INTERNSHIP TRAINING

At

NATIONAL HEALTH MISSION, MADHYA PRADESH

Title of the study: "To evaluate knowledge of ASHAs in relation to provision of HBNC services, District Umaria, M.P."

Anil Kumar

PG/15/008

Under the Guidance of

Dr. Manish Priyadarshi

Post Graduate Diploma in Hospital and Health Management

2015-17

International Institute of Health Management Research, New Delhi

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A Report

By

Anil Kumar

Post Graduate Diploma in Hospital and Health Management

2015-17

International Institute of Health Management Research, New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Anil Kumar** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **National Health Mission, Madhya Pradesh** from **13th February 2017** to **30th April 2017.**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. A.K. Agarwal

Dean, Academics and Student Affairs

IIHMR, New Delhi

Dr. Manish Priyadarshi

IIHMR, New Delhi

कार्यालय मुख्य चिकित्सा एवं स्वस्थ्य अधिकारी , जिला उमरिया (म0प्र0)

Completion of Dissertation

The certificate is awarded to

Anil Kumar

In recognition of having successfully completed his Internship

In the department of

Rashtriya Bal Swasthya Karyakram

And has successfully completed his Project on

To evaluate knowledge of ASHAs in provision of Home Based Newborn Care, Umaria, Madhya Pradesh

Date: 30th April 2017

National Health Mission, Madhya Pradesh

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for Learning we wish him/her all the best for future endeavors

Training & Development Zonal Head-Human Resources

30-5-17

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी
जिला उमरिया (म.प्र.)

CERTIFICATE OF APPROVAL

The following dissertation titled **"To Evaluate knowledge of ASHAs in relation to provision of HBNC services"** at **"National Health Mission, Madhya Pradesh"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Pawan Kumar	
Dr. Pradeep Panda	PK Panda
Dr. Manish Priyadarshi	

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Anil Kumar,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He/ She is submitting this dissertation titled "**To Evaluate knowledge of ASHAs in relation to provision of HBNC services**" at "**National Health Mission , Madhya Pradesh**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. A.K. Agarwal

Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. Manish Priyadarshi

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कार्यालय मुख्य चिकित्सा एवं स्वस्थ्य अधिकारी , जिला उमरिया (म0प्र0)

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

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Dr. Manish Priyadarshi

Associate Professor

IIHMR-Delhi

Mr. Anil Singh

District Epidemiologist

NHM- M.P.(Ditt. Umaria)

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **To Evaluate knowledge of ASHAs in relation to provision of HBNC services**" and submitted by **Anil Kumar** Enrollment No. **PG/15/008** under the supervision of **Dr. Manish Priyadarshi** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **13th February 2017** to **30th April 2017** 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

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FEEDBACK FORM

Name of the Student: Anil Kumar

Dissertation Organization: National Health Mission, Madhya Pradesh

Area of Dissertation: To evaluate knowledge of ASHAs in provision of Home Based Newborn Care, Umaria, and Madhya Pradesh

Attendance: 100 %

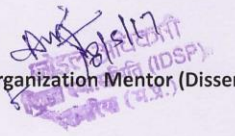
Objectives achieved: Yes

Deliverables: Yes , Improve KSA to health workers

Strengths: Hardworking , Punctual with positive attitude

Suggestions for Improvement: No

Suggestions for Institute (course curriculum, industry interaction, placement, alumni):No



Signature of the Officer-in-Charge/ Organization Mentor (Dissertation)

ACKNOWLEDGEMENT

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

To start with, I take immense pleasure to thank **Dr. Sanjiv Kumar** (*Director-International Institute of HealthManagement Research-Delhi*) and **Dr. A. K. Aggarwal**(*Dean, International Institute of Health Management Research-Delhi*) for placing me in such an esteemed organization (Care India) to perform my dissertation and start my career with; and my mentor, **Dr. Manish Priyadarshi** for her timely advice and encouragement for the successful conduction of my project.

I am highly indebted to Dr. Prabhakar Tiwari , Deputy Director of HR cell , NHM, M.P., and Dr. Viney Dubey, Deputy Director RBSK for providing me with this opportunity to be a part of Naltional Health Mission ,M.P. and giving me time and space from the induction and training schedule, to perform my fieldwork.

Also, I wish to thank Mr. Anil Singh , District Epidemiologist , for their continuous guidance in the training programme and arranging transport and other requirements for the completion of our desired field visit.

TABLE OF CONTENTS

ABBREVIATIONS

HBNC	Home Based newborn care
RBSK	Rashtriya Bal Swasthya Karyakram
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
WHO	World Health Organization
PHC	Primary Health Centre
CHC	Community Health Centre
FRU	First Referral Unit
MMR	Maternal Mortality Ratio
M & E	Monitoring and Evaluation
DPM	District Program Officer
DHO	District Health Officer
MoHFW	Ministry of Health and Family Welfare
IEC	Information Education Communication
MDGs	Millennium Development Goals
ANMs	Auxiliary Nurse midwives
Mos	Medical Officers
UNICEF	United Nations Children's Fund
BCC	Behaviour Change Communication
SBA	Skilled birth attendant

ABSTRACT

Background- About one thirds to half of all deaths of children less than five years of age occur in the first month of life and of these a large number occur in the first day of life. Of the 6.6 million under-five child deaths that occur globally every year, about 44 percent occur in the neonatal period (the first 28 days of life) , the proportion is even higher – around 54 percent – in countries from the WHO South East Asia Region (SEAR). India contributes to one-fifth of global live births and more than a quarter of neonatal deaths. About 0.76 million neonates died in 2012, the highest for any country in the world that year. Four states – Uttar Pradesh, Madhya Pradesh, Bihar, and Rajasthan – alone contribute to about 55 percent of total neonatal deaths in India. There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours.

Objective: To evaluate knowledge of ASHAs in relation to provision of HBNC services, District Umaria, M.P."

Methods: This was descriptive cross sectional study. Non probability convenient sampling method was used for sample size.75 ASHAs from three blocks of Umaria district of Madhya Pradesh participated. Knowledge was assessed using a semi structured questionnaire.

Results: This study provide a snapshot that 64% (48) ASHAs have moderate knowledge in provision of HBNC services and only 0.08% i.e., only 6 ASHAs have good knowledge of providing HBNC services and 28% of ASHAs have inadequate knowledge. The number of visits to be provided in institutional delivery was clearly known to 62% of ASHA's, however, the number of visits to be given in home delivery was not as clear. The knowledge of ASHA with regard to criteria for high risk group newborn was adequate as 70 % of them knew signs and symptoms. Knowledge on sepsis medicine and vaccination of newborn was inadequate as only 42.66% and only 61% of ASHAs known what should be done is baby has sepsis and till how many vaccines should be given to newborns respectively.

Conclusion: This study provide us that ASHAs have moderate knowledge in provision of home based newborn care they have good hands measuring and newborn temperature, and also having good knowledge on recognizing high risk group newborn but this would be not enough for reducing neonatal rate .Thus ASHA's HBNC visit can help to minimize newborn mortality but to assure that ASHAs should have adequate knowledge.

ORGANIZATION PROFILE

NATIONAL HEALTH MISSION

The National Health Mission (NHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. NRHM seeks to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

NHM has six financing components:

(i) NRHM-RCH Flexipool,

(ii) NUHM Flexipool,

(iii) Flexible pool for Communicable disease,

(iv) Flexible pool for Non communicable disease including Injury and Trauma,

(v) Infrastructure Maintenance and

(vi) Family Welfare Central Sector component.

The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources

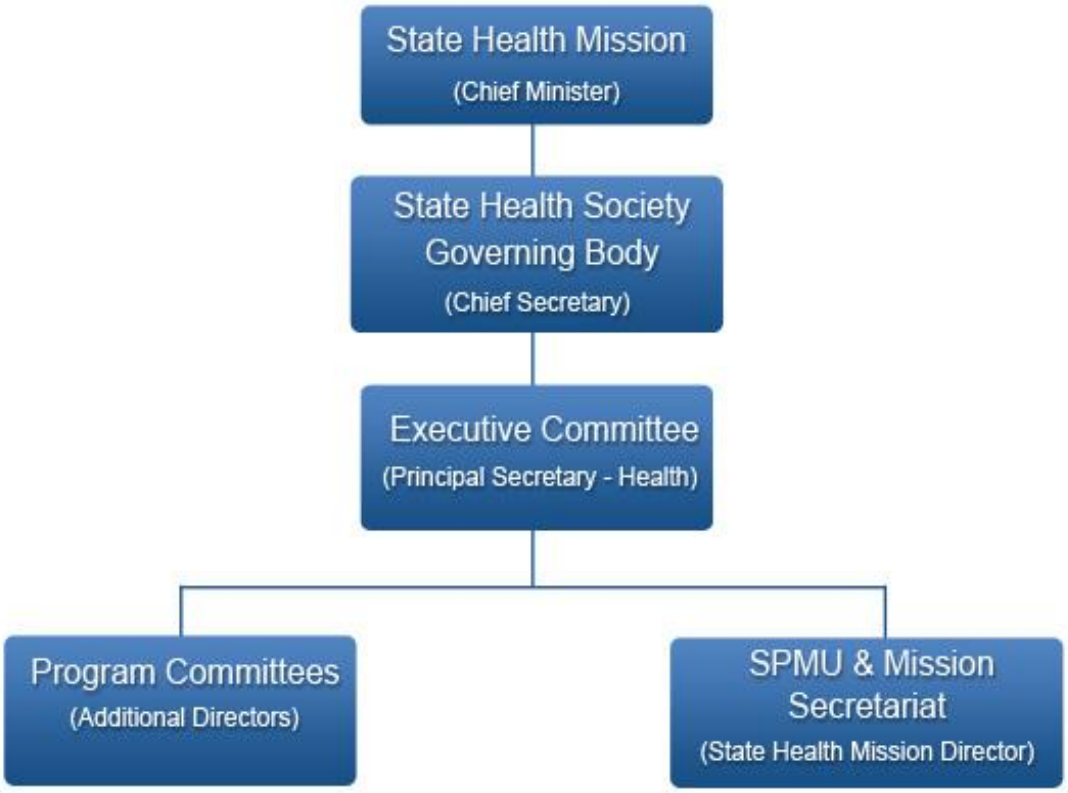
management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indictors.

Mission

The vision is to provide accessible, affordable and quality universal health care, both preventive and curative, which would be accountable and at the same time responding to the needs of the people.

Objectives:

- Reduction of infant mortality and maternal mortality.
- Universal access to public health services such as women's health, child health, drinking water, sanitation and hygiene, nutrition and universal immunization.
- Prevention and control of communicable and non-communicable diseases.
- Population stabilization, gender & demographic balance.
- Access to integrated comprehensive primary health care.
- Promotion of healthy lifestyles.



STATE'S MISSION

All people living in the state of Madhya Pradesh will have the knowledge and skills required to keep themselves healthy, and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life , and enables them to lead a healthy productive life'. Thus, it may be observed that the State's vision has primarily two components, namely empowering the people living in the State with knowledge and skills required to keep them healthy and equity in access to effective and affordable health care. The State of Madhya Pradesh also subscribes to the vision adopted by the National Rural Health Mission. Consequently, the adapted vision components to be pursued by the State are presented in the below:- Equip people with knowledge and skills required to keep themselves healthy. Provide effective healthcare to rural population throughout the State with special focus on worst performing districts, which have weak public health indicators and/or weak infrastructure. These districts will receive special focus. These are: Dindori, Damoh, Sidhi,Badwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur.Raise level of public spending on health from 0.89% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling. Undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the State. Revitalize local health traditions and mainstream AYUSH into the public health system. Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns. Address inter-district disparities. Pursue time bound goals and publish report to the people of the state on progress. Improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

PROGRAMME UNDER NATIONAL HEALTH MISSION MADHYA PRADESH

1. REPRODUCTIVE MATERNAL NEWBORN CHILD HEALTH + ADOLESCENT

Reduction of MMR has been the priority agenda of the State Govt. Madhya Pradesh is showing the steady trend of decline in the MMR which is evident from various survey data. The MMR of MP was 310 in 2010-11 AHS and with the constant decline in MMR; it is now

227 as per AHS 2012-13 and 221 as SRS 2011-13. Mamta Abhiyan phase-I was launched on 11th April 2013 which shows a strong political and programmatic commitment for reduction of MMR. Phase- I focused on strengthening of infrastructure, Human resource, Supportive services at facilities (Drugs, Diet, Diagnostic, cleanliness and security). Subsequently Phase-II was launched on 26 June 2014 to focus on improving quality of services through supportive supervision, Generating awareness among the community through IEC and BCC.

MP envisions achieving the goal of reduction of MMR to 100 by 2017 as per the 12th five year plan. Under RMNCH+A, identification of 17 high priority districts (HPDs) which are low performing in terms of process indicators (HMIS) are the focus districts in terms of HR, Infrastructure for achieving overall improvement in health indicators of MP. Analysis at State level has been done and weak areas have been identified for planning district specific interventions for improving the particular area as per RMNCH 5x5 matrix.

2. CHILD HEALTH

Background Millennium Development Goal 4 (MDG 4) calls for reducing by two-thirds the mortality rate of children under the age of 5 years, between 1990 and 2015. Almost 90% of all child deaths are attributable to just five conditions: Neonatal Causes, Pneumonia, Diarrhoea, Malaria and Measles. According to SRS 2013, MP has shown highest fall in Neonatal Mortality in the country by 3 points while National fall is by 1 point. Similarly MP has shown highest decline in U-5 mortality this year by 4 points while national decline is 3 points. MP no longer has the dubious distinctions of having highest NMR and U-5 mortality in the country.

3. RASHTRIYE BAL SWASTHYA KARYAKRAM

Rashtriye Bal Swasthya Karyakram is committed to improve survival outcome in children in age group of 0-18 years through screening, early identification and management of Defects at Birth, Deficiencies, Diseases, Developmental delays including disabilities– '4 Ds', and assured link to care, support, and treatment to meet these challenges.

In this regard, the initial step of deputing trained and dedicated Mobile Health Teams for screening of children from birth to 18 years of age group for selected health conditions under Rashtriya Bal Swasthya Karkyakram (RBSK) has been treated well by the Madhya Pradesh. For accelerated implementation of the programme, the next vital step is confirmation of preliminary findings, referral support, and management & follows up of screened children for

which early intervention centres are to be established at the District Hospital level across the state. DEIC will be the hub of all activities, will act as a clearing house and also provide referral linkages.

4. RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

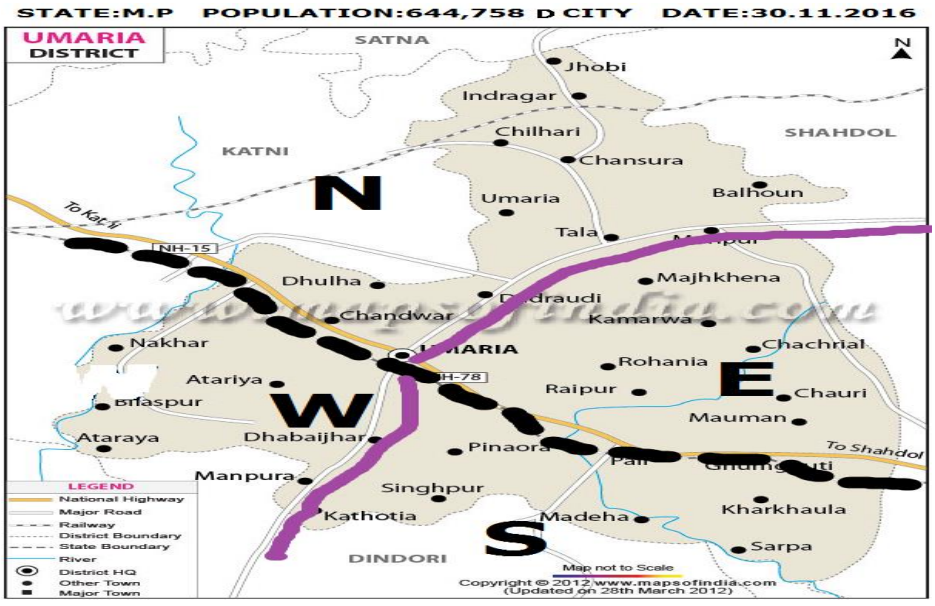
The Ministry of Health & Family Welfare has launched a health programme for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues.

The Rashtriya Kishor Swasthya Karyakram was launched on 7th January, 2014. The key principle of this programme is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well-being and by accessing the services and support they need to do so.

To guide the implementation of this programme, MOHFW in collaboration with UNFPA has developed a National Adolescent Health Strategy. It realigns the existing clinic-based curative approach to focus on a more holistic model based on a continuum of care for adolescent health and developmental needs.

The Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme), will comprehensively address the health needs of the 243 million adolescents. It introduces community-based interventions through peer educators, and is underpinned by collaborations with other ministries and state governments

DISTRICT PROFILE



Umaria district is located to the North East of Madhya Pradesh. Mathematically the coordinates of the District extend from 23o38' to

24o20' North and 80o28' to 82o12' East. It has geographical area of 4548 sq.km. The greatest length of the district is about 150 km. from north to south and the greatest width is about 60km from east to west. The population of the district on the basis of 2011 census is 644,758. Out of which about 83% population resides in rural areasThe district has extensive forests. About 42% of the total area is covered by forests only. The District is rich in minerals. The most important mineral found in the district is coal and as a result 8 mines are being operated by South Eastern Coalfield Limited in the district. The famous Bandhavgarh National Park (Tala) and Sanjay Gandhi Thermal Power Station Mangthar (Pali) are located in the district. Umaria was formerly the headquarters of the South Rewa District and thereafter the headquarters town of the Bandhavgarh tehsil. It is situated at a distance of about 69 Km. from Shahdol, the parent district. Metalled roads connect the town with Katni, Rewa Shahdol etc., on which regular buses ply. Umaria is also a railway station on the Katni-Bilaspur section of the South-Eastern Railway.

S.No.	Name of Block	CHC	PHC	SC	Lab	Village	MO	ANM	ASHA
1	Karkeli	1	5	37	4	274	7	72	298
2	Manpur	1	5	38	2	216	6	65	258
3	Pali	1	2	14	3	103	3	42	112
	Total	3	12	83	9	593	16	179	668

KEY LEARNING & OBSERVATION

- An entire set of programmes are running under the MoHFW in the state of Madhya Pradesh, but the ground level implementation and performance is in a miserable state.
- There is a huge communication gap and too much overlap and confusions in the work profiles of M&E, DPM, IDSP and Health Department because one person handles more than two programs.
- Work profiles of government officials, i.e. DHOs, AMOs and MOs in the Department of Social Work, Government of M.P., is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.
- The agony of cultural taboos is still widely prevalent in M.P. Also, the caste system affects the functioning of the AWCs and ASHAs at large. There are a few communities like Gond and Kole, the presence of which is not acceptable to higher caste groups like Thakurs and Brahman, which often results in preventing their children from going to AWCs if AWW or AWH belong to any other community or other caste groups are also benefited at the same AWC.
- The physical state of AWCs and Schools are miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space.
- There is a severe shortage of home visits by the ASHAs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, and birth preparedness, newborn care.
- Since long, the entire focus in the field of healthcare in M.P. has been on immunization and institutional deliveries only, and thus the nutrition component was missed heavily, which has resulted in very high malnutrition rates in M.P.
- There is huge gap in between villagers and government scheme that most of villagers didn't know about the scheme like RBSK.
- Lack of HR and duties of AMO other than RBSK programs like MSS hamper programs.
- If beneficiaries are capable to incur operation cost they never look towards Government hospitals, they believe private institutes are much more far better than government institutes.

- Here in district, Umaria WASH project is in its pilot phase. It has been only three months passed to run this program still it is on its running phase but this project revealed the reality of District hospitals and other healthcare facilities like Public health care that how much they take care and feel worry about their patients.
- Sometimes patient by itself knew about disease and which medicine is good for him. And I have seen it's during my OPD roaming that a patient was telling to doctor that which medicine doctor should prescribe to him say, "Doctor saheb glucose ki bottle aur wo peeliwali bottle likh den. If doctor oppose to doing this they ready to fight with them.
- Convincing villagers for operation is cumbersome task even it will be more difficult if you will take approval of their surgery.
- Still for mentally weak child they prefer Ojhas rather than RMP.
- Villagers not willing to go hospitals for surgery even though government is helping them.
- In field I have seen unhygienic conditions of villagers and no one was there to counselling them for the same concern.

PROJECT

To Evaluate knowledge of ASHAs in relation to provision of HBNC services

INTRODUCTION

About one thirds to half of all deaths of children less than five years of age occur in the first month of life and of these a large number occur in the first day of life. Of the 6.6 million under-five child deaths that occur globally every year, about 44 percent occur in the neonatal period (the first 28 days of life) , the proportion is even higher – around 54 percent – in countries from the WHO South East Asia Region (SEAR). India contributes to one-fifth of global live births and more than a quarter of neonatal deaths. About 0.76 million neonates died in 2012, the highest for any country in the world that year. Four states – Uttar Pradesh, Madhya Pradesh, Bihar, and Rajasthan – alone contribute to about 55 percent of total neonatal deaths in India. Prenatal asphyxia and malformations to be the other two significant causes of neonatal mortality .The neonatal mortality rate (NMR) of the country did decline from 52 per 1000 live births in 1990 to 29 per 1000 live births in 2012 (SRS 2012) but the rate of decline has been slow, and lags behind that of infant and under-five child mortality rates. The slower decline has led to increasing contribution of neonatal mortality to infant mortality. Infant Mortality Rate (IMR) has declined from 146 in 1951 to 42 in 2012 in India. However, the decline in neonatal mortality rates has been slow in the last two decades. Each year, of the almost 26.5 million infants born in India, about 0.78 million die before they complete one month of life and a total of million die before their first birthday. NMR therefore now constitutes nearly 69 % of the total IMR. Any further reductions in IMR reduction can only come from declines in NMR.[i] .In an attempt to address the issue of high neonatal mortality, The Government of India launched the HBNC program in 2011 with the purpose of improving community newborn care practices, early detection of neonatal illnesses and appropriate referral through home visits. The services are supposed to be delivered by the Accredited Social Health Activists (ASHAs), the frontline workers at the village level responsible to deliver preventive care services for mothers and newborns in the community[ii].The guidelines were revised in 2014 to include expectations for ASHA to make timely institutional referrals during pregnancy and home visits to promote and provide

essential newborn care, identify illness, and refer infants, if needed[iii]. ASHA workers were trained in these specific competencies of maternal and newborn healthcare using modules 6 and 7 of National Rural Health Mission (NRHM)[iv].Several studies shows that there is gradually decline NMR because of HBNC. There is enough evidence from all over the world that if appropriate newborn care is given from the moment of birth, almost all of these lives can be saved. After nine months of pregnancy, a mother and family are racked by sorrow and guilt.

If they lose this precious child, and society has to make every effort to prevent it. One way of doing so is to promote institutional delivery- so that a trained nurse or midwife or doctor is available at the moment of birth. However, nation-wide about 40% of births occurring outside institutions. There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours. Even where there is institutional delivery, the mother and child leave for home within one or two days and in the rest of the month, it is upto the ASHA to make the home visit nearly 40% of all under-five child deaths occur in the first 28 days of life (the neonatal or newborn period). Just three causes – infections, asphyxia, and preterm birth – together account for nearly 80% of these deaths (WHO/UNICEF Joint Statement). There is enough evidence from all over the world that if appropriate newborn care is given from the moment of birth, almost all of these lives can be saved. After nine months of pregnancy, a mother and family are racked by sorrow and guilt if they lose this precious child, and society has to make every effort to prevent it. One way of doing so is to promote institutional delivery- so that a trained nurse or midwife or doctor is available at the moment of birth. However, nation-wide about 40% of births occurring outside institutions. There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours. Even where there is institutional delivery, the mother and child leave for home within one or two days and in the rest of the month, it is upto the ASHA to make the home visit. Proper nutrition and hygiene are the answers in many cases, while other deaths can be prevented by using widely available vaccines and medications to prevent and treat infections, by having skilled health care at hand during and after delivery,

by recognizing and promptly treating obstetric complications, by keeping the baby warm and the umbilical cord clean, and by improving breastfeeding.

PROBLEM STATEMENT

5.9 million Children under the age of 5 years died in 2015. More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions.

Leading causes of death in children under 5 years are preterm birth complications, pneumonia, birth asphyxia, diarrhoea and malaria. About 45% of all child deaths are linked to malnutrition.

Children in sub-Saharan Africa are more than 14 times more likely to die before the age of 5 than children in developed regions.

A child's risk of dying is highest in the neonatal period, the first 28 days of life. Safe childbirth and effective neonatal care are essential to prevent these deaths. 45% of child deatss under the age of 5 years take place during the neonatal period.

Preterm birth, intrapartum-related complications (birth asphyxia or lack of breathing at birth), and infections cause most neonatal deaths. From the end of the neonatal period and through the first 5 years of life, the main causes of death are pneumonia, diarrhoea and malaria. Malnutrition is the underlying contributing factor in about 45% of all child deaths, making children more vulnerable to severe diseases.

2.7 million babies die every year in their first month of life and a similar number are stillborn. Within the first month, up to half of all deaths occur within the first 24 hours of life, and 75% occur in the first week. The 48 hours immediately following birth is the most crucial period for newborn survival. This is when the mother and child should receive follow-up care to prevent and treat illness.

Globally, the number of neonatal deaths declined from 5.1 million in 1990 to 2.7 million in 2015. However, the decline in neonatal mortality from 1990 to 2015 has been slower than that of post-neonatal under-5 mortality: 47% compared with 58% globally. This pattern applies to most low- and middle-income countries. If current trends continue, around half of the 69 million child deaths between 2016 and 2030 will occur during the

neonatal period. The share of neonatal deaths is projected to increase from 45% of under-5 deaths in 2015 to 52% in 2030. Moreover, 63 countries need to accelerate progress to reach the Sustainable Development Goal (SDG) target of a neonatal mortality rate of 12 deaths per 1000 live births by 2030.

Child Health Goals under NRHM Child Health Indicator Current status NRHM Goals(2012-17) IMR (Infant Mortality Rate) 38 < 25 Neonatal Mortality rate 28 < 20 Under 5Mortality Rate 46 < 25 Causes of Childhood Mortality: As per WHO 2012 estimates, the causes of Child Mortality in the age group 0-5 years in India are (a) Neonatal causes (52%), (b) Pneumonia (15%), (c) Diarrheal disease (11%), (d) Measles (3%), (e) Injuries (4%) and (f) others (15%). However, The major causes of neonatal deaths are Infections (16%) such as Pneumonia, Septicemia and Umbilical Cord infection; Prematurity (18%) i.e. birth of newborn before 37 weeks of gestation and Asphyxia (10%) i.e. inability to breathe immediately after birth and leads to lack of oxygen.

- As per data from HMIS 2015-2016 Umaria revealing some facts that were,

Children (age 6 months above) exclusively breastfed(%)	57%
Children under 3 years breastfed within one hour of birth(%)	82.7%

Est. Live birth	Reported Live Birth	Newborn breastfed within Hr
17766	11842	11065
Weight	Newborn weight at birt	11453
	Newborn births<2.5KG	1182

Infant Mortality Rate		
	M.P.	Umaria
within 24 hrs (Nos.)	742	94
upto 1 week of Birth (Nos.),	494	227
Between 1 & 4 week of Birth (Nos.)	746	6
Between 1 & 11 months of Birth (Nos.)	419	156
Total reported infant deaths	23401	483
DEATH UP TO 4 WEEKS of BIRTH		
Asphysia	3.00%	
Sepsis	6.40%	
Low birth weight	37.30%	
Other	53.20%	

RATIONALE

About 0.76 million neonates died in 2012, the highest for any country in the world that year. Four states – Uttar Pradesh, Madhya Pradesh, Bihar, and Rajasthan – alone contribute to about 55 percent of total neonatal deaths in India. Prenatal asphyxia and malformations to be the other two significant causes of neonatal mortality.

Proper nutrition and hygiene are the answers in many cases, while other deaths can be prevented by using widely available vaccines and medications to prevent and treat infections, by having skilled health care at hand during and after delivery, by recognizing and promptly treating obstetric complications, by keeping the baby warm and the umbilical cord clean, and by improving breastfeeding.

More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions.

Leading causes of death in children under 5 years are preterm birth complications, pneumonia, birth asphyxia, diarrhea and malaria. About 45% of all child deaths are linked to malnutrition.

There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours. Even where there is institutional delivery, the mother and child leave for home within one or two days and in the rest of the month, it is upto the ASHA to make the home visit.

REVIEW OF LITERATURE

Study in Gadchiroli, Maharashtra between 1993 and 1998 demonstrated a significant decline in mortality in neonates (by 62%) and infants (by 46%) and prenatal mortality rate (71%) by third year. The decline was attributed primarily to a significant reduction in neonatal sepsis (by 76%) and birth asphyxia (by 47.6%)[v]. While both mothers and newborns need care during the period after birth, this statement focuses on the care of the newborn child. As per integrated study done by WHO & UICEF revealed that home-based newborn care

interventions can prevent 30–60% of newborn deaths in high mortality settings under controlled conditions. Studies conducted in Bangladesh, India and Pakistan have shown that home visits can reduce deaths of newborns in high mortality, developing country settings by 30 to 61%[vi].

In March to April 2008, WHO implemented a 10-min educational program on basic neonatal care for women receiving prenatal care. The educational intervention was a structured, face-to-face interactive module taught by using pictographic and written materials about temperature control, umbilical cord care and signs of neonatal illness. Assessed knowledge before and immediately after the module using a standardized interview tool .The result was, out of recruited 101 women (average age=26.3 years), the knowledge of neonatal care increased by 10% on immediate post test, especially regarding knowledge of umbilical cord care and temperature control (normal temperature ranges, thermometer use). Maternal education (P=0.025) and previous births (P=0.037) correlated positively with higher pre test scores. Higher maternal education correlated with higher post test scores[vii].

The study explored the relationship between the knowledge of community health workers, anganwadi workers and auxiliary nurse midwives and their antenatal home visit coverage and effectiveness of the visits, in terms of essential newborn health care practices at the household level in rural India. We used data from 302 AWWs and 86 ANMs and data from recently delivered women (RDW), who were residents of the CHW catchment areas and gave birth to a singleton live baby. Using principal component analysis, knowledge scores for preventive care and danger signs were computed separately for AWWs and ANMs and merged with RDW data. A multivariate logistic regression model was used to estimate the adjusted effect of knowledge level. A generalized estimating equation (GEE) was used to account for clustering. The Coverage of antenatal home visits and newborn care practices were positively correlated with the knowledge level of AWWs and ANMs. Initiation of breastfeeding in the first hour of life (odds ratio 1.97; 95% confidence interval (CI): 1.55–2.49 for AWW, and odds ratio 1.62; 95% CI: 1.25–2.09 for ANM), clean cord care (odds ratio 2.03; 95% CI: 1.64–2.52 for AWW, and odds ratio 1.43; 95% CI: 1.17–1.75 for ANM) and thermal care (odds ratio 2.16; 95% CI: 1.64–2.85 for AWW and odds ratio 1.88; 95% CI: 1.43–2.48 for ANM) were significantly higher among women visited by AWWs or ANMs who had better knowledge compared with those with poor knowledge[viii].

A recent prospective study by Baqui et al provides data on the timing of cause-specific neonatal deaths is asphyxia. Almost all deaths due to asphyxia (97.8 percent) occur in the first week of life, with 70 percent of them occurring within the first 24 hours (day 0). Preterm birth complications, about three fourths of deaths due to prematurity (74.8 percent) occur in the first week of life, with 30 percent in the first 24 hours (day 0). Sepsis, Less than 50 percent of neonatal deaths secondary to sepsis occur in the first week of life. About 30 percent of sepsis related deaths occur in the second week, while around one fifth in weeks 3 to 4 and Diarrhea cause 7.0% deaths per year.

Studies shows that implementing a specific intervention package likely to reduce morbidity and mortality among LBW babies during the first year of life in two community development blocks of Haryana. They administered oral co-trimoxazole and injectable gentamicin to suspected cases of sepsis. The neonatal, infant, and perinatal mortality rates reduced by 62.2, 45.7 and 71 percent, respectively. A reduction in cause-specific mortality was noticed particularly in neonatal sepsis. The Integrated management of child illness (IMCI) strategy addresses the most common causes of child mortality and case management of the five major diseases in children under five years: bacterial pneumonia, diarrhea, malnutrition, measles and malaria. The IMCI directed through improvement of skills of health workers. The Government of Bangladesh and Pakistan are implementing the IMCI on pilot basis. The project has ensured a steady supply of drugs and other supplies to the intervention facilities with intensive monitoring and supervision. This initiative is part of the global Multi-country Evaluation of IMCI supported by WHO and USAID. Initial evidence shows an increase in care-seeking from appropriate healthcare providers for sick children aged less than 5 years. Activities in newborn care included by UNICEF are, assisting couples to develop a birth plan, how to access services, and ways to facilitate mobilization of resources for services, developing behavioral change communication strategies to raise awareness about and create demand for maternal health services, including emergency obstetric care, establishing community supports that increase utilization of appropriate services when needed, including transportation, communication, and funds for medical services, strengthening the ability of government health service providers to enhance their capacity to provide high-quality emergency obstetric care services and, strengthening the linkages between the community and the health personnel through stakeholder committees.[ix]

METHODOLOGY

STUDY DESIGN – Descriptive cross sectional study

POPULATION – ASHAs from blocks of Umaria District.

SAMPLE SIZE - A sample consists 75 ASHAs.

SAMPLING TECHNIQUE- Non probability sampling technique was used.

STUDY AREA- Study area was Umaria's three blocks namely – Manpur, Pali and Karkeli.

STUDY GROUP- Study group comprised of 75 ASHAs from all three blocks of Umaria All ASHAs having Home Based Newborn Care training. The nature and purpose of the study was explained to the ASHA worker .The study was carried out with their proper verbal consent and co-operation.

TOOLS APPLIED- A semi structured questionnaire was used as tool for data collection. Questionnaire was framed using UNICEF questionnaire and local Kahana NGO questionnaire. Questionnaire was translated into local language so that ASHAs understand it's easily. Tool was having parameters like temperature, weight and high risk group of newborn to assess ASHAs knowledge.

DATA COLLECTION- Primary data was collected from ASHAs workers.

ETICAL CONSIDERATION- Proper verbal ethical consideration was taken. Prior information was given before visiting any ASHA review meeting (as far as possible). Confidentiality was ensured to all respondents.

DATA ANALYSIS- Data was obtained and enter into excel. Microsoft Excel 2007and SPSS versions 22 were used to analyze data.

LIMITATION- Sample size is small because ASHAs not came to meeting in good strength

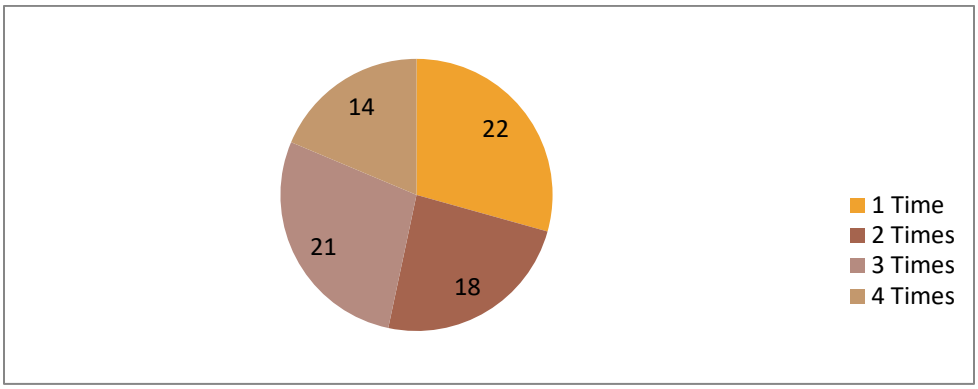
Time was constraints

Government work also hampers study

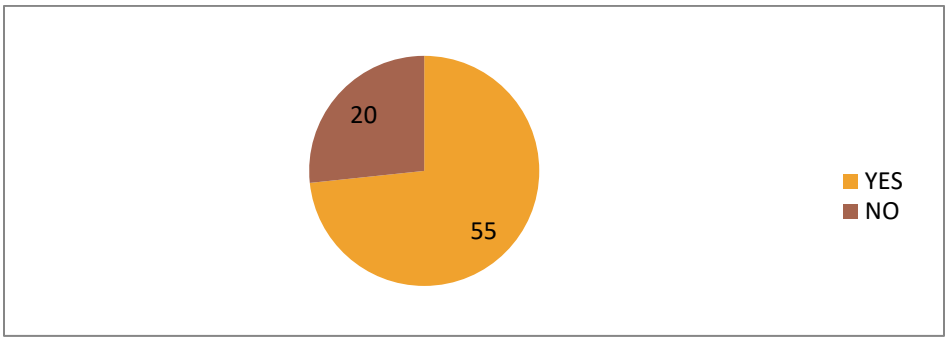
FINDINGS

Following questions were used for assessing knowledge of ASHAs.

1. How many times you were participated in HBNC Training?

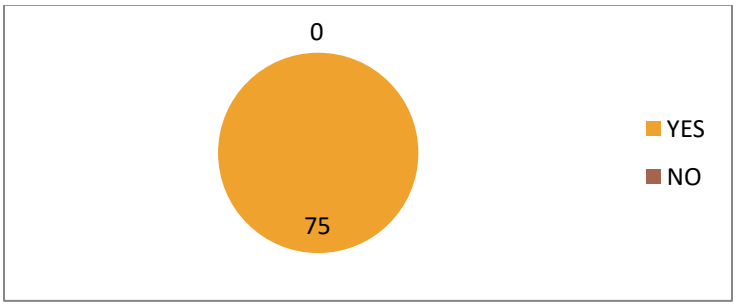


2. If newborn baby having temperature less than 94^0C. What will be your approach to get him normal body temperature?



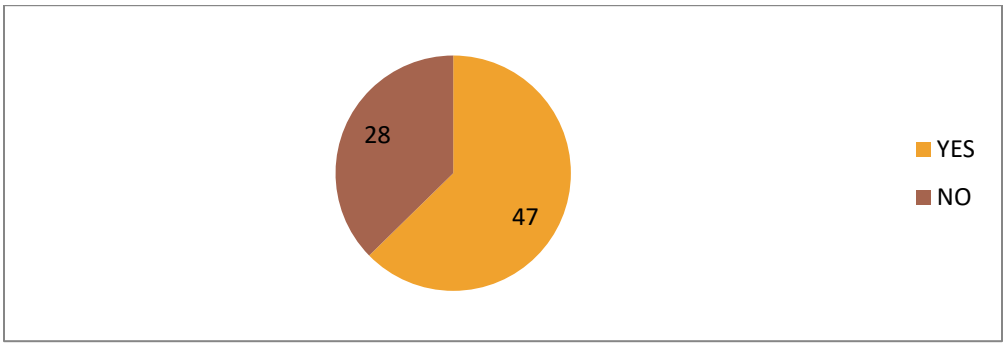
Interpretation- Out of 75, 55 ASHAs having knowledge regarding how to get newborn normal temperature.

3. For first __ months newborn should fed only mother breast milk.



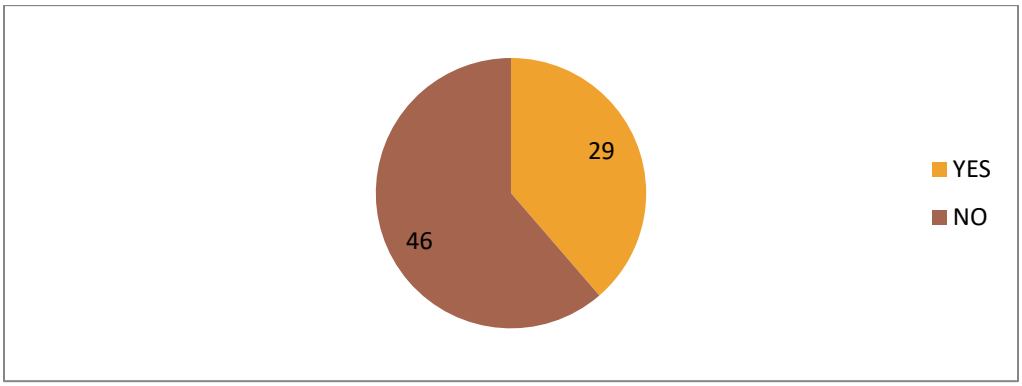
Interpretation- All ASHAs having knowledge regarding mother breast feeding. That for first 6 months mother breast milk is good for newborn health

4. Newborn shouldn't make bathe till he'll not turn ___ old.



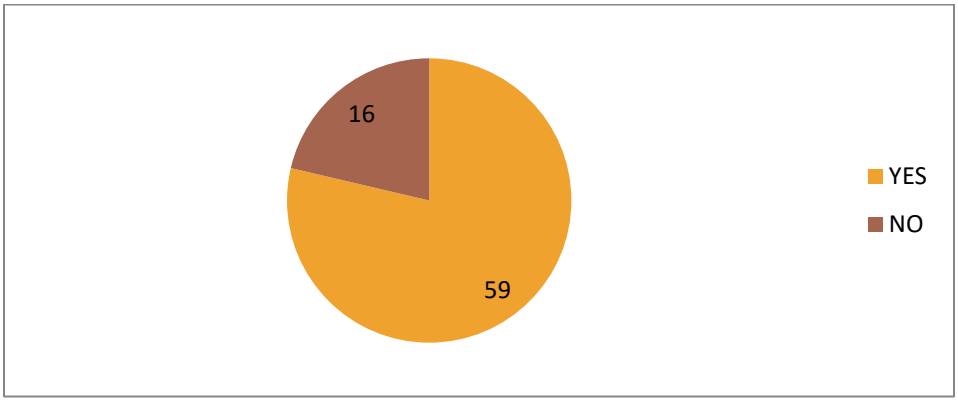
Interpretation- 51 out of 75 ASHAs having knowledge when we should give newborn bathe.

5. Which medicine you'll give to newborn if he is having sepsis?



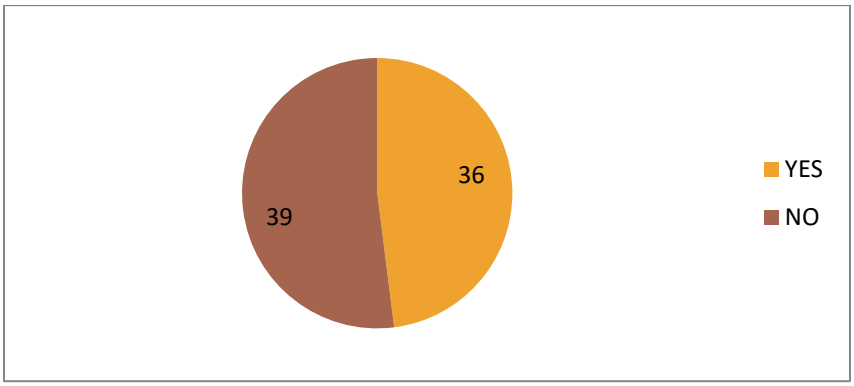
Interpretation- out of 75, only 38 ASHAs having knowledge regarding which medicine should be given to newborn at time of sepsis.

6. Which newborn baby do you feel come under high risk group?



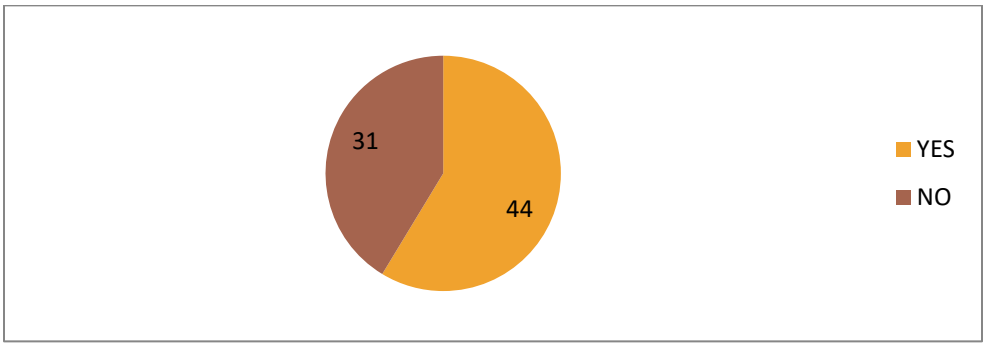
Interpretation- Out of 75, 70 ASHAs having knowledge regarding which newborn born come under high risk group

7. Within 6 weeks newborn should be immunized by which vaccines?



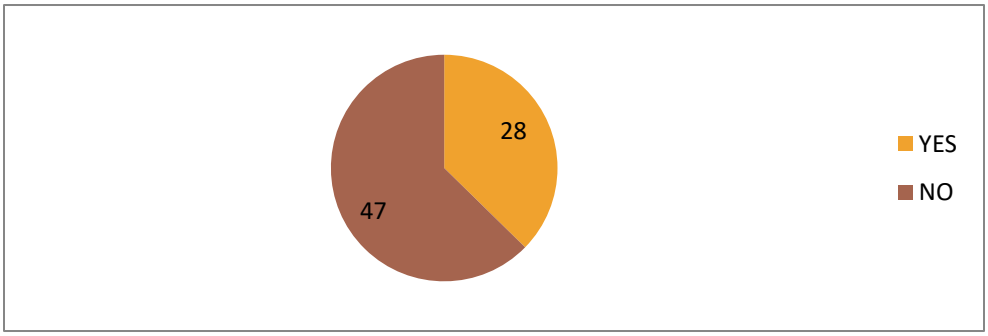
Interpretation- Out of 75, 46 ASHAs having knowledge regarding immunization of newborn. Which is a concern area because; main reason for launching HBNC was to ensure newborn immunization.

8. Give two symptoms of Asphyxia?



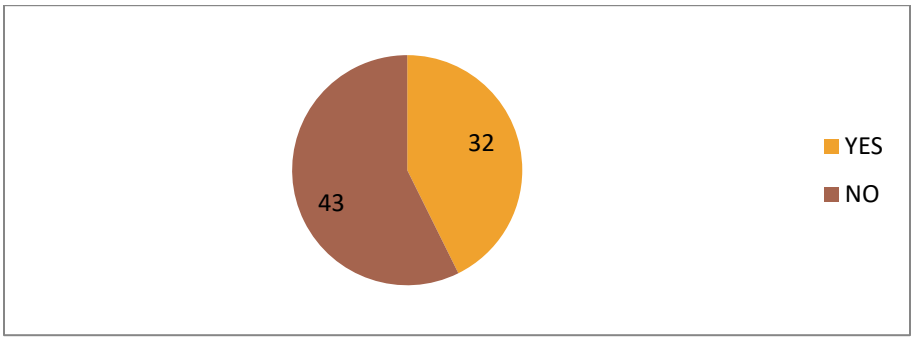
Interpretation- Out of 75, 64 ASHAs having knowledge regarding what are symptoms of Asphyxia.

9. If newborn delivered in home you will visit ___ time his house.



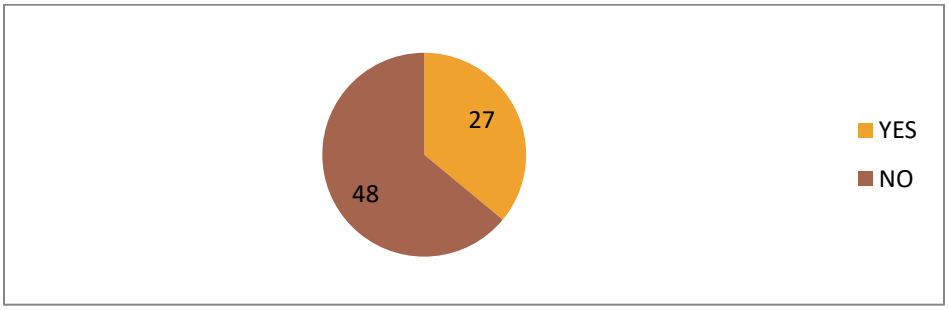
Interpretation- Out of 75, 48 ASHAs having knowledge regarding how many time she should visit newborn home and when.

10. What should be idle body temperature of newborn?



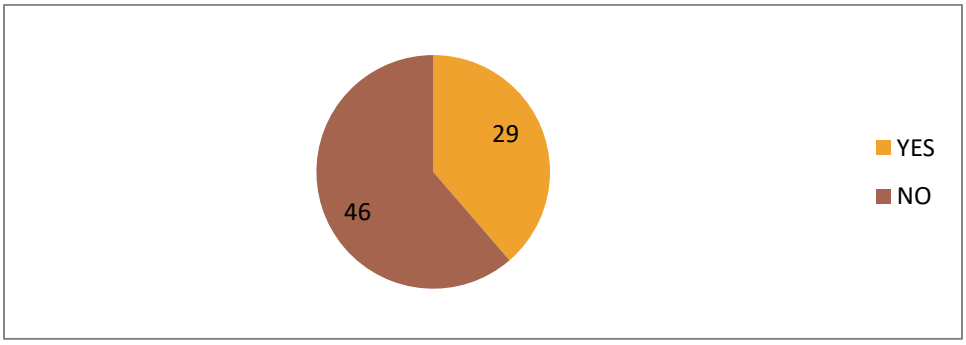
Interpretation- Out of 75, 63 ASHAs having knowledge regarding idle body temperature of newborn.

11. If newborn having blood in his excretion than you will call it_____.



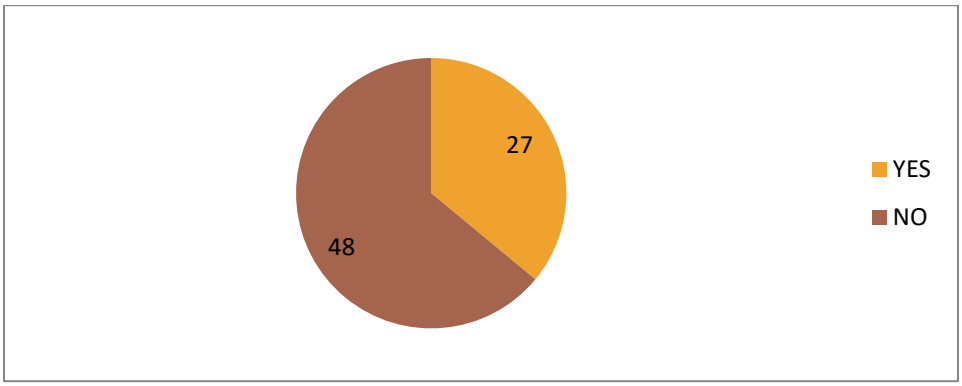
Interpretation- Out of 75, 62 ASHAs having knowledge regarding If newborn having blood in his excretion what it should call and what should be the necessary step.

12. If newborn having temperature 99^0C than he has_____



Interpretation- All ASHAs having good knowledge in relation to fever of newborn and what should be the next step to cure this, they were also aware.

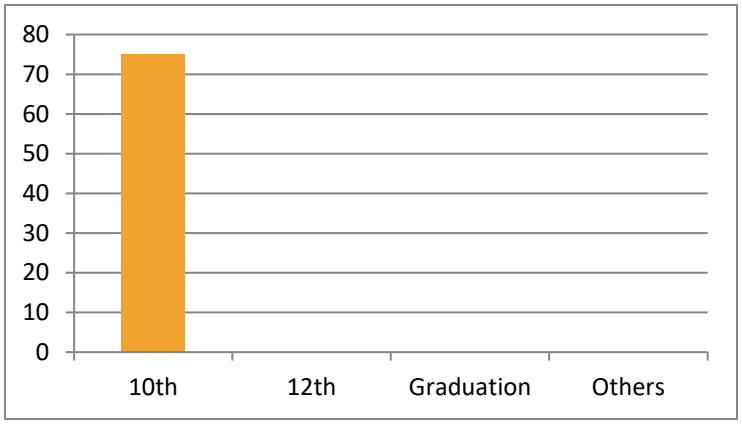
13. Give two symptoms of Pneumonia?



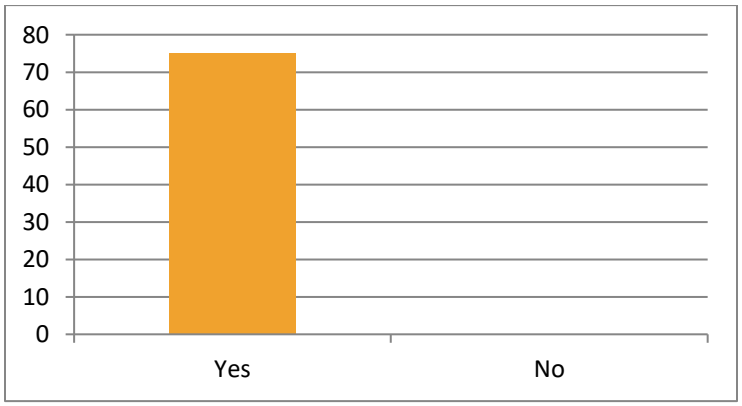
Interpretation- 69 out of 75 knows symptoms of Pneumonia.

RESPONSE ON SOCIOECONOMIC STATUS

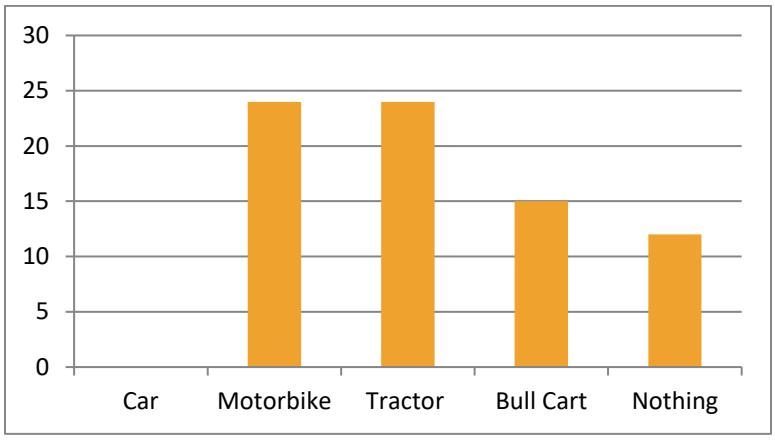
Your higher qualification?



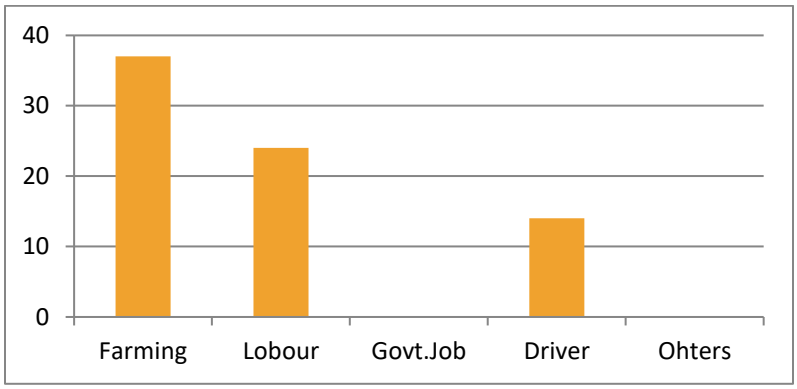
Do you have mobile phone?



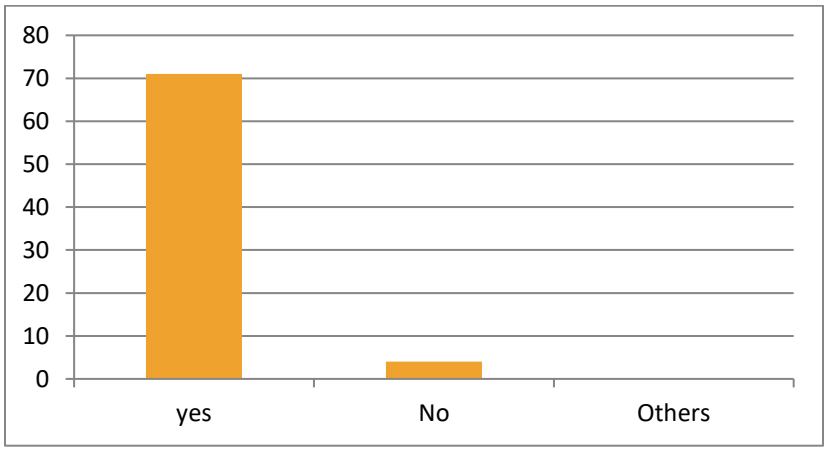
Do you have any conveyance?



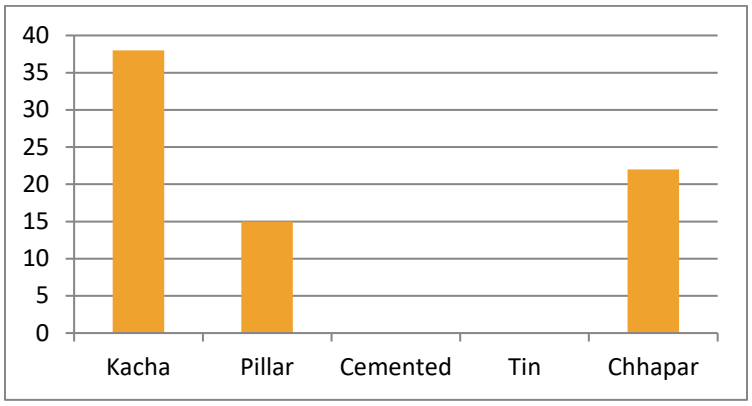
Other source of income?



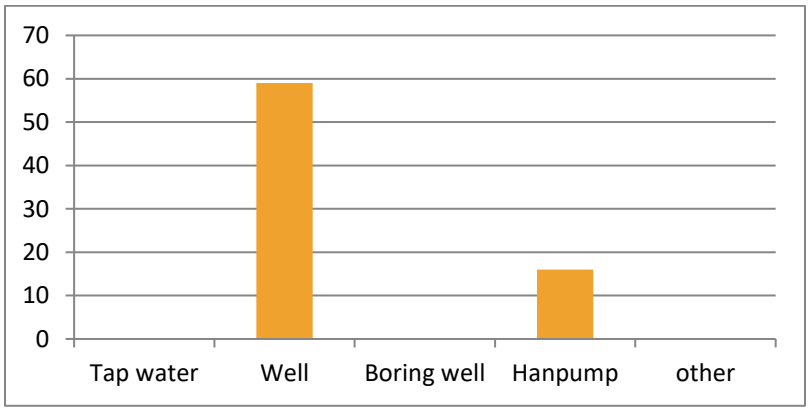
Do you electricity connection in your house?



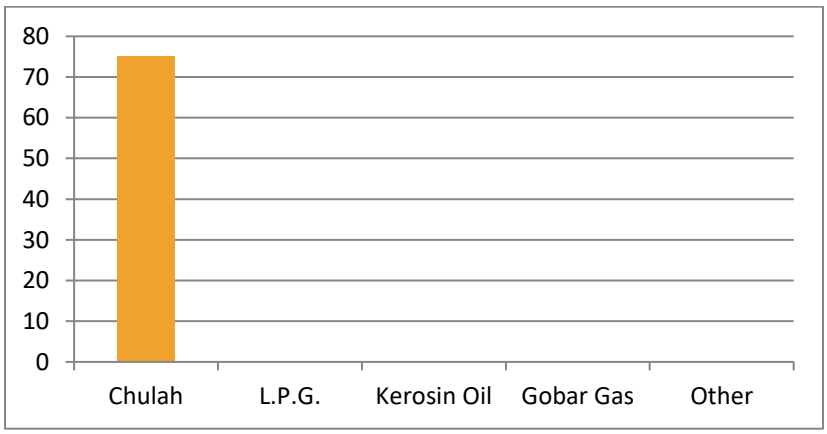
Type of house?



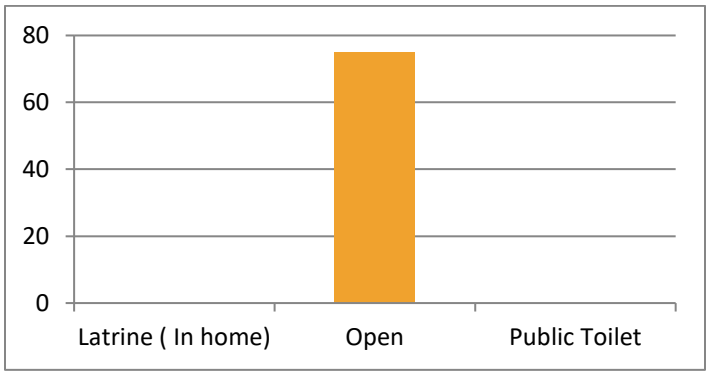
Source for drinking water



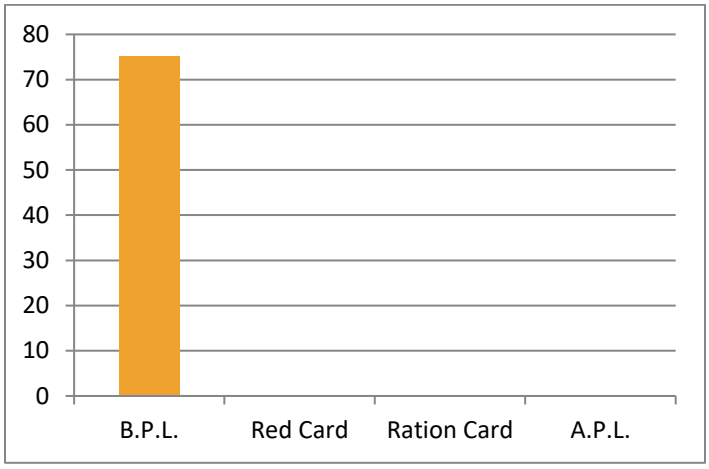
Source for cooking?



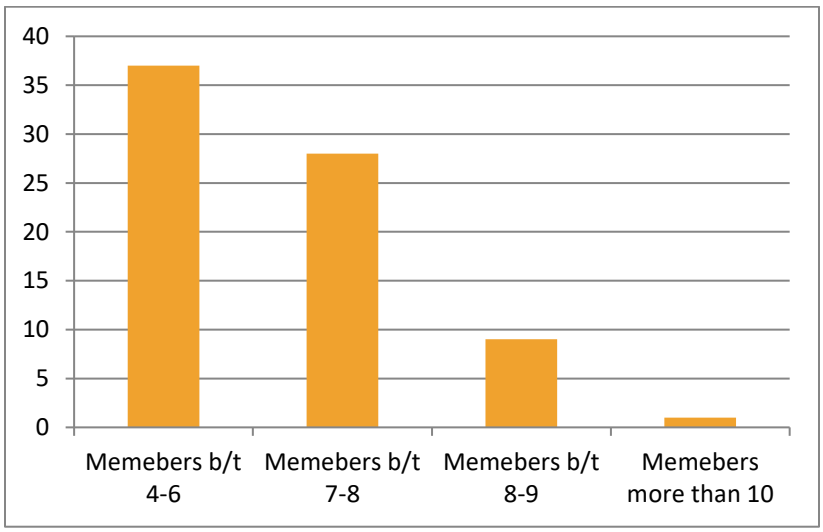
Where do you go for toilet?



Which Card do you have?



Family members in house?



Interpretation on Socioeconomic Status-

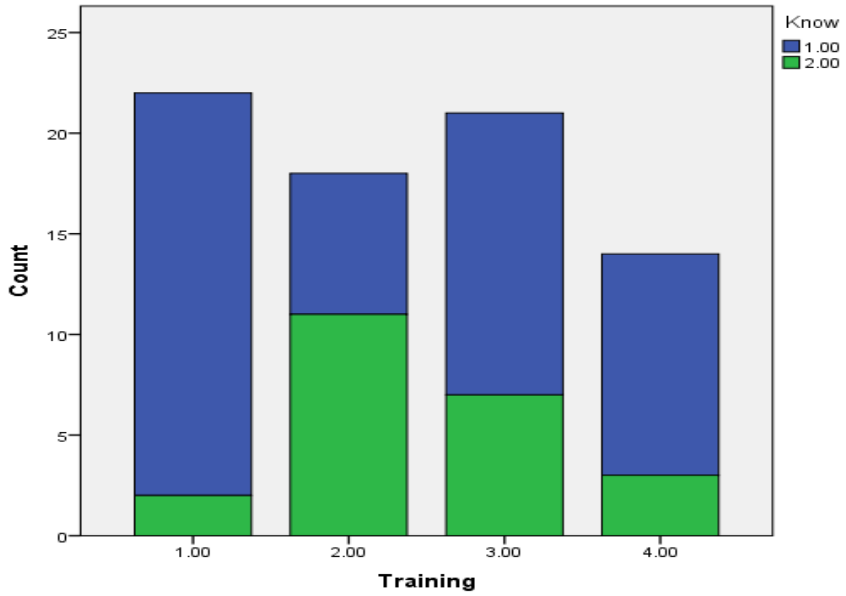
All ASHAs were selected as per government norms as in criteria of qualification. With the help of above data we can interpret that though India is going through their transition phase and so many villages have adopt use of toilets instead of open defecation but above data revealing that open defecation is still famous in some villages instead of government scheme. Instead of government scheme use of LPG gas in Umaria with the help of above data we can say that still there are so many villages which still using chullah through which we can interpret that there is still lacuna between villagers and government scheme. On an average ASHAs having family of members between 7-8 that is way sometimes she not able attend ASHAs training and review meetings. 78% still using well as source of drinking water. 48% other source of income of ASHAs family were farming which might be one of the reason ASHAs are not able attend meeting and training because in some area women and men both used to work on their farming . Only 62% having conveyance and there are so many villages which not having a good frequency of transportation. With observation it was came to know that ~ 45% of ASHAs not able to attend monthly review meeting and training session because of not having good connectivity of transport and even traditional beliefs not allow them to attend such type meeting and sessions.

- Association in between number of participation in training

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Training * Know	75	100.0%	0	0.0%	75	100.0%

Mean	6.36
1	**score less than 6**
2	**Score more than 6**



Training * Know Crosstabulation

Count

		Knowledge		
		1.00	2.00	Total
Training	1.00	20	2	22
	2.00	7	11	18
	3.00	14	7	21
	4.00	11	3	14
Total		52	23	75

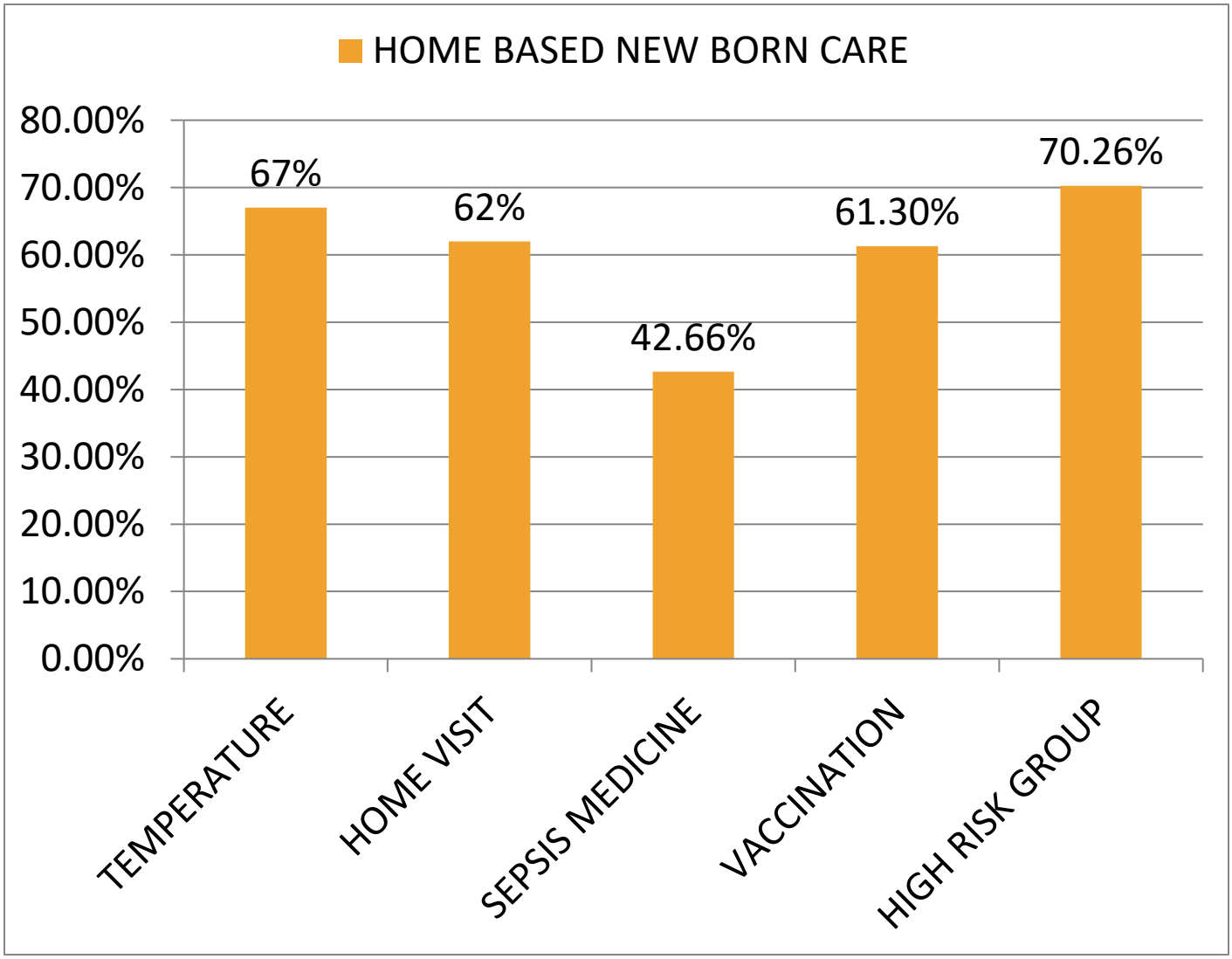
Chi-Square Tests

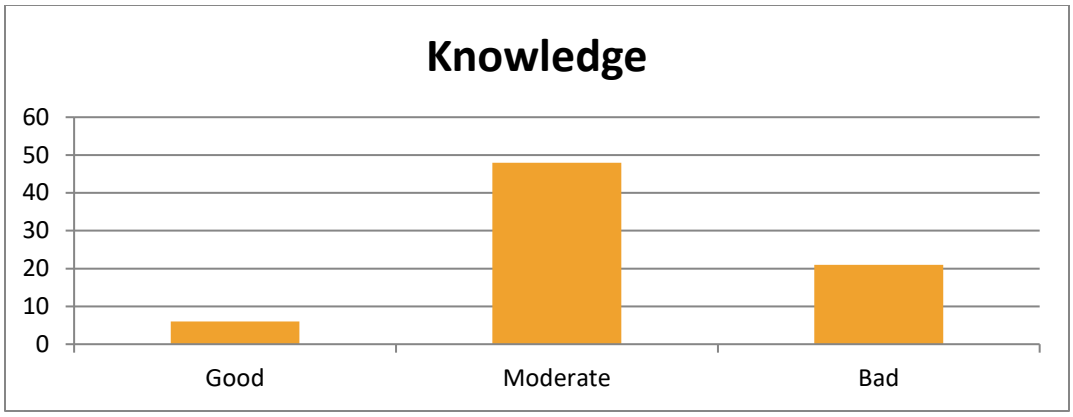
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.295[a]	3	.004
Likelihood Ratio	13.718	3	.003
Linear-by-Linear Association	.385	1	.535
N of Valid Cases	75		

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.421	.004
	Cramer's V	.421	.004
N of Valid Cases		75	

RESULT –





This study provide a snapshot that 64% (48) ASHAs have moderate knowledge in provision of HBNC services and only 0.08% i.e., only 6 ASHAs have good knowledge of providing HBNC services and 28% of ASHAs have inadequate knowledge .

- Study revealed that 67 % of ASHAs having good knowledge regarding temperature of newborn what should be done if newborn having temperature less than 97.3 F and what approach should be adopt if newborn having temperature below or equal to 94 F. .
- How many times and when they should visit newborn child home for screening/checkups only 62% of ASHAs were aware regarding for the same issue.
- In case of sepsis medicine only 42.66% ASHAs were aware which an issue of concern.
- Only 61.30% ASHAs having knowledge of newborn vaccination.
- Over all 79.5% of ASHAs out of 75 having adequate knowledge in relation to newborn vaccination, home visit, sepsis medicine, body temperature and high risk group criteria.

CONCLUSION

This study provide us that ASHAs have moderate knowledge in provision of home based newborn care they have good hands measuring and newborn temperature, and also having good knowledge on recognizing high risk group newborn but this would be not enough for reducing neonatal rate .Thus ASHA's HBNC visit can help to minimize newborn mortality but to assure that ASHAs should have adequate knowledgeThus, 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.

RECOMMADATION

- Intensive training session and knowledge assessment test should be there should in every 6 months and segregate ASHAs as per knowledge.
- Segregate ASHAs for different- different programs.
- Assess knowledge of trainer who will going to trained ASHAs.
- Take knowledge assess test of ASHAs every 6 months.
- IEC regarding HBNC in community so that general masses also aware for the same and call ASHAs on emergency.
- Whenever there would be training and review meeting, ASHAs who staying far from the spot, organise transport for them.
- Random Monitoring should be needed.
- Regular feedback from ASHAs by higher authority to avoid gap and to know the ground reality so they can improve the services according to need.

QUESTIONNAIRE

Following Questionnaire were used as tool.

1. How many times you were participated in HBNC Training?_____
2. If newborn baby having temperature less than 94^0C. What will be your approach to get him normal body temperature?
3. For first __ months newborn should fed only mother breast milk
4. Newborn shouldn't make bathe till he'll not turn ___ old
5. Which medicine you'll give to newborn if he is having sepsis?
6. Which newborn baby do you feel come under high risk group?
7. Within 6 weeks newborn should be immunized by which vaccines?
8. Give two symptoms of Asphyxia?
9. If newborn delivered in home you will visit ___ time his house.
10. What should be idle body temperature of newborn?
11. If newborn having blood in his excretion than you will call it_____.
12. If newborn having temperature 99^0C than he has_____
13. Give two symptoms of Pneumonia?

Questionnaires for Socioeconomic Status

- Your Name
- Caste
- Sex
- Age . Address
- Your higher qualification? (1). 10^{th} (2) .12^{th} (3). Graduation (4). Others
- Do you have mobile phone? (1). Yes (2). No
- Do you have any conveyance?

  (1). Car (2). Tractor (3). Motor Bike (4).Bull cart (5). Nothing
- Other source of income?

  (1). Farming (2). Driver (3).Govt. Job (4).Labour (5). Other
- Do you electricity connection in your house? (1). Yes (2). No (3). Other
- Type of house? (1).Mud (2).Shedding (3).Cemented (4). Pillar (5).Tin
- Source for drinking water?

  (1). Well (2). Borewell (3). Handpump (4). Tapwater. (5). Other
- Source for cooking?

  (1).Hearth (2).LPG gas (3).Gobar Gas (4).Kerosin oil (5). Other
- Family members in house?
- Which Card do you have? (1).BPL (2). Red Card (3).Ration Card (4). APL
- Where do you go for toilet?

  (1). Toilet (In home) (2.)Open Defecation (3). Public Toilet

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