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ROLE OF ASHA IN BRINGING SUBSTANTIAL HEALTH AND ECONOMIC BENEFITS IN RURAL AREAS THROUGH HBNC SERVICES: A CASE STUDY UNDER BOKAKHAT BLOCK PHC IN GOLAGHAT DISTRICT OF ASSAM.

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Abstract: The Indian government has implemented home-based newborn care (HBNC), in an effort to alleviate the burden of newborn fatalities during the first week of life. Since its introduction in 2011, HBNC has been the primary community-based approach to newborn health, with a focus on Accredited Social Health Activists (ASHA). Providing care for each baby through a series of home visits by an ASHA during the first six weeks of life is one of the main tasks in HBNC. Every newborn is examined by the ASHA, which also conducts follow-up for sick newborns, early detection of illness or danger signs in newborns, postpartum care counseling, postpartum complication identification, and counseling for the adoption of appropriate family planning.

The majority of the newborn babies pass away in the first week of their lives. India has one of the highest neonatal mortality rates in the world, despite an increase in the number of deliveries that take place in institutions. One of the main challenges in guaranteeing high-quality health and neonatal care is the lack of educated personnel and inadequate infrastructure. Therefore, in order to prevent neonatal death, it is imperative that neonates receive the best care possible throughout their first month of life. A number of programs have been implemented under the National Rural Health Mission (now National Health Mission) to quicken the child mortality rate to decline. This essay aims to demonstrate the efficacy of HBNC services in bringing substantial health and economic benefits rural areas under Bokakhat subdistrict of Golaghat in Assam. In order to gather the information needed for the study, a field study was carried out in the study region by visiting the pregnant women after they gave birth. Additionally, efforts were undertaken to learn about the limitations of HBNC services in the research region as well as the challenges that ASHAs experienced when providing their services.

Key Words: ASHA, HBNC, Newborn Health, Home Visit, Neonatal Mortality.

Introduction:

Approximately 2.4 million infants worldwide, mostly in underdeveloped nations, pass away in the first month of life each year (World Health Organisation, 2022). Neonatals' survival during the first month of life is critical due to the high risk of infection. Due to a shortage of necessary medical facilities, qualified healthcare professionals, and trained health attendants, especially in rural regions, India alone is responsible for one-fourth

of all newborn deaths worldwide. Due to the dire economic circumstances, the majority of people in rural India are unable to pay for hospital treatment. Furthermore, the traditional methods of newborn care used in rural areas also cause the high neonatal mortality rate to occur in India. Although India's neonatal mortality rate (NMR) has been falling over the past few decades, the country's 2019 NMR data of 21.7 per 1000 live births is still significantly higher than the WHO Millennium Development Goal of 12 per 1000 live births by 2030. In Assam, the neonatal death rate decreased from 32.8 per 1000 live births in 2015–16 to 22.5 per 1000 live births in 2019–2020. India can only attain the Millennium Development Goal for child survival if it achieves significant reductions in neonatal mortality. At 195 per lakh live births in 2018–2020, Assam has the highest maternal mortality ratio (MMR) in all of India. Despite the remarkable rise in institutional deliveries, home births continue to occur, and many mothers choose to go home within a few hours of giving birth in the hospital. To help these babies survive the first day and beyond, home-based newborn care, or HBNC, must be accessible to both institutional and home-born babies.

The Indian government implemented home-based newborn care (HBNC) in 2011 as a means of reducing neonatal death and morbidity rates more quickly, particularly in rural and isolated areas where access to treatment is either scarce or far away.

In 2005, the National Health Mission (NHM) established Accredited Social Health Activists (ASHA) to provide HBNC services for mothers and children. According to the National Health Mission (2014), ASHA's primary duties include conducting routine home visits, promoting health awareness and practices, encouraging and mobilizing mothers to give birth in health centers, educating people about child healthcare, nutrition, health hygiene, and sanitation etc. Until the first 42 days of life, ASHA visits every newborn in accordance with a predetermined schedule. This comprises one extra visit within 24 hours of delivery in the case of home births and six visits in the case of institutional deliveries on the third, seventh, fourteen, twenty-first, twenty-eight, and forty-second days after birth. Additional visits will be made to SNCU released kids, preterm babies, low birth weight babies, and sick newborns. After completing the planned house visits, ASHAs receive an incentive payment of Rs. 250 per infant.

Objectives:

The following objectives guided the conduct of the current investigation.

1. To evaluate HBNC's standing in the research region.
2. To evaluate ASHA's present understanding, mindset, and procedures around several HBNC issues.
3. To identify the risks, obstacles, and knowledge gaps that ASHA faces when administering HBNC.

Methodology:

The Study was conducted in the service area of Bokakhat block PHC in Golaghat district of Assam for the period 2022-23 (from April, 2022 to March, 2023). Under this BPHC there are 21 sub centers, 2 PHCs, 1 CHC and 1 Civil Hospital. The total number of population is more than 1,70,000. During this period, a total of 1760 deliveries occurred but only 350 mothers of newborn age 03 days to 60 days were randomly selected for conducting the survey. Interview was conducted with mothers to fill the interview schedule. All 158 numbers of ASHAs in the area of new born babies were included in our study for assessment of their knowledge and awareness about HBNC services. Status of HBNC was determined on the basis of home visit done by ASHA. A semi-structured, pre-tested questionnaire was used for study. Thus the study was primarily based on the primary data. Secondary data were also collected from books, journals etc. for the study.

Table 1: Number of total delivery occurred and Number of newborn received HBNC visits in the study area

SL. No.	Data Item Name	April, 2022	May, 2022	June, 2022	July, 2022	August, 2022	Sep. 2022	Oct. 2022	Nov. 2022	Dec. 2022	Jan. 2023	Feb. 2023	March, 2023	Total
1	Total number of New Pregnant Women registered for ANC	281	279	215	213	181	169	144	205	216	244	247	238	2632
2	Number of Institutional Deliveries conducted	94	111	89	108	189	196	183	186	168	151	142	133	1750
3	Number of Home delivery	0	2	0	0	1	2	2	2	1	0	0	0	10
4	Total number of (Home delivery +Institutional) reported	94	113	89	108	190	198	185	188	169	151	142	133	1760
5	Number of new-born received 6 HBNC visits after Institutional Delivery	144	186	148	128	259	163	240	214	315	191	152	157	2297 (with area delivery)
6	Number of newborns received 7 Home Based Newborn Care (HBNC) visits in case of Home delivery	0	2	0	0	1	2	2	2	1	0	0	0	10

Source: Joint Director of Health Service, Swahid Kushal Konwar Civil Hospital, Golaghat, Assam.

From the table 1, it was evident that conducting a study on all the mothers or newborn baby is quite impossible therefore, a total of only 350 newborns with an age range of 03 to 60 days were randomly included in the current study. Majority of the mothers were Hindu by religion and more than half of the mothers (67.14%) belonged to nuclear families. Almost all the mothers were educated. Among them 48.85% mothers were educated up to middle school level, 22.85% up to primary school level, 18.57% up to High School level, and only 1% mothers were educated up to HS level and above. The illiterate mothers were only 6.57%. So far as occupation of mothers is concerned, 60.85% of mothers were housewives, 22.57% of mothers were partially appointed in certain jobs, and remaining 16.57% were unskilled mothers. It was observed that 26.28% of families lived in lower socioeconomic class, 19.43% in middle class, and remaining 54.28% belonged to upper lower class. [Table 2]. The data shows that the majority of the newborns got the entire age appropriate home visit. During the home visits, majority of the newborns temperature and weight were measured. ASHA washed her hands with soap and water before examining the baby in 92% of the cases [Table 3].

Table 2: Social Characteristic of Mother

N= 350

1. Religion	N	%
Hindu	306	87.42
Muslim	37	10.57
Christian	7	2
2. Type of family		
Nuclear	235	67.14
Joint	115	32.85
3. Educational Status		
Illiterate	23	6.57
Primary school	80	22.85
Middle	171	48.85
High school	65	18.57
Higher Secondary and above	11	3.14
4. Occupation of mothers		
House wife	213	60.85
Un-skilled worker	58	16.57
Partially appointed	79	22.57
5. Socioeconomic Status		
Middle Class	68	19.43
Upper lower Class	190	54.28
Lower class	92	26.28

Source: Field visit

Table 3: Number of Home visits and services provided during Home visit by ASHA, N=350

Characteristics	N	%
Age appropriate Home visit to the Newborn	322	92
General Examination of Mother	324	92.57
General Examination of Newborn	324	92.57
Weighing of newborn	324	92.57
Temperature measurement of new born	324	92.57
ASHA washed her hands with soap and water before examining the baby	321	91.71

Source: Field visit

On the day of the HBNC visit, ASHA measured the weight, temperature, and performed a general examination on all babies who were seven days or younger. Newborns' weight, temperature, and overall health were 79.41%, 79.41%, and 72.06% on the 28th day of the HBNC visit, respectively. Less than half of the neonates (44.63 %,) had a general examination by ASHA on the 42nd day of the HBNC visit, whereas the majority was weighed and had their temperatures taken. These results showed that the HBNC services provided by ASHA (weighing, temperature measurement, and general examination) decrease as the number of HBNC visits rises [Table 4]. 89.14% of the mothers received counseling for exclusive breastfeeding, 41.14% regarding appropriate positioning and attachment, and 59.43% regarding breastfeeding frequency. 57.43% on when to give the baby their first bath, only 24% on skin-to-skin contact, 66.57% on cord care, and 36% on eye care, respectively. 72.85% of the mothers received hand washing advice, and 78.57% received Immunization advice. 96% and 78% of mothers, respectively, received counseling on danger signs, fever, and fast breathing. During the ASHA home visit, only 32.86%, 18.29%, 4%, and 2.29% received counseling on chest drawing, hypothermia, lethargy/unconsciousness, and convulsion, respectively [Table 5].

Table: 4 HBNC Services given by ASHA on 3rd, 7th, 14th, 21st, 28th & 42nd day

Age at day of visit (in days)	No. of new-born	Weighting of new-born		Temperature measurement of new-born		General examination of new-born	
		N	%	N	%	N	%
3	7	7	100	7	100	7	100
7	21	21	100	21	100	21	100
14	28	25	89.28	25	89.28	23	82.14
21	49	46	93.88	46	93.88	39	79.59
28	68	54	79.41	54	79.41	49	72.06
42	177	103	58.19	103	58.19	79	44.63

Source: Field visit

Table: 5, Counseling given to mothers by ASHA regarding various aspects of newborn Health during HBNC visit:,N=350

1. Counseling given by ASHA to mother	N	%
Exclusive breastfeeding	312	89.14
Proper positioning and attachment	144	41.14
Frequency of breastfeeding	208	59.43
Timing of first bath	201	57.43
Proper wrapping of baby	173	49.42
Skin to skin contact	84	24
Care of cord	233	66.57
Care of eye	126	36
Immunization	275	78.57
Hand washing	255	72.85
2. Counseling of mothers about Danger signs of newborns		
Fever	336	96
Fast breathing (≥60 breaths/min)	273	78
Chest in drawing	115	32.86
Not taking feed	108	30.86
Convulsion	8	2.29
Hypothermia	64	18.29
Lethargy/unconscious	14	4

Source: Field visit

Although there were 158 numbers of ASHA workers under Bokakhat Block PHC but the survey was conducted only with 60 ASHAs who rendered their HBNC services for 350 newborn babies. (ASHA faced a number of challenges during their HBNC visits. For example, they had limited knowledge about HBNC, including mandatory vaccines, infection care, and hypothermia risk. 11.7% of ASHA faced with this problem of

Knowledge gaps. 8.3% of ASHA have difficulty in recording information in registers. Similarly, 18.3% of ASHA could not counsel new mothers on important topics, such as hand washing, immunization, or danger signs for their lack of proper knowledge on HBNC.

The Service quality of 13.3% of ASHA were not found to be satisfactory as they could not perform services consistently, such as weighing, measuring temperature, or performing general examinations. ASHAs may be dissatisfied with the incentives they receive for their work. However, the common problem was that the supply of medicines to ASHA workers during their HBNC visit was not adequate for them. 15% of ASHA faced with this problem. (Table 6)

Table: 6, Problem faced by ASHA during HBNC visits, N=60

1. Problem faced by ASHA		
Characteristics	N	%
Unavailability of medicine	9	15
Knowledge gaps	7	11.7
Recording issues	5	8.3
Counseling challenges	11	18.3
Service quality	8	13.3
None	40	66.7
2. Suggestion for betterment of HBNC services		
Medicine should be made available	25	41.7
Providing regular training on newborn care, monitoring, and supportive supervision	3	5.0
None	32	53.3
3. Enhancing communication to raise support and awareness in the community		
Average	9	15
Good	51	85
Very good	0	0
4. Family support during home visit		
Poor	0	0
Average	9	15
Good	51	85
Very good	0	0
Making ASHAs more accountable through the use of a voucher scheme	17	28.3

Source: Field visit

Conclusion and Recommendation:

Our present study concluded that majority of newborns got the entire age appropriate home visit. Although the HBNC programme can potentially bring substantial health and economic benefits to rural people, it faces several operational challenges. First, expanding HBNC in areas without current ASHA coverage is a difficult task in itself, considering the need for engaging, training and deploying additional workers. Second, the effectiveness of HBNC depends not only on coverage, but also on the incentives and quality of training provided to ASHAs, and regular monitoring and evaluation. Finally, the HBNC programme cannot succeed without improving higher-level healthcare facilities to which the ASHAs can refer sick newborns. ASHA must be assessed regularly in order to identify their basic needs, knowledge gaps, challenges and difficulties to quality HBNC services. Proper training on HBNC at regular interval significantly improved their knowledge, practices, and attitude toward their responsibilities, which is crucial for improving newborn health status. The study suggests following recommendations: Need to improve the coverage and quality of the HBNC program by improving the pace and quality of training, operationalizing an effective supportive supervisory mechanism and timely reimbursement of ASHA incentives. Health education for the community focused on newborn care

practices like exclusive breastfeeding for 6 months, proper positioning and attachment, timing of first bath, proper wrapping of baby, skin to skin contact, cord care and eye care, immunization and hand washing. The community and mother needs to be educated about danger signs of newborns.

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