

Essential New Born Care - “Home Based Care by Asha Workers”

Anu Gauba¹, Dr. Kochu Thresiamma Thomas²

¹PhD Scholar, Department of Nursing, NIMS, Jaipur, Rajasthan, India

²Professor, PhD Co-ordinator NIMS, Jaipur, Rajasthan, India

Abstract: Neonatal mortality in developing countries is one of the most important problems that need immediate attention in order to achieve Millennium Development Goals. About 4 million newborns die in the world every year, 90% of them in the developing world. Most of these deaths are preventable by simple interventions in the community. However, in most of the target countries, the implementation of essential newborn care has been very poor. The home based or community care packages include maternal care, essential newborn care, improving the behavior change communication of the community, resuscitation of newborn babies at the time of home delivery, and management of sick newborns with antibiotics at home. Studies have reported one-third to two-third reduction of mortality among newborns after home based care interventions.



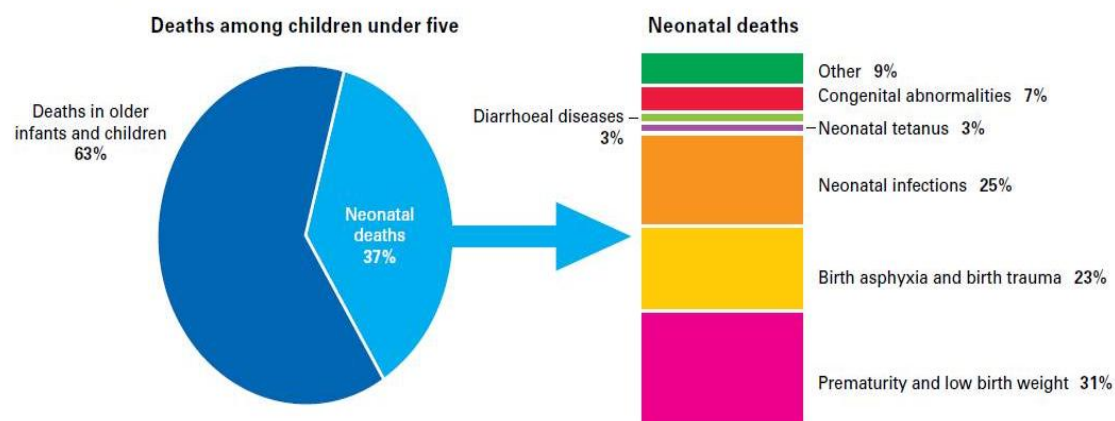
1. Introduction

Of the 3.1 million newborn deaths that occurred in 2010, a quarter to half of them occurred within the first 24 hours after birth. Many of these deaths occurred in babies born too early and too small, babies with infections, or babies asphyxiated around the time of delivery. Labour, birth and the immediate postnatal period are the most critical for newborn and maternal survival. Unfortunately, the majority of mothers and newborns in low- and middle-income countries do not receive optimal care during these periods.

Studies have shown that many newborn lives can be saved by the use of interventions that require simple technology. The majority of these interventions can be effectively provided by a single skilled birth attendant caring for the

mother and the newborn. Care of all newborns includes immediate and thorough drying, skin to skin contact of the newborn with the mother, cord clamping and cutting after the first minutes after birth, early initiation of breastfeeding, and exclusive breastfeeding.

After the first hour of life, newborns should receive eye care, vitamin K, and recommended immunizations (birth dose of OPV and Hepatitis B vaccine). They should be assessed for birth weight, gestational age, congenital defects and signs of newborn illness. Special care should be provided for sick newborns, those who are preterm and/or low birth weight, and those who are exposed or infected by HIV or have congenital syphilis.



Source: World Health Organization. *The Global Burden of Disease: 2004 update*. World Health Organization, Geneva, 2008.

Figure 1: Causes of Neonatal Death

About Accredited Social Health Activist (ASHA)

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.



Following are the key components of ASHA:

- ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
- She should be a literate woman with due preference in selection to those who are qualified up to 10 standard wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training

episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.

- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.
- Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.
- ASHA will be 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.
- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.
- She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
- ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
- ASHA will mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
- She will act as a depot older for essential provisions being made available to all habitations like Oral Rehydration

Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.

- At the village level it is recognised that ASHA cannot function without adequate institutional support. Women's committees (like self-help groups or women's health committees), village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support to ASHA.



List of Drugs being provided in ASHA Kit

ASHA is provided with a drug kit containing a set of drugs/equipment and products that enable her to provide basic level care and enhance her credibility in the community. The drug kits mainly contain drugs for minor ailments. She is also provided with a Home Based Newborn Care kit for providing growth assessment of newborn care after training in 6th & 7th module.

The list of drugs and equipments is given below:

S. No.	Contents of Drug KIT
1	DDK for Clean deliveries at home
2	Tab. Paracetamol
3	Paracetamol syrup
4	Tab. Iron Folic Acid (L)
5	Tab. Punarvadu Mandur (ISM Preparation of Iron)
6	Tab. Dicyclomine
7	Tetracycline ointment
8	Zinc Tablets
9	Povidine Ointment Tube
10	G.V. Paint
11	Cotrimoxazole syrup
12	Paediatric Cotrimoxazole tablets
13	ORS Packets
14	Condoms
15	Oral pills (In cycles)
16	Spirit
17	Soap
18	Sterilized Cotton
19	Bandages, 4cm X 4 meters
20	Nischay Kit
21	Rapid Diagnostic Kit
22	Slides for Malaria & Lancets
23	Emergency Contraceptive Pill
24	Sanitary napkins (to promote Menstrual Hygiene amongst adolescent girls)

No.	List of Items in ASHA Equipment Kit
1	Digital Wrist Watch
2	Thermometer
3	Weighing Scale (for newborn)
4	Baby Blanket
5	Baby Feeding spoon
6	Kit Bag
7	Communication Kit
8	Mucous Extractor

2. Availability of ASHAs

In rural areas

There is one Community Health Volunteer i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. The States have been given the flexibility to relax the population norms as well as the educational qualifications on a case to case basis, depending on the local conditions as far as her recruitment is concerned.

In urban areas

- Prior to the selection of ASHA it is important that City/District health Society undertakes mapping of the city/urban areas with vulnerability assessment of the people living in slums or slum like situations and identifies these "slum/vulnerable clusters" for selection of ASHA.
- The general norm for selecting ASHA in urban area will be "One ASHA for every 1000-2500 population". Since houses in urban context are generally located within a very small geographic area an ASHA can cover about 200-500 households depending upon the spatial consideration.
- When the population covered increases to more than 2500 another ASHA can be engaged. In case of geographic dispersion or scattered settlements of socially and economically disadvantaged groups the "slum/vulnerable clusters" selection of ASHA can be done at a smaller population.
- In cases where a particular geographic area has the presence of more than one ethnic/vulnerable group, selecting more than one ASHA below the specified population norm will be desirable. In such a case one ASHA could be selected for and from a particular vulnerable group so that their specific needs are addressed through an appropriate understanding of the socio-cultural practices of that community.
- The selected ASHAs will be preferably co-located at the Anganwadi Centre that are functional at the slum level, for delivery of services at the door step.
- In urban habitations with a population of 50,000 or less, ASHAs will be selected as in rural areas.
- The other community volunteers built under other government schemes can also be utilized for this purpose.

Key Findings from Performance Needs Assessments and Baseline Surveys in Uttar Pradesh (2008-2009)

- Only two percent of recently delivered women received a home visit from an ASHA after delivery.

- 2) The frequency of ASHA home visits was low and ASHAs needed improved counselling skills to effectively negotiate behaviour change at the household level.
 - 3) A strong system was not in place to provide ongoing capacity-building or support to the ASHAs.
 - 4) There was considerable scope to improve the usefulness of the monthly ASHA meetings, especially for capacity building, problem-solving and progress reviews. The meetings were too large and lacked structure.
 - 5) There was no mechanism in place to support ASHAs at district level for continuing education and the ASHA mentoring group was not active.
- [6] National Rural Health Mission 2005–2012: Mission Document (PDF), MoHFW, archived from the original (PDF) on 12 June 2009
 - [7] Update on the ASHA programme (PDF), Ministry of Health and Family Welfare., January 2015
 - [8] National Institute of Health and Family Welfare. (2005) "Frequently Asked Questions on ASHA." Government of India. Accessed April 23, 2007,
 - [9] Ministry of Health and Family Welfare (MoHFW). (2005c). ASHA.. Government of India. Accessed July 20, 2008.
 - [10] UNICEF. Progress for children :problems estimating low birth weight incidence;2007.(http://www.childinfo.org/low_birthweight.html)

Key Technical Assistance Approaches the Project, in partnership with state and district officials, identified specific TA approaches to strengthen ASHA support mechanisms. These approaches were:

- 1) Building ASHA capacity in counselling and conducting home visits.
- 2) Strengthening monthly meetings for continuing education and performance improvement.
- 3) Strengthening supervisory skills of ANMs and LHVs to provide guidance and on-site support to ASHAs.
- 4) Forming and building capacity of Technical Resource Groups (TRGs).
- 5) Integrating equity and gender focus in technical assistance approaches

3. Conclusion

ASHAs, as one of the first points of contact for pregnant women in rural areas, can provide important information at critical time periods (e.g. antenatal period, immediately following birth, and periodically throughout the postnatal period), to promote healthy maternal and newborn care practices and facilitate identification and referral of maternal and newborn complications. To reduce the infant and neonatal mortality rates, the Government of Uttar Pradesh (GOUP) launched the Comprehensive Child Survival Programme (CCSP) in 2007. One of the key objectives of CCSP is to support ASHAs in promoting home-based newborn care, information and essential services in the community and identifying high risk newborns for timely referral and management. CCSP is largely based on World Health Organization's Integrated Management of Neonatal and Childhood Illness (IMNCI) initiative.

References

- [1] https://www.who.int/maternal_child_adolescent/newborns/care_at_birth
- [2] <https://www.healthynewbornnetwork.org/>
- [3] <http://www.nhm.gov.in/communitisations/asha.htm>
- [4] Strengthening ASHA Support Mechanisms for Improved Newborn Care in Uttar Pradesh October 2012 Pg 1-8.
- [5] ASHA, Ministry of Health and Family Welfare (MoHFW), 2005, archived from the original on 22 April 2009