

Majority of the ASHA‟s had received all rounds of training for module 6 and 7, thus 95.10 percent of them had completed training for both rounds. The remaining 4.9 percent of ASHA were those who had recently joined and had undergone no training.

11.2 c) Felt Need for training

A major lot of the ASHA respondents (90.2%) felt there was no further need for training on HBNC as they found to have gained adequately from the training sessions already held. A very small proportion of them (4.9%) however wanted further training . The rest were the newly appointed ASHA‟s with no trainings received.

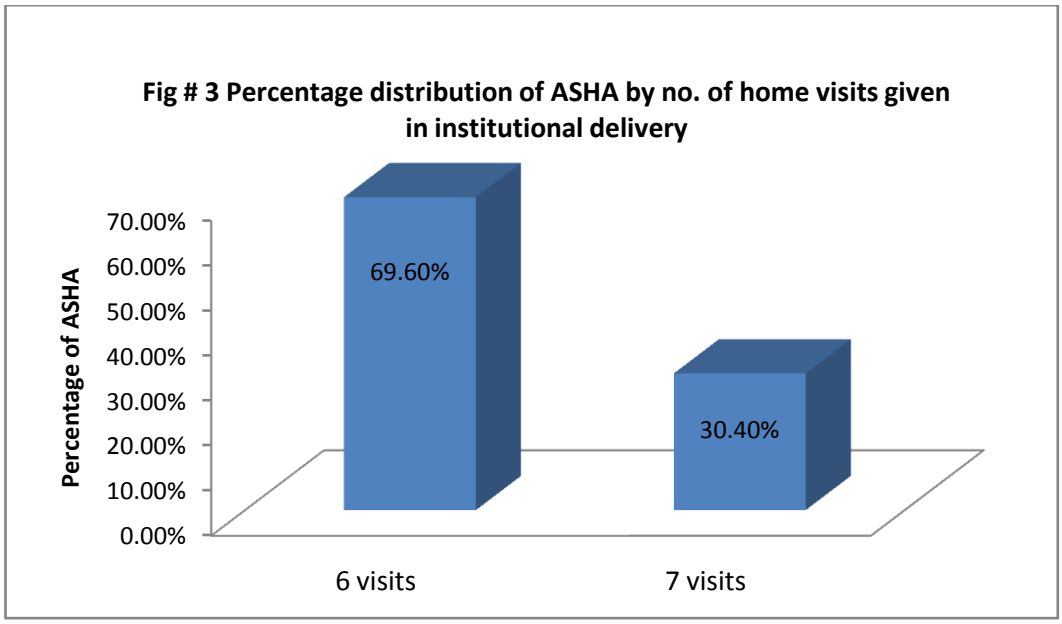
11.2 d) Last Training Session



The last training session on HBNC was held more than one year back in case of one third (33.3%) of the respondents, and was held 6 months to 1 year back in 26.5% of the ASHA"s. Training was held 1to 3 months back only in 20.6% of the respondents. The N/A were the newly formed ASHA that had received no training .

11.3 Home Visits provided by ASHA in institutional delivery:

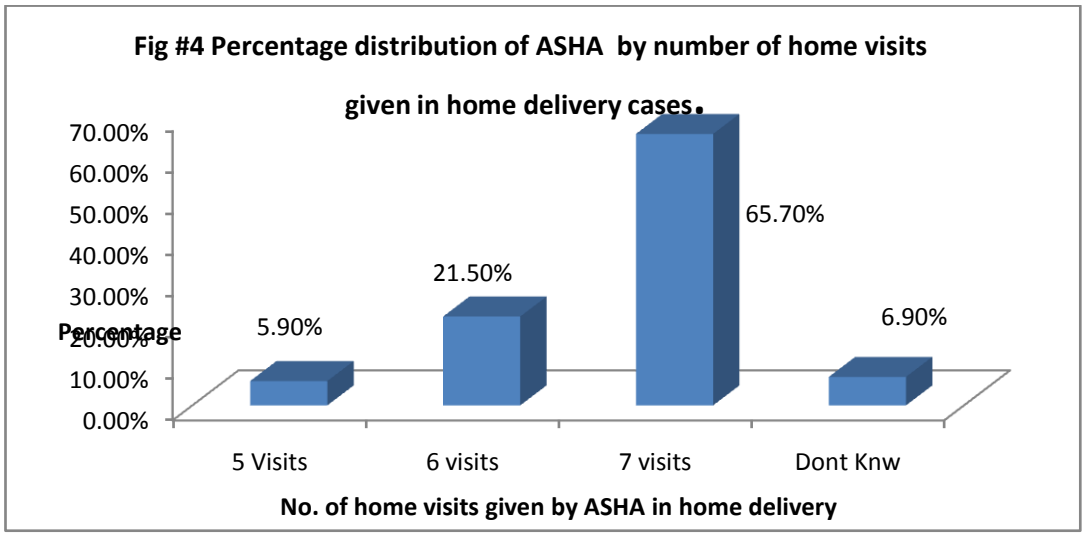
Home visits after birth is a strategy to deliver effective elements of care to newborns and increase newborn survival. This strategy has shown positive results in high mortality settings by reducing newborn mortality and improve key newborn care practices.



The operational guidelines for HBNC services requires a minimum of 6 visits to be made by ASHA in case of institutional delivery.(i.e essentially on 3, 7, 14, 21, 28, 42 days) and once every two weeks till the child is two years old.

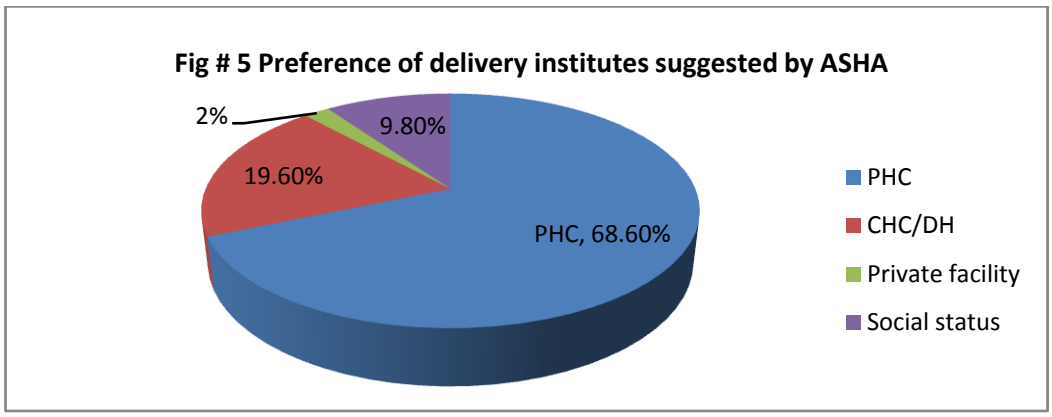
The study reveals that 69.6% of ASHA made all the 6 visits to the new born and the remaining 30.4% made 7 visits for the new born . They had a clear idea of the frequency and the day"s at which the visit needed to be made at the home.

11.4 Home Visits provided by ASHA to newborns in home deliveries



Majority of the respondents provided seven visits including one additional home visit on day 1 in case of home delivery in their areas against 21.5% of ASHA who gave only 6 visits for the new born in home deliveries. A small section of ASHA (5.9%) said they provided only 5 visits to babies born at home. Whereas , a good number (6.9%)of them were not aware of the minimum number of visits to be given to new borns in home delivery. The results show that the exact number of visits to be made in case of home delivery was not very clear to ASHA as only 65.7% ensured ell the seven visits were made to newborns in home delivery cases. The reason they gave was no home deliveries were occurring in their areas. However , they could not give the exact number of visits to be given in case home delivery was reported in their area

11.5 Delivery referral suggestions by ASHA

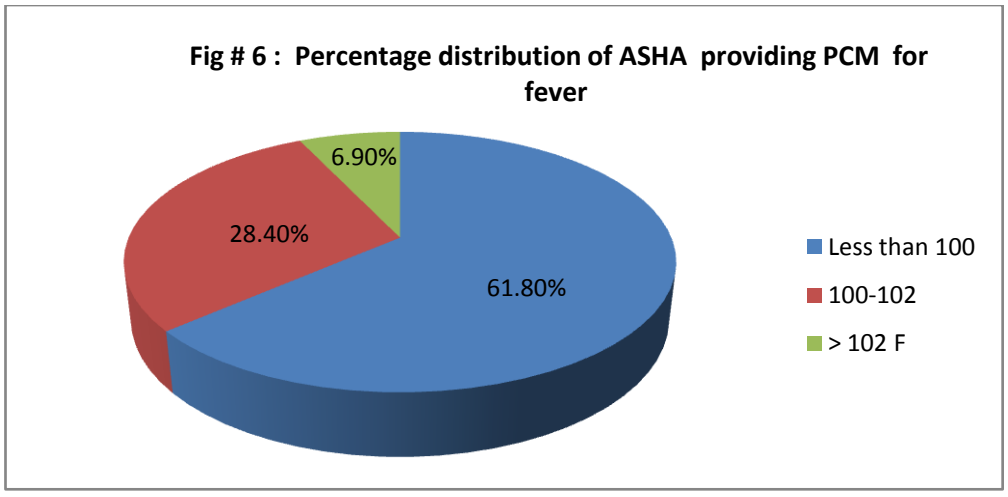


A large number of ASHA"s primarily advised the Antenatal women to visit PHC for conducting delivery due to its close proximity to the village, whereas nearly 19.6% percent advised them to go for CHC/ DH directly. Only a small fraction of 2 percent ASHA referred pregnant women for delivery to private facility.

It was found that none of the ASHA were advising the pregnant women to visit Sub centre for getting delivery conducted although most of the SC"s were conducting deliveries in Kheda and the motivation by ASHA for referral played an important role in conducting deliveries at health facilities.

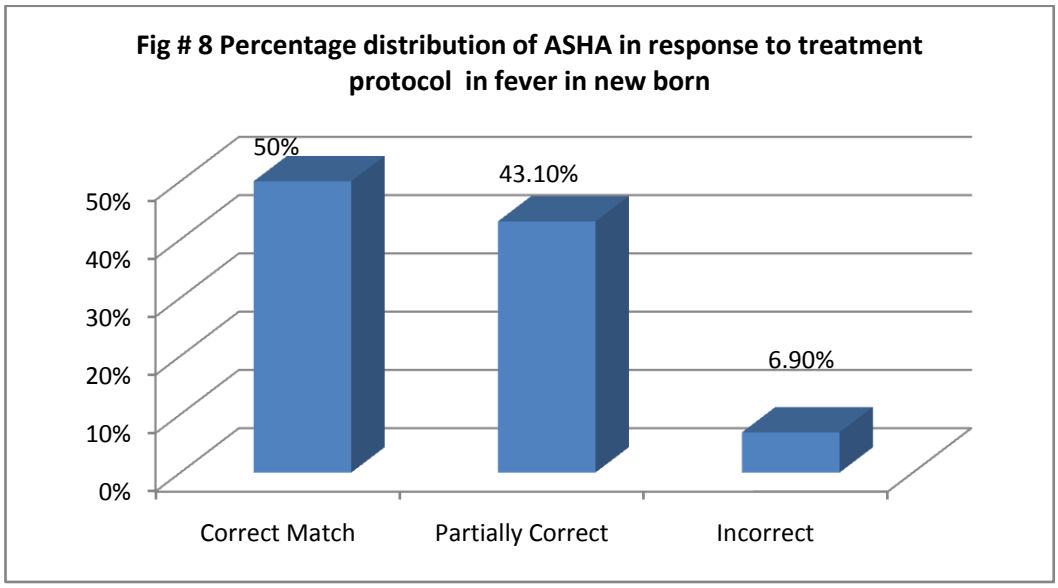
A significant (nearly 10 percent) of ASHA made referral advice to ANC mothers on the basis of social status of family .

11.6 Treatment of fever in Ante natal Mothers :



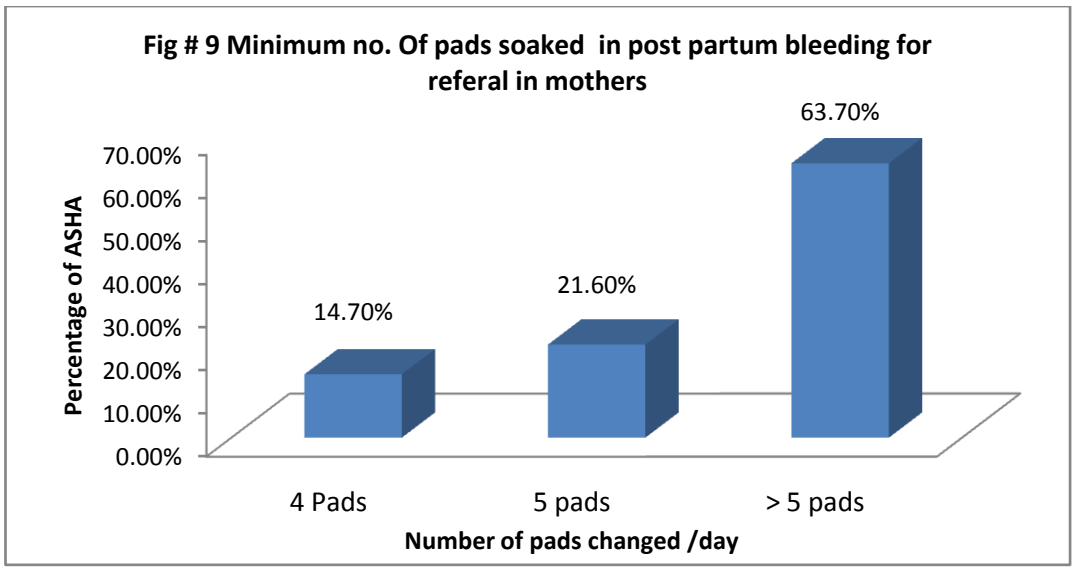
Majority of the ASHA agreed that they would provide tablet PCM for fever and would be giving it for fever measuring less than 100 degree Fahrenheit. Only 28.4% percent of the ASHA had been providing tablet PCM in fever 100-102 degree Fahrenheit. Nearly 6.9 percent of them agreed that they give PCM to ANC mothers only when temperature was above 102 Fahrenheit.

11.7) Treatment protocol for fever in newborns :



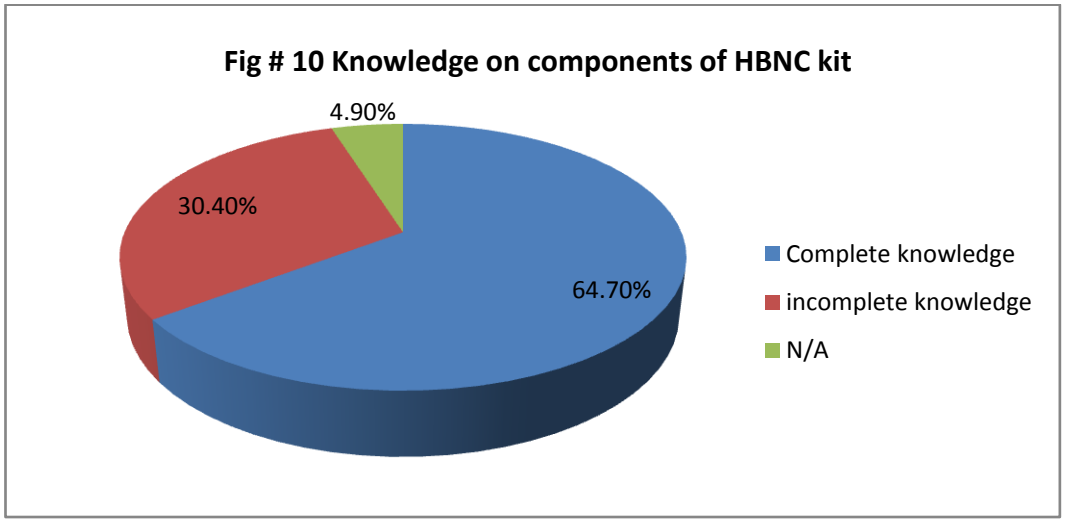
Only Half of the ASHA"s correctly knew , what is to be done for different grades of fever in the newborn. Almost 7 percent of them were completely unaware of the fever management in newborns whereas, the remaining 43.10% percent were partially correct in managing new born with temperature less than 95 F(35 C) with hypothermia management and Kangaroo care for baby. Baby with body temperature more than 99 F (37.2 C) shall be re-examined after some time and shall be referred to PHC or mother shall be treated with PCM for fever treatment in such baby. whereas babies with fever in between 95-97 shall be given Kangaroo care along with adequate breast feeds by mother to fulfil the caloric needs of baby.

11.8 Criteria for referral based on number of pads used in post partum bleeding:



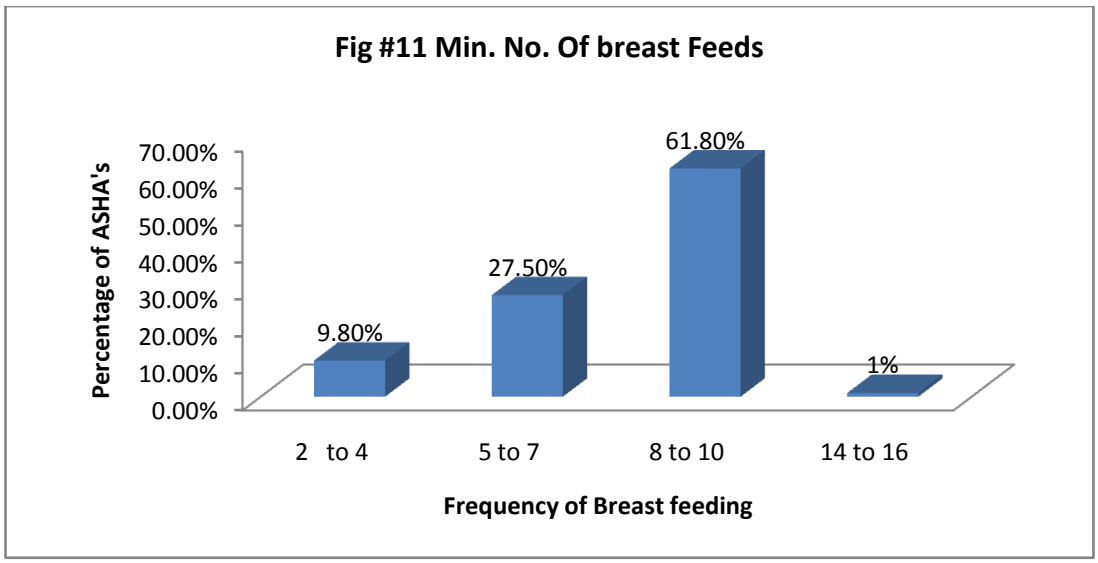
Nearly 64 percent of the ASHA respondents were aware that the post partum mother needed referral to health facility if she had bleeding leading to change of more than 5 pads a day in post partum period. The ASHA also enquired about the consistency and smell associated with the discharge.

11.9 Components of HBNC kit



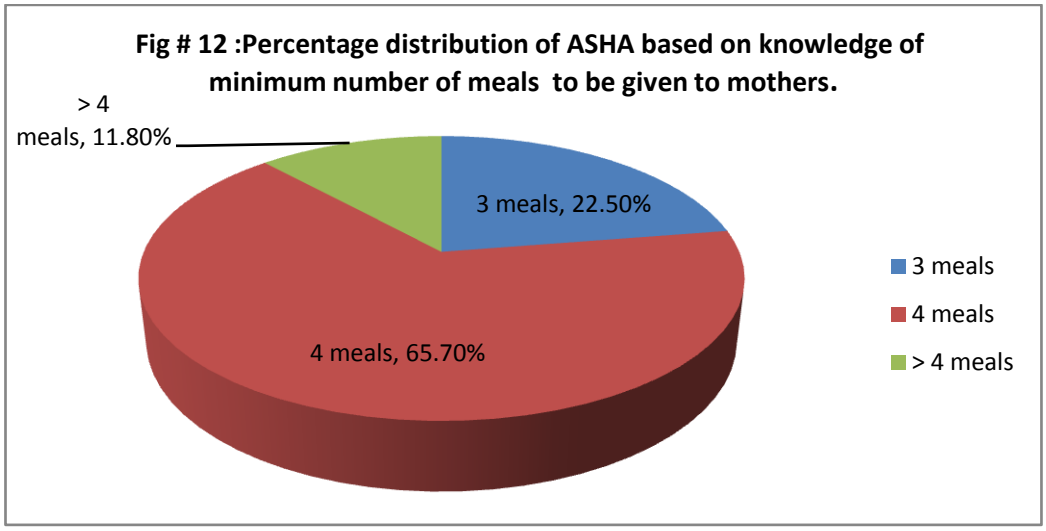
Nearly two third of ASHA had complete knowledge about all components of the HBNC kit , although all of them had received the kits apart from 4.9% of the new ASHA"s.

11.10) Minimum number of breastfeeds to be provided to newborns:



A significant number (61.8 percent) of ASHA"s knew that the new born baby should be fed atleast 8-10 times a day . Among the rest 27.5percent of them asked thee mothers to feed the baby atleast 5-7 times whereas almost 10 percent of them only suggested 2-4 breast feeds for the new born. All ASHA asked the mothers to feed the baby ass many times as the baby needed feed in case of maximum number of feeds needed by baby.

11.11) Minimum number of meals for pregnant women:



The minimum number of meals to be suggested for pregnant women in antenatal period was 4 in case of 65.7 percent of ASHA. Only 11.8% adviced more than 4 meals a day to the pregnant women during antenatal counselling.

11.12 Examination of newborns during home visits:

Fig# 13 : Percentage distribution of ASHA examining signs/ symptoms in newborns during home visits

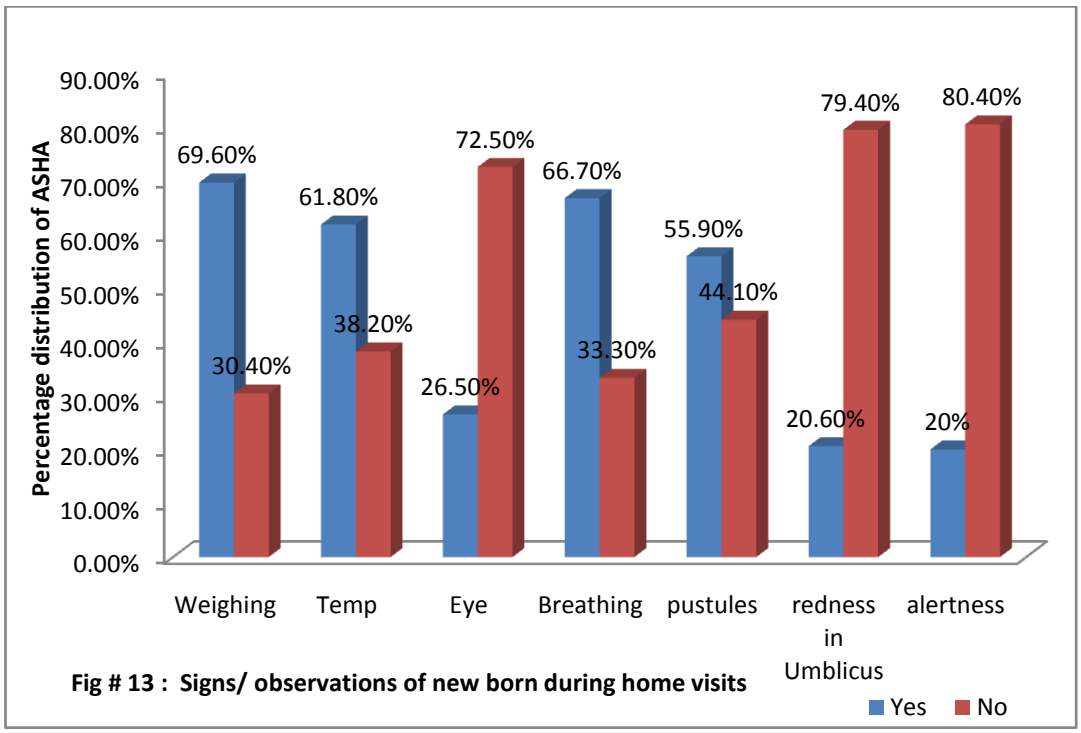
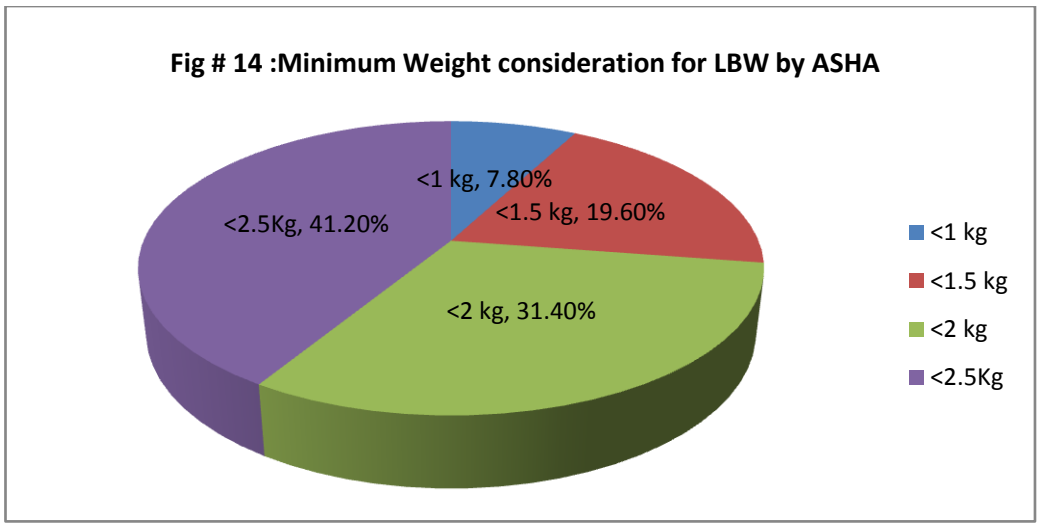


Fig # 13 : Signs/ observations of new born during home visits

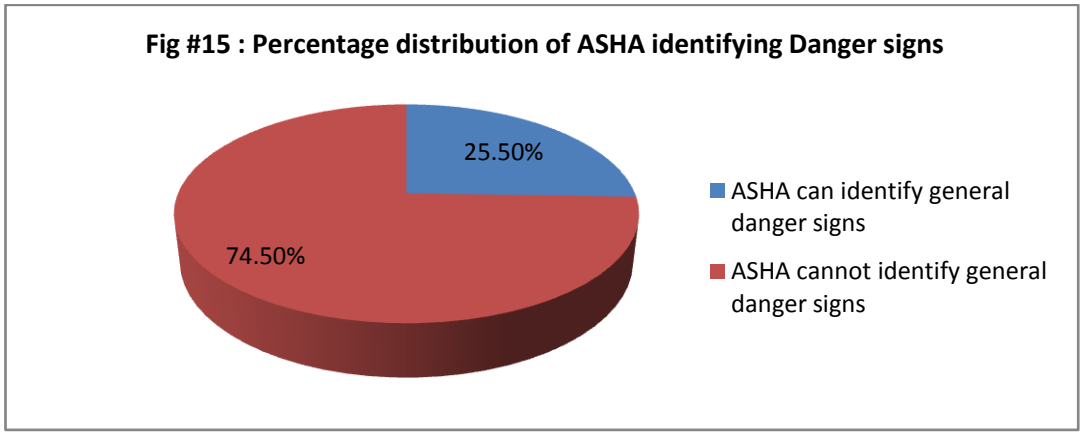
Although ASHA were providing home visits to new born both in case of institutional and home deliveries , it was found that majority of them were not covering all essential components of new born examination as reflected in the results. Weighing was conducted by only 69.6% percent of the ASHA , whereas breathing and temperature was recorded by 66.7 and 61.8 percent of the ASHA"s respectively. Only 26.5% percent of the ASHA were examining eyes in newborns . Level of consciousness or alertness and redness in umbilicus were the least examined features in new born ,being examined by only 20 and 20.6 percent of ASHA suggesting that sensory/ motor defects and infections were left unnoticed at primary level of care.

11.13 Criteria for Low Birth Weight Baby :



Against the expectations , less than half (41.2percent) of the ASHA"s could identify the criteria for low birth weight babies. Nearly, one third of them identified 2 kg as the criteria for low birth weight in newborns and 1.5 kg was the criteria for 20 percent of the ASHA"s. The remaining 8 percent identified babies with 1 kg weight as Low birth weight baby.

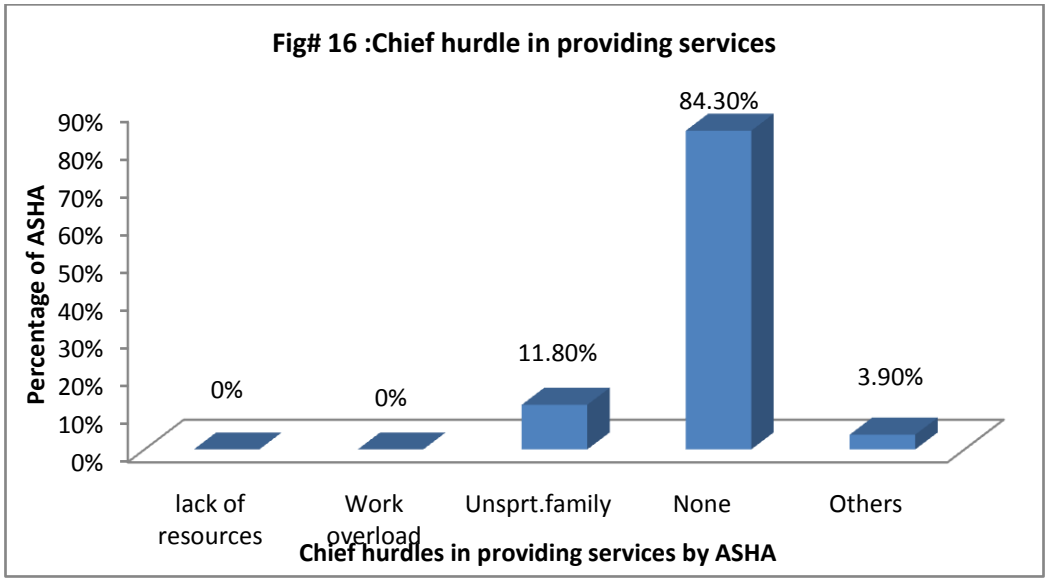
11.14 Identification of general Danger Signs in fever:



Three fourth of the ASHA respondants agreed that they are unable to identify general danger signs amongst babies with fever. Amongst the quarter (25.5 percent) of the respondants who agreed to have identified the signs

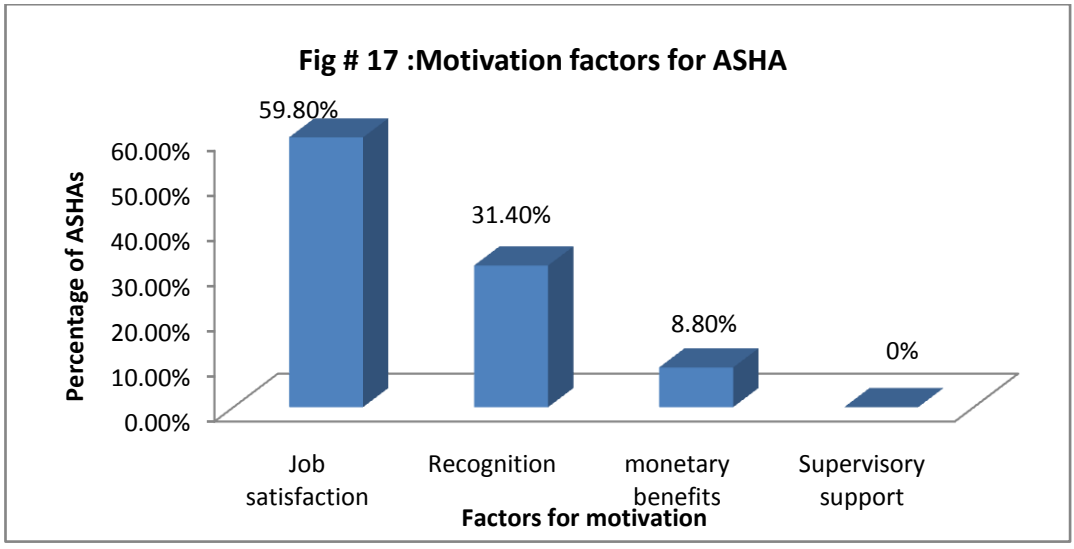
Socio Economic Factors affecting services provided by ASHA:

11.15 Chief hurdle in providing HBNC services



Most of the ASHA (84.3%) agreed that they were not facing any specific problem in providing HBNC services at household level. A small fraction of them however faced some problem as far as support/ compliance of family of beneficiary was concerned. Around 4 percent of them said that they occasionally felt problems like reluctant family members due to socio cultural beliefs and social status of the beneficiaries.

11.16 Motivation for Job/ work



Nearly 60 percent of the ASHA felt job satisfaction was the main motivational factor for them to be working as ASHA , Recognition by society and appreciation of work/efforts by society was the next leading factor in 31.4 percent of the ASHA‟s. Monetary benefits although was the associated factor in majority of ASHA but it was the chief cause of motivation in 9 percent of the ASHA‟s.

11.17 Payment of incentive :

All of the ASHA agreed that they were being paid incentive on time and had no problems/ delays in payment. However, most of the ASHA felt that they were not being paid in proportion of the work done/ care provided by them.

12. Conclusion

Although majority of ASHA had been provided basic training in HBNC (module 6,7) a significant number of them were not clear about the treatment protocol to be followed in basic ailments like fever , both in newborns and antenatal mothers.Noticeably, almost all of them could enlist high pregnancy conditions , and referral was mostly suggested for PHC"s. The knowledge of ASHA was found adequate in providing post natal care as far as minimum number of breastfeeds to the newborn and minimum number of pads soaked in post partum period was concerned. The ASHA"s however, were not considering all essential signs/ symptoms to be examined in newborns during home visits.

The HBNC strategy"s success in reducing neonatal mortality ultimately depends on ASHAs making timely home visits and properly identifying, treating, reporting and referring sick infants. Improving ASHAs" ability to correctly assess and classify illness requires strengthening their skills, improving the clarity and usability of HBNC formats as decision support tools, and ensuring ongoing supportive supervision.

For this, the minimum Education level of ASHA should be atleast high school since basic reading and writing skills and calculations need to be assessed correctly . The ASHAs should be given refresher training atleast once every year so that she can revise the training module and guidelines of HBNC in presence of the trainer and make her skills and services more effective. Also refresher course will help her learn from the peer experiences and help her incorporate effective practices in her daily activities. Good performing ASHA can share her practices and experiences and help provide new ways to make services more effective

Provision of effective supervision by the ASHA facilitators through direct observation and on spot/ field mentoring could help in providing Corrective measures that can be incorporated to enhance the skills in ASHA.

Regular Competency assessment at PHC and taluka level will help evaluate the current knowledge levels of ASHA so that areas of weak knowledge and skills are known and further planning can be made for making ASHA"s more effective

Recognition of ASHA at community level for her contribution will act as motivating factor for better performance. Thus, there is need to revise/expand basket of incentives to ensure that ASHA stays interested in her work. In most places, she values what she does and wants to grow within that space. This places the onus on state governments and programme managers to find ways to nurture her voluntary spirit and help her in career advancement.

All these efforts would help to increase the participation and role of ASHA in effective implementation of HBNC services and would lead to better outcomes.

13. Limitations of Study

1. The study was conducted in a limited time period hence the sample size had to be limited to 102 ASHA , keeping in view the time at disposal.

2. The study could not include the perception of the beneficiaries and supervisors such as Medical Officer, FHW about role of ASHA in providing HBNC services

14. References

1) National Rural Health Mission, Ministry of Health and Family Welfare Government of India. Home Based Newborn Care: Operational Guidelines.NirmanBhavan, New Delhi; 2011

2) Bang AT, Bang RA, Reddy HM "Home based neonatal care summary and application of the field trial in rural Gadchiroli, India."""Journal of perinatology, 2005 March 25, suppli: S108-S122

3) ASHA modules 6 and 7 ; Skills that save life.

4) Sudesh kumar ; An action plan to assess the current situation of maternal and new born care at government health facility in Jharkhand.

5) Replicating the home based new born care in India; Report of the convention ; New Delhi, August, 2006) (http://nipccd.nic.in/mch/fr/nbc/erl27.pdf)

6) Operational guidelines on maternal and new born health. (http://tripuranrhm.gov.in/Guidlines/Maternal_Newborn_Health.pdf)

7) Emily Das, Dharmendra sing Panwar, Elizabeth Fischer, Girdhari Bohra and Martha Carlough : Performance of Accredited Social Health Activists to Provide Home-based Newborn Care: A Situational Analysis; Journal, Indian Paediatrics,Feb, 2014. **)**

8) Home visits for the newborn child: a strategy to improve survival**.**http://www.unicef.org/spanish/health/files/WHO_FCH_CAH_09.02_eng.pdf

9) A study on effectiveness of structured teaching program on knowledge regarding home based new born care (www.rguhs.ac.in/cdc/onlinecdc/uploads/05_N043_29134.doc)

15. **Annexure**

CONSENT FORM

Form id No-

Namaskar, This study is being conducted by …… to assess the role of ASHA in providing HBNC services to the beneficiaries.

The following questions are to get an idea of your understanding of the HBNC services to be provided and the main hurdles in the implementation of the services by the ASHA.

This information provided by you would be kept confidential and would only be used for academic purpose and would not affect your performance/ incentives in any way. Participation in this survey is voluntary and if you choose to participate, you may withdraw at any time. The survey will take 5 -10 min. However we hope that you will take part in the survey since your participation is important

Certificate:

I hereby make clear that I have read out the information sheet to the potential participant and have explained the purpose of study and consequences to the ASHA. The participant has voluntarily agreed for the participation and is willing to answer the questions

Signature of interviewer: Signature of interviewee:

Questionnaire for ASHA (Tick the correct answer)

Section # 1 (General Information)

1) Name.....
2) Age..... 3) Name of SC.....

4) Years of Education

a) primary b) middle c) High school d) Higher Secondary
e) Graduate

Section # 2 (Training sessions)

4.) Have you received induction training on HBNC?

a) Yes b) No

5) .Tick the module for which training is received?

a)Module 6 b) Module 7 c) Both. d) None

6). Was the training adequate to understand the services to be provided?

a) Yes b) No

7). When was the last training session held?

a) 1-3 months back b) 3-6 months back

c) 6mnths-1 year back d) more than 1 year

Section # 3 (Understanding of HBNC : knowledge/ Services)

8.) What is the number of home visits in case of institutional delivery?

a) 3 b) 4 c) 5 d) 6 e) 7

9). What is the number of home visits in case of home delivery?

a) 3 b) 4 c) 5 d) 6 e) 7

10). Which of the following is a case of high risk pregnancy ?

a) severe anaemia b) haemorrhage c) multiple pregnancy

d) hypertension e) all the above

11). Where is the pregnant women advised to go for delivery in case of high risk pregnancy?

a) SC b) PHC c) CHC/ DH d) Private facility.

12) At What temperature should mother be treated with PCM if she has fever?

a) Less than 100 b) 100-102 F c) More than 102

13). Match the following in case of fever in new born.

a) Fever more than 99 F 1) hypothermia management

b) Fever between 95-97F 2) Paracetamol / referral

c) fever less than 95 F 3) Adequate feeding practices along with kangaroocare

14) If post partum mother faces bleeding and .....number of pads are changed , she should be referred to hospital.

a) 3 b) 4 c) 5 d) more than 5

15) Do you provide options/ counselling for family planning to the mother in post natal period?

a) Yes b) No.

16). Are you aware of the components of HBNC kit?

a)Complete knowledge b) Incomplete knowledge c) No idea

17.) What is the minimum number of breast feeding a baby should be given in 24 hrs?

a) 2-4 b) 5-7 c) 8 - 10 d) 14-16

18) What is the minimum number of times the mother shall take full meal in 24 hrs?

a) 1 b) 2 c) 3 d) 4

19) Which of the following is examined by you to access new born care?

a)	Weighing	Yes	No
b)	Measuring temperature	Yes	No
c)	Examine warm/cold to touch	Yes	No
d)	Difficulty in breathing	Yes	No
e)	Pustules	Yes	No

f) Redness in umbilicus Yes No
g) Unconsciousness Yes No

20.) A baby is considered low weight if the baby is below.....Kg.

21.) Which of these is component of new born care?

a)Dry the baby b) keep baby warm c) initiate breast feeding d) All

22.) Can you identify danger signs of fever in new born?

a) Yes b) No

(If no skip quest. 23)

23) Which of these is to be noticed in fever of new born?

a) Not able to drink or breastfeed b) Vomits everything
b) Has convulsions d) Is lethargic or unconscious e) all of the above

Section # 4 (Social Factors)

24) What is the chief hurdle faced in providing services?

a) Lack of resources/ logistic b) work overload

c) Non compliance of family/ mother d) Others (specify).....

25). Is the incentive paid on time ?

a) Yes b) No

26). What is motivating force for the job/service?

a) Job satisfaction
b) Recognition
c) Monetary benefits
d) Supervisory motivation/ support.

Any Suggestions /
Recommendations.....

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